SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

March 14, 2013

Upon Adjournment of Joint Legislative Budget Committee Hearing

Room 4203, State Capitol
(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.

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4120 Emergency Medical Services Authority

1. Overview

The Emergency Medical Services Authority (EMSA) develops and implements emergency medical services systems (EMS) throughout California and sets standards for the training and scope of practice of various levels of EMS personnel. The EMS Authority also has responsibility for promoting disaster medical preparedness throughout the state, and, when required, managing the state's medical response to major disasters.

Budget Overview. The budget proposes expenditures of $28 million ($6.8 General Fund and $2.6 million federal funds) and 64.3 positions for EMSA. See table below for more information.

Table: EMSA Budget Overview

Fund Source	2011-12 Actual	2012-13 Projected	2013-14 Proposed	BY to CY Change	% Change
General Fund	$6,644,000	$6,695,000	$6,757,000	$62,000	.9%
Federal Trust Fund	1,401,000	2,554,000	2,605,000	51,000	2%
Reimbursements	13,313,000	14,714,000	14,749,000	35,000	.2%
Special Funds	3,072,000	3,477,000	3,919,000	442,000	13%
Total Expenditures	**$24,430,000**	**$27,440,000**	**$28,030,000**	**$590,000**	**2%**
Positions	**65.7**	**64.3**	**64.3**	0	**0%**

Subcommittee Staff Comment. This is an informational item.

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

1. Please provide a brief overview of EMSA's programs and budget.

2. Please provide an update on the impact of the federal sequestration on EMSA programs. What programs may be impacted?

2. Paramedic Licensing and Enforcement Program Workload

Budget Issue. EMSA requests an increase in Emergency Medical Services Personnel (EMSP) Fund expenditures of $270,000 to (1) improve paramedic application processing time, (2) pay for the additional expenses associated with the acceptance of electronic payments during the paramedic licensing process and increased travel expenses associated with the monitoring of paramedics on probation, and (3) streamline the investigatory process.

EMSA proposes to redirect two positions (a Management Services Technician and an Office Technician) from other programs to the Paramedic Licensing Program to address the workload associated with this proposal. As a result, there would be an overall increase of EMSA budget authority of only $136,000.

Background. EMSA's Paramedic Licensing Program is a fee supported program that processes paramedic applications, issues licenses, and provides technical assistance to the state's 19,000 paramedics. The fee revenue is deposited into the Emergency Medical Services Personnel (EMSP) Fund.

This request is for the following three purposes:

1. ***Decrease Paramedic Application Processing Time.*** Currently, it takes EMSA 45 days to process a licensing application, from the time the application is received until the application is evaluated, and 4-6 weeks for licensure renewal applications (or longer if information is missing). The 2010-11 budget approved of a staffing augmentation that resulted in an average processing time for new and renewal licensure applications of one hour, decreased a backlog of applications, and ensured that random audits of continuing education (CE) credits reported by paramedics were continued. In 2011-12, due to the budget crisis, staffing was reduced, resulting in an increase in application processing time to 1.76 hours, the discontinuation of the random audits of CEs, and a new backlog of applications.

   EMSA expects these two new positions to decrease the processing time from 1.76 hours to 1.19 hours per application.

2. ***Accept Electronic Payments for Paramedic Licensing Process.*** Government Code Section 6163(a)(1) requires all state agencies to accept payments via credit cards or other types of electronic payments. This BCP will enable the EMSA to institute a credit card payment system for individuals to pay new and renewal licensure application fees. According to the EMSA, this will bring the program into compliance with the Government Code, enhance customer convenience, achieve operational efficiencies, expedite the availability of the funds, and increase collection rates for payments.

3. ***Streamline and Improve Paramedic Investigative and Enforcement Efforts.*** The EMSA proposes to streamline and improve the investigation processing time of its Special Investigators (SIs). According to the EMSA, SIs function as probation monitors

while in the field, conducting interviews with probationers and gathering documents directly from law enforcement, courts, and district attorneys. As a result of budgetary reductions at all levels of government, it takes longer for the Paramedic Enforcement Program to receive documentary evidence from courts and law enforcement agencies necessary to complete the investigative process. To help streamline this process, under this proposal, SIs would now go directly to law enforcement agencies to retrieve necessary documentary evidence; thereby, reducing the overall case processing time. According to EMSA, this will extend the length and cost of travel, but will improve due process, increase the effectiveness of interviews and collection of physical evidence and improve probation monitoring.

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

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

1. Please provide an overview of this budget proposal.

4140 Office of Statewide Health Planning and Development

1. Overview

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 $122.7 million ($74,000 General Fund and $1.3 million federal funds) and 471.6 positions for OSHPD.

Table: OSHPD Budget Overview

Fund Source	2011-12 Actual	2012-13 Projected	2013-14 Proposed	BY to CY Change	% Change
General Fund	$0	$74,000	$74,000	$0	0%
Federal Trust Fund	4,425,000	1,648,000	1,290,000	-$358,000	-22%
Reimbursements	348,000	993,000	931,000	-$62,000	-6%
Special Funds	92,663,000	133,795,000	120,391,000	-$13,404,000	-10%
Total Expenditures	**$97,436,000**	**$136,510,000**	**$122,686,000**	**-$13,824,000**	**-10%**
Positions	**415.5**	**475.2**	**471.6**	-4	-1%

Subcommittee Staff Comment. This is an informational item.

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

1. Please provide a brief overview of OSHPD's programs and budget.

2. Are any OSHPD programs impacted by the federal sequestration?

2. Mental Health Services Act Workforce and Education Training – Five-Year Plan

Budget Issue. OSHPD requests $196,000 Mental Health Services Act Fund (Proposition 63) to contract with an independent evaluator to develop and carry out a needs assessment that will inform its required Five-Year Workforce Education and Training Plan. (This is a one-time request.)

Background on WET Five Year Plan. The 2012 budget transferred the Mental Health Services Act (MHSA) workforce education and training (WET) component to OSHPD (from the eliminated Department of Mental Health). The MHSA WET targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness.

AB 1467, a 2012 budget trailer bill, requires OSHPD to develop a Five-Year WET Plan. The Five-Year Plan must be informed by an evaluation of the relative efficacy of current state-level WET strategies and must include objectives to establish, expand, and/or promote the following: high school, university and post-secondary education pathways; scholarships, loan forgiveness and stipends for current and prospective public mental health system employees; regional partnerships; psychiatric residency programs; staff training curriculum; and the employment of consumers and family members in the public mental health system.

The Five-Year Plan must be developed pursuant to a stakeholder process and be approved by the California Mental Health Planning Council. To fulfill these requirements, OSHPD proposes to carry out a needs assessment to determine the efficacy of the current state-level WET programs, present the outcomes of the needs assessment to key public mental health stakeholders, engage stakeholders in the development of a new Five-Year Plan, and draft a new Five-Year Workforce Education and Training Plan.

The current Five-Year WET Plan is effective until April 1, 2013 and will serve as a baseline.

Update on Transfer of MHSA WET Program to OSHPD in 2012. Since the transfer of the WET Program on July 1, 2012, OSHPD has engaged in the following activities:

- Created an advisory committee comprised of stakeholders to advise OSHPD on MHSA WET programs.
    - At the January meeting, OSHPD received initial feedback on the draft Five-Year Plan Vision, Values, and Mission. Meeting minutes and materials are available on the Foundation website at www.oshpd.ca.gov/HPEF/wet.
    - OSHPD developed the WET Five-Year Plan Advisory Sub-Committee to focus on the Five-Year Plan. The Sub-Committee held their first meeting on February 27, 2013 and provided feedback on the stakeholder engagement process, needs assessment scope of work, and draft Five-Year Plan Vision, Values, & Mission.

- In March, the Foundation will be starting the focus groups and community forums. A total of 14 are planned and specific locations are still to be decided.

- Begun a stakeholder engagement process to develop the Five-Year Plan due April 2014

- Issued two Psychiatric Residency Request for Proposals (RFP). The second RFP was issued and posted on February 1, 2013. The Psychiatric Residency Program trains psychiatric residents in the public mental health system.

- Finalized awards for the 2012-13 Mental Health Loan Assumption Program Cycle. 1,823 applications were received, over 1,300 applications reviewed and 1,109 were awarded.

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

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

1. Please provide an overview of this budget proposal.

2. Please provide an update on the transition of the MHSA WET component to OSPHD.

4260 Department of Health Care Services & 4800 California Health Benefit Exchange

1. CalHEERS Overview

Background. As required by the Affordable Care Act (ACA), states must establish a health insurance exchange or use a federally established exchange. California's Health Benefit Exchange (Covered California) was established by AB 1602 (Perez, Statutes of 2010) and SB 900 (Alquist, Statutes of 2010).

The Exchange is an independent state agency 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. The ACA requires coordination between Exchanges, Medicaid (Medi-Cal in California), and Children's Health Insurance Programs to ensure a seamless, integrated process for individuals seeking health care coverage under an Exchange.

In addition, the ACA requires the establishment of a single statewide web portal for Medicaid applicants. This portal can include referrals to the human services programs (e.g., CalWORKs and CalFresh). The ACA's provisions will significantly impact the three Statewide Automated Welfare Systems (SAWS)—LEADER, CalWIN, and C-IV—that currently determine eligibility for CalWORKs, CalFresh, and Medi-Cal.

The CalHEERS Project is jointly sponsored by the Exchange and the Department of Health Care Services (DHCS). The CalHEERS Project has acquired Accenture, LLP as a prime vendor to develop the CalHEERS solution that will support the implementation of a statewide healthcare exchange.

The primary business objective of CalHEERS is to provide a 'one-stop shop' to determine eligibility for California's entire health coverage program offered by the Exchange, Department of Health Care Services (DHCS), and the Managed Risk Medical Insurance Board.

The federally mandated implementation date of January 2014 requires a very aggressive schedule and increases the risks for a project of this size and impact to citizens.

CalHEERS has an Independent Validation and Verification (IV&V) contract with an outside entity. The IV&V assesses adherence to established IT project standards and provides recommendations on project improvements to the CalHEERS oversight agencies. Additionally, it provides a monthly assessment report that objectively illustrates the strengths and weaknesses of the project.

Project Schedule Delays Related to Medi-Cal. At the February 26, 2013 Exchange meeting, two delays to the CalHEERS project schedule were noted: (1) the interface between CalHEERS and the SAWS systems would be delayed from October 1, 2013 until January 1,

2014 and (2) the Medi-Cal health plan selection process in CalHEERS would be delayed until the spring of 2014.

These delays have fiscal and programmatic impact on county eligibility processing, as county workers will be required to double-enter data in both CalHEERS and SAWS for persons applying for Medi-Cal and other human services programs (e.g., CalFresh).

Additionally, county staff will now need to be trained to use CalHEERS to complete the Medi-Cal MAGI (Modified Adjusted Gross Income) eligibility processing since the interface between CalHEERS (with the MAGI rules) and SAWS will not be ready in October.

Contingency Plans. According to Covered California and DHCS, contingency plans have been created to address a variety of situations in which one or more portions of CalHEERS and/or the share eligibility service via interfaces to SAWS, MEDS, the federal Hub, and other state interfaces are not ready for Go-Live.

In addition to those plans, the CalHEERS Project anticipates creating temporary alternative procedures (either manual or automated) to ensure services are delivered if the system changes cannot be implemented when needed. For example, a County Eligibility and Enrollment Workgroup is developing business process flows and identifying training needs to manage MAGI Medi-Cal enrollment through counties during the open enrollment period until the CalHEERS-SAWS interface is operational, tentatively planned for December, 2013.

Subcommittee Staff Comment. CalHEERS' timely implementation is critical to the success of California's implementation of the ACA. It is important to remember that that the primary business objective of CalHEERS is to determine eligibility for California's **entire** health coverage program offered both by Medi-Cal and the Exchange.

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

1. Please provide an overview of the CalHEERS Project.

2. Please provide a status update on CalHEERS deliverables and the project timeline.

3. **Decision Criteria.** It appears that the project sponsors could have competing interests in ensuring that the functionality most relevant to their programs is implemented timely (i.e., Covered California's priority is health coverage offered under the Exchange and DHCS's priority is Medi-Cal).

   What criteria are used to make decisions about project schedule changes? How was this criteria applied to make the decision to delay the SAWS interfaces and the Medi-Cal health plan selection?

4. **High Risk for Interface Delays.** According to the IV&V January 2013 report, there is a high level of risk for interface designs. The IV&V report indicates that interface designs lack the level of detail necessary to develop a technical design which could result in

schedule delays. According to the project timeline, the interface with MEDS is scheduled for October 2013. Is there any potential risk of delay for this interface? What would be the impact of a delay in this interface?

5. How does/will the CalHEERS project work with affected stakeholders in developing contingency plans?

0530 Health and Human Services Agency – Office of Systems Integration

1. CalHEERS

Budget Issue. The Governor's budget requests an increase in Office of Systems Integration (OSI) reimbursement authority in the amount of $115,356,396. The increase in reimbursement authority is requested for OSI to provide project management services for the design, development, implementation and operation/maintenance for the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) Project. These costs will be reimbursed by Covered California (California's Health Benefit Exchange), the Department of Health Care Services (DHCS), and the Managed Risk Medical Insurance Board (MRMIB).

CalHEERS Total Project Costs, 2013-14

Entity	Cost	Federal Funds	General Fund
OSI	$115,356,396	$112,220,039	$3,136,357
Non-OSI	$23,482,317	$22,869,474	$612,843
Total	$138,838,713	$135,089,513	$3,749,200

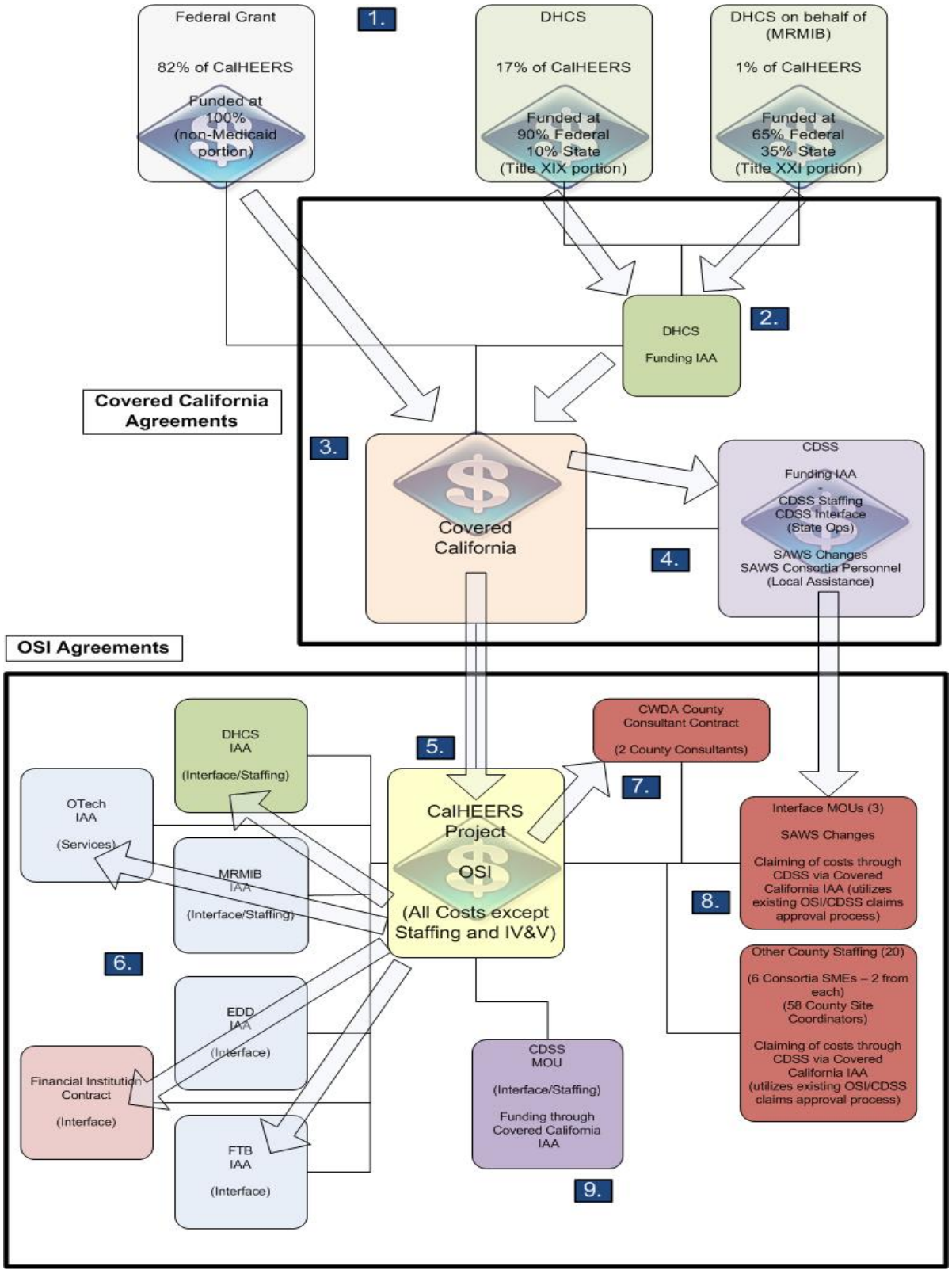
CalHEERS Funding Sources (See table on next page for diagram on how funds flow to OSI.)

Entity	Exchange Grant (82%)	Title XIX (DHCS) (17%)		Title XXI (MRMIB) (1%)		Total Funds
	100% Federal	Federal	General Fund	Federal	General Fund	
OSI	$94,592,245	$16,877,978	$2,732,610	$749,817	$403,747	$115,356,396
Non-OSI	$19,255,500	$3,461,339	$530,654	$152,635	$82,188	$23,482,317
Total	$113,847,745	$20,339,317	$3,263,264	$902,452	$485,935	$138,838,713

CalHEERS Budget Summary - OSI

	2012-13	2013-14
Development and Implementation	**$146,233,875**	**$85,099,492**
State / Program Partner Personnel	$7,665,880	$6,794,514
Systems Integration Services	$123,556,996	$67,267,027
Interface Development	$5,506,078	$2,850,588
Project Management and Technical Support Services	$4,198,422	$3,249,697
OTech Services	$3,300,000	$3,600,000
CalHEERS Consultants	$2,006,499	$1,337,666
Operations and Maintenance	**$0**	**$30,256,904**
State / Program Partner Personnel	$0	$308,016
Systems Integration Services	$0	$27,156,988
Interface Development	$0	$1,715,334
Project Management and Technical Support Services	$0	$1,076,566
OTech Services	$0	$0
Total OSI Costs	**$146,233,875**	**$115,356,396**

Diagram 1 – CalHEERS Proposed Funding



Background. OSI has been chosen by the Exchange to provide project management services during the design, development and implementation and system stabilization of the CalHEERS solution to help meet the federally mandated timelines and requirements. In order to provide adequate project management for the CalHEERS Project, OSI requires reimbursement from the Exchange for the costs associated with these project management services in 2013-14.

LAO Findings and Recommendation. The LAO recommends approval of this proposal. It finds that approval of this proposal facilitates the need to complete the project by January 1, 2014, and provides the required project management services to mitigate project risk. It also finds that the CalHEERS project creates an opportunity to learn lessons about the advantages and disadvantages of a streamlined approach to IT project management processes.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding OSI's role in the CalHEERS project. It is recommended to approve this request to ensure continued development and management of the CalHEERS project.

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

1. Please provide a brief summary of the proposal.

4260 Department of Health Care Services

1. Assessment of Administration's Estimates for ACA Medi-Cal Simplification & Comparison to LAO & CalSIM

This item provides an overview of the Administration's recently released cost estimate for the Medi-Cal simplification provisions of the Affordable Care Act (ACA) (the "mandatory" expansion of Medi-Cal), an assessment of this cost estimate, and a comparison of this estimate with projections from the LAO and UC Berkeley Center for Labor Research and Education's CalSIM model.

Background. The ACA requires a Medicaid (Medi-Cal in California) expansion to currently eligible populations through eligibility and enrollment simplifications. Currently, Medicaid eligibility is based on several factors, including linkage to a specific coverage group, income eligibility (including allowable deductions), assets, residency status, and citizenship status. Childless adults currently are not eligible for Medi-Cal unless they are disabled or aged.

Major changes include the following:

- Establishing a new standard for determining income eligibility, based on Modified Adjusted Gross Income (MAGI), consistent with the standard used to determine eligibility for premium tax credits.

- Eliminating the asset test for individuals whose eligibility determination is based on MAGI.

- Conducting an "ex parte" review when making a redetermination of eligibility. Redeterminations must be made based on available information with a primary reliance on electronic data.

Due to a number of factors, including the requirement that most individuals obtain coverage (individual mandate), Medi-Cal enrollment and eligibility simplifications, and marketing and outreach activities conducted by California's Health Benefit Exchange (Covered California), it is anticipated that Medi-Cal enrollment will increase.

The Governor convened an extraordinary session that began on January 28, 2013, to consider and act upon legislation necessary to implement the ACA. SBX1 1 (Hernandez and Steinberg) and ABX1 1 (Perez) have been introduced to implement the ACA's Medi-Cal simplification provisions discussed above and the state-based expansion of Medi-Cal to low-income adults with incomes up to 138 percent of the federal poverty level (FPL). These bills are identical as the Legislature is working collaboratively on these vehicles.

Budget Proposal and Revised Estimate. The 2013-14 Governor's January Budget includes $350 million General Fund as a placeholder for the costs of the increase in Medi-Cal caseload

as a result of the above described changes. The Administration refers to this as the mandatory expansion of Medi-Cal under the ACA.

In February, the Administration provided a revised and more detailed estimate for the mandatory expansion. Now, the Administration estimates that the General Fund costs of the mandatory expansion will be $188.7 million in 2013-14, $659.6 million in 2014-15, and $729.1 million in 2015-16, when costs are fully phased in.

DHCS's Major Premise – Disenrollments will be Drastically Reduced. The Administration's estimate is premised on the notion that the redetermination simplification provisions of the ACA will dramatically reduce the disenrollment rate and; consequently, individuals will retain coverage at a higher rate. It finds that 525,601 individuals, who would have been disenrolled will retain coverage.

The Administration classified individuals who discontinue enrollment into three categories of leavers and assumes a certain rate of retention for each of these categories:

(1) Short-term leavers – Individuals who disenroll from Medi-Cal and return within one to six months are considered "short-term" leavers. The Administration assumes that 100 percent of these individuals will retain continuous coverage. (265,508 individuals)

(2) Longer-term leavers – Individuals who disenroll from Medi-Cal and return within seven to 12 months are considered "longer-term" leavers. The Administration assumes that 75 percent of these individuals will retain continuous coverage. (126,508 individuals)

(3) Non-returners - Individuals who disenroll from Medi-Cal and return within 13 to 18 months are considered "non-returners." The Administration assumes that 40 percent of these individuals will retain continuous coverage. (133,435 individuals)

The total base caseload is also adjusted by 33 percent to attempt to capture currently eligible but unenrolled individuals, given that marketing and outreach activities conducted by Covered California and the requirement that most individuals obtain health coverage are likely to result in additional enrollment among this population. (200,506 individuals)

Finally, the Administration assumes that about 82,000 children in families with incomes up to 150 percent of the federal poverty level (FPL) who are eligible for Healthy Families, but not enrolled would enroll into Medi-Cal.

Based on these assumptions, the estimate projects that Medi-Cal enrollment would increase by a total of about 809,000. This increase in caseload would be fully phased in by September 2014, or just nine months after these ACA provisions are effective.

Table: Summary of Administration's Caseload Estimate

Category of Individual	Number
Individuals who would have discontinued, but retain Medi-Cal coverage	525,601
Eligible individuals, but never enrolled	200,506
Eligible children with incomes under 150, but not enrolled	81,994
Total Estimated Increase within Nine Months	808,101

LAO Findings and Estimate. The following table below shows the LAO's range of estimated costs for these additional enrollees under three different scenarios. The LAO finds that the moderate-cost scenario is most likely. Under this scenario, it estimates that the General Fund costs associated with this population would be $104 million in 2013-14, about $290 million in 2014-15, and $359 million in 2015-16. Under the moderate scenario, the LAO estimates that average monthly enrollment will increase by 154,016 in 2013-14 and 410,447 in 2014-15.

Table: LAO's Estimated Annual Medi-Cal Costs for Mandatory Expansion

Range of Estimated Annual Medi-Cal Costs for Health Care Services to Currently Eligible but Unenrolled Population Under the ACA[a]

(In Millions)

	Low-Cost Assumptions			Moderate-Cost Assumptions			High-Cost Assumptions		
State Fiscal Year	Total Cost	Federal Funds[b]	State Funds	Total Cost	Federal Funds[b]	State Funds	Total Cost	Federal Funds[b]	State Funds
2013-14	$65	$35	$30	$222	$118	$104	$540	$286	$254
2014-15	180	98	83	618	328	290	1,517	804	714
2015-16	222	120	102	765	407	359	1,897	1,005	893
2016-17	245	145	101	849	482	367	2,127	1,198	929
2017-18	259	157	103	901	522	379	2,279	1,309	970
2018-19	274	165	109	958	554	404	2,447	1,404	1,043
2019-20	289	174	115	1,015	587	429	2,620	1,501	1,119
2020-21	305	184	122	1,080	623	457	2,814	1,610	1,204
2021-22	323	194	129	1,150	663	487	3,027	1,731	1,297
2022-23	341	205	136	1,222	703	518	3,248	1,855	1,393

Key Assumptions

Eligible population in 2014	2.4 million	2.5 million	3.1 million
Average take-up rates[c]	8%	20%	33%
Annual average cost per new enrollee in 2014	$1,169	$1,440	$1,694

[a] Estimates do not include administrative costs, such as additional costs for eligibility determinations.

[b] Applicable federal matching rate depends on whether the enrollee is currently eligible for the Medicaid matching rate or currently eligible for the Children's Health Insurance Program matching rate.

[c] The "take-up rate" is the percent of eligible individuals who actually enroll. Estimates assume take-up is complete by July 1, 2016.

ACA = Patient Protection and Affordable Care Act.

The LAO finds that the short– and long–term costs from additional enrollment among the currently eligible Medi-Cal population under the ACA are subject to uncertainty. Some of the major areas of uncertainty include: (1) the size of the eligible, but not enrolled population, (2) the percent of the eligible population that will enroll (take–up rate), and (3) the cost of providing services to each additional enrollee.

CalSIM. In addition to the Administration and LAO's estimates, under the CalSIM model, which was created by the UCLA Center for Health Policy and Research and UC Berkeley Labor Center for Labor Research and Education, it is estimated that the total General Fund costs associated with this population would be between $143 million and $378 million in 2014, between $125 million and $380 million in 2016, and between $134 million and $407 million in 2019.

It should be noted that the CalSIM model is being used by California's Health Benefit Exchange to produce enrollment estimates and the California Health Benefits Review Program (CHBRP) to simulate and project the effects of the ACA in California. (CHBRP provides the Legislature with independent analysis of proposed legislation related to health insurance benefits. Policy makers consult CHBRP reports for guidance on issues of health benefits policy design.)

Estimate Comparison Chart. The chart below presents a high-level overview of these various estimates. It should be noted that for the purpose of creating this chart, certain generalizations were made for ease of comparison (e.g., the CalSIM estimates are based on a calendar year; whereas, the Administration's and LAO's estimates are based on the state fiscal year).

Table: Already Eligible/Mandatory Medi-Cal Expansion Estimates

	DHCS	LAO Moderate	CalSIM Base	CalSIM Enhanced	Comments
Medical inflation	5%	5.1% Medicaid/ 4.2% CHIP*	2.30%	2.30%	*LAO's medical inflation is an average annual rate over their 10-year forecast period
Caseload growth rate	3%	1%	0.07%	0.07%	This rate is compounded annually.
Take-up rate	N/A	20%	10%	40%	*DHCS did not estimate the total currently eligible but not enrolled, so does not have an estimated take-up rate. *LAO's take-up rate is average of 30% for Medi-Cal and 10% for HFP.
Full take-up achieved	Sept. 2014	July 2016	2018	2016	
Total number eligible but not enrolled	N/A	2.5 million	2.5 million	2.5 million	*DHCS did not estimate the total currently eligible but not enrolled.
Average monthly enrolled into Medi-Cal (Caseload)					
2013-14	239,283	154,016	200,000	440,000	
2014-15	814,960	410,447			
2015-16	858,000	488,218	230,000	490,000	
2016-17	883,000	519,251			
2018-19	965,000	529,688	240,000	510,000	
Medi-Cal Per Member Per Month (PMPM)					
2013-14	$136	$125	$135	$150	
2014-15	$143	$131	$138	$153	
2015-16	$150	$136	$141	$157	
Healthy Families Program (HFP) PMPM					
2013-14	$93	$104	$129	$129	
2014-15	$98	$109	$132	$132	
2015-16	$103	$113	$135	$135	
General Fund costs					
2013-14	$188,436,000	$103,844,679	$143,000,000	$378,000,000	
2014-15	$661,461,000	$289,528,711			
2015-16	$732,111,000	$358,553,824	$125,000,000	$380,000,000	
2016-17	$797,364,000	$367,000,000			
2018-19	$1,057,892,000	$404,000,000	$134,000,000	$407,000,000	

*CHIP is the Children's Health Insurance Program (formerly the Healthy Families Program and now the Targeted Low-Income Children's Program under Medi-Cal).

Administration's Estimate Built on Questionable Assumptions. Stakeholders, including Senate staff, the LAO, and researchers, have raised various concerns about the Administration's estimate.

The Administration's methodology is different from other estimates and most of its key assumptions are generally informed by DHCS's "best thinking" on what it believes will happen with the simplification provisions and outreach. In contrast, the LAO and CalSIM estimates are based on rigorous published research.

It is recognized that all estimates are approximations for what is expected to occur and that many of these variables are subject to significant uncertainty, but clarity, consistency, and transparency of assumptions and methodology provides more assurance and comfort with estimates. As discussed below, the Administration has not been able to provide supporting documentation for many of its assumptions.

The Administration's questionable assumptions include:

- **Caseload Too High.** The biggest concern with the Administration's estimate is its projected enrollment. The Administration's estimated caseload is substantially larger than any of the other estimates and it has not provided any basis for this estimate.

  It argues that this estimate is built on the premise that there will be a significant reduction in disenrollments at annual redetermination and generally points to prior Medi-Cal simplification efforts that occurred in the early 2000's as support for this assumption.

  However, it has not provided any details or data to support these assumptions. Specifically, it has not provided rationale regarding the retention rates (of 100 percent, 75 percent, and 40 percent for the different categories of persons who are discontinued) of persons who are discontinued at the annual redetermination process.

  Additionally, it has not provided any data to support that an additional 33 percent of its base estimate are eligible, but not enrolled.

- **Take-Up Rate Questionable.** The Administration's estimate for when all persons who are eligible, but not enrolled, would enroll in Medi-Cal is considerably more ambitious than the other estimates. The Administration projects that all individuals who are eligible but not enrolled would enroll by September 2014. This is almost two years earlier than other estimates.

  This estimate also assumes that all redeterminations occur in nine months instead of 12. Under changes that are implemented at the redetermination process, the process necessitates at least 12 months to complete given that redeterminations happen in each of the 12 months of a year.

This estimate assumes that a year's worth of annual redeterminations occur between January and September 2014 and provides no explanation on how it plans to complete this expedited redetermination process.

- **Estimate Does Not Account for Natural Attrition.** The Administration's estimate does not account for the natural attrition of people leaving the program (because they have moved out of state or have a change in employment, for example). Its estimate assumes that almost all individuals will remain on the program because of the redetermination simplification provisions.

- **Caseload Growth Rate Too High.** The Administration expects caseload to grow at 3 percent annually. This growth rate is high and does not reflect the declining unemployment rate which should sharply reduce caseload growth. Additionally, DHCS's projected caseload growth for Medi-Cal in 2013-14 is about 1 percent absent the growth from the Healthy Families transition to Medi-Cal. It is unclear why this estimate assumes a greater growth rate than what was projected in the November 2012 estimate.

- **Medical Cost Inflation Too High.** The Administration's medical cost inflation appears high for many reasons, including:

    - It double counts caseload growth. The Administration's medical cost inflation rate is the past 10-year average in change of spending for Medi-Cal. This average is based on Base spending which includes caseload growth. If the past 10-year average is reduced by the average 10-year caseload growth rate, then the medical cost inflation factor would be about 2 percent.

    - It takes into account the increases in federal supplemental spending a result of the Medi-Cal hospital financing waiver and hospital quality assurance fee, for example. These supplemental federal funds do not impact the General Fund and should not be used to determine a medical cost inflation rate for the General Fund.

    - The medical cost inflation rate is over one percent higher than the rate projected by research conducted on behalf of DHCS for the "optional" Medi-Cal expansion under ACA. Under this estimate, the average of the most recent three years of estimates used in pricing of Medi-Cal managed care capitation rates is 4.25 percent. It is recognized that DHCS generally funds at the lower end of this average which is anywhere between 3.25 percent and 3.75 percent.

Enrollment of This Population May Reduce Costs in the Long-Term. The Administration acknowledges that individuals that are eligible but unenrolled are likely healthier and could reduce the overall cost of care. However, since DHCS cannot develop its actuarially-based rates on this assumption (because it does not have utilization data for this population), it recognizes that in the long-term, overall costs may be reduced as a result of this healthier population.

Subcommittee Staff Comment and Recommendation—Hold Open. The Administration's estimates are unclear, inconsistent, and based on its "best thinking" rather than transparent data or research; this does not provide a comfortable level of confidence in their numbers.

It is recommended to hold this item open to continue more in depth discussions regarding these assumptions. Staff looks forward to a more comprehensive assessment of the Administration's estimates using the LAO forecast and CalSIM model.

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

1. Please provide an overview of the Administration's estimate.

2. Please provide the basis for the assumptions used to develop this estimate.

3. Please comment specifically on the research and data used to justify the caseload estimates.

4265 Department of Public Health

1. Overview

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 ($114.5 million General Fund) for the DPH as noted in the Table below and 3,777.5 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 $698.3 million is for state operations and $2.7 billion is for local assistance. The budget for 2013-14 reflects a net decrease of $104 million as compared to the revised 2012-13 budget.

Department of Public Health

Summary of Expenditures (dollars in thousands)	**2013-14**
Public Health Emergency Preparedness	**$97,831**
Public and Environmental Health	**$3,137,923**
Chronic Disease Prevention and Health Promotion	309,629
Infectious Disease	613,286
Family Health	1,815,824
Health Information and Strategic Planning	27,196
County Health Services	17,390
Environmental Health	354,598
Licensing and Certification Program	**$200,704**
Licensing and Certification of Facilities	186,902
Laboratory Field Services	13,802
Total Program Expenditures	**$3,436,458**
Funding Sources	
General Fund	$114,499
Federal Funds	$2,014,499
Genetic Disease Testing Fund	$115,734
Licensing and Certification Fund	$88,637
WIC Manufacturer Rebate Fund	$255,000
AIDS Drug Assistance Program Rebate Fund	$265,075
Water Security, Clean Drinking Water, Beach Protection Fund	$26,018
Safe Drinking Water Account of 2006	$50,312
Childhood Lead Poisoning Prevention Fund	$22,714
Radiation Control Fund	$22,549
Food Safety Fund	$7,761
Reimbursements	$266,396
Other Special Funds (numerous)	$187,264
Total Funds	**$3,436,458**

Subcommittee Staff Comment. This is an informational item.

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

1. Please provide a brief overview of DPH's programs and budget.

2. Please provide an update on the impact of the federal sequestration on DPH programs. What programs may be impacted?

2. Environmental & Occupational Disease Control Contract Conversion to State Staff

Budget Issue. DPH's Division of Environmental and Occupational Disease Control (DEODC) requests to convert 11 contract positions into full-time permanent state positions in order to eliminate reliance on contracting for essential program services. These positions include: three full-time equivalent (FTE) information technology (IT) contract positions in the Division Office for IT support; two positions in the Occupational Lead Poisoning Prevention Program (OLPPP) for investigatory and research activities; and six positions in the Environmental Health Investigations Branch (EHIB) to support the Asthma Prevention and Environmental Health Programs.

The conversion of contract positions to state positions would save $48,000 in annual costs. In addition, according to DPH, this conversion to state staff will align these programs with the Governor's directive to reduce reliance on external contracts, and will comply with Government Code (GC) Section Code 19130. It will also develop/enhance state institutional capacity, rather than leaving expertise to external consultants, and help retain knowledge and skills within state staff.

Background. Historically, DEODC has hired contractors to perform various state functions for its programs. The following DEODC contracts are affected by this proposal:

- **DEODC IT.** Since the creation of DPH (in 2007), DEODC has contracted out for essential IT support, which includes Local Area Network (LAN) and Wide Area Network (WAN) administration; Response and Surveillance System for Childhood Lead Exposures (RASSCLE) project support; desktop/end user support; operational recovery planning; information security; etc. IT services are provided to over 350 workstations and maintain 19 servers. Because DEODC has insufficient position authority for civil service employees to carry out IT support functions, DEODC has contracted out for these functions.

- **Occupational Lead Poising Prevention Program (OLPPP).** OLPPP was established by legislation in 1991 as a statewide program to provide public health services to prevent and reduce lead poisoning in California workers and their children who may be exposed to lead from the workplace. Since 1991, OLPPP has contracted for staff to carry out program responsibilities because it did not have sufficient position authority to carry out its mandates.

- **Asthma Prevention Program, Disease Cluster, and Environmental Health Programs.** This program encompasses asthma disease surveillance (including periodic public reports on asthma prevalence, hospitalizations, mortality and other data), support for asthma research in California, implementation of school-based asthma programs, and other public health approaches to address asthma. These functions are carried out in part by contract staff, under this proposal, the major portion of these asthma reduction programs would be conducted by state staff.

Other contract staff provide assistance with DPH's responses to disease clusters and environmental health responses. Under this proposal, these activities would be performed by state staff.

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

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

1. Please provide an overview of this budget proposal.

3. Export Document Program

Budget Issue. DPH requests $287,000 and 3.0 full time permanent positions for the Export Document Program to meet statutorily mandated activities to respond to each request for issuance of an export document within five working days of receipt of the request.

Background. The Food and Drug Branch (FDB) at DPH ensures the safety of foods, drugs, medical devices, and cosmetics through the inspection, regulation, and education of food, drug, and cosmetic and medical device manufacturers.

Health and Safety (H&S) Code Sections 110190-110240 require FDB to issue export documents to California processors of food, drugs, medical devices, and cosmetics. H&S Code Section 110220 (d) requires FDB to respond to each request for issuance of an export certificate within five days of receipt.

FDB considers two primary factors in determining whether an export document should be issued. First, the system of manufacture and quality control used to produce the products must be adequate; this is determined during FDB's inspections of manufacturers, distributors, and wholesalers. Second, the products must be properly labeled; this is determined by a review of product labeling at the time the export document is requested.

California processors of food, drugs, medical devices, and cosmetics have advised FDB that an increasing number of foreign countries now require the export certification documents before products can be imported from California. These documents certify that the manufacturer and its products meet DPH requirements, and it does not object to the sale of the products in California or the shipment to other countries. FDB understands that exporters need these documents quickly to avoid shipping delays and unnecessary storage costs.

Within the last three years, FDB has seen a 38 percent increase in the number of export document applications that include requests to have the certificates notarized. Requests that include multiple product labels, labeling and advertising, special wording, and notary requirements require labor intensive processing, specialized review, and result in additional review time needed to complete the export documents. Applications such as these contribute to the current eight week review timeframe.

The demand for export documents requested by the California processors of food, drugs, medical devices, and cosmetics and the associated workload has increased significantly from 1,731 application requests for certificates in 2001 to approximately 9,500 in 2012. According to DPH, the current staffing level of 1.5 positions and their classification level do not provide adequate staffing resources to meet the increased demand for export certificates.

The Export Document Program Fund has collected annual fee revenue in excess of $300,000 for the past three years. The current Fund Condition Statement projects a reserve of $2.0 million at the end of 2012-13. The increased demand for export certificates over the past several years has created this reserve.

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

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

1. Please provide an overview of this budget proposal.

4. Stop Tobacco Access to Kids Enforcement (STAKE) Act

Budget Issue. The budget requests $129,000 from the Sale of Tobacco to Minors Account and 1.0 permanent position (a staff counsel) to implement the provisions of AB 1301 (Hill, Statutes of 2012) which increases tobacco control efforts in California and requires DPH to notify the Board of Equalization (BOE) of a third, fourth, or fifth STAKE Act violation committed by the same retailer within a five-year period.

Background. The goal of the STAKE Act is to reduce the illegal sale of tobacco products to minors. The California Tobacco Control Program (CTCP) was established as a result of the passage of Proposition 99, the Tobacco Tax and Health Protection Act of 1988. CTCP is responsible for supporting a statewide tobacco control program that includes conducting a statewide media campaign, conducting evaluation and surveillance activities, and conducting community outreach, policy, and cessation activities. Since 1995, DPH has administered the STAKE Act Program.

DPH expects that retailers throughout the state will appeal STAKE violations more frequently because multiple violations will now lead to disciplinary action on the retailer's BOE license and consequently have an adverse effect on their revenues due to the suspension of tobacco sales. This expected increase in the number of appeals for STAKE Act violations will result in an increased workload and DPH will incur increased costs to litigate these appeals through administrative hearings.

An appeal requires DPH legal staff to review the facts of the case, prepare, and litigate the case in an administrative hearing in front of an administrative law judge (ALJ). The ALJ would issue a proposed decision in which DPH has 100 days to adopt the decision as final. When the Department adopts a decision as final, the Food and Drug Branch receives a copy and the decision would trigger the 60-day period to notify BOE. DPH is requesting one additional staff counsel to handle the anticipated increased number of appeals.

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

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

1. Please provide an overview of this budget proposal.

5. Emergency Preparedness - Extension of Limited-Term Positions

Budget Issue. DPH requests an extension of 76.8 limited-term positions for a four year period to align with the federal grant period (from 2012-13 through 2016-17) and associated funding authority of $9.4 million to support public health emergency preparedness responsibilities.

These positions are a continuation of limited-term positions originally established in 2003-04 and reestablished as limited-term positions every two years since then. These limited-term positions are scheduled to expire on June 30, 2013. The positions are located in several organizations throughout DPH, including but not limited to the Emergency Preparedness Office, the Center for Infectious Diseases, the Center for Environmental Health, the Center for Chronic Disease Prevention and Health Promotion, the Office of Public Affairs and the Administration Division.

All proposed positions are dedicated to working on public health and healthcare emergency preparedness activities. These activities include:

- Ensuring medical surge capacity to care for a massive influx of patients
- Coordinating the receipt and distribution of medical countermeasures (Strategic National Stockpile)
- Conducting laboratory testing
- Disease surveillance and epidemiology
- Monitoring drinking water and food safety
- Radiologic/Nuclear Power Plant safety
- Environmental health
- Maintaining emergency operations coordination/Duty Officer Program
- First responder and health care worker health and safety
- Providing public information in preparation for and response to a disaster
- Ensuring emergency communications
- Tracking hospital bed and resource availability
- Pre-hospital care, triage and patient transportation
- Developing systems to register and activate licensed health care professionals to volunteer during disasters
- Decontaminating patients
- Educating and training healthcare workers
- Supporting fatality management and evacuation plans

Background. DPH receives federal funds to support public health emergency preparedness responsibilities through the following grant awards:

- **Public Health Emergency Preparedness Cooperative Agreement (PHEP)**
  The PHEP Cooperative Agreement funds State and local health departments to enhance the California public health system's preparedness and response to public health emergencies. Based on Health and Safety Code Sections 101315-101319, DPH

allocates 70 percent of this grant to fund local health department preparedness activities and funds State operations within the remaining 30 percent.

The PHEP grant has delineated 15 Public Health Preparedness Capabilities with supporting Functions, Resource Elements and Performance Measures that State health departments must meet. These Public Health Preparedness Capabilities are outlined in Attachment A. The Functions required by these Capabilities include ongoing public health emergency preparedness workload to prepare for and manage DPH's response to public health emergencies such as planning response procedures; conducting laboratory testing; providing public information in preparation for and response to a disaster; coordinating surveillance and epidemiology in response to emergencies; ensuring electronic communications during emergencies; operating the Joint Emergency Operations Center (JEOC) shared by DPH, the Emergency Medical Services Authority and the Department of Health Care Services in response to emergencies; training DPH and local health department staff in preparedness activities; managing emergency supplies of pharmaceuticals; oversight of local health department preparedness; and coordination of public health and medical care response capabilities.

- **HPP Cooperative Agreement (HPP)**
  The HPP Cooperative Agreement provides funding to prepare hospitals, clinics and other health care facilities and emergency medical services systems to respond to disasters. This includes the need to ensure the health care system has the capacity to surge as needed in an emergency and to safely evacuate health care facilities when necessary. During these disasters, health care systems must convert operations quickly from their current patient capacity to surge capacity, the maximum patient load a health care system can handle, or to evacuate patients from the facility to another location that can provide the necessary level of care.

  The HPP grant has eight Healthcare Preparedness Capabilities with supporting Functions, Resource Elements and Performance Measures that States are required to meet. These Capabilities include, but are not limited to, increasing the ability of health care systems to provide needed beds; engaging with other responders through interoperable communication systems; tracking bed and resource availability using electronic systems; developing systems to register licensed health care professionals who volunteer to assist during emergency response; protecting health care workers with proper equipment; decontaminating patients establishing and enabling partnerships of healthcare organizations; educating and training health care workers; enhancing fatality management and health care system evacuation/shelter in place plans; and coordinating regional exercises. The Healthcare Preparedness Capabilities are delineated in Attachment B.

Federal funds have been reduced from $98.1 million in 2004-5 to $75.63 million in 2012-13; a reduction of 22.9 percent. Under these reductions, DPH has prioritized the retention of staff for public health and medical preparedness activities.

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

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

1. Please provide an overview of this budget proposal.

6. Office of Health Equity Update

Background. The Governor's 2012 budget proposed the creation of a new Office of Health Equity (OHE) at DPH. The OHE would be created by consolidating the following entities:

- Office of Multicultural Health at DPH
- Office of Women's Health at the Department of Health Care Services (DHCS)
- Office of Multicultural Services at the Department of Mental Health (this department was eliminated in 2012)
- Health in All Policies Task Force at DPH
- Healthy Places Team at DPH

Concerns were raised by various stakeholders during last year's budget process finding that the Administration's 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. As a result, Legislative staff and stakeholders worked together to strengthen the administration's proposal. This modified proposal was approved by the Legislature and included in AB 1467 (a 2012 budget trailer bill).

AB 1467 established OHE to align state resources, decision making and programs to accomplish all of the following:

1) Achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantage and historical injustice, including, but not limited to, vulnerable communities and culturally, linguistically, and geographically isolated communities;

2) Work collaboratively with the Health in All Policies Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote health and mental health;

3) Advise and assist other state departments in their mission to increase access to, and the quality of, culturally and linguistically competent health and mental health care and services; and

4) Improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and achieving health equity.

OHE is comprised of three units: Community Development and Engagement Unit (CDEU); Policy Unit (PU); and Health Research and Statistics Unit (HRSU). Currently OHE consists of fourteen positions; seven of which are filled. Additional contract positions will be added to the OHE based on recent grant funding opportunities.

Deputy Director. AB 1467 created an OHE Deputy Director, who is appointed by the Governor and is subject to confirmation by the Senate. The Deputy Director of OHE will report to the DPH Director and work closely with the Director of the Department of Health Care Services (DHCS) to ensure compliance with the requirements of the office's strategic plans, policies, and implementation activities.

A Deputy Director has not yet been appointed. DPH is in the process of conducting interviews.

Advisory Committee. The law requires that an advisory committee be established within OHE to provide input and recommendations on issues related to eliminating mental and health disparities and achieving health equity amongst California's vulnerable population groups.

The committee will participate in four meetings per year and make recommendations on a broad range of health and mental health related issues that address the diversity of multicultural communities in California as a whole. AB 1467 requires that the advisory committee meet by October 1, 2013.

DPH has received 109 applications from persons interested in participating in this committee and is in the process of creating a grid to ensure that all perspectives are represented on the committee. DPH anticipates that the advisory committee will be composed of 20 to 30 members.

Strategic Plan. OHE is also required to develop a comprehensive, cross-sectoral strategic plan to eliminate health and mental health disparities and inequities with collaboration of external and internal stakeholders. The strategies and recommendations developed will take into account the needs of vulnerable communities to ensure strategies are developed throughout the state to eliminate health and mental health disparities and inequities. This plan will establish goals and benchmarks for specific strategies in order to measure and track disparities and the effectiveness of these strategies. OHE will seek input from the public on the plan through an inclusive public stakeholder process.

The first report is due by July 01, 2013. DPH indicates that it is unlikely that it will meet this deadline.

Collaboration with Department of Health Care Services. AB 1467 requires that an interagency agreement be established to outline the process by which DPH and DHCS will jointly work to advance the mission of the office, including responsibilities, scope of work, and necessary resources.

OHE is in the process of establishing this interagency agreement.

OHE Budget. See following table for a summary of OHE's budget.

Table: Office of Health Equity's Budget Summary

Fund	2012-13	2013-14
General Fund	$337,745	$340,037
Air Pollution Control Fund	$322,930	$111,320
Cigarette and Tobacco Surtax Fund, Unallocated Account	$220,439	$228,759
Federal Trust Fund	$352,205	$465,977
Mental Health Services Fund	$17,342,117	$17,352,000
Cost of Implementation Account, Air Pollution Control Fund	$0	$212,087
Total	**$18,575,436**	**$18,710,180**

California Reducing Disparities Project (CRDP). One of OHE's responsibilities is the CRDP. The CRDP is a statewide policy initiative (funded with Mental Health Services Act Funds—Proposition 63) to improve access, quality of care, and increase positive outcomes for racial, ethnic and cultural communities in the public mental health system.

The project focuses on five populations: African-American; Latino; Native American; Asian and Pacific Islander; and Lesbian, Gay, Bisexual, Transgender, and Questioning individuals. These groups are required to establish Strategic Planning Workgroups (SPWs) that will produce population-specific reports that will form the basis of a statewide comprehensive strategic plan on reducing disparities.

All of the five population reports have been approved and posted on the DPH website. Recommendations from these reports will be incorporated into a comprehensive draft strategic plan. Once finalized, the California Reducing Disparities (CRD) Strategic Plan will be used as a guide to identify new service delivery approaches from multicultural communities using community-defined evidence to improve outcomes and reduce disparities. Furthermore, the Strategic Plan will serve as a blueprint to implement these strategies at the local level.

According to the December 2012 update on the OHE, a 30-day public review and comment period of the CRDP Strategic Plan would commence in December, 2012. However, this public review period has not yet begun because the CRDP Strategic Plan is still under internal department review. DPH hopes to have the draft available for public comment at the end of March. The delay in review and approval of this plan could delay Phase II of CRDP.

Subcommittee Staff Comment—Hold Open. This office was created almost nine months ago; however, it appears that DPH has not made progress on any major responsibilities. These delays interrupt the momentum of projects, such as the CRDP, that improve access to care for disadvantaged communities. It does not appear that this issue has been a high priority for the Administration. Health equity is an extremely important topic and the design of this office was intended to produce outcome-oriented solutions to address disparities.

It is recommended to hold this item open and have DPH report at a future subcommittee hearing on any progress it has made on key OHE responsibilities.

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

1. Please provide an update on OHE activities including an update on hiring the Deputy Director, selecting the Advisory Committee, completing an Interagency Agreement with DHCS, and completing the Strategic Plan.

2. Please discuss the activities that OHE and DHCS on which plan to collaborate.

3. Is the Office of Health Equity a priority for DPH? Please explain.

7. Licensing and Certification (L&C) Program Update

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.

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 fees are calculated based solely on the statutorily prescribed workload methodology as contained in statute.

The "credits" are applied to offset fees (e.g., hold the fee stable or reduce the fee) for 2013-14 and total $15.1 million. They are as follows:

- $3.5 million credit for miscellaneous revenues for change in ownerships and late fees.
- $11.6 million credit from the program reserve (which is largely a result of vacancies due to the state's hiring freeze).

Background on L&C 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—the 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/LicCertAnnualReport2013.pdf

The DPH Fee Report of February 2013 proposes slight changes to fees as shown in the table below.

Table: Proposed Licensing and Certification Fee Schedule (February 2013)

License Fees by Facility Type			
Facility Type	Fee Per Bed or Facility	FY 2012-13 Fee Amounts	FY 2013-14 Proposed Fee Amounts
Alternative Birthing Centers	Facility	$ 2,975.24	$ 2,380.19
Adult Day Health Centers	Facility	$ 4,164.92	$ 4,164.92
Chronic Dialysis Clinics	Facility	$ 3,578.29	$ 2,862.63
Chemical Dependency Recovery Hospitals	Bed	$ 191.27	$ 191.27
Community Clinics	Facility	$ 718.36	$ 718.36
Correctional Treatment Centers	Bed	$ 573.70	$ 573.70
Home Health Agencies	Facility	$ 4,315.47	$ 3,452.38
Hospices (2-Year License Total)	Facility	$ 4,641.96	$ 3,713.56
Hospice Facilities *	Bed	$ 312.00	$ 312.00
Pediatric Day Health/Respite Care	Bed	$ 188.01	$ 150.41
Psychology Clinics	Facility	$ 1,476.66	$ 1,476.66
Referral Agencies	Facility	$ 4,368.01	$ 3,494.41
Rehab Clinics	Facility	$ 259.35	$ 259.35
Surgical Clinics	Facility	$ 2,487.00	$ 2,487.00
Acute Psychiatric Hospitals	Bed	$ 266.58	$ 266.58
District Hospitals Less Than 100 Beds	Bed	$ 266.58	$ 266.58
General Acute Care Hospitals	Bed	$ 266.58	$ 266.58
Special Hospitals	Bed	$ 266.58	$ 266.58
Congregate Living Health Facilities	Bed	$ 312.00	$ 312.00
Intermediate Care Facilities (ICF)	Bed	$ 312.00	$ 312.00
Skilled Nursing Facilities	Bed	$ 312.00	$ 312.00
ICF - Developmentally Disabled (DD)	Bed	$ 580.40	$ 580.40
ICF - DD Habilitative	Bed	$ 580.40	$ 580.40
ICF - DD Nursing	Bed	$ 580.40	$ 580.40

* Pursuant to SB 135 (Chapter 673, Statutes of 2012), a new Hospice Facility licensure category was established. In the first year of licensure, the fee shall be equivalent to Congregate Living Health Facilities.

CMS Concerns with L&C. On June 20, 2012, the federal Centers for Medicare and Medicaid (CMS) sent a letter to DPH expressing its concern with the ability of DPH to meet many of its current Medicaid survey and certification responsibilities. In this letter, CMS states that its analysis of data and ongoing discussions with DPH officials reveal the crucial need for California to take effective leadership, management and oversight of DPH's regulatory organizational structure, systems, and functions to make sure DPH is able to meet all of its survey and certification responsibilities.

The letter further states that "failure to address the listed concerns and meet CMS' expectations will require CMS to initiate one or more actions that would have a negative effect on DPH's ability to avail itself of federal funds."

In this letter, CMS acknowledges that the state's fiscal situation in the last few years, and the resulting hiring freezes and furloughs, has impaired DPH's ability to meet survey and certification responsibilities.

As a result of these concerns, CMS set benchmarks for DPH to attain and is requiring quarterly updates from DPH on its work plans and progress on meeting these benchmarks. In its July 2012 report to CMS, DPH reported that it met 30 of the 33 benchmarks for that quarter. In its September 2012 report to CMS, DPH reported that it met 38 of the 41 benchmarks for that quarter. DPH indicates that it still faces challenges in (1) meeting the 10-day timeframe to forward to certain non-compliances to the CMS regional office and (2) closing complaints within 60-days and was unable to meet benchmarks related to these challenges.

Insufficient Staff to Address Workload. According to the L&C 2012 November Estimate, in order for L&C to meet 100 percent of its mandated workload, an additional 122 positions are needed in the field. However, the Administration has no proposal to increase staff to ensure that mandated work be performed or to improve the state's ability to meet all of the CMS benchmarks discussed above.

In the past, there has been a reluctance to add L&C positions because it has been difficult to fill Health Facility Evaluator Nurses (HFEN) positions and; consequently, these classifications had a high vacancy rate. (HFENs conduct health facility surveys and respond to complaints.)

However, in its December 2012 report to the Subcommittee, L&C noted that the HFEN vacancy rate was 4 percent (which is generally considered a very low vacancy rate). Consequently, it appears that there is genuinely a need for additional HFENs to perform L&C activities.

Subcommittee Staff Comment and Recommendation—Hold Open. As discussed above, L&C proposes to use fund reserves to decrease L&C fees and is not requesting any additional staff to meet its mandated workload. Given CMS' concern, it is unclear why the reserve funds are not being used to address workload needs. It is recommended to hold this item open in order to continue these discussions.

Questions. The Subcommittee has requested the L&C Program to respond to the following:

1. Please provide a brief summary of the L&C Fees, including the key credits and adjustments.

2. Please provide an update on CMS' concerns and the steps DPH has taken to meet CMS benchmarks.

3. Please explain how L&C determined that an additional 122 positions would be needed to meet workload requirements.

4. Please provide an update on the status of regulations on hospital administrative penalties and hospital fair pricing.

8. L&C - STAR Staffing Audit Section

Budget Issue. DPH requests an increase of $200,000 in reimbursement authority (from the Department of Health Care Services) to perform increased workload regarding the auditing of required nursing hours per patient day for free-standing skilled nursing facilities (SNFs).

To complete this workload, two Associate Governmental Program Analyst positions and one Office Technician from the Staffing Audit Section will be used to create three Staff Counsel positions in the Office of Legal Services. (The requested increased reimbursement authority is the salary differential of these positions.)

Background. Health and Safety Code Section 1276.5 requires L&C to assess administrative penalties when a SNF fails to meet the nursing hours per patient day requirements. When a penalty is assessed, the facility may file an appeal. DPH anticipates receiving 50 appeals per year. The positions requested under this proposal would conduct quality assurance of this process and work on appeals.

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

Questions. The Subcommittee has requested the L&C Program to respond to the following question:

1. Please provide a brief summary of this proposal.

9. L&C - Healthcare Associated Infection Public Reporting

Budget Issue. DPH request an increase of $1.2 million from the Internal Departmental Quality Improvement Account (IDQIA) for the next two years to continue eight contract positions in the Health Associated Infections (HAI) Program's Infection Preventionist (IP) Liaison Unit.

Background. SB 739 (2006), SB 158 (2008), and SB 1058 (2008) created the HAI program at DPH. This program's mission is to improve the quality of care in California hospitals through the prevention of healthcare associated infections. This is achieved through the public reporting of infection rates and prevention measures and working with stakeholders to enhance infection prevention activities in hospitals.

The primary objectives of the IP team are to ensure use of HAI data for the prevention of infections. They perform all outreach to hospitals in the form of onsite visits, phone consultations, education/coaching to use data to reduce HAI, data validation and support. Hospitals may request assistance and/or are contacted by the locally-assigned liaison for high rates of infections or poor data quality. The HAI program also provides monthly regional conference calls, all educational offerings, and all outreach projects (i.e. prevention collaborative projects, data validation projects, "data for action" site visits).

These positions were supported from September 2009 – July 2013 by a federal grant.

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

Questions. The Subcommittee has requested the L&C Program to respond to the following question:

1. Please provide a brief summary of this proposal.

10. AIDS Drug Assistance Program (ADAP) Update

ADAP is a subsidy program for low- and moderate-income persons living with HIV/AIDS who could not otherwise afford drug therapies. Eligible individuals receive drug therapies through participating local pharmacies under subcontract with the ADAP Pharmacy Benefit Manager (PBM).

Comparison of Current Year & Budget Year. The Office of AIDS (OA) estimates that 37,167 people living with HIV/AIDS will receive drug assistance through ADAP in 2013-14, a decrease of 3,297 clients over the current year. The budget estimates expenditures of $435.7 million which reflects a *net* decrease of $32.9 million as compared to the revised current year.

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

Fund Source	Revised Current Year	Proposed Budget Year	Difference
General Fund	$16.875 million	$0.00	-$16.225 million
AIDS Drug Rebate Fund	$308.683 million	$264.158 million	-$44.525 million
Federal Funds – Ryan White	$125.876 million	$105.179 million	-$20.697 million
Reimbursements from Medicaid Waiver	$17.15 million	$66.339 million	$49.189 million
Total	**$468.584 million**	**$435.679 million**	**-$32.908 million**

New and Revised Assumptions. The ADAP budget includes a new assumption that the federal mandate to conduct six-month ADAP client eligibility re-certification results in increased workload and associate costs for the ADAP Pharmacy Benefits Manager. These additional costs are $778,539 in 2012-13 and $671,484 in 2013-14.

Additionally, the ADAP budget reflects revised assumptions regarding the shift of ADAP clients to the Low-Income Health Programs (LIHP) including (1) the additional delay in ADAP clients shifting to LIHP due to additional grace periods for LIHP application processing, and (2) changes to the LIHP implementation dates in counties.

ADAP Funding Sources. OA attempts to minimize the need for General Fund support by maximizing the use of special funds and federal funds. Consequently, the 2013-14 proposed budget includes no General Fund as a result of decreased ADAP expenditures and the availability of Safety Net Care Pool Funds (Reimbursements from the 1115 Medicaid Wavier).

Federal funds (Safety Net Care Pool Funds) are available from the state's 1115 Medicaid Waiver administered by the Department of Health Care Services. These funds are not restricted and therefore may be used for expenditures not allowable under the Ryan White Payer of Last Resort federal provision. Thus, in 2013-14, DPH will use these funds to cover the

costs associated with clients eligible for other public assistance programs, including Medi-Cal and LIHP. (The Ryan White Payer of Last Resort federal provision requires that Ryan White federal funds or AIDS Drug Rebate Funds can only be used to pay for services if there is no other payer source.)

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 $45,961 (over 400 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 deduction, 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.

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 60 cents in rebates. This 60 percent level is based on an average of rebate collections (both "mandatory" and "supplemental" rebates).

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 parts of the federal HRSA grant award. The 2012 HRSA Ryan White Part B HIV Care Grant amount is $151.2 million. Three parts of the grant (Minority AIDS Initiative, ADAP Supplemental, and Part A Transfer Funds, totaling $10.0 million) do not have a match requirement. The remaining parts

of the grant (Formula, ADAP Earmark and Emerging Community funds, totaling $141.2 million) do have a state match requirement, making the state match $70.6 million for 2012-13.

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 2010-11 expenditures, is $502.5 million.

LIHP Transition. During last year's Subcommittee #3 hearings, concerns were raised that OA's oversight and engagement in the transition of ADAP clients to LIHP was inadequate. Consequently, AB 1467, a 2012 budget trailer bill, required OA to provide guidance on the LIHP transition and to consult with stakeholders regarding the transition of ADAP clients to LIHPs. Stakeholder advisory calls occur every two weeks.

Additionally, given the uncertainty regarding the rate at which ADAP clients may transition to LIHP, AB 1467 required DPH to report to the Legislature by October 1, 2012, if any of the projections or assumptions used to develop the ADAP budget for 2012-13 may result in a potential shortfall or inability of ADAP to provide services to eligible ADAP clients. On October 1, 2012, DPH notified the Legislature that it would be able to provide services to eligible ADAP clients and did not face any projected shortfall.

ADAP and Health Care Reform. The ADAP estimate identifies changes under the Affordable Care Act (Medi-Cal expansion and health coverage provided through the California Health Benefit Exchange) as potential future fiscal issues effecting ADAP. The Administration indicates that it will present its assessment of these impacts in the May Revise.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open pending updated information at May Revise.

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

1. Please provide an overview of the ADAP budget.

2. Please provide an update on the transition of ADAP clients to LIHP and the department's efforts to ensure that there are no interruptions in care or services.

3. Please provide DPH's initial thoughts on how ADAP may be impacted by implementation of the Affordable Care Act in California.

11. Proposition 50

Budget Issue. The DPH requests the following:

- A $22 million local assistance appropriation in Proposition 50, Water Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002.
- Budget Bill Language to revert, effective June 30, 2013, all unspent Proposition 50 funds ($63.3 million) from the 2009-10 appropriations.
- Provisional Budget Bill Language that authorizes DPH to increase its Proposition 50 expenditure authority above the requested $22 million appropriation upon approval from the Department of Finance (DOF).

Background. DPH has statutory authority to administer a regulatory program to ensure California public drinking water supplies meet all applicable federal and state drinking water standards. DPH's Drinking Water Program (DWP) has regulated and permitted public water systems (PWS) since 1915.

DWP provides ongoing surveillance and inspection of PWS, issues operational permits to the systems, ensures water quality monitoring is conducted, and takes enforcement actions when violations occur. The program oversees the activities of approximately 8,000 PWS that serve more than 34 million Californians. In addition, DPH is designated by the U. S. Environmental Protection Agency (EPA) as the primary agency responsible for administering the federal Safe Drinking Water Act (SDWA) in California.

In 2002, California voters approved Proposition 50, a $3.44 billion water bond measure known as the Water Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002. Proposition 50 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 $293.5 million to projects and $60.3 million remains available to be committed. DPH has received project applications for $73.7 million.

LAO Findings and Recommendation. The LAO recommends that the Legislature reject the Administration's proposed provisional budget bill language that would allow DOF to increase expenditure authority above the requested $22 million. The LAO finds that the Administration should request the level of funding it believes necessary to fund shovel–ready projects in 2013–14. Historically, this is how funding to implement Proposition 50 has been appropriated.

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to:

- **Approve** the $22 million local assistance appropriation in Proposition 50, Water Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002.
- **Approve** the Budget Bill Language to revert, effective June 30, 2013, all unspent Proposition 50 funds ($91.5 million) from prior appropriations through 2009-10.
- **Reject** the Provisional Budget Bill Language that authorizes DPH to increase its Proposition 50 expenditure authority above the requested $22 million appropriation upon approval from the Department of Finance (DOF). Staff concurs with the LAO's finding and recommendation that this provisional language should be rejected as DPH should request the level of expenditure authority necessary for 2013-14.

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.

12. Proposition 84

Budget Issue. DPH requests the following:

- A $48 million local assistance appropriation for Proposition 84, Safe Drinking Water, Water Quality and Supply, Flood Control, River and Coastal Protection Act of 2006.
- Provisional Budget Bill Language is also requested that authorizes DPH to increase its Proposition 84 expenditure authority above this $48 million appropriation upon approval from the Department of Finance (DOF).

Background. On November 6, 2006, California voters passed Proposition 84, a $5.4 billion water bond measure, known as the Safe Drinking Water, Water Quality and Supply, Flood Control, River and Coastal Protection Bond Act of 2006. Under the provisions of Proposition 84, DPH is responsible for administering three grant programs under Chapter 2 "Safe Drinking Water and Water Quality Projects" with approximately $300 million in grants for public water systems. The Proposition 84 funds are designated in the Public Resources Code as follows:

- Section 75021(a) provides $10 million to DPH for grants and direct expenditures to fund emergency and urgent actions to ensure that safe drinking water supplies are available to all Californians.
- Section 75022 provides $180 million to DPH for grants to small community drinking water systems for infrastructure improvements and related actions to meet safe drinking water standards with priority given to address chemical and nitrate contaminants. It also allows DPH to expend up to $5 million of the funds for technical assistance to eligible communities.
- Section 75023 provides $50 million to DPH to provide the 20 percent state match to access the federal capitalization grant for public water system infrastructure improvements. These funds are deposited into the Safe Drinking Water State Revolving Fund (SDWSRF) account (Section 116760.30 of the Health and Safety Code) and are available for loans and grants to public water systems to meet safe drinking water standards.
- Section 75025 provides $60 million to DPH for the purpose of loans and grants for projects to prevent or reduce contamination of groundwater that serves as a source of drinking water.

Proposition 84 provided $300 million to DPH to address contaminated drinking water, of which $219 million is available for projects (after bond costs and administration is considered). Of this, $124 million remains to be committed. According to DPH, there are expectations from stakeholders and the Administration that DPH will need to commit all the remaining funds in order to address contaminated water as quickly as possible. DPH is expecting to have all funds encumber into funding agreements by June 30, 2015.

In order to carry out the program, DPH requests new appropriation authority to align appropriations with planned expenditures. DPH indicates that it will spend the money at a different pace than originally anticipated. In part, this is due to actions in 2008 – the bond freeze and the excess appropriation authority DPH awarded through SBX2 1. The bond freeze prohibited the department from issuing funding agreements for 18 months; then DPH had to ramp up again. Although a BCP was approved to stretch the appropriation over five years, this was not enough time for DPH to expend the funds. As a result, the appropriation authority is out of alignment with planned expenditures.

DPH anticipates the ability to expend more than the $48 million requested for 2013-14 and is requesting Provisional Budget Bill Language that will allow DPH to increase its Proposition 84 expenditure authority above this $48 million appropriation upon approval from the Department of Finance.

LAO Findings and Recommendation. The LAO recommends that the Legislature reject the Administration's proposed provisional budget bill language that would allow DOF to increase expenditure authority above the requested $48 million. The LAO finds that the Administration should request the level of funding it believes necessary to fund shovel–ready projects in 2013–14. Historically, this is how funding to implement Proposition 84 has been appropriated.

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to:

- **Approve** the $48 million local assistance appropriation for Proposition 84, Safe Drinking Water, Water Quality and Supply, Flood Control, River and Coastal Protection Act of 2006.
- **Reject** the Provisional Budget Bill Language that authorizes DPH to increase its Proposition 84 expenditure authority above this $48 million appropriation upon approval from DOF. Staff concurs with the LAO's finding and recommendation that this provisional language should be rejected as DPH should request the level of expenditure authority necessary for 2013-14.

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

1. Please provide an update regarding Proposition 84 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.

13. Recycled Water Program

Budget Issue. The DPH requests 3.0 one-year limited-term positions and $700,000 in reimbursement authority with the State Water Resources Control Board (SWRCB) to develop and adopt water recycling criteria for indirect potable reuse of recycled water through ground water recharge and surface water augmentation. The proposal also includes convening of an expert panel to review and make a finding on the criteria for the indirect potable reuse using surface water augmentation. (SWRCB has submitted a corresponding budget request.)

Background. California water supplies are increasingly limited due to changes in weather patterns, population growth, and other factors. Recycled water is wastewater which has been treated and is suitable for various uses. Depending on the degree of treatment, recycled water may be suitable for many uses, including: domestic uses, such as tap water; agricultural uses, such as irrigation; recreational uses, such as swimming pools; or industrial uses, such as water used for cooling in manufacturing processes.

Senate Bill (SB) 918 (Pavley, Statutes of 2010) seeks to expand the use of a recycled water as a water resource. Recycled water is wastewater that has been treated to meet standards determined to be appropriate, based on the beneficial use of the recycled water and the potential human exposure. Increased use of recycled water would expand the availability of existing potable water supplies, would improve water system reliability in the event of ongoing drought or other water shortages, could provide an economic benefit to communities by decreasing the need for importation of more expensive water supplies, and by allowing communities to expand their water supplies to accommodate the expected growth of the state.

SB 918 requires:

- DPH to develop and adopt criteria (regulations) for indirect potable water reuse, as follows:
    - For groundwater recharge by December 31, 2013; and
    - For surface water augmentation by December 31, 2016, after the expert panel makes a finding that the criteria are adequately protective of public health.
- DPH to investigate and report to the Legislature by December 31, 2016, on the feasibility of developing regulations for direct potable reuse. A draft report must be available for public review by June 30, 2016, with a minimum 45-day public review and comment period.
- DPH to convene an expert panel to advise them. The bill describes the professional composition of the panel. The panel would:
    - Review the draft criteria for surface water augmentation, and must make a finding that the criteria is adequately protective of public health before DPH may adopt the criteria.
    - Advise DPH on the investigation of the feasibility of developing criteria for direct potable reuse.
- DPH to convene an advisory group comprised of representatives of water and wastewater agencies, local public health officers, environmental organizations, environmental justice organizations, public health nongovernmental organizations, and

the business community to advise DPH regarding the development of uniform water recycling criteria for direct potable reuse.

DPH, in consultation with SWRCB, to submit written reports to the Legislature as part of the annual budget process from 2011 – 2016 on the progress of developing and adopting the criteria for surface water augmentation and the feasibility investigation.

SB 918 authorizes the SWRCB to provide funding from the Waste Discharge Permit Fund to assist DPH with the requirements of SB 918. DPH has met with SWRCB, which has indicated that the annual amount available in this fund varies based on penalties collected. SWRCB has informed DPH that $1.4 million is available starting July 1, 2012 to begin the implementation of SB 918.

According to DPH, the funding available from SWRCB is insufficient to fund all the requirements of the statute. If additional funding is identified at a future time, DPH will submit another BCP to request the additional appropriation authority necessary to complete the mandates of SB 918.

The 2012 Budget Act appropriated $700,000 in expenditure authority to the SWRCB from the Waste Discharge Permit Fund to begin a contract wth DPH to implement provisions of SB 918. DPH and SWRCB are still working on an interagency agreement for these efforts.

LAO Findings and Recommendation. The LAO recommends approval of this proposal on a workload basis to meet the requirements of SB 918. However, the LAO recommends that DPH report at budget hearings on which competing statutory priorities are delaying implementation of SB 918. This information will allow the Legislature to assess whether DPH's prioritization of workload reflects the Legislature's priorities. The LAO also recommends the Legislature require DPH to report at budget hearings on the additional resources that would be necessary to fully meet the statutory requirements of SB 918.

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

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

1. Please provide a brief summary of this proposal.

2. What activities of SB 918 will not be funded under this request?

3. What are the additional resources that would be necessary to fully meet the statutory requirements of SB 918?

14. Women, Infant, and Children Program

Budget Issue. DPH requests an increase of $35.5 million in federal funds and $2 million in WIC Manufacturer Rebate Funds for the WIC program. This requested increase in expenditure authority is a result of the expectation that the WIC participant levels will increase by 1.32 percent and an increase in food costs of 2.56 percent. Additionally, manufacturer rebates are anticipated to increase by 4.2 percent based on the anticipated increase in participation and the increased per-can rebate received under the infant formula rebate contract.

Table: WIC Expenditures

Fund Source	2012-13 Projected	2013-14 Proposed	BY to CY Change	% Change
Federal Trust Fund	$1,236,175,000	$1,271,641,000	$35,466,000	3%
Special Funds	253,000,000	255,000,000	$2,000,000	1%
Total Expenditures	**$1,489,175,000**	**$1,526,641,000**	**$37,466,000**	**3%**

DPH states that about 1,507,914 WIC participants will access food vouchers in 2013-14. An estimated $65.50 is the monthly average participant cost for food.

Of the total federal grant amount, $990.6 million is for Base Food and $355.4 million is for Nutrition Services and Administration. The $255 million in Manufacturer Rebate Funds 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 last 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.

Maximum Reimbursement Rate Methodology. The maximum amount that vendors are reimbursed for WIC food is based on the mean price per redeemed food instrument type by peer group with a tolerance for price variances (referred to as MADR). Effective May 25, 2012, USDA directed CA WIC to remove 1-2 and 3-4 case register WIC vendors from the MADR-determination process and instead set MADR for these vendors at a certain percentage higher than the average redemption value charged by vendors with five or more registers in the same geographic region. The USDA was concerned that California was paying 1-2 and 3-4 cash register stores up to 50 percent higher than prices paid to other vendors.

CA WIC submitted a plan to USDA to address price competitiveness, MADR methodology and cost containment on October 3, 2012 and anticipates a decision from USDA shortly.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open the impact of USDA's decision on MADR will impact the May Revise estimates.

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

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

2. Please provide an update on the Maximum Reimbursement Rate Methodology.

Michelle Baass 651-4103
Senate Budget & Fiscal Review

OUTCOMES: Senate Subcommittee #3 on Health & Human Services
Thursday, March 14 (Room 4203)

4120 Emergency Medical Services Authority

1. Overview

- Informational item

2. Paramedic Licensing and Enforcement Program Workload

- Motion – Approve budget change proposal.
- Vote – 3-0

4140 Office of Statewide Health Planning and Development

1. Overview

- Informational item

2. Mental Health Services Act Workforce and Education Training – Five-Year Plan

- Motion – Approve budget change proposal.
- Vote – 2-0 (Senator Emmerson not voting.)

4260 Department of Health Care Services & 4800 California Health Benefit Exchange

1. CalHEERS Overview

- Informational item

0530 Health and Human Services Agency – Office of Systems Integration

1. CalHEERS

- Motion – Approve budget change proposal.
- Vote – 3-0

4260 Department of Health Care Services

1. Assessment of Administration's Estimates for ACA Medi-Cal Simplification & Comparison to LAO & CalSIM

- Hold open.

4265 Department of Public Health

1. Overview

- Informational item

2. Environmental & Occupational Disease Control Contract Conversion to State Staff

- Motion – Approve budget change proposal.
- Vote – 3-0

3. Export Document Program

- Motion – Approve budget change proposal.
- Vote – 3-0

4. Stop Tobacco Access to Kids Enforcement (STAKE) Act

- Motion – Approve budget change proposal.
- Vote – 3-0

5. Emergency Preparedness - Extension of Limited-Term Positions

- Motion – Approve budget change proposal.
- Vote – 3-0

6. Office of Health Equity Update

- Hold open

7. Licensing and Certification (L&C) Program Update

- Hold open and keep subcommittee updated on status of regulations on hospital administrative penalties and hospital fair pricing

8. L&C - STAR Staffing Audit Section

- Motion – Approve budget change proposal.
- Vote – 3-0

9. L&C - Healthcare Associated Infection Public Reporting

- Motion – Approve budget change proposal.
- Vote – 3-0

10. AIDS Drug Assistance Program (ADAP) Update

- Hold open

11. Proposition 50

- Motion – Modify budget change proposal, as follows:
    - **Approve** a $65 million local assistance appropriation in Proposition 50, Water Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002.
    - **Approve** the Budget Bill Language to revert, effective June 30, 2013, all unspent Proposition 50 funds from prior appropriations through 2009-10.
    - **Reject** the Provisional Budget Bill Language that authorizes DPH to increase its Proposition 50 expenditure authority above the requested $22 million appropriation upon approval from the Department of Finance (DOF). Staff concurs with the LAO's finding and recommendation that this provisional language should be rejected as DPH should request the level of expenditure authority necessary for 2013-14.
- Vote – 3-0

12. Proposition 84

- Motion– Modify budget change proposal, as follows:
    - **Approve** the $48 million local assistance appropriation for Proposition 84, Safe Drinking Water, Water Quality and Supply, Flood Control, River and Coastal Protection Act of 2006.
    - **Reject** the Provisional Budget Bill Language that authorizes DPH to increase its Proposition 84 expenditure authority above this $48 million appropriation upon approval from DOF. Staff concurs with the LAO's finding and recommendation that this provisional language should be rejected as DPH should request the level of expenditure authority necessary for 2013-14.
- Vote – 3-0

13. Recycled Water Program

- Motion – Approve budget change proposal.
- Vote – 2-1 (Senator Emmerson voting no.)

14. Women, Infant, and Children Program

- Hold open

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

March 21, 2013

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

Room 4203
(John L. Burton Hearing Room)

Staff: 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 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.

ISSUES RECOMMENDED FOR VOTE-ONLY

A. 5180 Department of Social Services

1. Proposed Transfer of CalFresh Outreach Plan from the Department of Public Health (DPH) to the Department of Social Services (DSS)

Given DSS's role as the state agency that oversees administration of CalFresh (California's Supplemental Nutrition Assistance Program), the Governor's budget proposes to transfer, as of January 1, 2013, operational management of the CalFresh Outreach Plan from DPH to DSS. This includes proposed expenditure authority of $661,000, the transfer of 3.8 existing positions, and the establishment of two additional new positions. All 5.8 positions have been approved by the U.S. Department of Agriculture's Food and Nutrition Service and are 100 percent federally funded.

Recommendation: APPROVE the proposed move of the program to DSS.

ISSUES FOR DISCUSSION

A. Some Context Setting: The Recession, Unemployment, and Poverty in California

The Recession & Recovery: The 2007–2009 "Great Recession" was the most severe economic contraction since the Great Depression. Additionally, according to the Legislative Analyst's Office (LAO), the nation's recovery has been slow by historical standards. In its November 2012 report, *The 2013-14 Budget: California's Fiscal Outlook,* the LAO indicated that up to that time, national Gross Domestic Product growth since the recession had been in the range of two percent per year, and forecasted that it would remain between two percent and three percent per year in all but one year between now and 2018. The LAO also indicated that United States employment is forecast to grow at 2 percent or less each year through 2018.

With respect to California, the LAO indicated that the state's recovery is similarly "tepid" compared to historical standards. For example, the LAO indicates that:

> "…after the 1981–1982 recession, it took over two years for the number of jobs in California to return to the pre–recession peak. After the 1990–1991 recession and the resulting cutbacks in the defense industry, it took over five years. After the 2001 recession and the bust of the "dot–com" bubble, it took four years. [As shown in a chart within the report], the total decline in jobs during and after the 2007–2009 recession—about 1.4 million jobs (9 percent of seasonally–adjusted employment)—was far greater than in the prior recessions shown. Moreover, the projected recovery period is *much* longer than for the prior recessions shown. Our forecast assumes that seasonally adjusted employment in California reaches its pre–recession peak in early 2015, or 7.5 years after its pre–recession peak in July 2007."

Unemployment in California: The LAO noted that despite the slowness of the recovery from the recession, some improvements in the state's job market are evident. Still, according to the California Employment Development Department, unemployment rates continue to be high, at 9.8 percent in December 2012. Low-income families are also more likely to be unemployed than the workforce as a whole, and during economic downturns less educated workers sustain bigger job losses than those with more education.[1] Recent reports additionally indicate that women, who are heads of most CalWORKs recipient households, are recovering from the recession more slowly than men, and that the economic downturn reduced employment for single mothers far more than for married parents.[2]

Poverty in California: Measures of poverty are intended to draw a line between whether or not a family has minimal resources necessary to meet the most basic needs (i.e., food, shelter, and clothing). Relying on the U.S. Census Bureau's official Poverty Measure, California had more than 6 million residents who lived in poverty in 2011 (or 16.6 percent of the population). In 2010, nearly one in four (23 percent) of California's children was considered impoverished. Federal poverty guidelines vary by household size, with recent estimates below:

2012 Preliminary Federal Poverty Thresholds	Source: U.S. Census Bureau
Persons in family	**Annual Poverty Guideline**
1	$11,722
2	$14,960
3	$18,287
4	$23,497
5	$27,815
8	$39,872
9 or more	$47,536

As discussed later in this agenda, at $638 per month, today's highest CalWORKs grants available for a family of three (the grant level for families in a high-cost county that include an aided adult and have no other income) result in income of $7,656 annually, or roughly 40 percent of the income federal guidelines indicate it would take to meet basic needs.

Government Programs Intended to Lessen Poverty & the Supplemental Poverty Measure (SPM): The Senate and Assembly Human Services Committees recently held a hearing on the U.S. Census Bureau's SPM (materials available here: http://shum.senate.ca.gov/hearings). After decades of criticism of the official poverty measure, the SPM was created to provide a more refined look at poverty in the nation. This measure, for

[1] Wonho Chung, Phil Davies, and Terry J. Fitzgerald, *Degrees of Job Security* (Federal Reserve Bank of Minneapolis: December 2010); available online at: http://www.minneapolisfed.org/publications_papers/pub_display.cfm?id=4592.
[2] *Falling Behind: The Impact of the Great Recession and the Budget Crisis on California's Women and their Families* (California Budget Project; February 2012).

the first time, attempts to balance a family's receipt of tax credits, food and other aid, and child support against a greater accounting of costs that otherwise are not considered, such as housing expenses, work-related transportation costs, child care, health care, and others. Under the SPM, California became the state with the highest poverty rate in the country, with nearly a quarter (23.5 percent) of the state's residents living in poverty. One of the main reasons for this change is the SPM's adjustment for California's high housing costs.

The Consequences of Poverty: Research indicates that children who live in poverty are at significantly higher risk for health problems, lower educational attainment, and a number of other negative outcomes well into their adulthood. These challenges can include poor socio-emotional functioning, developmental delays, behavioral problems, asthma, poor nutrition, low birth weight, and pneumonia. Language ability, such as vocabulary, phonological awareness and syntax, also differs sharply as a function of high poverty at many different stages of development.

Staff Comment & Recommendation: These issues are informational and no action is required. Testimony will be provided by:

- Sarah Bohn, Economist & Researcher, Public Policy Institute of California
- Ann Stevens, Director, University of California, Davis Center on Poverty Research.

Questions:

1. Where are we today in terms of the recovery and employment rates for low-income families, particularly for single parents and those with lower educational attainment? What is expected during the upcoming year or two?

2. What interventions does evidence indicate can help families avoid the negative consequences of poverty?

B. 5180 Department of Social Services - CalWORKs

1. CalWORKs Overview

Budget Issue: California Work Opportunities and Responsibilities to Kids (CalWORKs), the state's version of the federal Temporary Assistance for Needy Families program, provides cash assistance and welfare-to-work services to eligible low-income families with children. In the last several years, CalWORKs has sustained very significant reductions (summarized below), as well as programmatic restructuring (described in detail later in the agenda). Assuming continuation of those changes, along with a $142.8 million increase for employment services, the Governor's budget includes $5.4 billion (federal, state, and local) in funding for CalWORKs. At $3.2 billion, the largest proposed expenditures are for cash assistance, while expenditures for Stage 1 child care, employment services, and administration are expected to total another $2.1 billion. In contrast to recent years, the budget does not include new CalWORKs reduction proposals.

Some Context About CalWORKs Recipients' Circumstances[3]**:** Around three-quarters of all CalWORKs recipients are children. Nearly half of those children are under the age of six. The vast majority (92 percent) of heads of CalWORKs recipient households are women. Two-thirds are single and have never married. Close to half have 11th grade or less education, and 10-28 percent are estimated to have learning disabilities. Around 80 percent of these adults report experiencing domestic abuse at some point and an estimated 19-33 percent have mental or emotional health problems.

Caseload & Spending Trends: Prior to federal welfare reform in the mid-1990s, California's welfare program aided more than 900,000 families. By 2000, the caseload had declined to 500,000 families. During the recent recession the caseload grew; but at an estimated 563,500 families in 2012-13, it is not anywhere close to the levels of the early 1990s. Most recently, the caseload declined 1.8 percent in 2011-12, and from there is expected to increase slightly in 2012-13 and 2013-14 (to a projected 572,000 families). According to the California Budget Project, welfare assistance represented 6.8 percent of the state's overall budget (including federal, state, and local resources) in 1996-97, compared with 2.9 percent in 2011-12.

Background on Welfare-to-Work Program: Adults eligible for CalWORKs are subject to a lifetime limit of 48 months of assistance. Unless exempt for reasons such as disability or caregiving for an ill family member, they must participate in work and other welfare-to-work (e.g., educational) activities. Depending on family composition, these activities are required for 20, 30, or 35 hours per week. The program also offers related services, such as childcare and transportation. Beginning January 1, 2013, there are new restrictions regarding what counts as an eligible work activity that will result in some adults losing all assistance after 24 months.

Child-Only Caseload: In more than half of CalWORKs cases (called "child-only" cases), the state provides cash assistance on behalf of children only and does not provide adults with

[3] Context information comes from sample data collected by the Department of Social Services (DSS) and from studies in single or multiple counties, as summarized in *Understanding CalWORKs: A Primer for Service Providers and Policymakers*, by Kate Karpilow and Diane Reed. Published in April 2010; available online.

cash aid or welfare-to-work services. There is no time limit on aid for minors. The maximum grant for two children is currently $516 monthly. In most child-only cases, a parent is in the household, but ineligible for assistance due to receipt of Supplemental Security Income, sanction for non-participation in welfare-to-work, time limits, a previous felony drug conviction, or immigration status. In the remaining cases, no parent is present, and the child is residing with a relative or other adult with legal guardianship or custody.

Federal Context: Federal funding for CalWORKs is part of the Temporary Assistance for Needy Families (TANF) block grant program. TANF was scheduled for reauthorization in 2010, but the federal government has since enacted several temporary extensions (the most recent through March 27, 2013). TANF currently requires states to meet a work participation rate (WPR) for all aided families or face a penalty of a portion of their block grant. States can, however, reduce or eliminate penalties by disputing them, demonstrating reasonable cause or extraordinary circumstances, or planning for corrective compliance. It is also important to note that federal formulas for calculating a state's WPR have been the subject of much criticism. For example, they do not give credit for a significant number of families who are partially, but not fully, meeting hourly requirements. California did not meet its federal WPR requirements for 2007, 2008, or 2009. The state is appealing penalties of $47 million and $113 million for 2008 and 2009, and it is unclear whether or when those penalties might be enforced.

The Work Incentive Nutritional Supplement (WINS) program is scheduled to begin January 1, 2014 and expected to improve the state's WPR very significantly. With similarities to programs in several other states, WINS will provide a state-funded benefit of $10 monthly to families receiving CalFresh (food stamps) who are meeting TANF work requirements. Because those state funds will be counted toward the state's TANF Maintenance of Effort (MOE) requirement, the beneficiary families count in the state's WPR.

Recent Reductions and Changes in CalWORKs are summarized below:

GRANT REDUCTIONS

	GF savings[4] (in 000s), if available	Effective Period
Suspension of annual cost-of-living adjustment (COLA) (enacted in 2008-09 budget)	$163,000	Ongoing
Suspension of COLA *and* 4% grant cut (2009-10)	$226,000	Ongoing
Elimination of statutory basis for future COLAs (2009-10)		Ongoing
Additional 8% grant cut (2011-12)	$314,000	Ongoing
Changes to earned income disregard that mean faster reductions to grants or exits from aid due to earnings (2011-12)	$83,000	7/1/11 through 10/1/13

[4] Savings figures on this page are annual in the first full-year of implementation. On an ongoing basis, exact savings will vary with caseload and other policy changes.

TIME LIMIT REDUCTIONS

Reduction of adults' lifetime time limit from 60 to 48 months (2011-12)	$104,000	Ongoing
Creation of a 24-month time limit with more flexible welfare-to-work activities before it has been reached and stricter requirements afterward (up to 48 total months) (2012-13)		Ongoing, with fiscal effect starting 2014-15

REDUCTIONS TO WELFARE-TO-WORK SERVICES

Exemption from welfare-to-work services for parents of one child from 12 to 24 months old or 2 or more children under age 6 (savings from not providing services) (2009-10)	$375,000	7/1/09 through 1/1/13 (with phase-out of policy then lasting 2 years)
Suspension of CalLearn intensive case management for teen parents (2011-12)	$43,600	7/1/11 through 7/1/12, with funding phased back in during 2012-13
Once in a lifetime welfare-to-work exemption for parents with children under 24 months old (2012-13)		Ongoing, beginning 1/1/13

In 2009-10 and 2010-11, the CalWORKs program temporarily benefitted from some enhanced federal funding under the American Recovery and Reinvestment Act (ARRA). Some of that funding allowed for corresponding General Fund cost avoidance, while other resources were used to create non-recurrent short-term benefits and invest in additional subsidized employment slots for clients.

Staff Comment & Recommendation: No action is required, as this is an overview item for context setting purposes.

The LAO will present an overview.

2. Implementation of Changes to Welfare-to-Work Activities, Hours, Time Limits & Exemptions Made by SB 1041

Budget Issue: As described in the chart on the previous pages, a 2012-13 budget trailer bill, SB 1041 (Chapter 47, Statutes of 2012), made significant changes to CalWORKs welfare-to-work rules, including the following changes (in addition to other provisions described later in this agenda):

1) Creation of a 24-month time limit with more flexible welfare-to-work activities before it has been reached and stricter requirements afterward (up to 48 total months),

2) A two-year phase-out of temporary exemptions from welfare-to-work requirements for parents of one child from 12 to 24 months old or 2 or more children under age 6, along with a new, once in a lifetime exemption for parents with children under 24 months, and

3) Changes to conform state law to the number of hours of work participation (20, 30, or 35, depending on family composition) required to comply with federal work requirements.

SB 1041 also requires DSS to contract with an independent, research-based institution for an evaluation and written report regarding the changes enacted in SB 1041. The report must be provided to the Legislature by October 1, 2017. In the interim, the department is required to annually update the Legislature regarding implementation of the changes made by the bill.

Additional Background on the Restructuring of Activities, Time Limits, and Hours: SB 1041 created a differentiation between welfare-to-work participation rules that apply before expiration of a 24-month time limit (which are more flexible than prior law in how they count education and treatment-related activities) and stricter rules that now apply after that time period (which can sometimes include more than 24 calendar months because of how months are counted). As a result of the rules that then apply, some adults are expected to lose assistance after 24 months. SB 1041 also allows for extensions of up to six months (reviewed at least every six months) of the more flexible rules for up to 20 percent of participants.

In addition to the complexities of needing to train workers, inform clients, and create procedures for implementing all of these rule changes for new clients, implementation of the changes requires meaningfully applying the new rules for previously existing clients as well, e.g., creating processes for existing clients who want to update welfare-to-work plans that were established under outdated rules and to cease sanctioning (i.e., reducing a family's cash assistance by the portion of aid intended for the eligible adult) individuals whose work participation previously did not meet the state's required activities and hours, but now could.

Background on Implementation Activities: To inform the development of administrative policies regarding implementation of these changes, as well as additional changes made by the bill, SB 1041 required DSS to convene stakeholder workgroups. Those workgroups met throughout the fall of 2012, and DSS released more than 12 resulting All County Letters, as well as a series of Informing Notices to explain the changes to clients.

To date, DSS has received 26 county strategy plans that cover how they intend to "re-engage" parents in approximately 15,000 families whose young-child exemptions are ending over the two-year time period identified by SB 1041. Beginning re-engagement dates vary throughout those counties. Strategies as to which groupings of clients will be re-engaged and in what order also vary by county.

DSS also released a statewide training document on February 28, 2013, and notes that prior to the release of this training aid most counties had designed and conducted their own SB 1041 implementation training based on guidance released in December 2012 and January 2013. DSS states that counties which have not yet conducted the training cited reasons including that training was still being developed, there was a lack of automation for new processes, and that there was insufficient time given other workload demands.

More recently, DSS has indicated that it plans to redirect staff to begin implementation-related visits to counties, starting with the nineteen largest. The first pilot visits will occur in geographically local counties. The structure and content of these visits will be developed by DSS and the County Welfare Directors Association (CWDA). The visits will be conducted by two to three person teams of CDSS staff. Depending on resources, county staff may also join these visits as peer reviewers.

Concerns Raised by Advocates: Advocates have been parties to the stakeholder discussions and have provided feedback on the state guidance. At the same time, however, they have expressed strong concerns with front-line implementation of the changes thus far. Anecdotally, they indicate that they are not yet observing the intended impacts of the increase in flexibility regarding activities or decrease in the required participation hours in a number of counties. In a letter to the Committee, the Western Center on Law & Poverty indicates that, "The first few months of implementation confirm advocate fears – that all SB 1041 means to many recipients is an even shorter time in welfare to work – nothing more." They identify this as particularly problematic because under current law, the new 24-month time clock is or will be ticking for many clients even while these other related, critical elements have not yet been implemented.

Advocates have also expressed concern regarding whether many clients will be able to access increased educational flexibilities that exist in the narrow, 24-month timeframe without priority for enrollment in necessary community college classes. Approximately 11,000 students receiving CalWORKs already have priority for enrollment because they also participate in the Extended Opportunity Programs and Services (EOPS) or Disabled Student Programs & Services (DSPS) programs. Another around 29,000 in 2010-11 (or one percent of community college students) do not currently benefit from priority for enrollment.

Staff Comment & Recommendations: Given the volume of recent reductions and restructuring, the CalWORKs program is in a state of flux. Successive reductions and changes to grants, time limits, and work participation rules have resulted in additional layers of complexity within an already complicated state program. With many changes happening at once and applying differently to varying recipient families, front line social workers, county and

state administrators, and client advocates face daunting challenges to ensure that the program is implemented as intended and is as effective as possible. Staff also shares the concern that the flexibilities created by SB 1041 with respect to educational opportunities could be undermined if students receiving CalWORKs cannot access necessary community college classes during the new and narrower 24-month time clock.

Therefore, **staff recommends** that the Subcommittee:

1) Direct the Administration and staff to work together, and to consult with counties, advocates, and/or other stakeholders as needed, to identify measurable data elements and other information that will fulfill the requirements for updates regarding SB 1041 implementation prior to receipt of the required evaluation, along with a schedule for those updates; and

2) Coordinate with Subcommittee 1 to determine if a statutory change to ensure priority enrollment for community college students receiving CalWORKs is appropriate.

Questions:

1. Please describe the Department's approach to monitoring implementation of the changes made by SB 1041 that are described above.

2. What kinds of measurable data elements might provide meaningful insight into the degree to which the changes in activities flexibility and hours, as well as the opportunities to update case plans and process to end outdated sanctions, are having their intended impacts on the ground? In what timeframes will information like that be available?

3. Early Engagement & Barrier Removal Requirements of SB 1041

Budget Issue: The 2012-13 trailer bill described in the previous item, SB 1041, also included a requirement for DSS, in consultation with a workgroup including specified stakeholders, to identify best practices and other strategies to improve efforts to engage clients in welfare-to-work as early and effectively as possible, and to assist them in removing barriers to success so that the initial months during which adults are subject to welfare-to-work requirements are as meaningful an opportunity as possible. The statute also indicates that this may require evaluating and restructuring the basic program flow for clients. Given the urgency of needing these reforms to be in place as soon as, or only shortly after, the new 24-month time limit took effect on January 1, 2013, DSS was required to report to the Legislature by January 10, 2013, regarding the recommendations developed, including those that would be implemented through administrative changes and those that would require statutory changes. DSS did not, however, convene this workgroup until October 30, 2012, and the required report has not yet been provided.

Background on Workgroup Discussions Thus Far: Stakeholder discussions in the workgroup with the Administration have focused in particular on a few programmatic concepts, including:

- The need to utilize information from more robust appraisals and/or assessments of clients' needs;
- The need for there to be more than one welfare-to-work track for participants (e.g., differentiating between those who are ready for work experience, those who need education and skill development, and those who have major barriers to be addressed);
- The need for more intensive case management services or other supports to allow families who have multiple barriers and/or are particularly in crisis to get stabilized; and
- A desire for expanded uses of subsidized employment opportunities.

Staff Comment & Reccomendation: The changes necessary to ensure early engagement of clients and improved processes for identifying and helping to remove barriers to success are critical elements of the package of changes made by SB 1041. Staff recommends that the Subcommittee, consistent with the requirements of SB 1041, direct the Administration to provide the required information in time to allow for consideration of any necessary statutory or fiscal changes during the 2013-14 budget development cycle.

Questions:

1. Please summarize the workgroup process to date and the main changes identified as necessary by those conversations.

2. When will the Administration make and/or provide the required recommendations for changes?

4. Employment Services Funding

Budget Issue: The Governor's budget proposes $2.0 billion in funding for the Single Allocation for CalWORKs expenditures on Stage 1 child care, employment services, and program administration. The breakdown of this funding includes:

- $896.5 million for employment services
- $561.9 million for administration
- $414.1 million for Stage 1 child care
- $122.6 million for substance abuse and mental health services
- $35.9 million for the Cal-Learn program for teenage parents

The proposed employment services funding includes a $142.8 million increase. Roughly two-thirds of the increase is a workload adjustment made because of a new methodology for calculating the costs of employment services on a cost-per-case basis. The need for change was created by the expiration of several years of temporary reductions in the program, which has had unintended effects on the ability to make other technical updates, as well as the enactment of ongoing, major changes in 2012-13. To devise the new methodology, the Administration consulted with the County Welfare Directors Association and relied on historical caseload and employment services budget data. The remainder of the change is tied to outreach, case management, and job development workload created by changes made to the program in SB 1041 as a part of the 2012-13 budget agreement.

As discussed under the previous agenda item, this adjustment does not address the required recommendations for early engagement and barrier removal-related policy or fiscal changes.

Staff Comment & Recommendation: Staff recommends that the Subcommittee approve the methodology change and the adjustments to employment services funding that are included in the Governor's budget, subject to updates and further adjustment at the May Revision.

Questions:

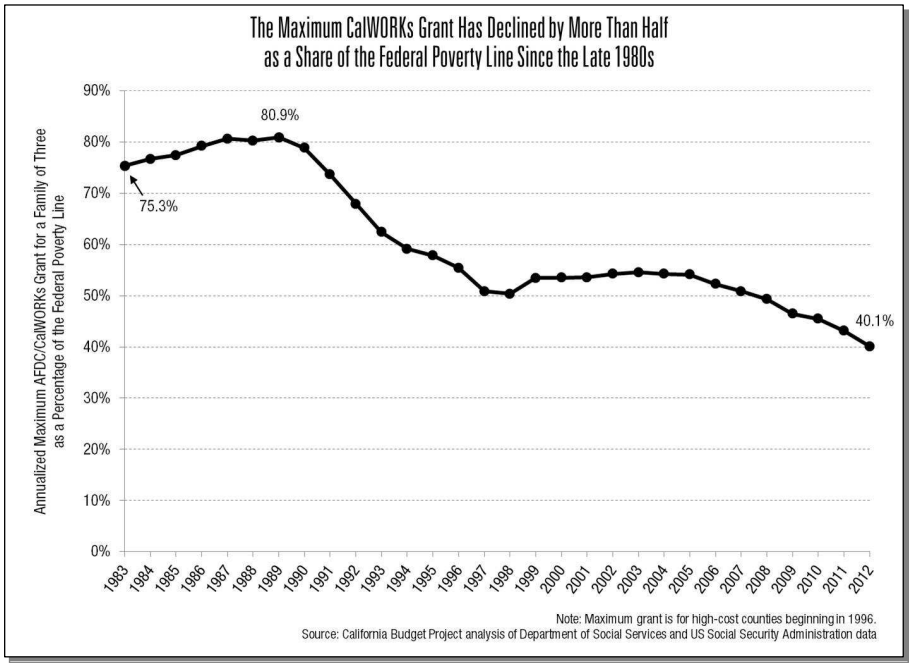
1. Please briefly summarize the proposed changes to employment services funding.

5. CalWORKs Grants

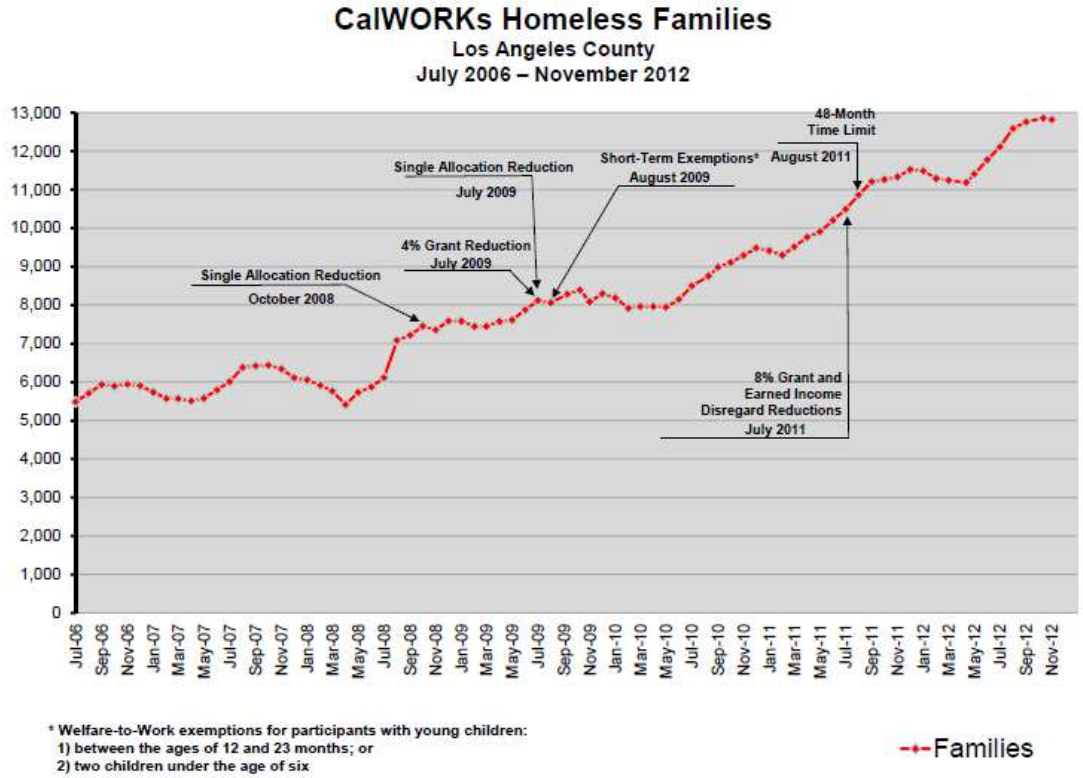
Budget Issue: As reflected in the CalWORKs Overview above, recent enacted budgets did not include cost-of-living adjustments to CalWORKs grants; and then in 2009-10, trailer bill language eliminated the statutory basis for those adjustments. In 2009-10 and 2011-12, grants were further reduced by four, and then an additional eight, percent.

Background on CalWORKs Grants: The average CalWORKs grant for recipient families is $467 monthly (up to a maximum of $638, or 40 percent of the Federal Poverty Threshold (FPL), for a family of three in a high-cost county with no other income). More than half of the time, the state provides cash assistance on behalf of children only and does not provide adults with cash aid or welfare-to-work services. These are known as "child-only" cases, and the highest grant a family of three with two children and no aided parents can receive is $516 monthly (or 32 percent of FPL).

Without cost-of-living adjustments and with recent reductions, the purchasing power of CalWORKs grants, which are the same today in actual dollars as they were in 1987, has declined dramatically. The chart below (included with permission from the California Budget Project) displays the comparison between maximum CalWORKs grants for families with an aided adult and no other income, and the FPL from the late 1980s until now.



Impacts of Recent Reductions on Families: While it is challenging to isolate the impacts of recent reductions in grants or other aspects of CalWORKs on families, we do hear anecdotally of the increasingly challenging circumstances families are facing, which can include falling into homelessness, among other impacts. The chart below, created by Los Angeles County, displays the number of CalWORKs Homeless families in Los Angeles County:



Staff Comment & Recommendations: This is an informational item, and no action is recommended at this time.

Questions:

1. Please summarize the recent history of grant adjustments and reductions.

2. What do we know about the impacts of these grant reductions and the declining purchasing power of grants on families?

6. TANF Transfer to the California Student Aid Commission

Budget Issue: The 2012-13 budget redirected an unprecedented amount of California's federal Temporary Assistance to Needy Families (TANF) block grant funding ($804 million) away from CalWORKs and to the California Student Aid Commission (CSAC) to be used for expenditures in the Cal Grants program, which provides financial aid for students obtaining a higher education. The funds were swapped, dollar-for-dollar, to redirect an equal amount of General Fund monies that would have been spent on Cal Grants to instead be spent on CalWORKs. The Governor's budget proposes to make the same swap in 2013-14, but at the even higher level of $942.9 million. This means that more than half of the Cal Grants program would be supported by federal TANF funding.

Background: CalWORKs is funded through a combination of California's TANF allocation ($3.7 billion annually), state General Fund, and county funds. In recent years, the state's TANF Maintenance of Effort requirement (MOE) has been $2.9 billion. The 2012-13 swap was made for the following reasons:

1) Given the level of reduction in the CalWORKs program, in the absence of identifying additional state funding that could be counted toward the state's TANF MOE, the state would have fallen below its required TANF MOE spending level.

2) The state obtains a work participation rate (WPR) benefit from funding a portion of CalWORKs cases, including many families in which the adult has timed off of aid and children continue to receive assistance (informally known as "safety net" cases), without TANF or MOE expenditures. If their assistance is funded with non-MOE General Fund, these families do not count in the state's WPR. DSS estimates that this results in an approximately six percent increase in the state's WPR.

If the state's caseload were to decline to 2004-05 levels, the swap could also be used to potentially lower the state's WPR because it would result in state spending in excess of the relevant MOE. However, because the state's caseload is not expected to be below that level, this potential WPR impact is not relevant in 2012-13 or 2013-14.

According to the Administration, the swap is an allowable use of TANF funds because the resources are targeted to low-income, unmarried students age 25 or younger and can be considered an investment in the prevention and reduction of out-of-wedlock pregnancies, which is one of TANF's articulated purposes.

Staff Comment & Recommendation: Staff recommends holding this issue open and identifies some concerns. Specifically, the level of the funding swap between TANF and General Fund resources previously used for Cal Grants is concerning because it reduces transparency in budgeting for the core purposes of the programs and results in an artificially higher reliance of CalWORKs on General Fund expenditures. This significantly higher reliance on the General Fund is especially problematic for CalWORKs because it is a program that is

intended to provide a safety net during times of economic contraction and as such, may experience necessary growth precisely when General Fund resources are scarcer.

Questions:

1. Please summarize why the 2012-13 budget included the swapping of TANF and General Fund resources between the CalWORKs and Cal Grants programs.

2. Is it necessary for the swap to include the full $943 million proposed in 2013-14? If so, why? And if not, how much of that amount is needed?

C. 5180 Department of Social Services – CalFresh

1. CalFresh Overview

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 $7.8 billion (all federal funds) in CalFresh benefits in 2012-13, rising to $8.8 billion in 2013-14. According to the U.S. Department of Agriculture's Economic Research Service, every $5 in new SNAP/CalFresh benefits generates as much as $9 of economic activity (gross domestic product), which represents a multiplier effect of 1.79.

A Snapshot:

- Approximately 1.6 million households (with an average of 2.4 persons per household) receive CalFresh benefits.
- This is estimated to represent only around half the eligible population.
- More than half of recipients are children.

The Governor's 2013-14 budget includes $1.6 billion ($635.5 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). This includes $62.8 million ($23 million GF) that was vetoed in 2012-13, but has been built back in for 2013-14.

Since 1997, the state has also funded the California Food Assistance Program (CFAP), a corresponding program for legal immigrants who are not eligible for federal nutrition assistance. The proposed CFAP budget includes $65.6 million GF for food benefits, with an expected average monthly caseload of around 19,000 households (with about 47,000 recipients).

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 $339 ($151 per person).

Caseload Trends[5]: 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, 20 percent in 2010-11, and 17

[5] Growth and caseload figures represent the "non-assistance" CalFresh caseload. Around another 320,000 households are estimated to receive CalFresh benefits along with CalWORKs in 2012-13.

percent in 2011-12. The Governor's budget assumes the following annual caseloads in recent years and up through 2013-14:

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	1,411,806
2012-13*	1,603,911
2013-14*	1,829,310

*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, 75 percent of eligible people received SNAP benefits in federal fiscal year 2010 (the last year for which data is available). In the western region of the country, the overall participation rate was lower at 66 percent. The participation rate for the working poor population was 65 percent nationally. California's overall participation rate was the lowest in the nation at an estimated 55 percent.[6] California's participation rate for the working poor population was also the lowest in the nation at an estimated 42 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 so steeply. With that said, from 2009 to 2010, California's rate did increase marginally (up two percent for all people and six percent for the working poor).

Reasons sometimes offered for California's poor performance with respect to CalFresh participation have included, among others, a lack of knowledge regarding eligibility among individuals who are eligible, frustration with application processes, concerns about stigma associated with receiving assistance, and misconceptions in immigrant communities about the impacts of accessing benefits.

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

[6] DSS has noted 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 a few percentage points higher if many those individuals who would otherwise be eligible for CalFresh were counted as participating. The state would still have the lowest participation rate in the nation.

September 2011, California's error rate was 4.1 percent. California was sanctioned $11.8 million, $114.3 million, and $60.8 million in 2000, 2001, and 2002, respectively.

Efforts to Improve Participation: DSS indicates that California continues to make significant program changes to increase access to the CalFresh program. Several of these changes were included in recently enacted legislation or administrative decisions to streamline application and other administrative policies. In addition to other recent forums for county/state dialogue about CalFresh efficiency and increased participation, and partly in response to a request from this Subcommittee last year, the Director of DSS has also asked each county to undertake a goal-setting process with respect to increased participation.

Staff Comment & Recommendation: Staff recommends that the Subcommittee ask the department to provide an update on its goals for increased participation in CalFresh statewide, including the impact on the number of eligible families and the state's participation rates.

Questions:

1. To what do you attribute California's CalFresh participation rate continuing to be so low?

2. How can the state better ensure that more eligible low-income Californians receive federally-funded CalFresh food benefits? What opportunities might be available as health care reform implementation gets underway and are they being pursued within the applicable planning processes?

2. County Match-Waiver for CalFresh Administration

Budget Issue: The Governor's budget proposes to extend for one year, in 2013-14, authorization for counties to access CalFresh administration funding without requiring a county match above and beyond an existing Maintenance of Effort (MOE) requirement. The maximum overall loss of CalFresh administration funding, if all counties were to access the entire match-waiver would be $220.2 million (half federal and half county funds). Based on preliminary claims for 2011-12, however, the department indicates that only 27 counties have utilized the waiver flexibility, accessing approximately $26.5 million from their General Fund allocation beyond the MOE.

Background: As a result of dramatic caseload increases and difficult fiscal situations for counties, the state has temporarily allowed counties to access the General Fund portion of their CalFresh Allocation without having to match the 15 percent county share-of-costs beyond the MOE. The waiver was enacted in 2010-11 trailer bill for two years, and then extended last year for one more. The Administration indicates that it is proposing an additional one year extension, in part to assist with the impacts to counties of the 2012-13 veto of $62.8 million ($23 million GF) in CalFresh administration base funding. As discussed in the previous agenda item, the CalFresh caseload is projected to continue to increase at significant rates in 2012-13 and 2013-14. To the degree that the 2012-13 veto negatively impacted counties' resources for handling the increased caseloads, the Administration believes that additional waiver flexibility is necessary.

Staff Comment & Recommendation: Staff recommends holding this issue open. The proposal to extend the match-waiver for one additional year seems reasonable. At the same time, particularly given ongoing concerns about participation rates, it will be important to again have administration costs fully funded in the near future.

Questions:

1. Please briefly summarize the proposal and the rationale for it.

D. 5180 Department of Social Services – State Hearings

Budget Issue: The Governor's budget proposes $20.3 million and 153.2 authorized positions for the State Hearings Division of DSS. This includes a request for $3.4 million ($1.3 million GF) to establish 21 new, permanent state staff positions to handle an increased state hearings caseload. The General Fund resources identified are proposed to be redirected from the payment of penalties for late hearing decisions. The department indicates that these late decisions are a result of caseload growth and that the amount of penalties has increased since 2006, totaling $1.1 million for 2011-12, and projected to be as high as $1.8 million yearly over the next three years. Correspondingly, the Governor proposes trailer bill language (TBL) to limit, for a period of three years, the department's exposure to those court-mandated penalties.

Background on State Hearings and Timeliness Requirements: State hearings adjudicated by impartial Administrative Law Judges (ALJs) employed through DSS are used to provide due process to recipients of and applicants for many of California's health and human services' programs, including Medi-Cal, CalWORKs, CalFresh, and In-Home Supportive Services, when they disagree with a decision made by their local county welfare department. Federal mandates require that all requests for hearings be adjudicated within 90 days of a recipient's request (or 60 days for CalFresh). Two court orders, in *King v. McMahon* and *Ball v. Swoap*, impose financial penalties on DSS for failing to adjudicate decisions within those specified timeframes. The penalties are paid to the prevailing claimant.

Under the court orders, the minimum daily penalty amount is $5.00 per day, or a minimum of $50, whichever is greater. However, if 95 percent of all decisions are not issued within the required deadlines in a given month, the daily penalty rate for that programmatic category increases by $2.50 over the penalty rate being paid to claimants the previous month. On the other hand, if 95 percent of all decisions related to that particular program are issued on time in a given month, the corresponding daily penalty rate decreases by $2.50 from the penalty rate being paid the previous month. The maximum daily rate under the court orders is $100 per day. According to DSS, recent processing times and average penalties are listed below:

Program	Timeliness Requirement (In Days)	Average Processing Time (In Days)	Average Days Late	Average Penalty
CalFresh	60	83.14	23.14	$976.62
CalWORKs	90	113.69	23.69	$1,118.77
IHSS	90	117.51	27.51	$1,585.32
MediCal	90	121.25	31.25	$2,714.25

The proposed TBL would reset the daily penalty to the minimum amount for a three-year period while the department directs the resources to instead increasing the number of staff who can adjudicate claims. The department believes that decisions would again be timely by the end of this period.

Recent Caseload Growth and Penalties: The department indicates that the state hearings caseload has increased significantly in the past five years (from approximately 80,000 requests for hearing and 14,000 decisions issued in 2007-08 to 96,000 requests and 18,000 decisions in 2011-12). The Great Recession and corresponding state fiscal crisis led to billions of dollars in reductions to California's health and human services programs, along with corresponding contractions in eligibility for and/or services provided by those programs. At least some of the significant caseload growth identified by the department is related to those changes.

In 2010-11, DSS requested statutory changes to lower the timeliness threshold for processing hearings and allow the department to hold videoconference hearings at its discretion. Those requests were rejected by the Legislature and the final budget instead included the addition of three ALJs and the permanent funding associated with those positions.

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

Questions:

1. Please briefly summarize the function of the state hearings division and the structure of the timeliness requirements and penalties for not meeting them.

2. Please briefly describe the proposal.

3. How did the department estimate the number of staff positions requested and whether they would be sufficient to allow for timely decisions?

E. 5180 Department of Social Services & Office of Systems Integration (OSI)– 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, CalFresh (Food Stamps), Foster Care, Medi-Cal, Refugee Assistance, and County Medical Services. The Los Angeles Eligibility, Automated Determination, Evaluation & Reporting (LEADER) system currently 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). Including project management expenditures, as well as the Welfare Data Tracking Implementation Project (WDTIP) system, the total proposed budget for SAWS in 2013-14 includes $291.7 million ($151.0 million TANF/GF).

1. LEADER Replacement System (LRS) & C-IV Migration

Budget Issue: As described above, LEADER is one of three existing consortia systems that comprise the SAWS. The proposed 2013-14 maintenance and operations costs for LEADER include $31.6 million ($15.7 million GF/TANF). OSI estimates costs for the design, development and implementation phase of a new system to replace LEADER (LRS) at $363.8 million over four years ($190.9 million GF/TANF, $144.1 million federal funds and $28.8 million county funds). Los Angeles County signed a contract with Accenture for the development of LRS in November 2012. OSI estimates the following schedule for the project:

LRS Project Schedule			
Major Tasks	**Revised Start Date**	**Revised End Date**	**Duration (Months)**
Design and Development	11/7/2012	9/31/2015	35
Pilot	10/1/2015	2/31/2016	5
Countywide Implementation	3/1/2016	10/31/2016	8
Performance Verification Phase	11/1/2016	04/28/2017	6
Operational Phase	5/1/2017	10/31/2023	78

As part of LRS approval, the Department of Finance also required an assessment within 90 days of the contract award to determine which California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) components may be leveraged by LRS as California's Health Benefit Exchange gets implemented, and the potential risks, timeline, cost savings or other efficiencies that may result. The analysis was completed in early February 2013 and the assessment is currently being reviewed by stakeholders. For additional information on the interfaces between SAWS and CalHEERS, please see the Subcommittee's agenda from March 14, 2013.

The Need to Replace LEADER: LEADER was implemented countywide in LA in 2001. 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 noncompetitive 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 Legislature first appropriated funding to support the planning process for a new system to replace LEADER in 2005-06. The project was then delayed several times.

Related Migration Project: Trailer bill language related to the 2011-12 budget (Chapter 13, Statutes of 2011) 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. In 2012-13, the budget additionally included a requirement for 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 the C-IV migration project are within the realm of reasonableness. In 2012-13, the Legislature also adopted 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. OSI estimates the following timing for the Migration project (to be updated after a migration strategy is chosen):

C-IV/LRS Migration Major Tasks	Start Date
C-IV Migration Planning	11/1/2012 – 4/30/2017
LRS Stabilization/C-IV Migration Preparation	5/1/2017– 4/30/2018
Migrate C-IV Counties	5/1/2018 –10/2019

Estimated costs for the LRS/C-IV Migration have not yet been determined. According to OSI, Los Angeles County, the C-IV consortium, Accenture, OSI, and program sponsors are all currently reviewing various migration strategies and associated costs. Once a strategy is chosen, a cost reasonableness assessment will then be completed.

Staff Comment & Recommendation: This item is mainly included for information and oversight purposes. Staff recommends that the Subcommittee remind the Administration of the continued interest in briefings and updates regarding LRS development and the Migration of C-IV, including at least one briefing for legislative staff before a Migration strategy is selected that includes information about the options being considered and their estimated costs.

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 costs for that migration?

3. What has the state heard from the federal government regarding its approval of the migration of C-IV?

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

March 21, 2013 Hearing Outcomes

Staff: Jennifer Troia

OUTCOMES

A. 5180 Department of Social Services

1. Approved (3-0) the proposed transfer of the CalFresh Outreach Plan from the Department of Public Health to the Department of Social Services.

2. Approved (2-1) the methodology change and $142.8 million adjustment to employment services funding that are included in the Governor's budget, subject to updates and further adjustment at the May Revision.

3. Held open the TANF transfer to the California Student Aid Commission.

4. Held open the county match-waiver for CalFresh Administration.

5. Held open the requests for staffing and penalty relief with respect to State Hearings.

OTHER NOTES

1. With respect to implementation of SB 1041, the Subcommittee:

    a) Directed the Administration and staff to work together, and to consult with counties, advocates, and/or other stakeholders as needed, to identify measurable data elements and other information that will fulfill the requirements for updates regarding SB 1041 implementation prior to receipt of the required evaluation, along with a schedule for those updates; and

    b) Voted (3-0) to coordinate with Subcommittee 1 to determine if a statutory change to ensure priority enrollment for community college students receiving CalWORKs is appropriate.

2. Directed the Administration to provide the information with respect to early engagement and barrier removal that is required by SB 1041 in time to allow for consideration of any necessary statutory or fiscal changes during the 2013-14 budget development cycle.

3. Requested that the department provide an update on its goals for increased participation in CalFresh statewide, including the impact on the number of eligible families and the state's participation rates.

4. Reminded the Administration of the continued interest in briefings and updates regarding LRS development and the Migration of C-IV, including at least one briefing for legislative staff before a Migration strategy is selected that includes information about the options being considered and their estimated costs.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

April 4, 2013

9:30 AM or Upon Adjournment of Session
(whichever is later)

Room 4203, State Capitol
(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 916-651-1505. Requests should be made one week in advance whenever possible. Thank you.

VOTE ONLY CALENDAR

4150 Department of Managed Health Care

1. Transfer of Legislative Unit to Director's Office

Budget Issue. The Department of Managed Health Care (DMHC) requests an internal transfer of the Legislative Unit from the Office of Legal Services to the Director's Office. This will include the transfer of four positions and $530,000 for 2013-14 and ongoing from the Health Plan Program to Administration. This is an organizational change only. There is no increase in funding or positions.

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

ISSUES FOR DISCUSSION

4150 Department of Managed Health Care (DMHC)

1. Overview

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 122 health care plans provide health insurance coverage to approximately 57 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.

Budget Overview. The budget proposes expenditures of $52.1 million and 346 positions for DMHC. See table below for more information.

Table: DMHC Budget Overview

Fund Source	2012-13 Projected	2013-14 Proposed	BY to CY Change	% Change
Federal Trust Fund	$5,391,000	$691,000	-$4,700,000	-87%
Reimbursements	$1,186,000	$2,739,000	$1,553,000	131%
Managed Care Fund	$49,715,000	$48,677,000	-$1,038,000	-2%
Total Expenditures	**$56,292,000**	**$52,107,000**	**-$4,185,000**	-7%
Positions	**352.8**	**346**	-7	-2%

Subcommittee Staff Comment. This is an informational item.

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

1. Please provide a brief overview of DMCH's programs and budget.

2. Medi-Cal Dental Managed Care Program Oversight

Budget Issue. DMHC requests to convert two limited-term positions to permanent to address the increased workload attributable to the expanded oversight of the Medi-Cal Dental Managed Care (DMC) plans and the transition of the Healthy Families Program (HFP) children to the Medi-Cal DMC program.

DMHC also requests $130,000 for consultant services to provide specialized dental expertise for the dental plan surveys. DMHC indicates that consultants provide specialized dental expertise beyond the scope of the health care service plan analyst classifications and will support DMHC in evaluating the specific elements related to dental care.

Total cost of this request is $378,000 (on an ongoing-basis) and would be funded by 50 percent Managed Care Fund and 50 percent federal funds (through reimbursement from the Department of Health Care Services seeking the federal match).

The requested positions would conduct triennial dental surveys and financial audits of Medi-Cal DMC plans commencing July 2013. The requested permanent positions are as follows:

- 0.5 Health Program Specialist (HPS) II
- 0.5 Associate Health Care Service Plan Analyst (AHCSPA)
- 1.0 Corporation Examiner

Background. Medi-Cal DMC plans are licensed and regulated by the DMHC pursuant to the Knox-Keene Health Care Service Plan Act of 1975. The DMHC is mandated by the Knox-Keene Act to conduct dental surveys and financial audits of dental managed care plans on three-year survey and five-year audit schedules.

The DHCS Medi-Cal Program contracts with Liberty Dental Plan, Access Dental, and Health Net Dental Plan in Sacramento county, effective January 1, 2013, and Los Angeles county, effective July 1, 2013, for a total of six DMC plans. Each dental plan receives a negotiated monthly per capita rate from the state for each Medi-Cal beneficiary enrolled in the plan. Medi-Cal DMC beneficiaries enrolled in contracted plans receive dental benefits from providers within the plan's provider network.

In Sacramento County, the dental Geographic Managed Care (GMC) is a mandatory program where certain populations of Medi-Cal recipients who are eligible to receive dental services must select one of the three available GMC plans for their dental care. In Los Angeles County, the dental managed care program is voluntary.

Increased DMHC Oversight of Dental Managed Care. 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 influx of consumer complaints to the Help Center and concern about the lack of access to dental care for children in that county. As a result, the subcommittee took action to adopt legislatively proposed trailer bill language and approve a

May Revise proposal to require DMHC to conduct non-routine surveys of DMC contracts operating in Sacramento County and conduct additional onsite dental surveys of the dental plans participating in the DMC program.

Prior to the 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; nor did they request, review, or evaluate DMC's enrollment data, quality issues, network adequacy, language assistance, or any other potential barriers to care.

Transition of Healthy Families Program. In addition to the expansion of DMHC oversight responsibilities described above, children currently in the HFP are in the process of transitioning to Medi-Cal in four phases, beginning January 1, 2013 through September 1, 2013. This will result in the addition of approximately 249,242 HFP children into the Medi-Cal DMC program. The DHCS indicates approximately 221,357 HFP children in Los Angeles County and 27,885 HFP children in Sacramento County will enroll in dental managed care plans in these two counties.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as more information regarding the Healthy Families Program transition (as discussed later in the agenda) is forthcoming.

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

1. Please provide an overview of this budget proposal.

2. Please provide a brief review of the findings from non-routine DMC surveys and the resulting corrective actions.

3. Health Premium Rate Review

Budget Issue. DMHC requests to convert two limited term positions, set to expire June 30, 2013, to permanent and $344,000 (on an ongoing-basis) from the Managed Care Fund to address the health premium rate review workload as specified in the Affordable Care Act (ACA) and supported by SB 1163 (Statutes of 2010).

The positions requested are one Senior Life Actuary and one Associate Life Actuary.

Background. SB 1163 (Statutes of 2010) requires health plans to submit premium rate information and giving the DMHC the authority to review premium rate filings effective January 1, 2011. Under SB 1163, health plans are required to submit premium rate information to the DMHC at least 60 days in advance of implementing a rate increase. Upon receipt of a premium rate filing, DMHC documents and publicly posts receipt of the rate filing, reviews the rate filing and makes a determination as to whether or not the proposed rate increase is justified, and then publicly posts the DMHC determination.

SB 1163 provides the rate review authority for all individual and small group market products, but limits review authority in the large employer market to only those rate increases deemed "unreasonable" through actuarial review.

SB 1163 requires the DMHC to make premium rate filing information available on its website and to accept and post public comments regarding the rate filings on the website. In addition, SB 1163 imposes a reporting requirement on the DMHC to submit quarterly reports to the Legislature with regard to any unjustified or "unreasonable" rate increases received. States are also required to monitor premium rate trends both inside and outside Exchanges established under federal health care reform.

Prior to January 1, 2011, the DMHC had limited authority to review health plan rate filings. The only rates that were required to be filed, with very limited scope review, were for the small group market Health Insurance Portability and Accountability Act (HIPAA)-guaranteed issue and conversion products. Health plans were not required to file individual and small group commercial products for premium rate changes. At the time, the DMHC did not have a rate review program or employ actuaries.

In response to the enactment of SB 1163, the DMHC submitted a 2011-12 budget request to address the new anticipated workload associated with the receipt, review and reporting of health premium rate data. The DMHC was granted two Associate Life Actuary positions for a two-year limited-term. Additionally, $600,000 was approved to obtain external actuarial consultant services.

Federal Grant for Rate Review Program. In addition to the above resources, DMHC applied for and received federal Cycle I and Cycle II grants to develop an approved premium rate review program. The use of the federal funds is limited to carrying out the requirements set forth in the federal grant. The federal grant's funding focus is policy oriented on the

development of a good rate review program, while the focus of SB1163 is on the actual collection and analysis of the premium rate data to determine if rate increases are justified, and the reporting of unreasonable rate increases to the Legislature.

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

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

1. Please provide an overview of this budget proposal.

4. Coordinated Care Initiative (CCI)

Budget Issue. DMHC requests to extend 13.0 limited term positions, set to expire June 30, 2013, and add 3.5 new limited term positions to address the workload associated with the transition of dual eligible enrollees in eight counties into managed health care under the Coordinated Care Initiative (CCI). These positions would expire on June 30, 2016.

DMHC also requests $334,000 for consultant services to perform triennial medical plan surveys and financial audits. DMHC indicates that consultants provide specialized medical expertise beyond the scope of the health care service plan analyst classifications and will support DMHC in evaluating the specific elements related to the care for dual eligible beneficiaries.

This proposal would be funded by 50 percent Managed Care Fund and 50 percent reimbursement from the Department of Health Care Services (DHCS) seeking a federal match.

The requested positions are:

Help Center – 11.5 Positions
- Attorney III (1.5)
- Health Program Specialist II
- Nurse Evaluator II
- Associate Health Care Service Plan Analyst
- Associate Governmental Program Analyst
- Consumer Assistance Technicians (5.0)
- Office Technician

Division of Financial Oversight – 2.0 positions
- Corporation Examiner IV Specialists

Provider Solvency Unit – 2.0 positions
- Corporation Examiners

Division of Licensing – 1.0 position
- Health Program Specialist I

Background. The 2012 budget authorized the Coordinated Care Initiative (CCI), by which persons eligible for both Medicare and Medi-Cal (dual eligibles) would receive medical, behavioral, long-term supports and services, and home- and community-based services coordinated through a single health plan in eight demonstration counties (Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara).

AB 1468 (a 2012 budget trailer bill) requires the Department of Health Care Services to enter into an Interagency Agreement with the DMHC to perform certain oversight and readiness review activities related to CCI, including:

- Provide consumer assistance to beneficiaries;
- Conduct medical plan surveys;
- Conduct financial audits;
- Conduct financial solvency audits, and
- Conduct reviews of the adequacy of provider networks of participating health plans.

In 2012-13, DMHC received a one-time augmentation of $1,097,000 and 13.0 one-year limited- term positions to address new workload attributable to the evaluation of plan readiness and oversight of health plans providing managed health care services for CCI.

Subcommittee Staff Comment and Recommendation—Hold Open. As will be discussed in more detail later in this agenda, details regarding CCI are still forthcoming; consequently, it is recommended to hold this item open.

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

1. Please provide an overview of this budget proposal.

2. Please provide a brief description of the CCI-related activities in which DMHC is currently engaged.

5. Medi-Cal Managed Care Rural Expansion

Budget Issue. DMHC requests 3.5 positions and $510,000 for 2013-14 and $470,000 for 2014-15 and ongoing to address workload attributable to the expansion of Medi-Cal managed care into 28 rural counties, as mandated by AB 1468 (a 2012 budget trailer bill).

This request also includes $130,000 for consultant services to perform annual medical surveys of health plans. DMHC indicates that consultants provide specialized medical expertise beyond the scope of the health care service plan analyst classifications and will support DMHC in evaluating the specific elements related to this managed care expansion.

The proposal will be funded by 50 percent Managed Care Fund and 50 percent reimbursement from the Department of Health Care Services (DHCS) seeking the federal match.

The Help Center positions requested are:

- 0.5 Nurse Evaluator II – Provide clinical review of cases and handle urgent nurse cases.
- 0.5 Associate Governmental Program Analyst – Resolve standard complaints involving a review of the complaint, contacting the patient, and reviewing the health plan response.
- 0.5 Associate Health Care Service Plan Analyst – Prepare, organize, conduct, and lead survey teams performing surveys on an annual basis.
- 2.0 Consumer Assistance Technicians – Respond to consumer phone calls and correspondence.

Background. AB 1467 (a 2012 budget trailer bill) authorizes the expansion of the Medi-Cal Managed Care program into 28 rural counties that currently offer only fee-for-service (FFS) Medi-Cal. AB 1468 (a 2012 budget trailer bill) DHCS to enter into an interagency agreement with the DMHC to conduct financial audits, medical surveys, and a review of the provider networks in connection with the expansion of Medi-Cal managed care into rural counties.

On February 28, 2013, DHCS announced that the state has chosen four health plans to provide managed care services to more than 400,000 Medi-Cal members in 28 rural counties, expanding Medi-Cal managed care to all of California's 58 counties.

Subcommittee Staff Comment and Recommendation—Hold Open. When this budget proposal was prepared, it was anticipated that only two health plans would be selected to serve the 28 rural counties. However, subsequent to the preparation of this proposal, DHCS announced that it has chosen four health plans to provide managed care services to 28 fee-for-service counties.

DMHC has indicated that it is working with the Department of Finance to assess the workload impact associated with four health plans (instead of two) being selecting for the expansion of Medi-Cal managed care to rural counties.

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

1. Please provide an overview of this budget proposal.

2. When will DMHC have an updated estimate regarding the workload impact from the rural Medi-Cal managed care expansion?

4280 Managed Risk Medical Insurance Board

1. Overview

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 – The 2012 budget transitioned this program to Medi-Cal in four phases starting January 1, 2013. The final transition phase is required to occur no later than September 1, 2013.
- 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 the federal poverty level (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 six 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 $611.3 million ($21.7 million General Fund) and 104.9 positions for MRMIB. The budget includes a $143.9 million General Fund reduction due to the transition of HFP enrollees to Medi-Cal. See table below for additional information.

Table: MRMIB Program Funding (dollars in thousands)

Program	**2012-13**	**2013-14**	**Change**
Major Risk Medical Insurance Program	$43,000	$42,949	-$51
Access for Infants & Mothers	$128,367	$128,036	-$331
Healthy Families Program	$887,591	$89,371	-$798,220
County Health Initiative Program	$2,210	$2,246	$36
Pre-Existing Conditions Plan (PCIP) Program	$350,982	$348,682	-$2,300
Totals Expenditures	**$1,412,150**	**$611,284**	**-$800,866**
General Fund	$165,508	$21,651	-$143,857
Federal Funds	$643,286	$126,394	-$516,892
Federal Funds—High Risk Health Insurance	$350,982	$348,682	-$2,300
Children's Health & Human Services Special Fund	$140,110	$5,212	-$134,898
Managed Risk Medical Insurance Fund	$43,000	$42,949	-$51
Other Funds	$69,264	$66,396	-$2,868

Subcommittee Staff Comment. This is an informational item.

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

1. Please provide a brief overview of MRMIB's programs and budget.

2. Phase-Out of MRMIP and PCIP

Budget Issue. The Governor's January Budget Summary indicates the Managed Risk Medical Insurance Program (MRMIP) and the Pre-Existing Condition Insurance Program (PCIP), health coverage programs for individuals with pre-existing conditions, will phase-out with the implementation of the federal Affordable Care Act (ACA) of 2010.

MRMIB has indicated that it is working with the Exchange regarding the transition of MRMIP and PCIP subscribers to the Exchange. However, details regarding this transition, such as the transfer of protected health information between the programs; are still being worked out.

It should be noted that the budget includes full year funding for MRMIP. This is because MRMIB must complete reconciliations for MRMIP. Under current statute, health plans have until December 31, 2014 to submit claim information. MRMIB anticipates that it would take an additional six months (until June 2015) to complete the reconciliations.

Background—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.

Background—PCIP. As a result of the ACA, 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 six months.

Federal Government Requires Closure to New Enrollment for PCIPs Nationwide. The federal government notified all state administered PCIPs to close to new enrollments after March 2, 2013. As the contractor that operates PCIP in California for CMS, MRMIB has closed PCIP enrollment except for persons coming into California with PCIP from another state and for persons who applied prior to March, but whose application was missing information.

California's PCIP has incurred costs of $529 million of its $761 million allocation.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue regarding the transition of MRMIP and PCIP subscribers to coverage under the Exchange.

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

1. Please provide an overview of this budget proposal.

2. What would facilitate a successful transition of MRMIP and PCIP subscribers to the Exchange?

3. Transition Plan for Healthy Families Program Staff

Budget Issue. The 2012 Budget Act and the proposed budget bill requires MRMIB, in conjunction with the Department of Health Care Services (DHCS), to submit a transition plan for the transfer of state administrative functions for the operation of the Healthy Families Program (HFP) to DHCS.

The purpose of the plan is to identify the personnel that would be moved from MRMIB to DHCS as children in the HFP are transitioned to Medi-Cal, identify the steps that will be taken to select the positions, notify staff, and/or advertise for recruitment.

This plan is due to the Legislature no later than January 10, 2013. The transition plan has not yet been received by the Legislature.

Background. AB 1494 (a 2012 budget trailer bill) provides for the transition of approximately 870,000 Healthy Families Program (HFP) subscribers to the Medi-Cal program beginning January 1, 2013, in four phases throughout 2013. See Healthy Families Program Transition item under the Department of Health Care Services for more information on this transition.

Subcommittee Staff Comment—Hold Open. It is recommended to hold this item open as the Legislature has not yet received this transition plan.

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

1. When will the Legislature receive this transition plan?

2. Please provide an overview of the transition plan and the Administration's proposal for further updates to the Legislature on staff transitions.

4260 Department of Health Care Services

1. Overview – 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, 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 the federal poverty level ($19,530 annually for a family of three).

Enrollment. Estimated average monthly Medi-Cal enrollment for the current year is 8.2 million people and for 2013-14 it is 8.7 million people. This increase in caseload is primarily due to the transition of Healthy Families Program enrollees to Medi-Cal.

Summary of Governor's Budget for 2013-14. As shown in the table below, the Governor proposes total expenditures of almost $59.8 billion ($15.3 billion General Fund, $35.9 billion federal Title XIX Medicaid funds, and $8.6 billion in other funds) for Medi-Cal in 2013-14.

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

	2012-13 Revised	2013-14 Proposed	Difference	Percent
Benefits	$56,939.60	$55,901.30	-$1,038.30	-1.8%
County Administration (Eligibility)	$2,769.10	$3,564.40	$795.30	28.7%
Fiscal Intermediaries (Claims Processing)	$337.70	$312.70	-$25.00	-7.4%
Total	**$60,046.40**	**$59,778.40**	**-$268.00**	**-0.4%**
General Fund	$14,897.10	$15,251.10	$354.00	2.4%
Federal Funds	$37,264.20	$35,918.00	-$1,346.20	-3.6%
Other Funds	$7,885.00	$8,609.30	$724.30	9.2%

Subcommittee Staff Comment. This is an informational item.

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

1. Please provide a brief overview of the Medi-Cal program and major budget proposals.

2. Healthy Families Program Transition to Medi-Cal

Budget Issue. The Administration estimates $129,000 General Fund savings in 2012-13 (compared to $13.1 million General Fund savings in the 2012 Budget Act) and $42.6 million General Fund savings in 2013-14, as a result of the transition of Healthy Families Program (HFP) subscribers to Medi-Cal.

These savings estimates are less than what was reflected in the 2012 Budget Act because of a slower transition of children and updated Medi-Cal managed care rates. See table below for a summary chart.

Table: Summary of Savings from Transition of Healthy Families Program to Medi-Cal

	2012-13 Revised	2013-14 Estimate
General Fund	-$129,000	-$42,645,000
Federal Funds	-$3,212,000	-$81,377,000
Total Funds	**-$3,341,000**	**-$124,022,000**

Background. The Governor's January 2012-13 budget proposed to shift children in the Healthy Families Program to Medi-Cal over a nine-month period beginning in October 2012. The Legislature adopted a modified version of this proposed transition.

AB 1494 (a 2012 budget trailer bill) provides for the transition of approximately 870,000 HFP subscribers to the Medi-Cal program beginning January 1, 2013, in four phases throughout 2013. These phases are:

- **Phase 1A** – Occurred on January 1, 2013 and included about 178,000 children in a HFP health plan that matches a Medi-Cal health plan.

- **Phase 1B** – Occurred on March 1, 2013 and included about 101,000 children in a HFP health plan that matches a Medi-Cal health plan.

- **Phase 1C** – Occurred on April 1, 2013 for approximately 36,000 children in five counties (Kern, Sacramento, San Joaquin, Stanislaus, and Tulare) and two health plans.

- **Phase 1C** – Will occur on May 1, 2013 and includes approximately 63,000 children in Los Angeles and San Diego enrolled in one health plan transitioning on May 1, 2013.

- **Phase 2** – Occurred on April 1, 2013 and includes about 228,000 children in a HFP health plan that is a subcontractor of a Medi-Cal health plan.

- **Phase 3** - Begins no sooner than August 1, 2013 and transitions about 135,000 children enrolled in a HFP plan that is not a Medi-Cal health plan and does not contract or subcontract with a Medi-Cal health plan into a Medi-Cal health plan in that county.

- **Phase 4** - Begins no earlier than September 1, 2013 and transitions about 43,000 children in HFP residing in a county that is not Medi-Cal managed care into the Medi-Cal fee-for-service delivery system.

Additionally, AB 1494 required:

- **Strategic Plan for Transition.** The development of a strategic plan for the transition by the California Health and Human Services Agency (CHHSA), the Managed Risk Medical Insurance Board (MRMIB), the Department of Health Care Services (DHCS), and the Department of Managed Health Care (DMHC). This plan was submitted on October 2, 2012.

- **Implementation Plans.** The creation of an implementation plan for each phase prior to transitioning children to Medi-Cal to ensure continuity of care with the goal of ensuring there is no interruption in services and there is continued access to coverage for transitioning individuals. AB 1494 requires the Administration to consult with stakeholders on the development of the implementation plans.

- **Network Adequacy Assessment**. The completion of a managed care health plan network adequacy assessment at least 60 days prior to the transition of children in Phase 1. This assessment must be submitted to the Legislature.

- **Monitoring of Transition.** The submittal of monthly status reports to the Legislature on the transition. These reports must include information on health plan grievances related to access to care, continuity of care requests and outcomes, and changes to provider networks (including provider enrollment and disenrollment).

Children in the HFP will transition into Medi-Cal's new optional Targeted Low Income Children's Program (TLICP) covering children with income up to and including 250 percent of the federal poverty level (FPL).

Network Adequacy Assessment Findings Lead to Phase 1 Sub-Phases. Prior to implementation of Phase 1 and Phase 2 of the transition, DHCS and DMHC completed network adequacy assessments, addendums to those assessments, and implementation plans for enrollees transitioning in these phases. During those assessments, potential interruptions to continuity of care for some transitioning HFP enrollees were identified.

Consequently, Phase 1 was split out into sub-phases to give more time to ensure no interruptions of care would occur. Additionally, Phase 1C will be implemented on two different dates as the state and CMS felt it was important to provide additional time for outreach to

enrollees is Los Angeles and San Diego counties to assist in selecting a new primary care provider, to the extent necessary.

Federal Approval Required Prior to Phase Transition. The Centers for Medicare and Medicaid Services (CMS) granted federal approval for DHCS to begin the transition via the Bridge to Reform 1115 Demonstration Waiver.

Federal CMS approval is required prior to each phase (and sub-phase). CMS has approved the transitions for Phase 1A, 1B, 1C, and 2.

Continued federal approval is contingent upon compliance to the Special Terms and Conditions (STC) as detailed in the waiver amendments and the state demonstrating the successful provision of coverage to children in previous phases, as well as provider network adequacy to serve the children in subsequent phases, and appropriate plans for maintaining continuity of care.

Transition Monitoring Reports for Phase 1A. AB 1494 and the STC of the waiver require the Administration to report every month on metrics to evaluate the transition and the impact on children and families with regard to maintaining coverage, timely access to care, continuity of care, provider capacity, and consumer satisfaction under each phase.

Two monitoring reports have been submitted. (The first report was submitted on February 15 and the second report was submitted on March 18.) These reports generally indicate that Phase 1A has gone smoothly and no continuity of care issues for medical, dental, mental health, or substance use disorder services have been identified.

Almost every child (99.85 percent) remained with the same health plan, as Phase 1A was only for children in HFP plans that matched Medi-Cal plans and whose provider network was determined adequate for transition. About 1 percent of the transitioning population had to choose a new primary care provider.

Greater Potential for Interruptions in Care for Phases 3 and 4. The risk of children losing access to care and services increases in phases 3 and 4 since the level of plan and provider overlap decreases in these phases. Additional education and outreach will be necessary to ensure that providers, application assistors, and families understand this transition and how it will be implemented in their county and health plan.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open pending May Revise updated estimates and the submittal of additional transition monitoring reports.

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

1. Please provide an update on the transition of HFP children to Medi-Cal.

2. Since the likelihood of children having to change providers increases in phases 3 and 4, please describe what additional steps the Administration is taking to ensure access to care and continuity of care.

3. How is the Administration working with providers to educate them about this transition? What more needs to be done? What are some lessons learned regarding provider outreach from the transition of seniors and persons with disabilities to Medi-Cal managed care?

3. Coordinated Care Initiative (CCI)

Enacted as part of the 2012 budget, the Coordinated Care Initiative (CCI) integrates medical, behavioral, long-term supports and services (LTSS), and home- and community-based services through a single Medi-Cal health plan for persons eligible for both Medicare and Medi-Cal (dual eligibles) in eight demonstration counties. Additionally, it integrates LTSS into Medi-Cal managed care for Medi-Cal-only individuals.

MOU Signed. On March 27, 2013, DHCS announced that it had entered into a Memorandum of Understanding (MOU) with the federal CMS regarding the state's Duals Demonstration, a component of the CCI. The MOU reflects the procedures under which CMS and the state plan will implement and operate Cal MediConnect, the name of the demonstration project. The project will begin no sooner than October 1, 2013 and continue until December 31, 2016.

Key provisions in the MOU that have changed since the 2012 budget include:

- **Shared Savings.** The CCI, as reflected in the 2012 budget, assumes that the state and the federal government will equally share (50:50) the savings as a result of the CCI. The MOU defines the state's the minimum savings percentages as 1 percent in the first year, 2 percent in the second year, and 4 percent in the third year. Payment rates to the health plans will be determined by applying these savings percentages to the baseline spending amounts.

  The Administration has not yet provided fiscal estimates explaining how these savings percentages affect the total estimated savings from CCI.

- **Timeline.** The MOU calls for implementing Cal MediConnect no earlier than October 2013. This means that the first notices any beneficiaries would receive about these transitions would come no earlier than July 2013. This is a change from the 2012 budget that had a launch date of March 2013.

- **Enrollment Strategies.** Eight counties will implement the Cal MediConnect program: Alameda, Los Angeles, San Bernardino, San Diego, San Mateo, Santa Clara, Orange and Riverside. Originally, all counties would phase-in enrollment over 12 months. The MOU lays out enrollment strategies for each county. Specifically, assuming an October 2013 start, San Mateo County enrollment will complete enrollment in January 2014 and Los Angeles County enrollment will happen over a 15-month period.

- **No Stable Enrollment Period.** The 2012 budget included an initial six-month stable enrollment period, during which eligible beneficiaries would remain in the same health plan. The MOU contains no language regarding a stable enrollment period. Beneficiaries enrolled in Cal MediConnect can opt out at any time.

- **Home and Community Based (HCBS) Waiver.** The original proposal called for closing most of California's HCBS waivers. Those waivers will now remain open.

- **Size of the Demonstration.** The total number of enrollees allowed under the MOU is estimated at 456,000. This is almost half the size of the number of enrollees (800,000) estimated in the 2012 budget.

- **Number of Participants in Los Angeles County.** The MOU sets a cap of no more than 200,000 enrolled beneficiaries in Los Angeles County. The 2012 budget had no such cap.

Other provisions included in the MOU are:

- **Quality Withhold Measures.** Under the demonstration, CMS and the state will withhold a percentage of their respective components of the capitation rate. The withheld amounts will be repaid subject to the health plan's performance, consistent with established quality thresholds. These thresholds are based on a combination of certain core quality withhold measures, as well as state-specified quality measures including behavioral health coordination and planning, and ensuring physical access to buildings, services, and equipment.

- **Risk Corridors.** Limited risk corridors will be established in order to provide a level of protection to the health plan and payers against uncertainty in rate-setting that could result in either overpayment or underpayment.

- **Additional Home and Community Based Services.** Health plans participating in the project will have the ability to provide additional HCBS, including supplemental personal care services, respite care, and nutritional supplements.

- **Dental, Vision, and Transportation Benefits Required.** The benefit package offered under this project must include preventative, restorative, and emergency oral health and vision benefits and must include non-emergency, accessible medical transportation.

- **Evaluation.** CMS has contracted with an independent evaluator to measure, monitor, and evaluate the impact of this project. The evaluator will assess how the project operates, how it transforms and evolves over time, and beneficiaries' perspectives and experiences.

Budget Issue. The budget proposes the following related to CCI:

- **Increased General Fund Savings in Current Year.** As a result of delaying the start date until the budget year, General Fund savings in the current year is $642 million, an increase of $34 million compared to the 2012 Budget Act. This is because the state does not have to pay overlapping Medi-Cal fee-for-service payments and Medi-Cal

managed care rates for the dual eligibles that would have transitioned in the current year.

This current year savings is not impacted by the MOU.

- **Decreased General Fund Savings in Budget Year and Ongoing.** The Governor's budget includes $171 million General Fund savings in 2013-14 and ongoing General Fund savings of $535 million starting in 2015-16 (when enrollment will be complete in all demonstration counties). At the time the 2012 budget was enacted, it was estimated that 2013-14 and ongoing General Fund savings would be $880 million. According to the Administration, the revised savings estimates more accurately reflect the number of people eligible for CCI.

  The MOU will have an impact on the estimated budget year and ongoing savings. Consequently, these estimates will change at May Revise.

Background. SB 208 (Statutes of 2010) requires DHCS to establish a demonstration program to begin enrolling persons who are eligible for both Medi-Cal and Medicare (dual eligible) into coordinated health care delivery models in up to four counties. During the 2010 Bridge to Reform Section 1115 waiver negotiations, CMS requested that California pursue the dual eligible pilots through a new federal initiative rather than as part of the waiver. California was one of 15 states to receive a $1 million design contract from CMS in April 2011.

SB 1008 (a 2012 budget trailer bill) and SB 1036 (a 2012 budget trailer bill) modified the original authority in SB 208 and created the Duals Demonstration Project/Coordinated Care Initiative (CCI). Under the CCI:

- Up to eight counties can participate in the Duals Demonstration Project. These counties are: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara. See table below for more information on the demonstration counties.

- Long-term supports and services (LTSS), such as In-Home Supportive Services, are shifted into Medi-Cal managed care for Medi-Cal-only individuals.

Under CCI, the state and CMS will jointly contribute to managed care rates that are designed to lower total Medicare and Medi-Cal spending for dual eligibles. The rates will be determined based on the assumption that by integrating LTSS under managed care, demonstration plans can prevent and substitute nursing facility stays for their members with less costly LTSS.

The rates also assume a reduction in hospital inpatient services under managed care. In future years, when CCI is fully implemented, General Fund savings are expected to result from both (1) LTSS integration, which mainly lowers Medi–Cal costs, and (2) reduced hospitalizations for dual eligibles, which mainly lowers Medicare costs.

SB 1008 contains a “poison pill” in that it requires that if a six-month stable enrollment period is not obtained in the project or the level of savings estimated in the 2012 budget act is not achieved, then the entire CCI project becomes inoperative.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as the Administration will be providing revised fiscal estimates reflecting the provisions of the MOU. The delayed start date, no stable enrollment period, and cap on participation in Los Angeles County, for example, will impact these estimates.

The revised estimate should be provided prior to May Revision to give the Legislature and stakeholders the opportunity to carefully evaluate and consider how these numbers interact with other proposals in the budget.

Additionally, it is anticipated that changes in statute will be necessary to implement the project, such as changes to the “poison pill.” It is recommended that the Administration share, as soon as possible, its proposed changes to law.

DHCS has been working closely with CMS over the last year regarding this project and is intimately familiar with the details of its proposed implementation. The Legislature and stakeholders have not been party to the conversations with CMS; consequently, it is reasonable for stakeholders, including the Legislature, to get details and assumptions as soon as possible to ensure a thorough understanding of the changes and implications.

This project impacts the lives of almost half a million Californians and the solvency of many of the state’s business partners (health plans and providers), it is important to ensure that the details are carefully considered.

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

1. Please provide an overview of the MOU and next steps regarding the project.

2. Please explain how CMS and the state will share the savings from this project.

3. Please provide a brief overview of the proposed risk corridors.

4. What is the Administration’s timeline for sharing updated fiscal estimates and proposed trailer bill language regarding this project?

4. CCI Long Term Care Division - Position Request

Budget Issue. DHCS's Long-Term Care Division requests the extension of one full-time limited-term position (a Health Program Manager III) for a three-year term. This position would continue work related to the implementation of the Duals Demonstration Project/Coordinated Care Initiative (CCI).

The cost for this position is $150,000 ($75,000 General Fund and $75,000 federal funds).

Background. SB 208 (Statutes of 2010) directed DHCS to establish pilot projects in up to four counties to develop effective health care models to provide services to persons who are dually eligible under both the Medi-Cal and Medicare programs (the Dual Demonstration). SB 1008 (a 2012 budget trailer bill) authorized CCI and expanded the Dual Demonstration to an additional four counties and included the integration of long-term supports and services (LTSS), including the Multi-Purpose Senior Services Program and In-Home Supportive Services, into a Medi-Cal managed care benefit.

The position requested to be extended in this proposal would help facilitate LTSS integration into managed care health plans participating in the Duals Demonstration. In addition, this position would work with the California Department of Aging and the California Department of Social Services, on developing the universal LTSS assessment process and tool.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as details on CCI are still forthcoming (as discussed in the agenda item above).

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

1. Please provide an overview of this budget proposal.

5. Emergency Preparedness Audits - Position Request

Budget Issue. DHCS requests three permanent full-time Health Program Auditor IV positions, effective July 1, 2013, to conduct audits of local health departments' use of federal public health emergency funds.

The total cost for these positions is $379,000 and would be funded with reimbursements from the Department of Public Health (who receives federal Centers for Disease Control and Prevention grants for these activities).

Background. DPH does not have audit staff to perform financial and compliance audits of local health department's (LHD) use of federal grant funds on a three year cycle, as required by Health and Safety Code Section 10137(g)(3). Consequently, it has entered into an interagency agreement with the Audits and Investigations (A&I) branch of DHCS to conduct these audits.

The CDC has approved the use of California's public health emergency preparedness funds to finance the LHD audits.

At the March 14, 2013 Subcommittee #3 hearing, this Subcommittee approved related positions at the Department of Public Health for a limited-term of four years to align with the federal grant period.

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to approve these positions on a limited-term basis for four years (until 2016-17) to align with the period of the federal grant that funds these positions. No other issues have been raised.

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

1. Please provide an overview of this budget proposal.

2. Does DHCS have any concerns with making these positions limited-term?

6. California Medicaid Management System (CA-MMIS) Replacement Project - Position Request

Budget Issue. DHCS requests a three year extension of 26 of the previously authorized 34 limited-term positions, to provide continued oversight of the California Medicaid Management Information System (CA-MMIS) Replacement Project through its completion in 2015-16.

The cost to extend 26 positions would be $3.52 million ($839,000 General Fund and $2.69 million federal funds). These positions are funded at a 90 percent enhanced federal funding rate as they support the CA-MMIS system replacement efforts (per federal CMS approval).

Background. CA-MMIS is used to process over 210 million claims annually for payment of medical services provided to Medi-Cal beneficiaries. DHCS contracts with a fiscal intermediary (FI) to maintain and operate CA-MMIS.

The CA-MMIS system replacement project was originally scheduled to begin in 2010 and end in 2015. However, due to delays in the execution of the FI contract and the assumption of operations by the new FI (Xerox State Healthcare, LLC), the system replacement project was delayed. Project planning began in October 2011 and the project is scheduled to be completed by June 30, 2016. A Special Project Report (SPR) was completed and approved by the California Technology Agency on July 26, 2012, to extend the project timeframe and expenditure plan.

According to DHCS, this information technology project is very important because the existing legacy CA-MMIS is aged, inflexible, and costly to modify. By extending these positions, it will allow for the project to move forward to help reduce waste, improve fraud detection, cost recovery, and support quality assurance activities.

CA-MMIS System Replacement Phases. The system replacement project is divided into four phases:

- Phase I - Replaces pharmacy claims processing drug rebates functionality.
- Phase II – Focuses on pharmacy authorizations.
- Phase III – Encompasses medical authorizations.
- Phase IV – Implements full Health Enterprise system.

Business rule validation is underway for Phase I and just beginning for Phase II. Work on Phases III and IV are expected to begin in 2014

Subcommittee Staff Comment—Approve. It is recommended to approve this request. No issues have been raised.

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

1. Please provide a brief description of the CA-MMIS system replacement project and timeline.

2. Please provide an overview of this proposal.

7. Continuation of 1115 Waiver Activities - Position Request

Budget Issue. DHCS requests to extend 18 limited-term positions through the end of the 1115 Waiver, which expires on October 31, 2015. DHCS also requests $1 million per year, for three years, in contract funds for actuary services and $10,000 for actuarial and auditing training.

The 2013-14 cost for this proposal is $3.165 million ($1.3 million General Fund, $1.7 million federal funds, and $107,000 reimbursement from counties).

Background. Effective November 1, 2010, CMS approved California's five-year, $10 billion "Bridge to Reform" Section 1115 Waiver proposal. Generally, the waiver expands health care coverage to uninsured adults; provides support for uncompensated care; improves care coordination for vulnerable populations; and promotes public hospital delivery system transformation.

Provisions of the waiver and waiver amendments that relate to this budget proposal are:

- The transition of seniors and persons with disabilities (SPDs) from voluntary to mandatory enrollment in Medi-Cal managed care in a phased-in manner over a twelve-month period commencing June 1, 2011.

- The development and implementation of intergovernmental transfers to allow the transfer of public funds between governmental entities.

- The transition of Adult Day Health Care (ADHC) to Community-Based Adult Services (CBAS).

- The transition of Healthy Families into the Medi-Cal managed care program.

- The expansion of Medi-Cal managed care into rural counties.

These 18 limited-term positions work on activities related to the above-specified provisions of the waiver and waiver amendments. Key activities performed by these positions include:

- **Administration Division (1 position) -** Prepare and analyze managed care reconciliations; analyze and interpret financial data for federal reporting (the adopted waiver requires the accounting federal reporting unit to produce 1,700 additional CMS reports annually to report and draw federal funding); respond to requests from program management and CMS auditors; process invoices for payment, issue and process difference checks; and prepare quarterly summary information.

- **Medi-Cal Managed Care Division (9 positions) -** Update managed care contracts with requirements specific to the Special Terms and Conditions of the 1115 Waiver, monitor the additional contract requirements specific to the 1115 waiver (e.g., SPD

specific network and medical reviews), and complete the 1115 waiver reporting required by the federal government.

- **Capitated Rates Development Division (5 positions) –** Review capitation rate development, provide fiscal analysis and health care plan analysis of the 1115 Waiver, provide oversight for risk adjustment and rate setting, and review the intergovernmental transfer process for public hospitals.

- **Information Technology Services Division (3 positions) –** Support the 1115 Waiver activities in regard to system modifications and enhancements, assist with technical documentation and testing of system changes related to the Waiver.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open.

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

1. Please provide a brief summary of this proposal.

8. Continuation of LIHP & DSRIP Activities - Position Request

Budget Issue. DHCS requests the extension of 26 limited-term positions and contract funds to continue the workload associated with the Low Income Health Program (LIHP) and Delivery System Reform Incentive Pool (DSRIP) components of the 1115 Bridge to Reform Demonstration Medicaid Waiver.

The cost for this request is $2.7 million ($260,000 General Fund, $1.4 million federal funds, and $1.1 million in reimbursements from counties).

The positions requested to be extended are:

- **Low Income Health Program (18 positions) -** Complete workload associated with the implementation, close-out, and transition of the LIHP to the Medi-Cal program and the Exchange.

- **Delivery System Reform Incentive Pool (3 positions and contract services) -** Complete workload associated with the DSRIP.

- **Hospital Financing Activities (5 positions) -** Complete workload associated with ongoing hospital financing activities, the final reimbursement activities for the Health Care Coverage Initiative, and the transition of the LIHP to the Medi-Cal program and the Exchange.

Background—LIHP. The Low Income Health Program (LIHP) is a voluntary, county-run program to provide a Medicaid-like coverage to low-income individuals who are uninsured. There are 17 LIHPs in operation, covering 52 counties, and each LIHP can have different income eligibility requirements. The County Medical Services Program (CMSP) LIHP includes 35 counties.

The LIHP is authorized under the state's 1115 waiver. The 1115 waiver provides a bridge to implement the ACA and an opportunity for county health departments to improve coverage, increase access to care, pay for uncompensated services, identify persons eligible for care under the ACA, and build the right delivery systems for a uninsured population with a 50:50 match of existing county health spending for the newly-eligible and federal funds.

The terms of this waiver limit operations of LIHP to December 31, 2013, as LIHP enrollees would be eligible for Medi-Cal or coverage offered through the Exchange starting January 1, 2014 (under provisions of the ACA).

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 138 percent of the FPL, and its federal funding through the waiver is uncapped. HCCI is coverage for low-to-moderate income adults with incomes between 138 percent and

200 percent of FPL, and its expenditures are capped. See the table that follows for LIHP enrollment information.

Table: Low Income Health Program (LIHP), November 2012 Monthly Enrollment

LIHP	Medicaid Coverage Expansion			Health Care Coverage Initiative			Total LIHP Enrolled
	Start Date	Upper Income Limit	Number Enrolled	Start Date	Upper Income Limit	Number Enrolled	
Alameda*	07/01/2011	133% of FPL	38,773	07/01/2011	200% of FPL	8,698	47,471
CMSP (County Medical Services Program)	01/01/2012	100	56,542			0	56,542
Contra Costa*	07/01/2011	133	9,726	07/01/2011	200	2,072	11,798
Kern	07/01/2011	100	6,322			415	6,737
Los Angeles	07/01/2011	133	212,916			185	213,101
Orange*	07/01/2011	133	34,030	07/01/2011	200	9,872	43,902
Placer	08/01/2012	100	2,164			0	2,164
Riverside	01/01/2012	133	24,594			0	24,594
Sacramento	11/01/2012	67	1,394			0	1,394
San Bernardino	01/01/2012	100	26,081			0	26,081
San Diego	07/01/2011	133	33,278			76	33,354
San Francisco	07/01/2011	25	9,383			1,072	10,455
San Joaquin	06/01/2012	80	1,769			0	1,769
San Mateo	07/01/2011	133	8,555			174	8,729
Santa Clara	07/01/2011	75	12,771			745	13,516
Santa Cruz	01/01/2012	100	2,163			0	2,163
Ventura*	07/01/2011	133	8,605	07/01/2011	200	2,997	11,602
TOTAL			**489,066**			**26,306**	**515,372**

*These programs are not currently operating an HCCI, the enrollment numbers reflect legacy program caseload.

Monterey implemented a LIHP in February 2013. Tulare implemented a LIHP in March 2013. According to DHCS, LIHPs in Stanislaus and Santa Barbara will likely not be established. Fresno, Merced, and San Luis Obispo have withdrawn their interest in creating a LIHP.

Transition of LIHP Enrollees to Medi-Cal. On January 1, 2014, LIHP enrollees will automatically transition to Medi-Cal or the Exchange. Welfare and Institutions Code Section 15910(c) requires that LIHPs be designed and implemented with the system and program elements that are necessary to facilitate the transition of LIHP enrollees to Medi-Cal coverage. Additionally, the Special Terms and Conditions of the Waiver requires implementation of a

simplified, streamlined process for transitioning eligible enrollees from LIHP to Medi-Cal or the Exchange in 2014 without need for additional determinations of enrollees' eligibility.

Background—DSRIP. The Delivery System Reform Incentive Pool (DSRIP) Program was created to support the efforts of California's Designated Public Hospitals (DPHs) to transform their health care delivery systems in order to enhance the quality of care and the health of the patients they serve. The program involves the development of hospital plans that include specific work efforts to encourage and create systems to prepare for implementation of federal health care reform.

The funding for DSRIP is $3.3 billion in federal funds ($6.6 billion total as counties use intergovernmental transfers to finance DSRIP projects) over a five-year period (November 1, 2010 – October 31, 2015) and is allocated among the 17 DPH systems. The focus in years one and two of the program is on building infrastructure and systems and the focus in years three through five of the program is on outcomes.

DSRIP projects fall within five distinct categories:

- **Category 1 - Infrastructure Development.** Lays the foundation for delivery system transformation through investments in people, places, processes and technology. Projects include implementing disease management registries, expanding primary care capacity and increasing training of the primary care workforce.

- **Category 2 - Innovation & Redesign.** Includes the piloting, testing and replicating of innovative care models. Many plans include projects to expand medical homes, integrate physical and behavioral health care, expand chronic care management models, redesign primary care and improve patient experience.

- **Category 3 - Population-Focused Improvement.** Requires all public hospital systems to report on the same 21 measures across four domains: (1) the patient's experience, (2) the effectiveness of care coordination (e.g., measured by hospitalization rates for heart failure patients), (3) prevention (e.g., mammogram rates and childhood obesity), and (4) health outcomes of at-risk populations (e.g., blood sugar and cholesterol levels in patients with diabetes).

- **Category 4 - Urgent Improvement in Care.** Requires public hospital systems to achieve significant improvement in targeted quality and patient safety measures that are particularly meaningful to safety net populations and have a strong base of evidence.

- **Category 5 – HIV Transition Projects.** Enables public hospital systems to implement infrastructure, program design, and clinical and outcome projects related to health care practices that support continuity of care for those LIHP enrollees who have been diagnosed with HIV, and who received their care formerly through Ryan White programs.

See table below for categories and projected allocation of funding. (Payments have been made through 2011-12.)

Table: DSRIP Project Category Projected Funding Allocations (in thousands)

Category	2010-11	2011-12	2012-13	2013-14	2014-15	Total
Infrastructure Development	$463,698	$420,949	$354,442	$160,343	$54,660	$1,454,093
Innovation & Redesign	459,671	415,085	315,697	144,867	68,085	1,403,407
Population-Focused Improvements	-	297,103	396,138	594,207	693,242	1,980,693
Urgent Improvement in Care	83,430	166,860	333,721	500,581	584,011	1,668,605
HIV Transition Projects	-	-	110,000	55,000	-	165,000
Total	**$1,006,800**	**$1,300,000**	**$1,510,000**	**$1,455,000**	**$1,400,000**	**$6,671,800**

Subcommittee Staff Comment and Recommendation—Hold Open. Staff had requested information on the planning for the transition of LIHP enrollees to Medi-Cal or the Exchange prior to this hearing. This information has not yet been received. It is recommended to hold this item open until the subcommittee receives more information regarding this transition.

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

1. Please provide a brief summary of this proposal.

2. Please provide an update on the planning for the transition of LIHP enrollees to Medi-Cal or the Exchange.

9. Assisted Living Waiver – Position Request

Budget Issue. DHCS requests to extend two limited-term positions for three years to work on the Assisted Living Waiver (ALW) program. These positions are set to expire on June 30, 2013. The total cost of these positions is $235,000 ($117,000 General Fund and $118,000 federal funds).

The two positions requested are:

- Health Program Manager I (HPM I) – This position would direct the expansion and administration of the waiver. This position would be responsible for executing the requirements of the waiver, conducting outreach and providing technical assistance to external partners, resolving all internal policy and system issues, overseeing financial audits, and monitoring the quality and effectiveness of the waiver.

- Research Analyst II (RA II) – This position would ensure that the fiscal oversight process is in compliance with the fiscal intermediary, which is required for this waiver by CMS and contingent upon renewal of this waiver.

Background. The ALW offers assisted living services in two settings: Residential Care Facilities for the Elderly and publically subsidized housing. Qualified participants have full-scope Medi-Cal benefits with zero share of cost and are determined to meet the Skilled Nursing Facility Level of Care, A or B.

The ALW expires February 28, 2014. The waiver extension application is currently in development (the application would extend the project through February 2019).

The ALW was preceded by the Assisted Living Waiver Pilot Project (ALWPP) which was created by AB 499 (Statues of 2000). It tasked DHCS to test the efficacy of assisted living as a Medi-Cal benefit and as an alternative to long-term nursing home placement. The ALWPP was tested in three counties: Sacramento (representing urban, northern California-350 beneficiaries); San Joaquin (representing rural, central California-50 beneficiaries); Los Angeles (representing urban, southern California-600 beneficiaries).

On March 1, 2009, CMS approved a statewide ALW, and granted it a five year waiver cycle. As of October 2012, approximately 1,840 individuals are enrolled in this program.

Medi-Cal enrollees interested in applying to the ALW do so through a Care Coordinator Agency (CCA), which initially ascertains eligibility through the Medi-Cal provider website and through a nursing assessment conducted by a CCA nurse. Final eligibility for the ALW is determined by DHCS's Long-Term Care Division. The allocation of waiver slots is limited to 60 waiver slots per county, per year, and is dependent upon CMS approval and state appropriations.

DHCS finds that these two positions would permit DHCS to significantly increase nursing facility transitions and develop the necessary community resources to enable thousands of additional Medi-Cal beneficiaries in several different counties to participate in these projects. The ALW results in potential savings for both Medicare and Medi-Cal as individuals are placed in a more cost effective placement.

LAO Findings and Recommendation. The LAO finds that there has been insufficient workload justification to support continuing the Health Program Manager (HPM) position. Specifically, the LAO finds that the workload data provided by DHCS related to the HPM position appears overstated. Therefore, the LAO recommends rejecting the request for the HPM position, resulting in $124,000 in savings ($62,000 General Fund).

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open.

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

1. Please provide a brief summary of this proposal and how DHCS proposes to expand the ALW.

2. What is DHCS's estimate as to the potential savings that could be realized if the ALW was expanded as proposed?

10. Public Assistance Reporting Information System (PARIS) Interstate – Position Request

Budget Issue. DHCS requests one full-time permanent Associate Governmental Program Analyst (AGPA) to operate the Public Assistance Reporting Information System (PARIS) Interstate program on a statewide basis.

This proposal does not seek new General Fund resources as funding for the new staff will come from redirection of program savings of $102,000 ($51,000 General Fund and $51,000 federal funds) resulting from the implementation of PARIS Interstate.

Background. On July 1, 2009, DHCS began participation in the PARIS data match process with three pilot programs to improve program integrity. PARIS is an information-sharing system, operated by the U.S. Department of Health and Human Services' Administration for Children and Families, which allows states and federal agencies to verify public assistance client circumstances affecting Medicaid program eligibility. PARIS includes three different data matches:

PARIS Data Match Type	Where Implemented?	2013-14 General Fund Savings
PARIS-Veterans allows states to compare their beneficiary information with the U.S. Department of Veterans Affairs.	Implemented in 10 counties.	$519,350
PARIS-Federal allows states to compare their beneficiary information with the U.S. Department of Defense and the U.S. Office of Personnel Management.	Implemented in 30 counties. DHCS plans to expand to 40 counties in 2013-14.	$332,400
PARIS-Interstate allows states to compare their beneficiary information with other states.	Implemented in 30 counties. DHCS plans to expand to 40 counties in 2013-14.	$1,474,000

PARIS-Interstate. DHCS' PARIS-Interstate program began with three counties; and currently has 30 participating counties; however, Los Angeles County is not yet included. Under PARIS-Interstate, DHCS sends residency verification letters to a limited number of Medi-Cal beneficiaries identified by PARIS-Interstate as receiving public assistance in another state. The residency verification letter requires a response from the beneficiary within ten days. If no response is received, or if the beneficiary responds, confirming they are not residents of California, DHCS considers the individual an ineligible, nonresident beneficiary and their benefits are discontinued. DHCS sends the list of discontinued, ineligible, nonresident beneficiaries to the county offices and the county workers update case files.

During quarterly PARIS-Interstate matches, DHCS identified approximately 1,300 ineligible nonresident beneficiaries on Medi-Cal in 2009-10, 2,700 in 2010-11, and 4,000 in 2011-12

The May 2012 Medi-Cal Estimate includes savings for PARIS-Interstate and PARIS-Federal of $8.5 million ($4.2 million General Fund) for 2011-12, and $17.7 million ($8.9 million General Fund) for 2012-13. These cost savings were achieved by avoiding actual managed care capitation payments through the identification of nonresident ineligible beneficiaries.

DHCS notes that if given the resources to expand PARIS-Interstate, DHCS will likely achieve double the savings as it is estimated that there are 957,334 Medi-Cal beneficiaries in Los Angeles County, who would be included in the PARIS file.

Subcommittee Staff Comment and Recommendation—Hold Open. No issues have been raised in regards to this proposal for additional resources related to PARIS – Interstate. However, as noted in the chart above, PARIS-Veterans is only in 10 counties. Staff is working with Senate Subcommittee #4 and the California Department of Veterans Affairs to explore options to expand PARIS-Veterans into more counties.

According to a DHCS PARIS report submitted to the Legislature in April 2012, other states have more aggressively maximized the PARIS-Veterans data match and have shown substantial cost avoidance/savings results. For example, Pennsylvania estimated annualized cost avoidance/savings of approximately $27.8 million from a period covering nine quarters. Pennsylvania worked 40,769 cases resulting in reducing 4,448 cases from Medicaid.

Given the potential increase in General Savings, it is recommended to hold this item open to evaluate how California could maximize its use of PARIS data matches.

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

1. Please provide an overview of this proposal.

2. Has DHCS had any discussions with the California Department of Veterans Affairs regarding the expansion of this data match into more counties?

11. Security Oversight of MEDS – Position Request

Budget Issue. DHCS requests the authority to establish five permanent, and two limited-term, full-time positions for $822,000 ($371,000 General Fund and $451,000 federal funds) to provide Medi-Cal Eligibility Data System (MEDS) program and systems management oversight authority, of county California Department of Social Services (CDSS) program administrators, as well as quality control to ensure compliance with federal requirements.

The request is for seven new positions, four Associate Governmental Program Analysts (AGPA), one Staff Information Systems Analyst (SISA), one Systems Software Specialist, and one Staff Programmer Analyst.

These positions will perform authorization, maintenance, and tracking of approximately 10,000 CDSS MEDS accounts; enter into county security agreements with CDSS' business partners; and to perform periodic assessments in the counties to ensure that counties are in compliance with SSA requirements regarding the safeguarding of information.

Background. CDSS has access to MEDS, a database maintained by DHCS. Some of the data in this database comes from the federal Social Security Administration (SSA). The SSA imposes strict requirements on any entity that has access to SSA data, and it required CDSS to submit a Corrective Action Plan (CAP) specifying its steps in maintaining the acceptable and sufficient level of security oversight.

Effective January 1, 2010, SSA executed an Information Exchange Agreement (IEA) with CDSS. The IEA requires CDSS to perform a range of security and privacy activities. The IEA focused on limiting access to SSA data to only authorized employees who need it to perform their official duties and the security procedures relating to protecting the privacy of SSA personally identifiable information.

SSA required CDSS recertify compliance with the IEA on June 30, 2012. The IEA recertification process revealed a number of deficiencies in the areas of management and oversight, computer security safeguards and physical security. CDSS was required to submit a CAP to the SSA because it was found that CDSS was inappropriately allowing county Adult Protective Services (APS) workers access to the SSA data within MEDS.

In order to satisfy the CAP and to strengthen the State's management oversight capabilities, DHCS will assist CDSS with authorizing access for county employees, reviewing and signing county security agreements, conducting periodic security assessments, responding to breach notifications, quality control, and ensuring compliance with federal requirements. DHCS currently works with county welfare agencies to provide this type of access assistance and oversight for the Medi-Cal program.

DHCS is requesting the position authority to establish the positions necessary to carry out the new work load that is required to ensure that CDSS programs are in compliance with SSA requirements, and for all the activities stated above.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open.

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

1. Please provide an overview of this proposal.

12. Women, Infant, and Children (WIC) Appeals – Position Request

Budget Issue. DHCS requests one new permanent full-time Health Program Auditor IV position and to convert one existing limited-term Administrative Law Judge position into a permanent full-time position. These positions would conduct the increasing number of Women, Infants and Children's (WIC) appeal hearings as a result of WIC's increased efforts to disqualify vendors that have failed to adhere to program policies and procedures.

These positions are funded through reimbursement funding from the Department of Public Health (DPH) at a total cost of $293,000.

Background. DPH administers the WIC Program which provides nutritious supplemental foods, nutrition education, and referrals to health and social services for low-income women, infants and children who are at nutritional risk. DPH contracts with DHCS's Office of Administrative Hearings and Appeals (OAHA) for the appeal functions related to WIC.

Over the last several years, the United States Department of Agriculture (USDA) has enhanced federal regulations governing the WIC Program to increase accountability. Specifically, federal WIC regulations require states to 1) conduct compliance activities on authorized grocers, 2) ensure grocers do not sell their stores to circumvent a State sanction for program violations and 3) deny authorization to grocers lacking business integrity. The federal regulations provide for stricter sanctions for grocers who violate program rules. In addition, federal regulations contain new requirements for more extensive monitoring of grocers.

In 2011-12, WIC denied 239 out of 534 new vendor applications due to stringent stocking requirements and a moratorium on new vendors. The WIC program has contracted with the State Controller's Office to conduct 200 audits of the vendors and agencies. In addition to the audits, the program routinely monitors over 250 vendors through undercover investigations and compliance buys. All these actions create appeal workload for DHCS when the actions are taken against the vendors and agencies.

The appeals workload has increased by over 50 percent from 2010-11 and over 400 percent from 2008-09. The increase in the number of WIC appeals has created a significant backlog and OAHA cannot meet the 120 day time frame for completing the first level appeal process. The staff requested in this proposal will be used to meet the appeal requirements mandated by the federal government.

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

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

1. Please provide an overview of this proposal.

13. HIPPA – Position Request

Budget Issue. DHCS requests the establishment of three permanent and two limited-term positions (three-year) in the Office of Health Insurance Portability and Accountability Act of 1996 (HIPAA) Compliance (OHC).

The total cost for these positions is $682,000 ($235,000 General Fund and $447,000 federal funds).

The following positions are requested:

- **Two Staff Information Systems Analyst (Limited-Term)** - Support the HIPAA ICD-9 conversion to HIPAA ICD-10. These two positions will work specifically on ICD-10 project management tasks, processes, documentation, and the development of best practices. The effective implementation date of this rule is October 1, 2014.

- **One Systems Software Specialist II (Permanent) and One Senior Information Systems Analyst (Permanent)** – Support and implement future HIPAA initiatives and enhancements related to the Short-Doyle Medi-Cal system for the behavioral health and substance abuse claims adjudication system that processes claims for all Mental Health Counties and Drug Program Direct Providers.

- **One Staff Information Systems Analyst (Permanent)** – Maintain and implement HIPAA compliant security solutions and perform mandated activities that will further protect the protected health information of millions of beneficiaries in DHCS programs.

These positions would address the anticipated workload attributed to health care reform, new federal HIPAA regulations, and the integration and expansion of technological systems.

Background. In 1996, the federal government enacted HIPAA to help beneficiaries maintain group health insurance coverage when they change jobs. The law also outlined a process to achieve uniform national health data standards and health information privacy in the United States. These provisions require all covered organizations to standardize the way they transmit and code health information for billing and record keeping purposes, and to protect the privacy and security of that information.

The Affordable Care Act (ACA) includes HIPAA-related changes, such as:

- More frequent HIPAA updates: New standards and operating rules can change every two years while the previous process resulted in only one significant update in ten years.

- New transaction standards: New HIPAA standards and compliance dates for:
  - National Health Plan Identifier (NHPI) by October 1, 2012
  - Electronic Funds Transfer by January 1, 2014
  - Claims attachment standards and operating rules by January 1, 2016

- New health plan certification requirements: Health plans will need to certify (i.e., document and test) their compliance with every HIPAA transaction and standard operating rule.
- Privacy and Security Requirements: HIPAA privacy and security requirements are exponentially increased for electronic health records and health information exchange, creating more exposure of protected health information with each exchange of information.
- Higher penalties for non-compliance: Penalties of $1 per covered life per day not certified compliant, up to a maximum of 20 days (approximately $200 million annually for Medi-Cal). Penalties are doubled if false statements are submitted with certification documents; penalty amounts are based on the number of beneficiaries.

According to DHCS, failure to maintain or achieve HIPAA compliance by established federal deadlines has several implications for DHCS, including additional administrative burdens for Medi-Cal providers, increased risk of federal penalties (monetary, and the withholding of federal funds), loss of support to HIPAA-implemented solutions, and additional breach reporting costs.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open.

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

1. Please provide a brief summary of this proposal.

14. Medi-Cal Electronic Health Records – Position Request

Budget Issue. DHCS' Office of Health Information Technology (OHIT) requests the extension of 11 limited-term positions for the administration of the Medi-Cal Electronic Health Record (EHR) Incentive Program.

Total cost for these positions is $1.3 million ($1.2 million federal funds and $93,000 reimbursement from outside entities, and [$38,000 General Fund]). DHCS is not requesting any additional General Fund in this proposal, as the $38,000 General Fund cost associated with these positions is covered by the General Fund support specified in AB 1467 (a 2012 budget trailer bill) for support costs associated with this program.

The positions requested to be extended are:

Two-Year Extension – July 1, 2013 to June 30, 2015 (8.0 positions)

- Two Staff Services Manager I
- Three Research Program Specialist II
- Three Associate Governmental Program Analyst

Three-Year Extension – July 1, 2013 to June 30, 2016 (3.0 positions)

- One Research Program Specialist II
- Two Health Program Auditor IV

Background. The Medi-Cal EHR Incentive Program is a multi-year program that began on October 3, 2011, and will operate through December 31, 2021. Since the implementation of the Medi-Cal EHR Incentive Program, DHCS has paid over 1,600 providers over $272 million in federal incentive payments.

The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the American Recovery and Reinvestment Act (ARRA) of 2009, authorizes $45 billion for federal Medicare and Medicaid incentive payments to qualified health care providers who adopt, implement, or upgrade and use electronic health records (EHRs). The goal of HITECH is to improve the quality, safety, and efficiency of health care through "meaningful use" of EHRs. HITECH will result in a significant increase in provider adoption and use of EHR systems. The use of EHR technology in this manner includes the use of electronic prescribing (e-prescribing), submission of clinical quality measures, reporting to immunization and disease registries, and exchanging health information between DHCS and its providers to improve the quality of patient care.

The HITECH Act authorizes state Medicaid programs to directly administer Medicaid EHR Incentive Programs. The programs will lead the efforts to advance patient safety and quality of care by incentivizing Medi-Cal providers to adopt, implement, or upgrade and use EHRs in a meaningful way.

On October 26, 2009, DHCS submitted a funding request to the federal Centers for Medicare and Medicaid Services (CMS) that was approved for $2.8 million to establish the OHIT and to provide funding for a consulting contract to begin the State Medicaid Health Information Technology Plan (SMHP) process. The department completed and received approval of the SMHP and Implementation Advance Planning Document on September 30, 2011.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open. The department indicates that it has not yet secured agreements for the $93,000 in reimbursements from outside entities. It indicates that it is currently exploring opportunities for this funding.

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

1. Please provide a brief summary of this proposal.

2. What is the status of the department's efforts to secure outside funding for this proposal? When does the department anticipate agreements may be reached?

Michelle Baass 651-4103
Senate Budget & Fiscal Review

OUTCOMES: **Senate Subcommittee #3 on Health & Human Services**
Thursday, April 4 (Room 4203)

VOTE ONLY CALENDAR

4150 Department of Managed Health Care

1. Transfer of Legislative Unit to Director's Office

- Motion – Approve.
- Vote – 3-0

ISSUES FOR DISCUSSION

4150 Department of Managed Health Care (DMHC)

1. Overview

- Informational item only, no vote.

2. Medi-Cal Dental Managed Care Program Oversight

- Held item open.

3. Health Premium Rate Review

- Motion - Approve
- Vote – 2-1 (Senator Emmerson voting no.)

4. Coordinated Care Initiative (CCI)

- Held item open.

5. Medi-Cal Managed Care Rural Expansion

- Held item open.

4280 Managed Risk Medical Insurance Board

1. Overview

- Informational item only, no vote.

2. Phase-Out of MRMIP and PCIP

- Held item open.

3. Transition Plan for Healthy Families Program Staff

- Held item open.

4260 Department of Health Care Services

1. Overview – Medi-Cal Program

- Informational item only, no vote.

2. Healthy Families Program Transition to Medi-Cal

- Held item open.

3. Coordinated Care Initiative (CCI)

- Held item open.

4. CCI Long Term Care Division - Position Request

- Held item open.

5. Emergency Preparedness Audits - Position Request

- Motion - **Modify.** Approve the positions on a limited-term basis for four years (until 2016-17) to align with the period of the federal grant that funds these positions
- Vote 3-0

6. California Medicaid Management System (CA-MMIS) Replacement Project - Position Request

- Motion – Approve.
- Vote 3-0

7. Continuation of 1115 Waiver Activities - Position Request

- Held item open.

8. Continuation of LIHP & DSRIP Activities - Position Request

- Held item open.

9. Assisted Living Waiver – Position Request

- Held item open.

10. Public Assistance Reporting Information System (PARIS) Interstate – Position Request

- Held item open.

11. Security Oversight of MEDS – Position Request

- Held item open.

12. Women, Infant, and Children (WIC) Appeals – Position Request

- Motion – Approve.
- Vote – 3-0

13. HIPPA – Position Request

- Held item open.

14. Medi-Cal Electronic Health Records – Position Request

- Held item open.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

April 11, 2013

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

Room 4203
(John L. Burton Hearing Room)

Staff: Jennifer Troia

* Also includes 0530 Health & Human Services Agency, Office of Systems Integration

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.

ISSUES RECOMMENDED FOR VOTE-ONLY CALENDAR

A. 4300 Department of Developmental Services (DDS)

1. Proposed trailer bill clean-up language for Welfare & Institutions Code Section 6500

DDS proposes to clarify that changes made last year to Section 6500 of the Welfare & Institutions Code were not intended to preclude court-ordered placements in settings less restrictive than developmental centers (DCs). The Department indicates that at least one public defender has misinterpreted the changes made in last year's budget trailer bills [AB 1472 (Chapter 25, Statutes of 2012) and AB 1471 (Chapter 439, Statutes of 2012)] in this manner.

The changes made in these 2012-13 budget trailer bills related to savings anticipated to be achieved within the DDS budget and included a series of statutory revisions intended to redesign services for consumers with challenging needs. These changes, which are anticipated to result in $20 million GF savings annually, include 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). Early implementation of the changes was discussed at an oversight hearing in October 2012.

Recommendation: APPROVE the proposed trailer bill language, to be refined as necessary in the trailer bill process.

ISSUES FOR DISCUSSION

Public testimony will be taken for items listed in this section.

A. 5180 Department of Social Services (DSS) – Child Welfare Services

1. Overview of Child Welfare Services (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 total proposed 2013-14 budget for the Realigned CWS and Adoptions programs is $5.2 billion ($2.4 billion federal funds, $1.6 billion 2011 realignment funds, and $1.2 billion county funds). In general, around half of child welfare funds support counties to administer or provide the programs and half support payments to care providers.

Foster Care Caseload Trends:[1] On October 1, 1998, there were approximately 117,000 children in foster care in California. By October 1, 2012, that figure had dropped to around 61,000 children (including around 4,400 children under probation department supervision who reside in foster care placements). The department attributes much of the recent decades' 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.

Some Background About Children In Foster Care: It is well documented that children and youth who experience foster care and those who emancipate from care are highly at risk for disproportionate challenges related to education, health, and mental health, among other domains. As of October 2012, 58 percent of foster children had been in care for less than two years, while 16 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] More than half of children exiting foster care reunify with their parents or other caregivers.

The following chart identifies where most children in foster care reside and the rates of monthly payments for their care and supervision:

[1] Data in this document on caseload and characteristics is from *Child Welfare Services Reports for California*. Retrieved March 27 and April 6, 2013, from the University of California at Berkeley Center for Social Services Research website. URL: http://cssr.berkeley.edu/ucb_childwelfare.

[2] Compared to the overall population of children in California, this reflects over-representation of children identified as Black and under-representation of children identified as Hispanic/Latino and White/Caucasian. Children identified as Native American are also over-represented, while Asian/Pacific Islanders are under-represented. There are a number of federal, state, and local initiatives that include work to reduce these disproportionalities and other identified disparities.

Placement Types	Percent of Children in Foster Care on 1/1/12*	Range of Basic Monthly Payment Rates	Potential Supplements for Children who Qualify	Administration and Social Worker Cost Built into Rate
Kin caregiver**	33%	Age 0-4 -- $640 Age 15-19 -- $799	Age 0-19 -- $200 to $2,000	$0
Guardian	11%			$0
Foster Family Home	9%			$0
Foster Family Agency-Certified Home	26%	Age 0-4 -- $829 Age 15-20 -- $988	Age 0-4 -- $189 Age 15-19 -- $189	Age 0-4 -- $868 Age 15-19 -- $968
Group Home	10%	Level 1 -- $2,223 Level 12 -- $9,419	$0	$0

* 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).

Performance Measures & Accountability: The federal Administration for Children and Families (ACF) conducts Child & Family Services Reviews (CFSRs) of states' child welfare systems, which include measures of outcomes related to the safety, permanency, and well-being experienced by children and families served, 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 outcome measures, but did achieve substantial conformity with three of seven systemic factors. According to ACF, challenges included high caseloads and turnover of social workers, insufficient foster homes, a lack of caregiver support and training, and a lack of needed services (e.g., mental health and substance abuse). In response, DSS developed a Program Improvement Plan (PIP). The department indicates that the state has now met all of the PIP targets and been released from any potential penalties resulting from the 2008 review. It is important to note, however, that not all of the PIP targets were set at a level that would necessarily bring the state into full compliance in future review.

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 monitored at the county-specific level and a process for counties to develop System Improvement Plans (SIPs).

Recent Budget Actions: As described in the next item, the 2011-12 and 2012-13 budgets realigned $1.6 billion in state funding for the CWS, foster care, and adoptions programs, to the counties. In addition, over the last several years, the state increased monthly care and supervision rates paid to group homes, foster family homes, and foster family agency-certified homes as a result of litigation.

Staff Comment and Recommendation: This is an informational item, and no action is required.

Questions:

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. Do you know when the federal government will conduct the next Child and Family Service Review? What efforts endure to improve outcomes that continue to need improvement?

2. Realignment of CWS and Adoptions Programs

Budget Issue: The 2011 public safety realignment and subsequent related legislation realigned approximately $1.6 billion for California's Child Welfare Services and adoptions programs (CWS) to the counties. Funding for a limited number of programs or activities and the licensing of children's residential placements was not realigned. The General Fund (GF) resources for CWS that became 2011 realignment funding reflected state costs for the following programs (many of which receive other matching funds as well):

CWS Program	Description	Realignment Funds (Formerly GF) In 2011-12
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	$431 million
Adoption Assistance Program	Monthly assistance payments to families who have adopted children who meet criteria for special needs	$382 million
Adoptions Programs	Adoption-related services and oversight	$64 million[3]
Child Abuse Prevention	Efforts to prevent abuse and neglect	$13 million
	Total	**$1.560 billlion**

Total realignment funding for Protective Services [which includes CWS and Adult Protective Services funding (APS)], as estimated for recent years and 2013-14 includes:

	2011-12	2012-13	2013-14	2014-15
Funding for Extended Foster Care (AB 12)		$18 million	$20 million	$15 million
Protective Services Growth Funding[4]			$158 million	$137 million
Total Realignment Base Funding for Protective Services (including CWS and APS)	$1.622 billion	$1.640 billion	$1.818 billion	$1.970 billion

[3] These costs do not include $6 million associated with Agency Adoptions.

[4] Growth is reflected here in the year it is anticipated to be distributed to the counties.

Additional Background on Financing Changes Under Realignment: Before the 2011 realignment, the department estimated the costs associated with meeting federal and state requirements for the estimated numbers of children and family to be served as part of the annual budget process. The state and counties shared non-federal costs for these programs 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, the total funding for CWS is instead determined by the amount available from designated funding sources (a specified percent of the state sales and use tax and established growth allocations) that are directed to the counties and corresponding matching funds. Both before and after realignment, certain CWS expenditures, including payment rates for care providers that are statutorily established, are provided on an entitlement basis.

Realignment Superstructure: The 2012-13 budget included an ongoing superstructure for the 2011 realignment. The two main accounts are: 1) the Support Services Account, and 2) the Law Enforcement Services Account. The Support Services Account has two Subaccounts: 1) Protective Services, and 2) Behavioral Health. Along with funding for Adult Protective Services, CWS funding is provided from the Protective Services Subaccount. Funding totaling $53.9 million for extended foster care for 18 to 21 year olds, pursuant to AB 12 (Chapter 559, Statutes of 2012) and subsequent legislation, will also be provided over three years in the Protective Services Subaccount base.

Under the superstructure, program growth will be distributed on roughly a proportional basis between accounts, and then subaccounts. The Protective Services Subaccount will receive 40 percent of growth funding allocated to the Support Services Account until $200 million identified for CWS base restoration is funded. Counties have authority to transfer a maximum of 10 percent of the lesser subaccount between subaccounts (but not the two main accounts) for up to one year. Proposition 30, which the voters passed in November 2012, also established mandate and fiscal protections for counties. Trailer bill provisions in 2012-13 additionally established programmatic flexibility that allows counties, via action by boards of supervisors after publicly noticed discussion, to discontinue some programs or services that were previously funded with only General Fund, including, e.g., clothing allowance and specialized care increments added to provider rates and Kinship Support Services Programs.

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 and regulation development, technical assistance, and ensuring federal compliance. After realignment, the state must maintain the bulk of these same responsibilities. Prior to realignment, the state was also at risk for the full costs of any federally imposed penalties stemming from federal Child and Family Service Reviews. Under realignment, counties whose performance contributed to an applicable penalty pay a share of the penalty if realignment revenues were adequate to fully fund the 2011 base and they did not spend a minimum amount of allocated funding on CWS.

Required Reporting on Realignment: DSS is required to report annually, beginning on April 15, 2013, to the Legislature regarding outcome and expenditure data and impacts of the realignment of CWS and APS programs. These reports must also be posted on the

department's website. Counties are not, however, required to report to DSS regarding the specific use of growth funds. While it is still early (especially given a lag in the timing of actual receipt of funds at the county level), the County Welfare Directors Association indicates that generally, a number of counties are considering using growth funds to hire staff or reinstate service contracts they previously reduced or eliminated due to state budget reductions.

Staff Comment & Recommendation: Together with Assembly Budget Committee and other Legislative staff, Subcommittee staff has been working with the Administration to ensure that key programmatic and fiscal information that used to be provided in January and May budget estimates will continue to be provided to the Legislature and public. It does not appear that a specific action is necessary to effectuate these goals at this point, but staff does recommend that the Subcommittee affirm its expectation that this kind of information will continue to be provided and direct staff to continue working with the Administration to achieve that end.

Questions:

1. To what extent will we know how growth funding is being used and with what impacts?

2. Do we know yet whether there are counties that have or plan to stop or change their implementation of formerly General Fund-only programs over which they were given additional flexibilities in 2012-13? Will we know if they do?

3. Continuum of Care Reform (CCR)

Budget Issue: The 2012-13 budget included trailer bill requirements (in SB 1013, Chapter 35, Statutes of 2012) for the department to develop, in consultation with a stakeholder workgroup, recommended revisions to the current rate-setting system, services, and programs serving children and families in foster care settings, with a particular focus on foster family agencies and group homes. SB 1013 also requires the department to develop performance standards and outcome measures for providers of foster care, again with a focus on foster family agencies and group homes, as well as transitional housing program-plus (THP-Plus). Further, SB 1013 suggests that the department, in consultation with the workgroup, may develop a better means of identifying children's needs and matching them with the most appropriate placements, as well as a procedure for identifying children who have been in congregate care for one year or longer, determining the reasons they remain in group care, and developing an individualized plan for their transitions to less restrictive, family-based settings. The department is authorized to temporarily make some changes through all-county letters and required to report on recommendations that necessitate statutory changes by October 1, 2014.

The Governor's budget also proposes $249,000 ($166,000 GF) and authorization to make one limited-term position (otherwise scheduled to expire on June 30, 2013) permanent, as well as funding for two years of consultant services, to support the department's CCR work.

Background on Placement Decisions: County child welfare and probation agencies are generally responsible for making decisions about where children in out-of-home foster care reside. They are required to attempt to place children in placements along the following order: 1) the home of the child's noncustodial parent, relatives, or extended family members, 2) foster family homes licensed by counties, 3) foster family homes certified by foster family agencies (FFAs), 3) group homes, and 4) specialized treatment facilities. As depicted in the chart on page 4, this is also generally the ordering of less to more costly placement types.

Background on the Use and Funding of Group Homes: Group homes have 24-hour staffing and licensed capacities to house at least six (and in a few instances up to over 200) children. 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 only 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 are unintended consequences of the state's use of group care.

Parallel with the decline in the number of children in foster care, the number of children in group homes has dropped in recent years (from 10,900 in 1998 to 6,200 as of January 1, 2013). As a proportion of overall foster care placements, group home placements have remained steady at around six to 10 percent. It is important to note, however, that the proportion of probation-supervised foster youth placed in group homes is much larger, at 55 percent as of January 2013 (versus seven percent of child-welfare supervised foster youth).

There are heavy restrictions on the use of group homes for children under age six. Children as young as six do, however, reside in group homes.

Based on a very preliminary look, the department indicates that there are 1,063 children (as of 2/21/2013) who have been in the same group home for at least one year. The distribution of these children by age and length in the group home is described in the chart below. This does not include children who may have been in more than one group home within a year or children who were in some other placement in between group homes. DSS is working on a methodology to bridge multiple group home placements together to get a more accurate count of the population of children who have resided in group homes for more than one year.

Number of Children By age group & time in the same Group Home	Total
7 years old	**4**
at least 1 year, but under 2 years in a GH	4
8-10 years old	**51**
at least 1 year, but under 2 years in a GH	36
2-3 years in a GH	15
11-13 years old	**207**
at least 1 year, but under 2 years in a GH	140
2-3 years in a GH	67
14-16 years old	**474**
at least 1 year, but under 2 years in a GH	313
2-3 years in a GH	157
7-10 years in a GH	4
17 years old	**327**
at least 1 year, but under 2 years	217
2-3 years in a GH	109
7-10 years in a GH	1
Total	**1,063**

Beginning in 2010-11, the budget has included around $196 million ($52 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 response to this increased cost and the other longstanding concerns mentioned above, as well as the need for DSS to redirect staff toward continuing to develop alternative placement options, since 2010-11, state law has also placed a moratorium, with some allowable exceptions, on the licensing of new group homes or approvals of rate or capacity increases for existing providers. The Governor's budget for 2013-14 proposes monthly rates for group homes of $2,223 to $9,419 per child.

Related Services & Initiatives: Monthly foster care 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. Several 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 and supports and family-based placements for children in foster care.

Staff Comment & Recommendation: Staff recommends holding this item open and continuing discussions with the department and stakeholders about opportunities for short-term, as well as long-term, reforms, particularly with respect to lengthy group home stays and the use of group care for younger children.

Questions:

1. What is happening to reduce the use of group homes and encourage the successful placements of more foster youth, including probation-supervised youth, in family settings?

2. What more can be done in the short-term to reduce in particular the use of group home placements for young children (e.g., six to twelve year olds) and the use of group homes as long-term placements (e.g., for more than one year)?

3. Is the CCR workgroup on track toward developing the required recommendations for changes in rate-setting and in measuring the outcomes achieved by foster care providers?

4. Staff for Title IV-E Waiver Demonstration Capped Allocation Project (CAP) & Resource Family Approval Project

Budget Issue: The Governor's budget proposes $596,000 ($298,000 GF) and authorization to extend for one additional year in 2013-14 two limited-term positions, as well as fund an evaluation, to assist with implementation of the Title IV-E Waiver Demonstration CAP. The budget also proposes $207,000 ($101,000 GF, $70,000 Local Revenue Fund, $36,000 federal funds) and authorization for two positions to continue implementation efforts for the Resource Family Approval Project.

Background on the Title IV-E Waiver Demonstration: On July 1, 2007, two California counties—Alameda County and Los Angeles County—began implementing the state's initial Waiver Demonstration CAP for funding under Title IV-E of the federal Social Security Act. Under this waiver, the counties received more flexible, capped Title IV-E allocations combined with related state and local capped allocations (instead of more open-ended, entitlement-utilization based funding that could be used only for a narrower set of purposes). Some of the goals were to assist the child welfare and probation systems in these counties to develop and implement alternative services to out-of-home foster care and to bring about better outcomes for children and families. DSS is currently in the process of negotiating with the federal government over terms and conditions for a new five-year extension of the state's initial Title IV-E waiver. Up to 21 additional counties have expressed interest in potentially participating in the new waiver extension as well. An evaluation of the initial waiver was completed by San Jose State University in December 2012. According to the department, the federal government will require additional evaluation of the waiver extension.

Background on the Resource Family Approval Project: The resource family approval pilot established by AB 340 (Chapter 464, Statutes of 2007) requires a three-year pilot program in up to five counties to establish a single, comprehensive approval process for foster care and adoptive families. This project was also included in the state's Program Improvement Plan in response to the 2002 federal Child and Family Services Review. After several prior implementation delays, a 2012-13 realignment-related budget trailer bill, SB 1013 (Chapter 35, Statutes of 2013), delayed the start date for the project to January 1, 2013, and extended authorization for the project statewide after the initial years of work in early implementation counties are completed. This project is intended to make the licensing process less cumbersome and to prevent unnecessary delays in finding permanent families for foster children. The current licensing process divides caregivers into relatives, foster family homes, and adoptive homes. All caregivers must meet health and safety standards, but the processes for each vary and can be duplicative.

Staff Comment & Reccomendation: Staff recommends that the Subcommittee approve the requested resources and positions to support the IV-E Waiver CAP extension and hold open the requested resources and positions related to the Resource Family Approval project.

Questions:

1. Please briefly summarize each request.

2. What are the most critical things we learned from the evaluation of the initial Title IV-E waiver implementation?

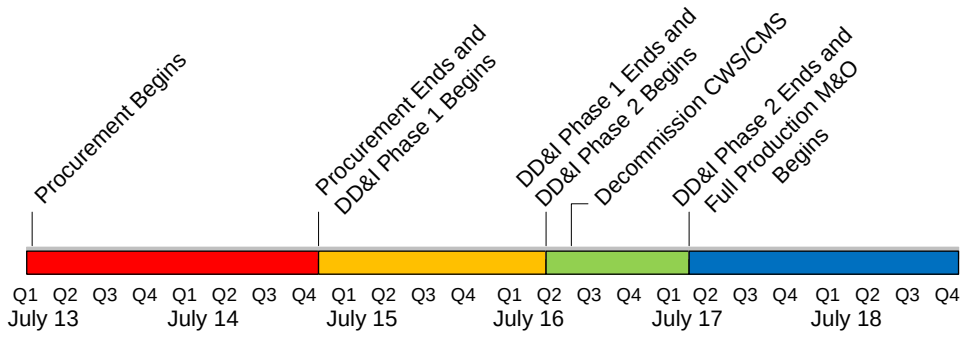
3. When are the early implementation counties for the Resource Family Approval project expected to begin using a unified approval process?

5. Child Welfare Services- New System Project

Budget Issue: The Governor's budget proposes $10.3 million ($4.6 million GF) in 2013-14 for planning activities at the outset of the Child Welfare Services- New System Project (CWS-NS). According to the Office of Systems Integration (OSI), the anticipated total one-time costs up through the design and development of the system, which is expected to finish in 2017, are $351.1 million ($154.9 million GF). Compared to continuing to operate the current Child Welfare Services/Case Management System (CWS/CMS) and making necessary changes, however, the Administration estimates that the state will realize savings by completing the CWS-NS system because of its reduced maintenance and operations costs. Additional analysis that compares the alternatives that led to the decision to move forward with the CWS-NS system is available online at: http://www.cdss.ca.gov/cdssweb/PG2400.htm.

Of the proposed 2013-14 funding, $4.3 million ($1.9 million GF) would support staffing at the Office of Systems Integration (OSI) ($2.4 million total, with authority to establish eight new positions) and the Department of Social Services (DSS) ($1.9 million total, with authority to establish nine new positions). With these additional positions, there would be a total of 18 staff at OSI and 13 staff at DSS dedicated to this initial phase of the project, along with six county consultants. The anticipated timeline for the project is:

Table 1 – CWS-NS Project Timeline



Background: 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 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 three years.

In 2011-12, the Legislature and Governor suspended a previous effort (called CWS/Web) to update CWS/CMS's outdated technology, improve efficiency, and better comply with federal requirements. The 2011-12 budget also included trailer bill language in Assembly Bill 106 (Chapter 32, Statutes 2011) that required the Administration to report on aspects of the CWS/CMS system and make recommendations about the best approach and next steps for addressing any critical missing functionalities. The Administration developed a CWS Automation Study Team (CAST) in response to these requirements. The report from the CAST was completed in 2012 and concluded that it was neither feasible nor cost-effective to maintain and enhance the old technology of the existing system. The recommended strategy for replacing it was a Buy/Build alternative that involves the purchase and customization of an application that is already available (e.g., off-the-shelf software or a system currently in use or production in another state). The Feasibility Study Report (FSR) for CWS-NS was approved by the California Technology Agency in January 2013.

Staff Comment & Recommendation: Staff recommends that the Subcommittee approve the requested staffing and corresponding resources for DSS and OSI.

Questions:

1. Please summarize the anticipated timeline and costs for developing the CWS- New System and decommissioning CWS/CMS and the need for the requested resources.

6. Foster Family Home and Small Family Home Insurance Fund

Budget Issue: The Administration proposes, in a spring finance letter, to reduce the previously proposed 2013-14 funding for the Foster Family Home and Small Family Home Insurance (FSH) Fund by $140,000 GF. The letter also proposes a one-time transfer of $2.3 million from the FSH Fund to the General Fund to return what the Administration identifies as excess surplus funds that have accumulated because recent expenditures have been lower than budgeted. After the transfer, the department estimates there would be a reserve of approximately $1.5 million that could be utilized if claims exceeded the new, lower amount the Administration proposes to include.

Total FSH funding, claims paid, and reserves for recent years and as proposed include:

Fiscal Year	Total Budgeted Funding	Total Budgeted GF	GF changes per FY	Reserve at end of fiscal year	Claims paid in fiscal year
2009-10	2,136,000	1,140,000	0	5,391,093	5
2010-11	2,136,000	1,140,000	-3,000,000* (transfer to GF)	3,166,637	2
2011-12	1,596,000	640,000	-500,000	3,538,389	2
2012-13	1,736,000	740,000	-400,000	-	-
2013-14	1,596,000	600,000	-140,000**	-	-

* DOF EO 11/12-27 (2010-11) as partial solution to backfill of GF for cancellation of sale of state buildings

** In addition to reduction of $140K to align expenditures; the Administration proposes a transfer of $2.3 million to the General Fund

Background: The FSH fund was established in 1986 to pay, on behalf of foster family homes and small family homes, claims of foster children or their parents or guardians stemming from an accident that results in injury neither expected nor intended by the foster parent. Foster family homes and small family homes that are licensed by DSS, or by a county, are currently eligible for coverage. Foster family agency (FFA)-certified homes or relative guardians providing care and receiving assistance through the Kinship Guardianship Assistance Payment Program (Kin-GAP) are not covered by this fund. The FSH fund also does not cover any loss arising out of a dishonest, fraudulent, criminal, or intentional act.

In September 2011, the Bureau of State Audits (BSA) released a report regarding the FSH Fund. The audit concluded that 90 percent of surveyed foster families were unaware of the existence of the FSH Fund and recommended that DSS improve efforts to inform the families. The audit also identified concerns with administration of the Fund and recommended that DSS revise its methodology for budgeting the annual resources needed. Finally, in response to part of the underlying request from the Joint Legislative Audit Committee, the audit identified an estimated cost of $967,500 if the Legislature and Governor were to extend coverage under the Fund to FFA-certified homes and an unknown cost to extend coverage to families receiving Kin-GAP. According to the department, legislation in 2012 (Chapter 642, Statutes of 2012) addressed some of the recommendations made by the BSA audit.

Staff Comment & Recommendation: Staff recommends that the Subcommittee hold this item open.

Questions:

1. To what does the department attribute the lower than budgeted expenditures from the FSH Fund?

2. How has the department improved outreach efforts to ensure that families know about the FSH Fund since the 2011 audit by the BSA?

3. What would happen if claims for FSH coverage in 2013-14 exceeded the amount budgeted for the Fund?

7. Proposed Suspension of Mandate Related to Investigating Abuse and Neglect Allegations

Budget Issue: The Governor's budget proposes to suspend, in 2013-14, parts of the Child Abuse and Neglect Reporting Act (CANRA) that collectively form what is called the Interagency Child Abuse and Neglect Reporting (ICAN) mandate. Suspending this mandate would make local compliance with the provisions of related statutes optional in 2013-14. Because the Commission on State Mandates (CSM) has not yet identified a statewide cost estimate for this mandate, the Governor's proposal would not result in any budgetary savings in 2013-14. However, the suspension of the mandate would stop any additional costs for local governments' compliance with the requirements from accruing during the budget year.

Background: CANRA requires individuals in certain professional occupations (who are referred to as "mandated reporters") to report child abuse and neglect to specified law enforcement agencies or county welfare and probation departments. CANRA further requires local law enforcement, county welfare, and probation agencies to forward certain reports of child abuse and neglect to the Department of Justice (DOJ) for entry into the state's central child abuse and neglect reporting system, the Child Abuse Central Index (CACI). Since the 1980 enactment of CANRA, the law has been amended several times to include additional mandated reporters and specify additional reporting and investigative requirements of child protective agencies. The provisions the CSM determined to be included in the ICAN mandate in 2007 required specified agencies to:

- Distribute the mandated report form to mandated reporters
- Accept reports from mandated reporters when the agency lacks jurisdiction, and forward the report to the agency with jurisdiction
- Refer, or "cross-report," to other child protective agencies known instances of: 1) child abuse and neglect, and 2) child deaths that are suspected to be related to child maltreatment
- Investigate child abuse and neglect reports to determine if they are substantiated, inconclusive, or unfounded, and submit a report to DOJ for cases that are not unfounded for entry in CACI
- Notify suspected child abusers of CACI reports related to them that are made to DOJ and inform mandated reporters of case disposition upon completing an investigation
- Obtain the original investigative report used to make the CACI report, and make an independent evaluation as it relates to the agency's investigation, prosecution, employment, licensing, or child placement decisions
- Notify relative caregivers that they are in CACI if this information becomes available when an agency evaluates the placement of children with relatives

Following the CSM decision, Chapter 468, Statutes of 2011 (AB 717, Ammiano), specified that as of January 1, 2012, local law enforcement agencies no longer are required to report child abuse and neglect cases to CACI. As many of the ICAN mandated activities related to CACI reporting (including investigations and preparation of the CACI report), Chapter 468 significantly limited the scope of the ICAN mandate for those agencies. Additionally, Chapter 468 limited the number of reports that county welfare agencies are required to make to CACI

to only those cases that are substantiated. The CSM released draft parameters and guidelines for reimbursement of the remaining ICAN mandate in March 2013 and is scheduled to consider them at a hearing on April 19, 2013.

LAO Analysis: While cautioning that any estimate of annual costs for the ICAN mandate is subject to significant uncertainty at this time, the Legislative Analyst's Office (LAO) estimates, based on a review of prior, somewhat similar state mandates, that the annual costs for the ICAN mandate in 2013-14 could be in the range of a few million dollars to the low tens of millions of dollars. In an analysis that can be found online at: http://www.lao.ca.gov/laoapp/budgetlist/PublicSearch.aspx?Yr=2013&KeyCol=725), the LAO additionally expresses concerns that suspending these mandates could weaken the state's system of child abuse and neglect reporting and tracking if some local agencies ceased sharing information and/or submitting reports to CACI. The LAO also identifies concern that the due process rights of individuals reported to CACI may be undermined if the mandate is suspended. The LAO therefore recommends that the Legislature reject the Governor's proposal to suspend the mandates in 2013-14 and instead establish a workgroup to evaluate the mandate, develop options to limit its costs, and consider alternative reimbursement methods for funding its activities and report back to the Legislature by the summer of 2013.

Staff Comment & Recommendation: Action on this item will be taken in Subcommittee #4 when they address mandate-related proposals more generally. Staff recommends that this Subcommittee coordinates with Subcommittee #4 and notes that irrespective of their decision regarding the 2013-14 suspension proposal, the workgroup recommended by the LAO appears to be a helpful endeavor.

Questions:

1. Please briefly summarize the activities included in the ICAN mandate and the potential effects of the proposal to suspend them.

B. 4300 Department of Developmental Services - Overview and Developmental Centers

1. Department Overview

With proposed 2013-14 funding of $4.9 billion ($2.8 billion GF), the Department of Developmental Services (DDS) oversees services provided to children and adults with developmental disabilities who reside in the community. These services are coordinated by 21 regional centers, which are non-profit organizations that provide diagnosis and assessment of eligibility and help plan, access, coordinate, and monitor consumers' services and supports. The Department also oversees the care provided to individuals with developmental disabilities who reside in four state-operated developmental centers (DCs) and one state-operated community facility.

The Governor's proposed 2013-14 budget, as compared to the 2012-13 budget, includes:

Program	Total 2012-13 funding	Total 2013-14 funding	2012-13 Average Caseload	2013-14 Average Caseload	2012-13 Authorized State Staff Positions	2013-14 Authorized State Staff Positions
Community Services	$4.2 billion	$4.3 billion	256,872	266,100		
Developmental Centers	$545 million	$539 million	1,552	1,304	5,154	4,768
DDS Headquarters	$38 million	$39 million			374.5	374.5

Eligibility & Caseload: To be eligible, an individual must have a disability that began before his or her 18th birthday. The disability must 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 due to an established risk of having developmental disabilities or a developmental delay. Eligibility for services and supports may last for the remainder of an individual's lifespan. Most services and supports are provided at no charge (a few exceptions that involve some cost sharing by specified parents of minor children are described later in this agenda). The developmental services caseload has grown each year from 2002-03 (when it included 190,000 individuals) to today.

Recent Reductions to the System: Between 2009-10 and 2012-13, state budgets have included significant General Fund cost containment solutions related to developmental services. Taken together, the savings resulting from these changes combined to over $1.3 billion General Fund in the years they were enacted.[5] The savings generally came from: 1) increased use of federal and other funding sources, 2) reductions in the rates of payments to

[5] Several of these changes also result in ongoing, annual savings, although the amounts will vary over time and in combination with caseload and other changes.

regional centers and service providers (ranging from 1.25 to 4.25 percent), and 3) administrative changes, cost-control measures, and some service reductions. As an example of a service reduction that stakeholders continue to express serious concern about the impacts of, in 2009-10 the budget restricted eligibility and services available to some infants and toddlers through the Early Start program.

In 2012-13, the budget solutions also included a series of statutory changes intended to redesign services for consumers with especially challenging needs. These changes 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 these individuals (including expanded availability of Adult Residential Facilities for Individuals with Special Health Care Needs and the creation of a statewide Specialized Resource Service).

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 describe the overall developmental services system and the factors driving anticipated increases in the number of consumers served and in their service utilization.

2. Developmental Center Budget Overview

Budget Issue: DDS operates four institutional Developmental Centers (DCs) and one smaller state-operated community facility that care for adults and children with developmental disabilities. The Governor's proposed budget for DCs includes $539 million ($279 million GF) to serve an estimated average of approximately 1,300 residents in 2013-14. Compared with last year's enacted budget, this includes an anticipated decline by 240 residents, 388 authorized state staff positions, and $11.2 million ($7 million GF) in funding.

Background: California has been reducing its use of DCs as a placement for individuals with developmental disabilities for decades (from a high of over 13,000 individuals in 1968 to around 1,500 currently). This reduction is consistent with national trends that support integrated services and reduced reliance on institutions, as well as the United States Supreme Court's 1999 decision in *Olmstead v. L.C., et al*. As a result, several DCs have also been closed (and as discussed below, the Lanterman DC is currently undergoing a closure process).

Under the law that existed prior to 2012 statutory changes, individuals with developmental disabilities could be placed in DCs through involuntary judicial commitment because they were deemed to be 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. 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 for individuals who may not be able to understand criminal

charges filed against them, others were considered avoidable with appropriate community resources. As a result, the 2012-13 budget included language restricting new admissions to DCs, except under specific conditions, including when individuals are committed under the state's Incompetent to Stand Trial statute and when 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 in crisis can be placed temporarily at the Fairview Developmental Center.

In part because of the large fixed costs to operate the grounds and facilities and serve remaining consumers, the budget for DCs has not declined to the same degree as the decline in the number of residents. The department determines the staffing needs of DCs by using established formulas that take into account the resident population, number of programs and units, square footage or acreage, and number of employees. Approximately 40 percent of staff are level-of-care nursing and professional staff, while the remaining 60 percent are non-level-of-care staff (e.g., medical director, groundskeeper, peace officers, housekeepers, plumbers, food service staff).

Staff Comment & Recommendation: This is an informational issue and no action is required.

Questions:

1. From 2012-13 to 2013-14, the overall budget for DCs is estimated to decline 1.6 percent, while the number of residents is estimated to decline by around 16 percent and number of authorized staff by around 8 percent. Please discuss the reasons for these differences in the degree of year-to-year change among these measures.

3. Sonoma Developmental Center

Budget Issue: Sonoma Developmental Center (SDC), in the town of Glen Ellen, California, has approximately 506 residents with developmental disabilities. The facility is authorized for approximately 1,502 state staff positions, 83 percent of which are currently filled. The proposed 2013-14 overall budget for SDC includes approximately $152.7 million ($79.2 million GF). This funding includes a $2.4 million increase ($1.3 million GF) that would allow the facility to hire approximately 36 additional direct care staff. The addition of these staff members would correspondingly allow staff who serve as shift leads to focus on supervision, without being counted toward required ratios of direct care staff to clients. Sonoma is the only DC where shift leads have been counted toward meeting those ratios.

Four out of 10 of SDC's Intermediate Care Facility (ICF) units, with 111 consumers who currently reside in them, were recently withdrawn from federal certification by DDS in response to notice that the federal government was moving to decertify the larger group of ICF facilities at SDC. The federal government's concerns, and DDS's resulting withdrawal of these units from certification, came on the heels of findings last year regarding multiple instances of abuse, neglect, and lapses in caregiving at SDC. DDS indicates that its decision to withdraw

these specific units from certification was based on the expectation that the problems faced in these units would take longer to resolve than those impacting the remainder of the ICF units. Given how recently DDS withdrew these units from certification, the Governor's January budget did not include the impacts of associated federal funding losses of approximately $1.4 million monthly. The Administration indicates that these funds will need to be backfilled for some months in 2012-13 and for any months in 2013-14 in which the units are still not certified. The Administration has not yet determined how these resources will be identified within or as an addition to DDS's budget authority for 2012-13.

Additional Background on the Problems at SDC: In July 2012, licensing staff from the California Department of Public Health (DPH) conducted an annual state licensing and federal certification survey of SDC. During the visit, DPH staff found numerous violations. 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, and failed to provide appropriate health care services and meet several other key requirements. According to page three 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, 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 with a condition called pica ate non-edible items such as gloves, buttons, sunglasses, paper and other items.
- 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.
- 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 death of one client that the investigators believed was caused by acute peritonitis related to a misplaced gastrostomy tube.

Staffing at SDC: In comparison to other DCs, it is notable that SDC has the highest vacancy rate (at 17 percent) and relies disproportionately on the use of overtime, including mandatory overtime (e.g., at 20,100 total hours and close to 7,100 mandatory hours in February 2013), in order to meet required staff to client ratios. The Sonoma DC also has a larger proportion than other DCs of unlicensed staff (at 37 percent as of March 1, 2013) serving in classifications for which licensure is relevant. The Department indicates that it is in the process of hiring additional staff to fill vacancies at the facility and reduce the use of overtime.

DDS Actions: DDS removed two top executives at SDC in the wake of the systemic concerns identified and recently announced the hiring of a new Executive Director for the facility. The department also contracted with an internal monitor for ongoing evaluation, required unannounced checks, and implemented a number of new policies designed to provide closer supervision and better training for staff. In March, the department entered into an agreement with the federal government that established a Program Improvement Plan (PIP) that includes corrective actions it must take in order to retain certification of the units that have not been decertified. The PIP outlines several actions SDC must take to remain certified, including entering into a contract with an independent entity that will perform a root cause analysis, developing action plans to correct identified deficiencies, and reporting monthly progress to DPH. The department has not yet indicated the timeframe in which it anticipates seeking recertification of the units that are currently without federal certification.

LAO Recommendation: Given the recent problems at SDC, as well as other significant concerns related to DCs spanning the last decade, the LAO recommends that the Legislature consider strengthening DC oversight by creating an independent Office of Inspector General (OIG). The LAO estimates costs of $500,000 to $1 million for this function and suggests that the department identify resources that could be redirected to provide that funding.

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

Questions for DDS:

1. Please briefly describe the central features of the Program Improvement Plan and identify approximately when you anticipate that the ICF units that are not currently certified may be ready for recertification.

2. What are your plans for addressing the fiscal impact of the loss of certification of the four units during the 2012-13 fiscal year and potentially in 2013-14?

3. With respect to staffing:

    a. Why was SDC's practice of having supervisory staff count toward required staffing ratios different than other DCs?

    b. How are the department and facility leadership working to decrease the use of overtime and increase the presence of licensed staff at the facility? When and how much can we expect to see improvements in these measures?

Questions for Panel of Stakeholders:

1. What, if any, improvements have you seen in the quality of care and safety of residents in the ICFs at SDC in recent months?

2. What are your most critical remaining concerns and what would you suggest might be done to alleviate them?

4. Closure Process for Lanterman Developmental Center

Budget Issue: The Governor's proposed 2013-14 budget for the Lanterman Developmental Center (LDC), which is in the process of transitioning its residents into community-based placements as part of a closure process, includes $89.3 million ($46.4 million GF). This is a decline of $11 million ($6.2 million GF) from 2012-13. The proposed funding level assumes continuation of $8.2 million ($4.4 million GF) in enhanced funding for 88 staff positions that would otherwise have been eliminated as the number of residents declined, pursuant to the standard ratios of staff to residents. These positions were approved as enhanced staffing related to closure activities as part of the 2012-13 budget.

Background: LDC is in Pomona and consists of 11 client residences, one acute hospital unit, a variety of training and work sites, and recreational facilities, including a camp. At its peak, LDC housed more than 1,900 individuals. DDS submitted its plan to close LDC to the Legislature in January 2010. The plan was approved in October 2010. At the time, there were approximately 400 residents and 1,300 staff at the facility. The Department indicated then that the closure process would take at least two years. As of March 1, 2013, there were 207 residents at LDC. The department recently estimated that the transitions of residents to the community would be completed in 2014.

The Transition Process: According to the department, the transition of each LDC resident 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 identifying or developing community resources to meet them. However, of the 207 remaining residents of LDC as of March 1, the Department indicates that 70 percent have a comprehensive assessment that has been completed within the past two years (up from 55 percent on December 1, 2012). Regional centers report that nearly all LDC residents will have updated assessments by June 2013.

Some Facts about LDC Residents:

- The majority have lived there for more than 30 years and are between 40 and 65 years old.
- 75% have profound intellectual disabilities.
- Primary service needs include:
  - 34% Protection and Safety
  - 25% Significant Health issues
  - 25% Extensive Personal Care
  - 15% Significant Behavioral issues

The department and 12 regional centers involved in the closure process use Community Placement Plans as one tool to help them identify and develop necessary community-based resources. DDS has also received recommendations from advisory groups and indicates that its staff meets regularly with parents and family members of LDC residents, LDC employees, and the involved regional centers.

The department indicates that the vast majority of former LDC residents who have moved to the community now reside in Adult Residential Facilities, which are licensed by the Department of Social Services. As part of the transition, DDS visits consumers who have moved into

community residences at 5 days, 30 days, 90 days, and 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.

One of the transition-related challenges identified by providers and regional centers is the time lags that can occur between community-based homes' licensure and their first occupancy, as well as full occupancy. DDS indicates that the average lag time between licensure and first occupancy has been 71 days for non-profit-owned homes and 120 days for other homes. The average lag between first occupancy and full occupancy has been 176 days for non-profit-owned homes and 209 days for other homes.

Anticipated Timelines: The Department has declined to give a target date for closure of the facility, indicating that the development of necessary community resources for each consumer is a continual and complex process. Some stakeholders have suggested that a closure date might help to guide the rest of the process toward more successful and timely completion; others have expressed concern that identifying such a date might create a distraction or inappropriate pressure to have consumers move before all necessary preparations have been made. In 2012, the Legislature requested for the Department to identify anticipated timeframes for the remaining transitions and steps in the closure process. The Department's response includes the following anticipated milestones and timelines:

- Completion of up-to-date comprehensive assessments for all remaining residents – June 2013
- All residential facilities that need to be developed are licensed and ready for occupancy – January 2014
- Specific living options are selected and initial transition planning meetings for all residents have been held. All new day programs are licensed and available to provide services – March 2014.

Community State Staff Program: The Department has indicated that it will continue to provide trainings and information about the Community State Staff program to DC staff, families of consumers who live at LDC, and community-based providers. The program allows LDC staff to leave the facility and work for a community-based provider serving consumers who transition into the community, while retaining their status and benefits as state staff. The program is voluntary for the employees and providers.

As of December 1, 2012, only one community-based provider and one regional center had entered into or completed the process of contracting to opt in to the program. At the same time, the regional centers serving people moving from LDC and other stakeholders indicate that there are some providers that employ former DC staff outside of the program. For example, Inland Regional Center reported to DDS knowledge of nine former LDC employees who have been hired locally outside of the program. San Gabriel/Pomona Regional Center

(SGPRC) reported that over the years, providers in their area have hired fourteen former DC staff for residential and day programs, nine for direct care positions, and four as consultants to vendored programs. SGPRC also reported hiring five former DC employees themselves.

One distinction between the Community State Staff program for the Lanterman closure and the program operated for the earlier Agnews DC closure is that the retention of status and benefits for LDC staff is limited to up to two years after the closure of LDC. At one point there were 120 state staff working in the community under the program after leaving the Agnews DC. Currently (around four years after the last residents transitioned out of the Agnews DC), the department indicates that 28 state staff continue working in the community through the program. In addition to other specific comments with respect to what might allow the program to be utilized more, the Lanterman Parents Coordinating Council has requested for the Legislature to remove the two-year time limitation on the program for LDC staff.

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

Questions:

1. What factors have led to delays in completing the closure process? How have and will the Department, facility leadership, regional centers, and other stakeholders address those concerns?

2. Particularly given that we are a few years into the closure process, why don't all LDC residents already have a current assessment of their needs (rather than around 70 percent as of March 1)?

3. Could it be helpful in some ways to identify a targeted closure date for LDC by which all consumers should have transitioned to the community? And on the other hand, what concerns might that raise?

C. 4300 Department of Developmental Services - Regional Center Local Assistance

The Governor's 2013-14 budget proposes a total of $4.3 billion ($2.5 billion GF) for developmental services that are anticipated to be provided to 266,100 individuals with disabilities who reside in the community. This includes an increase of $177.5 million ($89.2 million GF) due to updated caseload and expenditure information and the addition of 10,128 consumers to the caseload. Additional changes and proposals are described below.

Background: 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. Once individuals qualify for services under the Lanterman Act, the state provides these supports throughout their lifetime. These services and supports range from day programs to transportation or residential services. Determination of which services an individual needs is made by an interdisciplinary team that develops an Individualized Program Plan (IPP) (or Individual Family Service Plan (IFSP) if the consumer is an infant/toddler three years of age or younger). Services that are included in these plans are entitlements and regional centers purchase them if necessary (i.e., an individual does not have private insurance that covers the service and there is no "generic" or publicly provided service available).

1. Sunset of 1.25 Percent Reduction in Rates for Regional Centers and Community-Based Service Providers

Budget Issue: The Governor's budget includes a $46.7 million ($31.9 million GF) increase in costs resulting from the scheduled sunset of a reduction of 1.25 percent to the rates paid to regional centers and community-based providers of services.

Background: 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 $62 million GF). In 2010-11 and 2011-12, the reduction was increased to 4.25 percent (for estimated savings of $89 million and $108 million GF, respectively). In 2012-13, the reduction was decreased to 1.25 percent (for estimated savings of $31.9 million GF). There were corresponding federal funding losses each year.

The statutory provisions creating the payment reductions also established some exemptions, 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 could demonstrate to DDS that a non-reduced payment was necessary to protect the health and safety of a consumer.

Many stakeholders indicated that these rate reductions (particularly when combined with other reductions to the developmental services system) created significant hardships for regional center staff and community-based service providers, which also impacted developmental services consumers.

Staff Comment & Recommendation: Staff recommends approving the continued assumption that the rate reductions which have been in effect in recent years will expire.

Questions:

1. Please briefly summarize the background behind the budgeted increase and the impacts of the recent rate reductions.

2. Trailer Bill Language on Regional Center Payments for Health Insurance Co-Pays

Budget Issue: The Governor's budget includes increases of $15 million GF in 2012-13 and $9.9 million GF in 2013-14 to support payments by regional centers of health insurance co-pays for services identified as necessary in the consumer's IPP. The Department's estimates of these costs include both "co-pays" that are payments made by the insured directly to a health care provider for each service or visit, as well as what is known as "co-insurance" and refers to a balance of costs for services above and beyond what is covered by insurance.

The Administration also proposes trailer bill language to specify the conditions under which regional centers would be authorized to make such co-payments going forward- i.e., when necessary to ensure that the consumer receives the service or support, when health insurance covers the service in whole or in part, when the consumer (or family if the consumer is under the age of 18) has income that does not exceed 400 percent of the federal poverty level (FPL), and when there is no third party who is liable to pay for the cost. The Department estimates that roughly 50 percent of consumers or families, as applicable, have incomes below 400 percent of FPL. The proposed trailer bill language additionally provides flexibility for regional centers to cover co-pays for consumers or families with income above 400 percent of FPL under extraordinary circumstances when needed to successfully maintain the child at home or adult consumer in the least restrictive setting. The proposed trailer bill language also prohibits payment by regional centers of insurance deductibles (the amount the insured must spend on his/her own before insurance benefits can be utilized).

Background: Legislation, including recent budget trailer bill language, has emphasized the responsibility of regional centers to reduce state costs by pursuing services or funding from entities responsible for providing or paying for services to regional center consumers. This includes payment, as applicable, by health insurers and health plans. Related recent legislation confirmed the responsibility of insurers and health plans to pay the costs of behavioral health treatment (BHT) for individuals with autism (Chapter 650, Statutes of 2011 [SB 946, Steinberg]). BHT may be required as often as 3-5 times per week, which can result in significant copayments for families with private health insurance. The increased reliance on private insurance resulting from recent budget actions and the enactment of SB 946 has raised the issue of whether families with insurance are to incur the cost of copayments or whether copayments would be paid by regional centers, which would be responsible for the full cost of these services in the absence of insurance coverage.

The Department and other stakeholders have indicated that regional center practices with respect to insurance-related co-pays and deductibles have historically varied from region to region. The Department asserts that statutory clarification is necessary to establish a clear, statewide policy. Under existing state law, regional centers are required to identify and pursue all possible sources of funding for services, including but not limited to, government services and programs, e.g., Medi-Cal, and "private entities, to the maximum extent they are liable for the cost of services, aid, insurance, or medical assistance to the consumer." [Welfare & Institutions Code Section 4659(a)]. In the case of a covered service having a co-pay, the entity's maximum liability is typically the cost of the service less the co-pay. The Association of Regional Center Agencies recently obtained a legal opinion from a private attorney concluding that, under current state law, regional centers are responsible not only for copayments but also for insurance deductibles for services identified in a consumer's IPP or IFSP. The legal opinion was widely circulated, and the department indicates that it will likely result in more regional centers covering these costs.

The department has indicated that administering deductible coverage could be more complex because deductibles are not as directly linked to utilization of a specific service that is included in an IPP or IFSP and may apply to an entire family, not just the developmental services consumer in particular. Some stakeholders have disagreed with this characterization and indicated that billings for deductibles can, and sometimes already do, specify both the service and the recipient of that service.

Several stakeholders have indicated a desire to see the proposed changes go further– e.g., to cover deductible payments in addition and to require, rather than authorize, coverage of co-pays and/or deductibles. Some have also indicated a desire to see coverage of co-pays be limited to behavioral health treatment for individuals with autism, while others have disagreed with that position.

Background on Other Limited Costs Borne by Consumers and Families: The state provides diagnosis and eligibility assessment services free-of-charge. Once eligibility is determined, most 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 is not eligible for Medi-Cal. Finally, an annual family fee of $150 or $200 for specified families with adjusted gross incomes at or above 400 percent of the federal poverty level was enacted in a 2011-12 budget trailer bill. These limited cost-sharing programs have exemption and/or appeal processes that take into account factors such as parental income, the family's extraordinary medical and other expenses, the number of children receiving regional center services, or demonstrated need to enable the family to maintain the child in the family home.

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

Questions:

1. Please briefly summarize the reasons for the requested funds and trailer bill language.

2. Why doesn't the proposed language include coverage of deductible payments?

3. How much does the department estimate that it would cost to require, rather than authorize coverage of co-payments and co-insurance and to require payments of deductibles that are tied to services identified in IPP or IFSPs?

3. Proposed Elimination of Sunset for Annual Family Fee

Budget Issue: The Governor's budget assumes $7.2 million GF savings in 2013-14 from the continued payment of annual fees of $150 or $200 by families with children under the age of 18 living at home who receive services from regional centers beyond eligibility determination, needs assessment, and service coordination. As under existing law, the fees would only apply when the family has income above 400 percent of the Federal Poverty Level and the child or children do not receive Medi-Cal. There are also some specified exemptions, e.g., when necessary to maintain the child in the family home. The Administration also proposes trailer bill language to eliminate the sunset date that was enacted in 2011 of June 30, 2013, and as a result to make the program permanent.

The department estimated that 21,200 families should have been impacted by the annual fee policy in 2011-12; however, only 9,891 families were assessed a fee in that year, and the number of fees collected was even lower. The department indicates that it is working with regional centers to increase implementation of the existing requirements. Some stakeholders have expressed concerns regarding the complexities of administering the fees and their impacts on families.

Background on Costs Borne by Consumers and Families: See description under Item 2, immediately preceding this issue.

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

Questions:

1. Please briefly summarize the proposal and its anticipated impacts.

2. Why hasn't the existing annual family fee policy been more broadly implemented?

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

April 11, 2013 Hearing Outcomes

Staff: Jennifer Troia

OUTCOMES

A. 5180 Department of Social Services

1. Held open issues related to the Continuum of Care Reform (CCR) requirements from last year's trailer bill in anticipation of continued discussions with the department and stakeholders about opportunities for short-term, as well as long-term, reforms, particularly with respect to lengthy group home stays and the use of group care for younger children.

2. Approved (3-0) the requested resources and positions to support the IV-E Waiver CAP extension and held open the requested resources and positions related to the Resource Family Approval project.

3. Approved (3-0) the requested staffing and resources for DSS and OSI for planning activities associated with development of the Child Welfare Services- New System project.

4. Held open the proposed changes to the budget for the Foster Family Home and Small Family Home Insurance (FSH) Fund.

B. 4300 Department of Developmental Services

1. Approved (3-0) the proposed changes to Section 6500 of the Welfare & Institutions Code, subject to refinement in the trailer bill process.

2. Held open the requested resources for additional staffing and other issues related to the Sonoma Developmental Center.

3. Voted (2-1) to remove the two-year time limitation on the Community State Staff program associated with the closure of the Lanterman Developmental Center and adopted corresponding trailer bill language that may be necessary to effectuate that action. Held open the remaining issues raised related to the Lanterman Developmental Center.

C. 4300 Department of Developmental Services

1. Approved (3-0) the assumption that the 1.25 percent rate reduction applicable to regional centers and service providers will sunset as scheduled on June 30, 2013.

2. Held open the proposed funding and trailer bill language related to regional center payments for health insurance co-pays.

3. Held open the proposal to make permanent the annual family fee of $150 or $200 for specified services.

OTHER NOTES

1. The Subcommittee noted its expectation that key child welfare services-related programmatic and fiscal information that used to be provided in January and May budget estimates will continue to be provided to the Legislature and public.

2. The Subcommittee will coordinate with Subcommittee #4 with respect to the proposed suspension of the Interagency Child Abuse and Neglect Reporting mandate and noted that irrespective of the decision regarding the 2013-14 suspension proposal, the workgroup recommended by the LAO appears to be a helpful endeavor.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

April 18, 2013

Upon Adjournment of Senate Budget and Fiscal Review Committee

Room 4203, State Capitol
(John L. Burton Hearing Room)

AGENDA Part 1
(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.

4560 Mental Health Services Oversight and Accountability Commission (MHSOAC)

1. Overview

Mental Health Services Act (Proposition 63, Statutes of 2004). The Mental Health Services Act (MHSA) imposes a one 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 MHSA. 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 promote interagency collaboration. This is funded from five percent of the Community Services and Supports funds and five 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.

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, 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.

Subcommittee Staff Comment. This is an informational item.

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

1. Please provide a brief overview of the MHSOAC and an update on recent activities.

2. MHSOAC's Evaluation Master Plan

Background. The MHSOAC is mandated to evaluate the outcomes of investments made through the MHSA. On March 28, 2013 the MHSOAC approved an Evaluation Master Plan which prioritizes possibilities for evaluation investments and activities over a three to five year course of action.

The MHSOAC Evaluation Master Plan is the result of findings from interviews with approximately 40 key informant interviews, along with county visits. The plan focuses on individual, system, and community outcomes; provides specific evaluation activities and a general system by which to prioritize those and future evaluation activities; and identifies strategies for successful completion of all items described and prioritized in the plan. While the major focus of the plan is on the MHSA, the scope of the plan is broader.

The criteria applied to the evaluation questions include:

- **Consistency with MHSA:** Are the questions consistent with the language and values of the Act?
- **Potential for quality improvement:** Will answers to the questions lead to suggestions for and implementation of policy and practice changes?
- **Importance to stakeholders:** Are the questions a high priority to key stakeholders?
- **Possibility of partners:** Are there other organizations that might collaborate and/or partially fund the activity?
- **Context and forward looking:** Are there changes in the environment that make the questions particularly relevant? (e.g., the evolving health care environment; political concerns)?
- **Challenges:** Do the questions address areas that are creating a challenge for the system?

The criteria for the evaluation activity include:

- **Feasibility:** How likely is the evaluation activity to produce information that answers the evaluation questions?
- **Cost:** How many resources are needed to do the activity well?
- **Timeliness:** How long will it take to complete the evaluation activity?
- **Leveraging:** Does the evaluation activity build upon prior work of the MHSOAC or others?

The MHSOAC has identified the need for additional resources (staff and contracting funds) to carry out the activities specified in the Evaluation Master Plan. Specifically, it finds that six more staff and $300,000 for contracts would be needed for the budget year.

Subcommittee Staff Comment and Recommendation—Hold Open. Since the Evaluation Master Plan was approved after the January budget was submitted to the Legislature, it is

anticipated that a proposal to address the resources identified by the MHSOAC to carry out the Evaluation Master Plan will be included as part of the May Revision.

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

1. Please provide an overview of the Evaluation Master Plan.

2. Please provide a brief highlight of how the additional resources could further the activities outlined in the Evaluation Master Plan.

4260 Department of Health Care Services (DHCS)

1. Community Mental Health Funding and Overview

Overview of Recent Changes Regarding Community Mental Health. Over the last few years, many changes have taken place regarding the organization of community mental health programs. These include:

- **Elimination of Department of Mental Health.** The 2012 budget eliminated the Department of Mental Health (DMH) and transferred responsibilities for community mental health programs and services to various other state departments. (DMH was replaced by the Department of State Hospitals, whose primary function is to oversee state hospitals.)

- **New Responsibilities for Department of Health Care Services.** AB 102 (a 2011 budget trailer bill) transferred state administrative functions for the operation of the Medi-Cal Specialty Mental Health Services Program for adults and children and applicable functions related to federal Medicaid requirements, from DMH to DHCS. Additionally, the 2012 budget transferred Mental Health Services Act functions to DHCS.

  It was intended that these transfers would improve access to culturally appropriate community-based mental health services; effectively integrate physical and mental health services to more effectively provide services; improve state accountabilities and outcomes; and provide focused, high-level leadership for mental health services within the state administrative structure.

- **Realignment of Mental Health Services.** The 2012 budget implemented the 2011 Realignment of Medi-Cal Specialty Mental Health for adults and children. The 2011-12 budget realigned these programs but provided, on a one-time basis, $861 million in Mental Health Services Act funds to support these programs (and mental health services provided to special education students).

County Mental Health Plans. California has a decentralized public mental health system with most direct services provided through the county mental health system.

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 (2) Medi-Cal Specialty Mental Health Services for adults and children, (3) mental health treatment services for individuals enrolled in other programs, including special education, CalWORKs, and Healthy Families, and (4) programs associated with the Mental Health Services Act of 2004 (known as Proposition 63).

Medi-Cal Specialty Mental Health Services Program. California provides Medi-Cal "specialty" mental health services under a 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. Children's specialty mental health services are provided under the federal requirements of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for persons under age 21.

County Mental Health Plans are the responsible entity that ensures 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.

California's Medi-Cal Specialty Mental Health Services Waiver is effective until June 30, 2013.

The proposed budget includes $3.2 billion ($1.7 billion federal funds, $1.5 billion county funds, and $33 million General Fund) for Medi-Cal Specialty Mental Health Services. See following table for funding summary.

Table: Medi-Cal Specialty Mental Health Services Funding Summary (in millions)

2012-13				2013-14			
General Fund	**Federal Funds**	**County Funds**	**Total Funds**	**General Fund**	**Federal Funds**	**County Funds**	**Total Funds**
$13.5	$1,556.5	$1,472.6	$3,042.6	$33.3	$1,728.3	$1,527.7	$3,289.2

In 2013-14, it is projected that 235,072 adults and 243,146 children will receive Medi-Cal Specialty Mental Health Services (using the accrual methodology).

As discussed at the February 21, 2013 Senate Budget and Fiscal Review Committee hearing, implementation of health care reform, the federal Affordable Care Act, will have an impact on Medi-Cal Specialty Mental Health Services. It is expected that there will be an increase in Medi-Cal caseload resulting from (1) the increase in enrollment of individuals already eligible for Medi-Cal but not enrolled, and (2) the expansion of Medi-Cal to childless adults with incomes under 138 percent of the federal poverty level. The Administration did not address this issue in the January budget.

Mental Health Services Act (Proposition 63 of 2004). The Mental Health Services Act (MHSA) imposes a one 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). See Overview item under the Mental Health Services Oversight and Accountability Commission for more information on the MHSA.

The budget projects $1.4 billion in MHSA expenditures in 2013-14. See following table for MHSA expenditure summary.

Table: Mental Health Services Act Expenditure Summary

	2011-12	2012-13	2013-14
Local Assistance*	$1,812,375	$1,377,775	$1,362,650
State Administrative Costs	$29,994	$40,005	$40,104
Total	**$1,842,369**	**$1,417,780**	**$1,402,754**

*Counties receive MHSA funds from the State Controller's Office on a monthly basis.

Behavioral Health Realignment Funding. As discussed above, the 2012 budget implemented the realignment of Medi-Cal Specialty Mental Health Services. In 2011, the Drug Medi-Cal program was realigned to the counties. The table below provides a summary of realignment revenue for these two programs.

Table: Behavioral Health Realignment Funding (dollars in millions)

Account	**2012-13**			**2013-14**		
	Base	**Growth**	**Total**	**Base**	**Growth**	**Total**
1991 Realignment						
Mental Health Subaccount*	-	-	-	-	$68.5	$68.5
2011 Realignment						
Mental Health Account*	$1,120.6	$9.6	$1,130.2	$1,120.6	$11.1	$1,131.7
Support Services Account						
Behavioral Health Subaccount**	$959.4	$24.8	$984.2	$984.2	$73.8	$1,058.0
Total			**$2,114.4**			**$2,258.2**

*2011 Realignment changed the distribution of 1991 Realignment funds in that the funds that would have been deposited into the 1991 Realignment Mental Health Subaccount, a maximum of $1.12 billion, is now deposited into the 1991 Realignment CalWORKs MOE Subaccount. Consequently, 2011 Realignment deposits $1.12 billion into the 2011 Realignment Mental Health Account.
**Reflects $5.1 million allocation to Women and Children's Residential Treatment Services.

Subcommittee Staff Comment and Recommendation. The January budget was the first year DHCS completed the Medi-Cal Specialty Mental Health Services estimate and it did not

include detailed fiscal information that was previously provided by DMH. For example, information regarding Medi-Cal Specialty Mental Health Services, children's forecast by service type, adult's forecast by service type, approved claim information, information on unduplicated clients, and summary tables on service costs was not provided.

Stakeholders, including staff, use the detail fiscal information to track caseloads, service trends, and costs. The document provided in January does not facilitate this oversight.

Since January, staff has been working with DHCS on incorporating supplemental fiscal information into the budget documents. DHCS has committed to providing this information at the May Revision and has been very helpful in answering staff questions.

It is recommended to:

- **Hold open** the Medi-Cal Specialty Mental Health Services funding proposal as updated information will be provided at May Revise.

- **Adopt placeholder trailer bill language** to require supplemental fiscal information be included in budget documents to ensure that the Legislature and stakeholders have the information necessary to make informed decisions. This placeholder language would be consistent with Welfare and Institutions Code Section 14100.5 that requires DHCS to prepare and submit detailed information regarding Medi-Cal program assumptions and estimates for the budget.

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

1. Please provide a brief overview of community mental health and funding for these programs.

2. Please provide an update on the renewal of the Medi-Cal Specialty Mental Health Services Waiver. Does DHCS anticipate any changes to this waiver?

2. Behavioral Health Services Needs Assessment and Services Plan

Background. The state's Medi-Cal Section 1115 "Bridge to Reform" Waiver Special Terms and Conditions requires the state to complete a Behavioral Health Services Needs Assessment that includes an accounting of the services available throughout the state, as well as information on service infrastructure, capacity, utilization patterns, and other information necessary to determine the current state of behavioral health service delivery in California. (Behavioral health includes mental health and substance use disorder services.)

The waiver special terms and conditions also require the completion of a Behavioral Health Services Plan no later than October 1, 2012. This service plan will describe California's recommendations for serving the Medi-Cal expansion population, under federal health care reform, and demonstrate the state's readiness to meet the projected mental health and substance use disorder needs.

Behavioral Health Services Needs Assessment. DHCS contracted out to conduct a Mental Health and Substance Use System Needs Assessment. The primary purpose of the Needs Assessment was to review the needs and service utilization of current Medi-Cal recipients and identify opportunities to ready Medi-Cal for the expansion of enrollees and the increased demand for services resulting from health reform.

The Needs Assessment was completed in February 2012.

Key topics addressed in the Needs Assessment included:

- Prevalence of mental health and substance use service needs in California
- Analysis of Medi-Cal data for mental health and substance use services
- Medi-Cal expansion population
- Medicaid strategies for special populations
- Provider capacity and workforce analysis
- Health integration
- Behavioral information technology

Behavioral Health Services Plan. The Needs Assessment was to facilitate DHCS's development of a Behavioral Health Services Plan. The Services Plan would describe California's recommendations for serving the Medi-Cal expansion population, under federal health care reform, and demonstrate the State's readiness to meet the mental health and substance use disorder needs of this population. The Services Plan was due to the federal CMS on October 1, 2012. However, since federal guidance on the Medicaid Benchmark Benefit and Medicaid Behavioral Health Parity was not available in October 2012, the state and CMS agreed that the state could submit an outline of the Services Plan in October 2012 and that the state would have until April 1, 2013 to submit the Services Plan.

On April 1, 2013, DHCS submitted a letter to CMS and a draft Medicaid Alternative Benefit Plan Options Analysis prepared by Mercer. This Options Analysis was developed on behalf of

DHCS to provide information on the Medicaid expansion benefit options. DHCS has not been able to complete the Services Plan because a decision on the Medicaid benefit package and delivery system has not been made.

DHCS has indicated that it will submit the final Service Plan to CMS by October 1, 2013.

Subcommittee Staff Comment. The Administration has not engaged stakeholders in a discussion regarding how the state will be ready to meet the mental health and substance use disorder needs of the Medi-Cal expansion population. Additionally, the process by which DHCS decided to send the draft Options Analysis to CMS was not transparent as stakeholders were made aware of DHCS's intention only shortly before its submittal.

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

1. Please provide a brief overview of the purpose of the Needs Assessment and Services Plan.

2. What will be the process and timeline for creating and finalizing the Service Plan?

3. What has DHCS done to meaningfully engage with stakeholders in a discussion (1) on the state's readiness to meet the mental health and substance use disorder needs of the Medi-Cal expansion population and (2) on the development of the Services Plan? What more does DHCS plan to do?

3. Mental Health & Substance Use Disorder Services "Business Plan"

Background. With the transfer of community mental health and Drug Medi-Cal responsibilities to DHCS over the last few years, stakeholder concerns and suggestions for program improvements and innovations were raised.

As a result, DHCS partnered with the California Institute for Mental Health (CiMH) and the Alcohol and Drug Policy Institute (ADPI) to develop a stakeholder-informed business plan for addressing critical mental health and substance use disorder services. This business plan would be used to inform the actions of DHCS and counties in preparing for, and responding to, the changes facing the delivery of mental health and substance use disorder services in California.

A draft plan was made public in December 2012 and was organized into the following areas:

- Using Measurement to Improve Quality, Outcomes, and Ensure Accountability for Mental Health and Substance Use Delivery Systems
- Substance Use Delivery Finance
- Organizational Capacity for Current Substance Use Delivery Providers
- Reduce/Simplify Administrative Burden on Programs/Providers
- Service Integration for Mental Health, Substance Use Delivery, and Primary Care
- State and County Roles & Responsibilities
- Workforce Capacity & Skills

The last stakeholder meeting on this plan was held in December 2012.

Subcommittee Staff Comment—Informational Item. DHCS indicates that, since December, it has been working with the County Mental Health Directors Association and the California Association of Alcohol and Drug Programs Executives on finalizing the document, which will be made public at the end of April. It also indicates that is has been working with these two organizations to develop a process to prioritize issues in this plan.

Stakeholders have invested in this process in order to improve the delivery of mental health and substance use disorder services in the state, and it is important to keep momentum on this project and take action on program improvements.

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

1. Please provide an update on the Business Plan process. What are the next steps?

2. How will DHCS work with all stakeholders in prioritizing when items in the plans will be addressed?

4. County Mental Health Performance Contracts

Background. Since the 1991 realignment of certain mental health services to the counties, state law has required the state to maintain a county mental health services performance contract. This contract includes assurances that a county shall comply with, among other things:

- Requirements necessary for Medi-Cal reimbursement for mental health treatment services and case management programs provided to Medi-Cal eligible individuals.
- Provisions and requirements in law pertaining to patient rights.
- Data reporting requirements.
- Laws, regulations, and guidelines of the Mental Health Services Act (MHSA) (Proposition 63). This requirement was added by SB 1009 (a 2012 budget trailer bill).

As part of the Governor's 2012 budget proposal to eliminate the Department of Mental Health (DMH), the Administration proposed to eliminate county mental health services performance contracts as the last performance contract was from July 2007 until June 2010.

The Legislature rejected this proposal and (1) required that these contracts be overseen by DHCS and (2) added the provision that these contracts include the assurance that counties comply with the MHSA.

In October 2012, DHCS began meeting with stakeholders to review the previous contract (a boiler plate contract that is used with every county). It is currently working with the Mental Health Services Act Oversight and Accountability Commission to review contract language related to the MHSA and the Department of Public Health regarding contract language related to the California Reducing Disparities Project.

DHCS plans to have this contract language finalized in June and sent to the counties to be effective July 1, 2013 (without regard to the date of execution).

Requirements Related to Stakeholder Process for MHSA. Stakeholders have stressed the importance of adding contracts requirements to ensure an effective stakeholder engagement process that includes diverse stakeholder groups in MHSA mental health services planning and implementation.

Subcommittee Staff Comment and Recommendation. DHCS indicates that since these performance contracts are not related to counties receiving funding from the state, as the Medi-Cal Specialty Mental Health Services Program was realigned and counties receive direct allocations of MHSA funds, there is no clear method to ensure compliance with the performance contract.

However, DHCS maintains another contract with counties related to Medi-Cal and the drawdown of Medi-Cal federal funding for the Medi-Cal Specialty Mental Health Services Program.

It is recommended to **adopt placeholder trailer bill language** to integrate the county performance contracts and the state's contracts with counties regarding Medi-Cal Specialty Mental Health Services. One of the reasons for the transfer of community mental health programs to DHCS from DMH was to facilitate the comprehensive integration of mental health services to improve outcomes. Integrating these contracts would provide the state with the opportunity to link performance, outcomes, and program requirements.

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

1. Please provide an overview of county mental health services performance contracts.

2. What is the status of finalizing the performance contracts?

3. How is DHCS working with stakeholders to incorporate stakeholder suggestions, such as provisions related to a stakeholder process for MHSA?

5. Performance Standards for EPSDT Mental Health Services

Background. SB 1009 (a 2012 budget trailer bill) requires DHCS, in collaboration with California Health and Human Services Agency, and in consultation with the Mental Health Services Oversight and Accountability Commission, to create a plan for a performance outcome system for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program mental health services for children.

SB 1009 also requires that by no later than September 1, 2012, a stakeholder advisory committee shall be convened for the purpose of developing this plan and requires DHCS to provide a plan, including milestones and timelines for EPSDT mental health outcomes by no later than October 1, 2013.

In October 2012, DHCS convened a stakeholder advisory committee meeting. Since the October meeting, DHCS has (1) researched existing state and federal statutes and regulations for quality outcomes and measurement; (2) surveyed other states and county mental health plans on their existing performance and outcomes systems; and (3) developed a work plan including milestones, deliverables and timelines to move forward the performance outcome system.

In addition, DHCS has convened a smaller workgroup of subject matter experts with the intent of gaining knowledge and receiving input and recommendations on the framework and core components of a performance and outcomes measurement system.

The next stakeholder advisory committee meeting has not yet been scheduled.

Subcommittee Staff Comment. This is an informational item to get an update from the department on the status on developing this performance outcome system.

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

1. Please provide an update on this project.

2. Please discuss how DHCS plans to address all phases of services, screening, diagnosis, and treatment, as part of the performance outcome system.

3. How is DHCS working with Medi-Cal Managed Care Plans and County Mental Health Plans on this project?

6. Federal Bulletin on EPSDT

On March 27, 2013, the federal Centers for Medicare and Medicaid Services (CMS) issued an Informational Bulletin to help inform states about resources available to help them meet the needs of children under Early and Periodic Screening, Diagnostic and Treatment (EPSDT), specifically with respect to mental health and substance use disorder services.

Background. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is Medicaid's (Medi-Cal in California) comprehensive preventive child health service designed to assure the availability and accessibility of health care services and to assist eligible individuals and their families to effectively use their health care resources.

The EPSDT program assures that health problems, including mental health and substance use issues, are diagnosed and treated early before they become more complex and their treatment more costly.

Under the EPSDT benefit, eligible individuals must be provided periodic screening (well child exams), as defined by statute. One required element of this screening is a comprehensive health and developmental history, including assessment of physical and mental health development. Early detection of mental health and substance use issues is important in the overall health of a child and may reduce or eliminate the effects of a condition if diagnosed and treated early. If, during a routine periodic screening, a provider determines that there may be a need for further assessment, an individual should be furnished additional diagnostic and/or treatment service.

Table: How Does EPSDT Ensure That Young Children Receive Services?

Early	Identifying problems early, starting at birth
Periodic	Checking children's health at periodic, age-appropriate intervals
Screening	Doing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
Diagnosis	Performing diagnostic tests to follow up when a risk is identified, and
Treatment	Treating the problems found.

Source: Health Resources and Services Administration's EPSDT Program Background

Subcommittee Staff Comment. As discussed in previous items, the transfer of community mental health and Drug Medi-Cal (and the proposed transfer of most programs from the Department of Alcohol and Drug Programs, to be discussed later in the agenda) to DHCS, was intended to integrate all aspects of health care delivery into one department. This would facilitate a comprehensive view of how health care delivery programs impact individuals and how addressing health issues as early as possible improves outcomes and reduces costs.

DHCS now oversees all components of the EPSDT benefit. This recent federal bulletin highlights the importance of all steps in EPSDT and empowers states to recognize the importance and potential of this benefit.

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

1. How does DHCS monitor to ensure that all components of EPSDT, early and periodic screening, diagnosis, and treatment, are being provided? Are there requirements regarding EPSDT in Medi-Cal Managed Care Plan contracts?

2. What information reported by Medi-Cal Managed Care Plans, County Mental Health Plans, and county drug and alcohol departments facilitates this monitoring? Are there HEDIS (Healthcare Effectiveness Data and Information Set*)* measures that are used for this monitoring?

3. How does DHCS plan to use the bulletin and the identification of additional resources to improve the state's implementation of the EPSDT benefit?

7. Medi-Cal's Mental Health Fee-For-Service Provider Adequacy

Background. Medi-Cal mental health services are provided via three different delivery systems:

- **Medi-Cal Managed Care.** Medi-Cal managed care plans cover "basic" mental health care needs that can be met by a general health care practitioner or a physical health care specialist (i.e., services that primary care physicians can provide within their scope of practice).

- **Medi-Cal Fee-For-Service.** Medi-Cal fee-for-service (FFS) covers mental health care services that cannot be met by Medi-Cal managed care and do not meet medical necessity criteria to be covered under Medi-Cal Specialty Mental Health.

  If a county does not have Medi-Cal managed care, then "basic" mental health care needs are also provided by Medi-Cal FFS.

- **Medi-Cal Specialty Mental Health Services via County Mental Health Plans.** County mental health plans provide Medi-Cal specialty mental health services for adults with serious mental illness and children with serious emotional disturbance (under a Medicaid waiver). These services include: mental health services (assessment, therapy, rehabilitation, collateral, plan development); medication support services; day treatment intensive; day rehabilitation; crisis intervention; crisis stabilization; adult residential treatment services; crisis residential treatment services; psychiatric health facility services; psychiatric inpatient hospital services; targeted case management; and supplemental EPSDT services (including therapeutic behavioral services).

Medi-Cal Mental Health FFS Adequacy Unclear. A clear understanding of the breadth and geographic distribution of Medi-Cal mental health FFS providers is unknown. In the fall of 2012, DHCS performed data analysis to attempt to address questions such as:

1. Who are Medi-Cal FFS mental health providers?
2. Who is being served by Medi-Cal FFS mental health?
3. What mental health services are being covered by Medi-Cal FFS?

Because it appeared that Federally Qualified Health Centers (FQHCs) were the primary Medi-Cal FFS mental health providers, there were challenges in answering the above questions as FQHC claims information is bundled, which does not provide the ability to isolate mental health services.

Subcommittee Staff Comment. With the expansion of Medi-Cal under the federal Affordable Care Act, an understanding of the state's Medi-Cal mental health FFS network is important. Additionally, ensuring individuals receive the care they need before a more "basic" mental

health need evolves into a serious mental illness not only provides better health outcomes but could reduce costs to the systems.

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

1. Please provide an overview of this issue.

2. Has DHCS reached out to counties to explore options on developing the FFS network? Please explain.

3. What are Medi-Cal mental health FFS access standards?

8. Transfer of Mental Health Facility Licensing to DHCS

Budget Issue. The Administration proposes to transfer permanent positions and expenditure authority from the Department of Social Services (DSS) to DHCS for licensing and quality improvement functions related to mental health services.

DHCS will receive 12 permanent positions and expenditure authority of $728,000 ($337,000 General Fund, $391,000 Mental Health Facility Licensing Fund). DHCS has existing federal authority and is not requesting an augmentation. DHCS will also have oversight of the Mental Health Facility Licensing Fund (Fund), collecting and expending revenues related to mental health licensing and certification functions.

DSS will have a corresponding decrease in position and expenditure authority of $1,124,000 ($337,000 General Fund, $391,000 Mental Health Facility Licensing Fund, and $396,000 Reimbursement).

Additionally, the Administration proposes to transfer DSS's roles and responsibilities related to Lanterman-Petris-Short Act involuntary holds (pursuant to Welfare and Institutions Code Section 5150) to DHCS. These responsibilities include the approval of facilities designated by counties for 72-hour treatment.

The Administration proposes trailer bill language to implement these changes.

Background. The 2012 budget eliminated the Department of Mental Health (DMH), effective July 1, 2012, and transferred community mental health programs to various state departments. This reorganization placed community mental health policy leadership at DHCS, with a Deputy Director for Mental Health and Substance Use Disorder Services who is appointed by the Governor and confirmed by the Senate. The majority of community mental health functions transferred to DHCS; however, licensing and quality improvement functions related to Mental Health Rehabilitation Centers and Psychiatric Health Facilities transferred to DSS.

Rationale for Transfer. The Administration indicates that after careful review it has become clear that it is more beneficial and effective for the community mental health system to house licensing, certification, and policy in one department, DHCS. Under this proposal, consumers, family members, providers, and counties will, in many cases, have one state department to contact if they have community mental health provider-specific questions or concerns.

Since the transfer on July 1, 2012, some stakeholders have identified challenges in navigating multiple departments. Moreover, with both administration of Medi-Cal Specialty Mental Health and certain responsibilities for the Mental Health Services Act now at DHCS, DHCS is the policy leader on community mental health.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve the transfer of these positions and expenditure authority and to adopt placeholder trailer bill language to implement these changes. No issues have been raised regarding this proposal.

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

1. Please provide an overview of this budget proposal.

9. 1991 Realignment Growth Allocation Change – Proposed Trailer Bill Language

Budget Issue. The Administration proposes trailer bill language to reduce by 50 percent the share of 1991 Realignment growth funds allocated to mental health beginning in 2015-16.

If this proposal was implemented in the budget year, the mental health growth account would be reduced by $34 million. The Administration does not have a projection for 1991 Realignment growth funds in 2015-16.

Background. The fiscal structure for 2011 Realignment was established in SB 1020 (a 2012 budget trailer bill). As part of that structure, 1991 Realignment funds that would have otherwise have been deposited into the Mental Health Subaccount are deposited instead into the CalWORKs MOE Subaccount, which is provided to counties for their CalWORKs MOE obligation. Those dollars result in a one-for-one savings of General Fund for the Department of Social Services.

Per SB 1020, 1991 Realignment funds are to be deposited into the CalWORKs MOE Subaccount until it reaches a cap of $1.121 billion (expected to be reached in 2013-14), at which time excess funds are routed to the Mental Health Subaccount for counties to spend on mental health programs. 2011 Realignment also provides a set monthly amount for mental health, which takes the place of the 1991Realignment funds previously allocated to the Mental Health Subaccount.

Under the SB 1020 framework, the maximum offset to General Fund expenditures for CalWORKs is $1.121 billion, and all future growth in 1991-92 Realignment that would have gone to that account instead goes to the Mental Health Subaccount.

The Administration proposes that the SB 1020 structure for the CalWORKs MOE Subaccount was developed before the Coordinated Care Initiative proposal and the resulting In-Home Supportive Services (IHSS) maintenance of effort (MOE) were finalized. These program and policy changes will result in lower than usual Social Services Subaccount caseload growth, which will result in more general growth dollars being available to all Subaccounts in 1991-92 Realignment (Health, Mental Health, Social Services), as social services caseload growth has first call on growth dollars in 1991-92 Realignment.

Subcommittee Staff Comment and Recommendation—Reject. It is recommended to reject this proposal as it diverts funds from county mental health programs. Additionally, this proposal would not go into effect until 2015-16 and there is no reason why action would need to be taken now.

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

1. Please provide an overview of this proposal.

10. Drug Medi-Cal Program Funding and Overview

Budget Issue. The Drug Medi-Cal (DMC) program provides medically necessary substance use disorder treatment services for eligible Medi-Cal beneficiaries. The proposed budget includes $207.8 million ($95.2 million federal funds and $112.6 million local funds) for DMC. Since DMC was realigned in 2011, there is no longer General Fund support for this program. See following table for DMC funding summary.

At the time this agenda was prepared, DHCS had not provided unduplicated DMC caseload information.

Table: Drug Medi-Cal Program Funding Summary (dollars in thousands)

	2012-13				2013-14		
Service Description	**General Fund**	**County Funds**	**Federal Funds**	**Total Funds**	**County Funds**	**Federal Funds**	**Total Funds**
Narcotic Treatment Program	$0	$61,875	$61,799	$123,674	$64,267	$64,173	$128,440
Outpatient Drug Free Treatment Services	$0	$41,705	$25,759	$67,464	$43,695	$26,078	$69,773
Day Care Rehabilitative Services	$0	$11,441	$11,441	$22,881	$9,494	$9,495	$18,989
Perinatal Residential Substance Abuse Services	$0	$827	$827	$1,654	$673	$673	$1,346
Naltrexone Treatment Services	$0	$0	$0	$0	$0	$0	$0
Annual Rate Adjustment	$0	$0	$0	$0	-$1,997	-$1,723	-$3,720
Drug Medi-Cal Program Cost Settlement	-$2,827	$0	-$4,190	-$7,017	-$3,508	-$3,509	-$7,017
DRUG MEDI-CAL TOTAL	**-$2,827**	**$115,848**	**$95,636**	**$208,656**	**$112,624**	**$95,187**	**$207,811**

Background. Since 1980, the DMC program has provided medically necessary drug and alcohol-related treatment services to Medi-Cal beneficiaries who meet income eligibility requirements. Services include:

- **Narcotic Treatment Services** – These services are provided to beneficiaries that are opiate addicted and have substance abuse diagnosis, and/or are Early and Periodic Screening, Diagnosis and Treatment (EPSDT) eligible.

- **Outpatient Drug Free Treatment Services** – These services are designed to stabilize and rehabilitate Medi-Cal beneficiaries with substance abuse diagnosis in an outpatient setting.

- **Day Care Rehabilitative Services** – These services include outpatient counseling and rehabilitation services that are provided at least three hours per day, three days per week.

- **Perinatal Residential Substance Use Services** – These services provide rehabilitation services to pregnant and postpartum women with substance use disorder diagnosis in a non-institutional, non-medical residential setting. (Room and board is not reimbursed through the Medi-Cal program.)

- **Naltrexone Treatment Services** – These are outpatient services provided to individuals with confirmed opioid dependence who are at least 18 years of age, opioid-free, and are not pregnant.

The DMC program was transition from the Department of Alcohol and Drug Programs to DHCS, effective July 1, 2012. As part of this transition, a stakeholder process was convened in the fall of 2011. During this process stakeholders raised various recommendations on how to improve the DMC Program.

Subcommittee Staff Comment and Recommendation. It is recommended to:

- **Hold open** the DMC Program funding proposal as updated information will be provided at May Revise.

- **Adopt placeholder trailer bill language** to require summary DMC fiscal charts and unique caseload information be included in budget documents to ensure that the Legislature and stakeholders have the information necessary to make informed decisions.

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

1. Please provide a brief overview of the DMC Program budget.

2. Please provide an update on how DHCS is prioritizing and addressing recommendations raised during the transition of DMC to DHCS.

11. Drug Medi-Cal Legal Representation – Position Request

Budget Issue. DHCS requests to make one limited-term staff counsel position permanent to provide ongoing legal services to the Drug Medi-Cal (DMC) Program.

The cost of this position is $182,000 ($73,000 General Fund and $109,000 federal funds).

Background. DHCS conducts post-service and post-payment reviews and deters and detects DMC fraud resulting from questionable billing practices and complaint investigations. When misrepresentation of fact or suspicion of provider fraud is discovered, DHCS may refer their findings to the Department of Justice (DOJ) for criminal investigation and prosecution. The staff counsel acts as liaison between these departments, advises with respect to the suspension of the provider, and develops the necessary legal documentation to support the suspension.

In addition, DHCS notes that the staff counsel interprets policies and provides technical assistance to counties and other entities that provide DMC treatment program services; drafts amendments to the 1915(b) waiver; negotiates with the Centers for Medicare and Medicaid Services (CMS); briefs the California Health and Human Service's Agency and the Governor's Office on all DMC issues; drafts legislation necessary to implement DMC programs; and performs research and writes legal opinions on novel issues arising from realignment.

DHCS contends that continued adequate legal staff is necessary to support the DMC complaint workload, and to ensure the complaints are sufficiently addressed in a timely manner with confidentiality, consideration of program clients, and coordination of outside agencies, keeping in mind the fiscal integrity needs of the entire state.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open.

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

1. Please provide a brief summary of this proposal.

Michelle Baass 651-4103
Senate Budget & Fiscal Review

OUTCOMES: **Senate Subcommittee #3 on Health & Human Services**
Thursday, April 18 (Room 4203)
Part 1 of the Agenda

4560 Mental Health Services Oversight and Accountability Commission (MHSOAC)

1. Overview

- Informational item only, no vote.

2. MHSOAC's Evaluation Master Plan

- Held open.

4260 Department of Health Care Services (DHCS)

1. Community Mental Health Funding and Overview

- Motion – Approve staff recommendation:
  - **Hold open** the Medi-Cal Specialty Mental Health Services funding proposal as updated information will be provided at May Revise.
  - **Adopt placeholder trailer bill language** to require supplemental fiscal information be included in budget documents to ensure that the Legislature and stakeholders have the information necessary to make informed decisions. This placeholder language would be consistent with Welfare and Institutions Code Section 14100.5 that requires DHCS to prepare and submit detailed information regarding Medi-Cal program assumptions and estimates for the budget.
- Vote – 3-0

2. Behavioral Health Services Needs Assessment and Services Plan

- Informational item only, no vote.

3. Mental Health & Substance Use Disorder Services "Business Plan"

- Informational item only, no vote.

4. County Mental Health Performance Contracts

- Held open.

5. Performance Standards for EPSDT Mental Health Services

- Informational item only, no vote.

6. Federal Bulletin on EPSDT

- Informational item only, no vote.

7. Medi-Cal's Mental Health Fee-For-Service Provider Adequacy

- Informational item only, no vote.

8. Transfer of Mental Health Facility Licensing to DHCS

- Motion – Approve budget request for positions transfer, expenditure authority, and placeholder trailer bill language.
- Vote – 2-0 (Senator Emmerson absent.)

9. 1991 Realignment Growth Allocation Change – Proposed Trailer Bill Language

- Motion – Reject Governor's proposal.
- Vote – 3-0

10. Drug Medi-Cal Program Funding and Overview

- Motion – Approve staff recommendation:
  - **Hold open** the DMC Program funding proposal as updated information will be provided at May Revise.
  - **Adopt placeholder trailer bill language** to require summary DMC fiscal charts and unique caseload information be included in budget documents to ensure that the Legislature and stakeholders have the information necessary to make informed decisions.
- Vote – 3-0

11. Drug Medi-Cal Legal Representation – Position Request

- Held open.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

April 18, 2013

Upon Adjournment of Senate Budget and Fiscal Review Committee

Room 4203, State Capitol
(John L. Burton Hearing Room)

AGENDA Part 2
(Peggy Collins)

ISSUES FOR DISCUSSION
4200 Department of Alcohol and Drug Programs

PLEASE NOTE:

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling 916-651-1505. Requests should be made one week in advance whenever possible. Thank you.

ISSUES FOR DISCUSSION

4200 Department of Alcohol and Drug Programs (DADP)

1. Elimination of DADP and Transfer of Functions to Other State Departments

Governor's Budget Proposal: The Governor's budget reflects the elimination of the DADP on July 1, 2013, and the shift of department functions and $322.4 million ($34.1 million General Fund) to the Department of Health Care Services (DHCS) and the Department of Public Health (DPH). Of this, $289.9 million is in Local Assistance and $32.5 million is in State Support.

The following chart describes the functions and associated resources proposed to be transferred.

Department	Functions	Positions	Funds
Department of Health Care Services	Federal grant administration, parolee services programs, drug court technical assistance, licensing functions, counselor certification activities, narcotic treatment programs, driving-under-the-influence programs, data collection and analysis, statewide needs assessment and planning.	225.5	$313.7 million ($34 million GF)
Department of Public Health	Office of Problem Gambling	4.0	$3.7 million (no General Fund)

The Governor proposes no additional funding related to the elimination of the DADP and the transfer of its functions to the DHCS and the DPH. According to the CA Health and Human Services (CHHS) Agency's *Transition Plan for the Department of Alcohol and Drug Programs (Transition Plan),* released on January 10, 2013*,* the costs associated with this proposal are related to the transfer of informational technology systems and the relocation of staff and that these costs will be absorbed with existing resources at the DADP, the DHCS, and the DPH.

Background: The DADP directs, coordinates and provides leadership for the state's efforts to reduce or prevent alcoholism, narcotic addiction, drug abuse and problem gambling. The department is responsible for maintaining the statewide service delivery system and for coordinating efforts among other state departments, local public and private agencies, service and treatment providers, advocacy groups, and program users. The DADP manages data systems to collect statewide data on drug treatment and prevention.

DADP administers the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant, additional discretionary federal grants, the Parolee Services Network Program, the Narcotic Treatment Program, the Driving Under the Influence Program, the Office of Problem Gambling, and the Drug Court Program. DADP also certifies counselors, and certifies and licenses substance use disorder (SUD) treatment programs in the community.

As part of the 2011-12 state budget, the administrative functions of the Drug Medi-Cal (DMC) program was transferred from the DADP to the DHCS, along with 59.0 positions and associated state operations funding. Until its transfer, the DMC program accounted for about one quarter of DADP's functions.

Additionally, under the 2011 Realignment, community-based substance use treatment programs, previously supported in part by the General Fund, were transferred from DADP to counties. These include both regular and Perinatal Drug Medi-Cal programs and services; regular and Perinatal Non Drug Medi-Cal programs and services; and drug court programs. Under Realignment, funding for these programs was shifted from the state to local governments.

According to the *Transition Plan,* the federal government, a majority of states, and most California counties, have moved toward providing mental health services and substance abuse services through an integrated behavioral services department. In 2012, the Legislature approved the elimination of the Department of Mental Health and shifted its functions to the DHCS, the Department of Social Services (DSS), and the newly-created Department of State Hospitals. At DHCS, mental health services and the Drug Medi-Cal program are each divisions under a newly- established Deputy Director of Mental Health and Substance Use Disorder Services. To further consolidate behavioral health functions at the state level, the Governor has now proposed to transfer two mental health licensing functions of the DSS to DHCS. This proposal is discussed in the DHCS portion of today's hearing.

2011-12 Budget Act: Last year, the Governor's 2012-13 budget proposed to eliminate the DADP by July 1, 2012, and to transfer its functions to other state departments, as shown in the following chart.

Department	Functions	Positions	Funds
Department of Health Care Services	Federal grant administration, drug court technical assistance, program certification, data collection and analysis, statewide needs assessment and planning.	161.5	$305.6 million
Department of Public Health	Counselor certification, narcotic treatment programs, driving-under-the influence programs, Office of Problem Gambling	34.0	$12 million
Department of Social Services	Program licensing	36.0	$4.5 million

During the subcommittee hearing process, stakeholders raised strong concerns about the proposed distribution of DADP functions across three separate state departments and what such a decision could mean for access to services, consistency of policy development and application, and clarity of statewide leadership. However, in light of previous actions to reduce the DADP's scope of responsibility through Realignment and the transfer of the DMC program; continuing toward the unification of behavioral health programs; and in acknowledgement of federal health care reform, the Legislature approved the elimination of the DADP but delayed it by a year, until July 1, 2013. Further, responding to a proposal that many felt lacked sufficient details to assure (1) the appropriateness and readiness of receiving departments and (2) that the elimination and shifting would occur in a manner that would not be disruptive to consumers, families, and providers, the Legislature adopted trailer bill language (Senate Bill 1014, Chapter 36, Statutes of 2012) to require that the DADP conduct additional planning activities. Specifically, Chapter 36 requires the transition plan to include:

(1) A detailed rationale for the transfer of administrative and programmatic function or functions, including program and policy changes necessitated by the proposed transfer.
(2) A cost and benefit analysis for each transfer and for the proposal as a whole, if more than one transfer is involved, showing fiscal and programmatic impacts of the changes.
(3) A detailed assessment of how the transfer will affect continuity of service for providers, consumers, county counterparts, and other major stakeholders.
(4) If function transfers are proposed to more than one receiving department, a detailed explanation of the following:
(A) How preparation will occur to maximize a smooth transition across departments.

(B) How ongoing program and policy functions will be coordinated across departments after the transfer is implemented.
(5) A detailed description of the stakeholder process, including, but not limited to:
(A) A description of stakeholder participants which shall include, at a minimum, consumers, family members, providers, counties, and representatives of the Legislature.
(B) A schedule of stakeholder meetings convened, and other activities conducted to provide maximum stakeholder input prior to production of a draft plan and to review the draft plan prior to submission to the Legislature.
(C) A discussion of significant concerns raised by stakeholders and how they were or were not addressed in the plan.
(D) A description of an ongoing stakeholder process that will provide continued assessment of and recommendations for improvement to the delivery of alcohol and drug treatment services in California.

CHHS Agency Transition Plan: The CHHS Agency sponsored stakeholder discussions in the fall of 2012 in order to inform their development of a transition plan, pursuant to Chapter 36. This process included over 60 participants representing consumers, family members, providers, local government, state departments, and legislative staff. The most significant and universal concern raised during this process was the proposal to distribute DADP functions across multiple state departments. Participants repeatedly voiced concerns that this would result in confusion and increased costs for those who would have to negotiate across three state departments, rather than one; a lack of systemic focus on substance abuse; a diffusion, and eventual reduction, of departmental expertise; and a lessening of a strong voice within the Administration about issues of concern to the substance abuse services community.

The CHHS Agency published the *Transition Plan* on January 10, 2013. In response to the information gathered through the required stakeholder process, the Administration revised its proposal and its plan now calls for a shift of all of the substance use disorder programs to the DHCS, under the leadership of the Deputy Director of Mental Health and Substance Use Disorder Services.

According to the *Transition Plan*, this revised proposal improves upon last year's proposal in the following ways:

- Aligns with federal, state and county counterparts by consolidating responsibility for substance use disorder services and community mental health services under a single behavioral health services department.
- Promotes opportunities for improved health care delivery and outcomes by integrating behavioral health services with primary health care within the DHCS.
- Maintains programmatic expertise and continuity of service by moving all DADP programs, positions, and existing staff intact to DHCS.
- Improves oversight by consolidating behavioral health services in a single department, best positioned to manage the complexities of funding, collection and analysis of data, and facilitating strong federal/state/local partnerships.
- Unifies licensing and certification together in one department, improving communications, reducing redundancies, and enhancing responsiveness to providers, consumers, and families.

Under the transition plan, only the Office of Problem Gambling (OPG) is proposed to move to the DPH, where it will be housed within the Center for Chronic Disease Prevention and Health Promotion.

Proposed Trailer Bill Language: The Administration proposes the adoption of trailer bill language necessary to implement the elimination of the DADP and the transfer of functions to the DHCS and the DPH. This proposed language is primarily technical in nature. The proposed trailer bill language also includes a statement of intent as to the desired benefits and effect this transfer is hoped to provide.

The subcommittee may wish to consider modifying the proposed trailer bill language to provide (1) continued legislative oversight as this transition unfolds over the next few years, (2) continued stakeholder involvement and input as the delivery of healthcare services in California continues to evolve, and (3) establishing a baseline for evaluating, on an ongoing basis, how and why service delivery changed or improved as a result of this administrative transfer.

Legislative Analyst's Office (LAO) Recommendations: The LAO finds that the Administration has met the requirements, set forth in Chapter 36, to conduct a stakeholder outreach process in the development of a plan to transfer the administrative and programmatic functions of the DADP to other state departments. Additionally, the LAO finds the transition plan submitted to the Legislature broadly meets the other requirements of Chapter 36.

However, to ensure ongoing legislative oversight of the transfer process, the LAO recommends that the DADP, the DHCS, and the DPH report at budget hearings on how the transition will achieve the following goals, established in Chapter 36.

- ✓ Improve access to alcohol and drug treatment services, including a focus on recovery and rehabilitative services.
- ✓ Effectively integrate the implementation and financing of services.
- ✓ Ensure appropriate state and county accountability through oversight and outcome measurement strategies.
- ✓ Provide focused, high-level leadership within state government for alcohol and drug treatment services.

Questions. The subcommittee has requested the Administration respond to the following:

1. Please provide a brief description of the transition plan and the stakeholder process utilized to develop it.

2. Please describe how the transition will achieve the goals established in trailer bill, as outlined by the LAO above.

3. Please describe the costs associated with the transition and how they will be absorbed. Moving forward, discuss your cost/benefit analysis of this proposal.

4. What lessons for the transfer of DADP functions have been learned from the transfer of mental health services and the Drug Medi-Cal Program to the DHCS?

5. How will the meaningful stakeholder involvement fostered by the DADP be maintained and encouraged at the DHCS and the DPH?

6. How will a balance be achieved between integrating behavioral health services within the broader health care arena and ensuring the unique qualities and service needs of persons with behavioral health issues are recognized and met?

7. What data collection and other IT programs does DADP currently manage and how will these be integrated within the new departments?

8. How can the Administration and the Legislature best measure the success of this transition?

Subcommittee Staff Recommendation:

1) **Approve the elimination of the Department of Alcohol and Drug Programs and the transfer of its substance use disorder programs to the Department of Health Care Services and the transfer of the Office of Problem Gambling to the Department of Public Health. (BCP #1)**

2) **Approve placeholder trailer bill language, as proposed by the Administration and modified to include:**

    a. **A mechanism for continued legislative oversight as this transition unfolds over the next few years**
    b. **Continued stakeholder involvement and input as the delivery of healthcare services in California continues to evolve, and**
    c. **Establishing a baseline for evaluating, on an ongoing basis, how and why service delivery changed or improved as a result of this administrative transfer.**

Vote:

2. CA Problem Gambling Treatment Services Pilot (CPGTSP) Program

Governor's Budget Proposal: The Governor's budget requests a two-year extension of the two existing limited-term positions and $5 million (Indian Gaming Special Distribution Fund) expenditure authority annually for two years, in order to continue the delivery of services and data collection for the CPGTSP. Specifically, in addition to maintaining the existing programs, the Office of Problem Gambling (OPG) intends to continue to train and authorize new providers; provide ongoing advanced training and support to authorized providers; provide outcomes data and performance measurements; increase program visibility; and develop a request for proposals (RFP) for a third party evaluation of the CPGTSP. As the Governor's budget presumes that the OPG will move to the DPH in the budget year, this proposal is made by the DADP on behalf of the DPH.

Background: The OPG was established within the DADP in 2003 (Assembly Bill 673, 2003). The OPG is charged with the development of a problem gambling prevention program, which is the first priority for funding appropriated to this office, and includes a toll-free telephone service; public awareness campaigns; empirically-driven research; training of health care professionals and educators; and training of gambling industry personnel. Additionally, the OPG is required to develop a program to support treatment services, subject to the appropriation of funding.

The OPG base funding, which has been in place since 2003, is $3 million (Indian Gaming Special Distribution Fund), and three positions. In 2006, the OPG commissioned the *California Prevalence Study,* conducted by the National Opinion Research Center (NORC) at the University of Chicago, which found that 83 percent of Californians have gambled at some point in their lives and that 3.7 percent of Californians met the criteria for problem/pathological gambling. In 2008, OPG was allocated an additional $5 million (Indian Gaming Special Distribution Fund) and two three-year limited-term positions to develop and implement treatment programs for problem and pathological gamblers and their families, known as the California Problem Gambling Treatment Services Program (CPGTSP). This funding level and position authority has been extended in subsequent budget years, through the 2010-11 fiscal year. In 2011-12, the funding and position authority was extended for an additional two years.

Over the life of this funding, OPG has developed an infrastructure for the CPGTSP in four pilot regions (Sacramento, San Francisco, Los Angeles, and San Diego). Accomplishments include:

- Training of 456 individuals, of which 436 are licensed therapists.
- Establishment of two Problem Gambling Telephone Intervention programs.
- Creation of a free-standing, outpatient network of licensed, CPGTSP-authorized providers to deliver evidence-based care.
- Establishment of the Intensive Outpatient Program.
- Establishment of two residential treatment programs.
- Clinical trials, through work with the UCLA Gambling Studies Program, to examine the usefulness and effectiveness of novel treatment approaches.

Questions: The subcommittee has requested the Administration respond to the following:

1. Please briefly describe the function and achievements of the OPG since its establishment.

2. Please briefly describe the organization and achievements of the CPGTSP pilot program.

3. Please describe what CPGTSP will achieve through an additional two-year extension of the pilot program. What criteria will be used to determine whether and when this program should be permanently established?

Subcommittee Staff Recommendation:

1) Approve as proposed (BCP #2).

Vote:

Peggy Collins 651-1891
Senate Budget & Fiscal Review

OUTCOMES: **Senate Subcommittee #3 on Health & Human Services**
Thursday, April 18 (Room 4203)

ISSUES FOR DISCUSSION

4200 Department of Alcohol and Drug Programs (DADP)

1. Elimination of DADP and Transfer of Functions to Other State Departments (BCP #1)

Motion: Approve the elimination of the Department of Alcohol and Drug Programs and the transfer of its substance use disorder programs to the Department of Health Care Services and the Office of Problem Gambling to the Department of Public Health.
Vote: 2-0 (Senator Emmerson absent)

Motion: Approve placeholder trailer bill, as proposed by the Administration, and modified to include:

- A mechanism for continued legislative oversight as this transition unfolds over the next few years
- Continued stakeholder involvement and input as the delivery of healthcare services in California continues to evolve, and
- Establishing a baseline for evaluating, on an ongoing basis, how and why service delivery changed or improved as a result of this administrative transfer.

Vote: 2-0 (Senator Emmerson absent)

2. Problem Gambling Treatment Services Pilot Program (BCP #2)

Motion – Approve as proposed.

Vote – 2-0 (Senator Emmerson absent)

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

April 18, 2013

Upon Adjournment of Senate Budget and Fiscal Review Committee

Room 4203, State Capitol
(John L. Burton Hearing Room)

AGENDA Part 3
(Joe Stephenshaw)

4440 Department of State Hospitals

Items to be Heard

California Department of State Hospitals (4440)

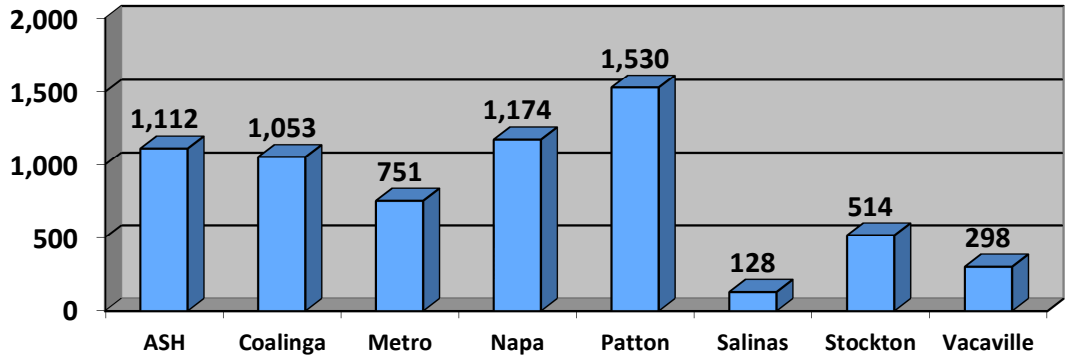
The California Department of State Hospitals (DSH) operates five state hospitals throughout California, including: Atascadero State Hospital (San Luis Obispo County), Coalinga State Hospital (Fresno County), Metropolitan State Hospital (Los Angeles County), Napa State Hospital (Napa County), and Patton State Hospital (San Bernardino County). Each state hospital provides inpatient treatment services for Californians with serious mental illnesses. Additionally, the department operates two correctional programs, Salinas Valley Psychiatric Program and Vacaville Psychiatric Program, and is in the process of opening a third correctional program at the California Health Care Facility in Stockton in the budget year.

The majority of the state hospital population, approximately 92 percent, is forensic or penal code related. Major categories of state hospital patients include:

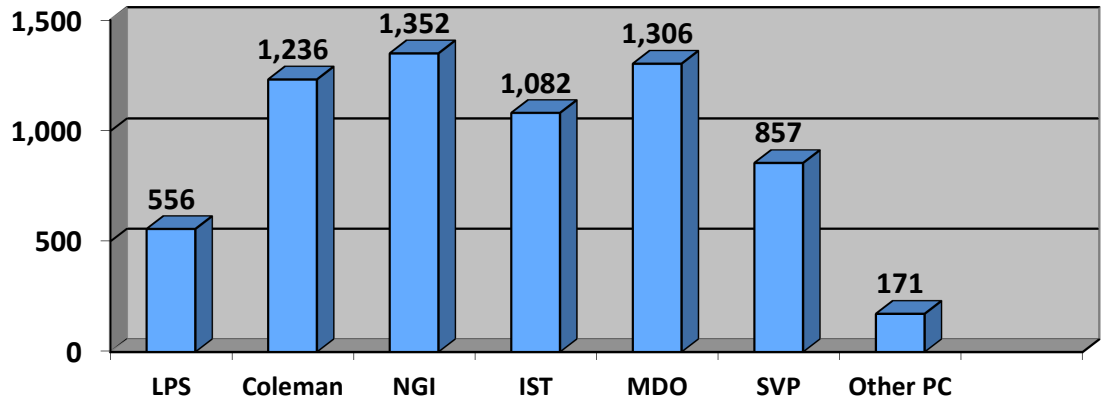
- Judicial commitments directly from superior courts - Not Guilty by Reason of Insanity (NGI) and Incompetent to Stand Trial (IST)
- Civil commitments as Sexually Violent Predators (SVPs)
- Referrals/transfers from California Department of Corrections and Rehabilitation (CDCR) including Mentally Disordered Offenders (MDOs) and Parolees
- Civil commitments from counties under the Laterman-Petris-Short Act

DSH projects providing inpatient mental health treatment services to approximately 6,560 patients in 2013-14.

Estimated State Hospital Population
2013-14



Estimated Patient Casepoad by Commitment
2013-14



The Governor's proposed budget includes $1.6 billion for DSH in 2013-14, an increase of approximately $139.6 million (9.7 percent) over the 2012-13 Budget Act. The proposed budget year position authority for DSH is 10,787.4 positions, an increase of 834.1 positions (8.4 percent) from the prior year. The increases in funding and positions primarily reflect the activation of 514 beds at the new California Health Care Facility in Stockton.

(dollars in thousands)

Funding	2011-12	2012-13	2013-14
General Fund (GF)	$1,313,572	$1,320,859	$1,457,306
GF, Prop 98	14,878	-	-
CA Lottery Education Fund	48	90	90
Federal Trust Fund	62,318	-	-
Reimbursements	793,316	119,036	121,491
Mental Health Services Fund	1,824,585	-	-
Mental Health Facility Lic Fund	391	-	-
Total	$4,009,108	$1,439,985	$1,578,887
Positions	9,816.7	9,953.3	10,787.4

Issue 1 – STOCKTON FACILITY ACTIVATION

Governor's Proposal. The Governor's budget proposes $67.5 million General Fund for the activation of 514 beds at the new California Health Care Facility (CHCF) in Stockton (a total of $100.9 million including full-year costs of existing positions authorized in 2012-13).

Background. The *Coleman* federal court monitors the provision of mental health care of California's prison inmates as the result of a class-action lawsuit brought against California Department of Corrections and Rehabilitation (CDCR) asserting that they were not providing adequate mental health care to inmates. Because of remedies required by the *Coleman* court, when inmates require inpatient mental health care, they are referred to DSH, which places them in either the 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 timeline.

In November 2009, the CDCR, working collaboratively with the Federal Receiver overseeing inmate medical care, filed a Long-Range Integrated Strategy Plan to reduce overcrowding and provide for increased medical and mental health treatment beds. Construction of the CHCF was included in the long-range plan and is key to ultimately satisfying both the *Coleman* and *Plata* (medical) courts.

The CHCF is currently under construction, with intake of inmates scheduled for July 22 of this year. The facility will include 1,722 beds of all security levels and will provide all necessary support and rehabilitation program spaces. CHCF establishes specialized housing with necessary treatment for a population of seriously and chronically, medically and mentally ill inmates. Within CHCF, DSH will be responsible for 514 licensed and Joint Commission accredited beds, which will be known as the Stockton Psychiatric Program (SPP). These beds will include 432 intermediate level-of-care beds for high-level (custody level IV) inmates and 82 acute level-of-care beds, which will serve inmates of all custody levels.

The SPP will employ a total of 931 clinical and administrative staff. DSH states that it has undertaken outreach and education efforts to affected staff at Vacaville and Salinas, thereby providing information about employment opportunities at SPP. The hiring plan has been phased in over a two-year period to accommodate building activations, licensing and patient movement plans. DSH expects to fill all positions by December 2013. The January 2013-14 budget does not include the savings from staff reductions at VPP and SVPP, however this savings is expected to be reflected in the May Revision.

The primary costs associated with this request include:

- Required positions for Stockton activation -- $65,242,000
- Psychiatrist-on-duty 24-hours per day -- $782,000
- Relocation costs for promotional staff -- $759,000

- 18.0 additional housekeeping staff -- $719,000

Staff Comment. These beds are a requirement of the federal court, not only as part of the court approved long-range bed plan, but, also included in CDCR's Blueprint (*The Future of California Corrections*), which is the Administration's comprehensive plan for improving the state's prison system in order to satisfy court requirement's (particularly *Coleman* and *Plata*) and achieve the fiscal savings resulting from the 2011 Public Safety Realignment.

Recommendation. Approve as budgeted.

Issue 2 – VACAVILLE PSYCHIATRIST-ON-DUTY

Governor's Proposal. The Governor's budget proposes $782,000 in both 2012-13 and 2013-14 to establish 24-hour on-site psychiatric coverage at Vacaville in order to better meet the needs of patients and to reduce overtime costs.

Background. California Code of Regulations, Title 22 requires that a psychiatrist be available at all times for psychiatric emergencies. Currently, Vacaville utilizes a Psychiatrist-on-Call (POC) program, which DSH deems insufficient to meet patient needs. Therefore, DSH is proposing to establish a Psychiatrist-on-Duty (POD) program that ensures 24-hour per-day, on-site coverage by a psychiatrist. According to DSH, POD coverage is necessary to meet Joint Commission Accreditation Standards.

DSH explains that savings may be realized with a POD, as POC get paid an hourly rate, including one hour for travel time; a POD would not be paid for travel time, and there would be reduced overtime pay for staff who are waiting for a POC to arrive. The department estimates that there will be approximately 4,300 psychiatric emergencies this year at the Vacaville facility.

DSH states that the absence of a POD program will threaten compliance with the *Coleman* court. CDCR provided funding for POD coverage until July 1, 2012 and will no longer support the program financially. POD coverage is also included in the proposed funding for the Stockton facility.

Staff Comment. The POD function was previously supported by CDCR. However, the majority of POD services are provided to DSH patients and, thus, it is reasonable that the responsibility fall upon DSH. Not providing this function will put the facility at risk of losing its license and of being in violation of the *Coleman* court.

Recommendation. Approve as budgeted.

Issue 3 – PERSONAL DURESS ALARM SYSTEM

Governor's Proposal. The Governor's budget proposes $16.6 million General Fund and 4 positions to install and support the Personal Duress Alarm System (PDAS) at Atascadero State Hospital (ASH) and Coalinga State Hospital (CSH), and to complete the PDAS project at Metropolitan State Hospital (MSH) and Patton State Hospital (PSH). The DSH also requests 3 positions at Napa State Hospital (NSH) to produce triple break-away lanyards that are part of the PDAS.

Background. The state hospitals have experienced a substantial increase in violence as the population has become largely a forensic population. The PDAS is one of the major safety initiatives being implemented at the state hospitals, involving each staff person wearing a personal alarm. The PDAS has been fully implemented at NSH and, based on its success, will be implemented at the other four hospitals. Implementation is underway at MSH and PSH, and this BCP proposes resources to begin implementation at CSH and ASH. The four positions requested will be divided equally between CSH and ASH, resulting in two positions each at all five hospitals. The three additional positions at NSH are for the purpose of producing triple break-away lanyards, which NSH staff developed in order to eliminate all strangulation risk. According to DSH, this type of lanyard is not produced by any manufacturers in the private sector, and that lanyard manufacturers generally are uninterested in producing them for the state hospitals due to liability concerns. The DSH estimates that approximately one-third of the lanyards will need replacement annually.

The budget includes a reduction of $5.6 million General Fund for the PDAS at MSH and PSH, reflecting an updated project schedule. The total cost of the PDAS project is $47.9 million.

Staff Comment. The PDAS is a key initiative undertaken by the department to improve hospital safety for both staff and patients. This proposal is standardizing personal alarm systems throughout the hospitals and replacing outdated systems that are not adequate to meet safety needs in state hospitals.

Recommendation. Approve as budgeted.

Issue 4 – ACTIVE DIRECTORY RESTRUCTURING

Governor's Proposal. The Governor's Budget proposes $1.1 million General Fund ($994,000 one-time and $140,000 ongoing), in 2013-14, to support the development and maintenance of a new single Active Directory (AD) domain, to centralize and consolidate eight existing independent ADs.

Background. In general, the state hospital system is extremely deficient in terms of information technology (IT). Due to a lack of up-to-date IT, it cannot operate as a single system. Instead, it operates as eight independent hospitals and facilities. One of the goals of DSH is to operate, manage, and oversee the hospitals as a single hospital system. According to DSH, a central AD is the essential foundation to implementing shared enterprise clinical systems, such as electronic health records (EHRs). DSH states that consistent patient services and effective management systems require sharing information and application capabilities, and a centralized AD is one of the foundational components to enabling an enterprise approach to EHR, patient treatment plan management, and other critical clinical applications. Within the current environment of eight independent domains, it is virtually impossible for DSH and hospitals to share clinical technologies and other information and to conduct any type of electronic communications.

Within this new centralized AD, DSH will consolidate these eight ADs into one centrally managed employee directory and into a single logical network as part of the California Government Enterprise Network. One of the major purposes of the centralized AD will be to assist with staff scheduling, which, according to DSH, is currently highly inefficient.

Staff Comment. The DSH lacks the infrastructure to operate as one system, which makes it extremely difficult for the department to track and collect information in a standardized or consistent manner. This not only impacts the department's ability to operate in the most efficient manner but also impacts their ability to provide information to policy makers. This proposal will allow the department to begin to lay the framework for establishing effective statewide IT capabilities.

Recommendation. Approve as budgeted.

Issue 5 – AUTOMATED STAFF SCHEDULING AND INFORMATION SUPPORT TOOL

Governor's Proposal. The Governor's budget proposes $5.4 million General Fund and 4 positions in 2013-14, and $1.2 million in 2014-15 and on-going, to implement an Automated Staff Scheduling and Information Support Tool (ASSIST). The DSH anticipates that ASSIST will eventually save approximately 5 percent of overtime costs, or at least $4.8 million.

Background. The state hospital system manages the schedules of an average of 1,000 "Level of Care" (LOC, direct patient care) staff and hundreds of Contract Registry staff at each facility on a 24-hour per day, seven-days per week basis. Currently, each facility uses an average of 23.1 positions on staffing and scheduling efforts. The estimated current annual cost of scheduling is over $10.5 million.

Each facility must schedule LOC staff in such a way as to meet court mandated staffing levels and classifications, as well as state statutory requirements, while considering the clinical and security needs of the patient population and an individual's specific clinical case, acuity level, necessary level of care and emergent conditions or situations that require enhanced observations. Moreover, the staffing office must take into account bargaining unit agreements, overtime rules, vacation bidding rules and immunization and certification requirements when generating schedules. The staffing office must manually create and maintain this schedule while covering an average of 50 unscheduled absences per day.

An ASSIST tool is used to create an efficient staff scheduling system. DSH states that the tool will help each facility responsible for generating schedules, relief pool lists, and reports on staffing and overtime costs in order to better manage their operations. The tool will improve management of staffing levels, overtime usage, and tracking of training and certification requirements throughout the hospital system. The effective management of schedules and overtime should ensure proper staffing ratios and ultimately a reduction in overtime costs.

Centralized staffing data also will allow DSH to respond to information requests regarding overtime costs and other aspects of scheduling. DSH expects this tool to ultimately reduce redundancies and inefficiencies in scheduling, thereby reducing overtime, and overtime costs. DSH states that hospital staff has repeatedly requested the acquisition of this tool, and that CDCR uses an ASSIST-type tool.

Staff Comment. This proposal is consistent with current efforts by the department to standardize and improve processes. In addition, it should result in ongoing savings due to reduced overtime usage that are greater than the ongoing costs of the tool.

Recommendation. Approve as budgeted.

Issue 6 – METROPOLITAN STATE HOSPITAL FIRE ALARM UPGRADE CAPITAL OUTLAY

Governor's Proposal. The Governor's budget proposes $633,000 General Fund, for the preliminary plan phase, to upgrade the fire alarm system at MSH in psychiatric patient housing and to provide a new central monitoring system. Total project costs are $8.9 million.

Background. According to the Administration, the fire alarms in all of the state hospitals are in need of upgrades; they proposed starting the upgrades with Napa because it has experienced the greatest number of problems and failures. Therefore, the 2011 Budget Act included $2.2 million General Fund for the preliminary plans and working drawing phase of the Napa project. In 2012, the budget act included $15.5 million to replace the fire alarm systems in several buildings at Napa State Hospital.

The existing fire alarm control panels and field devices 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 and are no longer listed by the State Fire Marshall's Office. The Administration states that there are numerous devices that fail on a continuous basis, which necessitates constant repair. MSH has a specialized fire protection contractor on the grounds conducting repairs nearly continuously. Overall, the systems lack serviceability and/or expandability and the technology is very outdated.

Given the deficiencies in the fire alarm system at MSH, when the fire alarm system malfunctions, Fire Watch is utilized to ensure all fire/life/safety measures are met. Fire Watch is an expensive process that is conducted by MSH Hospital Police working on overtime status. Since January 2012, the DSH-Metropolitan fire alarm system has failed 584 times. The fire alarms fail so regularly that the fire department considers them not credible and therefore does not respond unless hospital staff calls 911 directly. For these reasons, the DMH asserts that the fire alarm systems require replacement to protect the patients, staff, and visitors.

Staff Comment. This represents an ongoing effort to address a critical safety issue within state hospitals.

Recommendation. Approve as budgeted.

Issue 7 – PATTON STATE HOSPITAL (PSH) SECURITY PERIMETER FENCING CAPITAL OUTLAY

Governor's Proposal. The Governor's budget proposes $560,000 General Fund for the re-evaluation of existing working drawings to provide for increased security fencing and other related physical improvements for security purposes. The total project cost is $16.4 million. The CDCR anticipates annual savings of $4.8 million due to the reduction in security staff that will be possible as a result of this project.

Background. In response to an Assembly request, the former DMH toured the PSH security system in January 1998 to identify potential ways to enhance perimeter security. In March 1998, the Joint Legislative Audit Committee requested the Bureau of State Audits (BSA) to study security at the facility. The BSA audit recommended installation of a double fence, each 14 feet high with razor ribbon, closed-circuit TV and anti-climb mesh, electronic detection system devices, vehicle patrol outside, and bicycle patrol inside. In response to the BSA audit, DMH hired private consultants to study the problem in December 1999. Farbstein and Associates called for complete full double fencing, thereby shifting hospital security from CDCR to hospital-based police, and replacement of kiosk staff with mobile perimeter patrols.

The preliminary plans and working drawing phases of this project were completed, however, due to funding restrictions and other higher priorities, the project was officially placed in suspension in 2005. Currently, CDCR provides security at PSH and, because of current CDCR budget constraints, they state that they are no longer able to provide the level of security needed to meet the needs of the facility and the concerns of the nearby community.

The proposed project will include: 1) the demolition of ground guard posts, existing fencing, lighting, paving and selected trees and shrubs; and, 2) construction of a Level II design, double perimeter fence with barbed tape, fence detection system, 13 ground guard posts, two vehicle and pedestrian sally ports, perimeter patrol roadway improvements, modification to portions of the internal roads, new security lighting and closed-circuit television cameras.

Staff Comment. This project will rectify ongoing perimeter safety concerns and create a safer environment for staff, patients, and the community.

Recommendation. Approve as budgeted.

Issue 8 – NAPA STATE HOSPITAL SECURITY GATES AND FENCING CAPITAL OUTLAY

Governor's Proposal. The Governor's budget proposes $863,000 General Fund to fund the preliminary plan phase of security improvements in the patient housing courtyards at Napa State Hospital (NSH). Total project costs are $3.1 million.

Background. Due to the changing nature of the state hospital population and the age of many of the state hospital facilities, significant security vulnerabilities persist at the hospitals putting patients, staff, and the community at risk of violence. According to the Administration, the purpose of this project is to eliminate such vulnerabilities in the courtyard fencing and gates at NSH that have allowed forensic and civilly committed patients to climb over the fence and escape from the courtyards. A forensically committed patient escaped from the Secured Treatment Area (STA), resulting in improvements to the STA fence, however, according to DSH, NSH lacks the resources to make similar improvements to the courtyard fencing.

Staff Comment. This project also addresses a significant security concern and is consistent with efforts to improve hospital safety.

Recommendation. Approve as budgeted.

Issue 9 – OFFICE OF AUDITS

Governor's Proposal. An April Finance Letter proposes $529,000 General Fund and 4.5 positions to staff a new Office of Audits within DSH.

Background. The DSH currently does not have an internal audit function. Over the past five years, the department has been audited by the Department of Finance (DOF), Office of Audits and Evaluation (OSAE), and the Bureau of State Audits (BSA), and conducted an internal review of its administrative functions in 2011. The audit findings present a need for stronger internal audit and compliance capabilities to monitor, manage and improve department policies and procedures. Following are overviews of some of the audit findings in recent years.

- In 2007, the OSAE conducted an audit of the DMH budget, which included a couple of key findings: 1) the staffing model did not adequately reflect hospital workload; and, 2) funding was insufficient for annual operating expenditures. The OSAE also identified the seeds of a fiscal problem that would eventually become a major contributor to fiscal deficiencies: the DMH used salary savings to offset operating expenditures and equipment (OE&E). Over the following few years, salary savings would decrease as the number of vacancies decreased, and OE&E costs would rise, leading to unavoidable deficits. Per the 2012 Budget Act, the OSAE has just completed a follow-up audit that found, overall, DSH implemented 22 recommendations, implementation of nine recommendations is in progress, 46 recommendations have not been implemented, and eight are no longer applicable.

- In 2011, in order to gain a clearer understanding of the causes of fiscal deficiencies, the Department of Mental Health (DMH) assembled a team of staff and retired annuitants, with extensive state management experience, to investigate and analyze the state hospitals' budget. The original purpose of the project was to collect information necessary to develop recommendations for the new administrative structure for the newly proposed DSH. However, ultimately the scope of the project was widened to address the growing deficits and related fiscal challenges. Building on the 2007 OSAE audit, the 2011 report provided a similar, but clearer picture of the unsustainable fiscal management of the state hospitals, which they explained as a combination of increasing costs coupled with decreasing resources. The decreasing resources occurred through a combination of budget reductions, such as a $75 million reduction between 2008-09 and 2009-10, and the decreasing availability of salary savings mentioned above. The increasing costs are a more complex story, involving the following key issues: 1) the federal Civil Rights of Institutionalized Persons Act (CRIPA); 2) violence-related costs; 3) unfunded overtime; and 4) lack of budget transparency. The DMH report included 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.

These recent audits show that DSH has a critical need to ensure that all administrative policies and procedures are implemented consistently across all of its facilities. Historically, the hospitals have functioned as relatively autonomous entities. The department is now taking a system-wide approach to its hospital operations to improve the efficiency and effectiveness of its operations, ensuring that the hospitals are consistently compliant with state administrative rules and policies.

The proposed resources would consist of a Supervising Governmental Auditor and 3.5 Associate Management Auditor staff to develop a risk assessment, audit plan, and workload analysis. Once complete, an additional 1.5 audit staff positions will allow the DSH to dedicate one auditor to each of the major areas in administrative services: accounting, budgets, contracts, purchasing and personnel. This level of staffing would allow for a representative sampling of work to be reviewed from each facility on an annual basis.

Staff Comment. In recent years, the DSH has experienced significant fiscal and operational control issues. Audits and internal reviews have noted numerous deficiencies, many of which relate to a lack of central control and oversight. The department is currently taking steps to rectify these issues. As discussed in prior proposals in this agenda, the department is focused on moving toward a single system and establishing enhanced information tracking and sharing capabilities. This proposal is consistent with these efforts.

Recommendation. Approve as budgeted.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

April 25, 2013

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 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.

ISSUES RECOMMENDED FOR VOTE-ONLY

A. 4170 Department of Aging (CDA)

1. Chronic Disease Self-Management Education (CDSME) Grant Program

CDA requests budget authority for a three-year (September 1, 2012 to August 31, 2015), $1.7 million grant from the federal Administration on Aging (including $575,000 in 2013-14). The grant funding will be focused on serving low income, ethnically diverse, limited/non-English speaking, Medi-Cal eligible adults and/or veterans, with goals of improving their health and reducing health care expenditures. In cooperation with the Department of Public Health and local entities, CDA intends to conduct outreach and enrollment activities to ensure that over 9,000 seniors and/or adults with disabilities participate. The department also proposes provisional budget language in Item 4170-101-0890 to allow carryover of funds between years. No new positions are being requested.

2. Supplemental Nutrition Assistance Program Nutrition Education Obesity Prevention Program (SNAP-Ed)

CDA requests $3.6 million in budget authority over three state fiscal years (including $1.5 million in 2013-14), and authority for a two-year limited-term aging program analyst to support nutrition education and obesity prevention activities targeted to low-income adults aged 60 and older. Pursuant to an interagency agreement with the Department of Social Services, which administers the state's SNAP program (called CalFresh and still known sometimes as "food stamps"), CDA would administer the grant and distribute local assistance funding to the statewide network of Area Agencies on Aging (AAAs). The department estimates that the AAAs would provide services to approximately 70,000 participants in 2013-14 and 2014-15. No state match is required.

3. New Freedom Transportation Grant - Request for Extension

CDA requests additional budget authority of $106,000 and a six-month extension (through December 31, 2013) of limited-term position authority for one Staff Services Manager I to complete the activities of this grant. The goal of the project is to increase awareness of transportation services and options for seniors. It was originally approved in 2011-12.

Recommendation: APPROVE Items 1-3.

B. 4185 California Senior Legislature

1. Budget Change Proposal for Administrative Staff

The California Senior Legislature (CSL) requests $100,000 in California Fund for Senior Citizens resources and 1.0 two-year limited-term Office Technician to perform clerical duties in support of core program activities. The resources in the Fund come from taxpayer contributions. The CSL, which supports an annual four-day model legislative session, conducted by volunteer members that results in policy proposals, and ongoing standing committees, currently has one full-time authorized position.

Recommendation: APPROVE Item 1.

C. 5180 Department of Social Services

1. Community Care Licensing - Fingerprinting Fees

The Governor's budget proposes to avoid $1.4 million GF annually for an additional two years by 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.

Recommendation: APPROVE Item 1.

2. County Match-Waiver for CalFresh Administration

As discussed in the Subcommittee's March 21, 2013 hearing, the Governor's budget proposes to extend for one year, in 2013-14, authorization for counties to access CalFresh administration funding without requiring a county match above and beyond an existing Maintenance of Effort (MOE) requirement.

Recommendation: APPROVE Item 2, with the understanding that the counties will again be expected to fully fund CalFresh administration in the near future.

3. Transfer of Temporary Assistance to Needy Families Funding to California Student Aid Commission

As discussed in the Subcommittee's March 21, 2013 hearing, the 2012-13 budget redirected an unprecedented amount of California's federal Temporary Assistance to

Needy Families (TANF) block grant funding ($804 million) away from CalWORKs and to the California Student Aid Commission (CSAC), to be used for expenditures in the Cal Grants program, which provides financial aid for students obtaining a higher education. The funds were swapped, dollar-for-dollar, to redirect an equal amount of General Fund monies that would have been spent on Cal Grants to instead be spent on CalWORKs. The Governor's budget proposes to make the same swap in 2013-14, but at the even higher level of $942.9 million.

Recommendation: APPROVE the portion of the proposed TANF transfer that is necessary to meet (but not exceed) the state's required MOE level of spending. According to the Department of Finance, this amount will be determined in conjunction with the May Revision of the Governor's budget.

ISSUES FOR DISCUSSION

Public testimony will be taken for the items listed in this section.

A. 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 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 2013-14 Budget Overview

Fund Source	2011-12	2012-13	2013-14
General Fund	$306,590	$307,061	$312,910
Federal Trust Fund	$407,421	$468,518	$482,136
Child Support Collections Recovery Fund	$202,787	$203,869	$202,220
Reimbursements	$179	$123	$123
Total Expenditures	**916,977**	**979,571**	**997,389**
Positions	**491.5**	**593.5**	**593.5**

*dollars in thousands

1. Federal Performance Measures

Background: The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), and the Child Support Performance and Incentive Act of 1998 established defined metrics that would serve as performance measures in order to determine the level of federal incentives awarded to each state. Each state has been evaluated utilizing the same five performance metrics since Federal Fiscal Year (FFY) 2000.

2012 Federal Performance Measures

Statewide Paternity Establishment Percentage (PEP) measures the number of children born out-of-wedlock for whom paternity was acknowledged or established in the fiscal year compared to the total number of children in the state born out-of-wedlock during the preceding fiscal year. California measured 101.6 percent for Federal Fiscal Year (FFY) 2011. California's performance decreased in this measure by 5.4 percentage points from FFY 2011 to FFY 2012.

Cases with Support Orders Established measures cases with support orders as compared to total caseload. California measured 87.9 percent for FFY 2012. California's performance increased in this measure by 2.1 percentage points from FFY 2011 to FFY 2012.

Collections on Current Support measures the current amount of support collected as compared to the total amount of current support owed. California measured 61.4 percent for FFY 2012. California's performance increased in this measure by 2.8 percentage points from FFY 2011 to FFY 2012.

Cases with Collections on Arrears measures the number of cases with child support arrearage collections as compared with the number of cases owing arrearages during the federal fiscal year. California measured 63.5 percent for FFY 2012. California's performance increased in this measure by 1.9 percentage points from FFY 2011 to FFY 2012.

Cost Effectiveness for California compares the total amount of distributed collections to the total amount of expenditures for the fiscal year, expressed as distributed collections per dollar

of expenditures. California measured $2.47 for FFY 2012. California's performance increased in this measure by $0.18 from FFY 2011 to FFY 2012.

Staff Comment: Informational item included for discussion.

2. Child Support Automation

Background: Federal law requires that each state create a single statewide child support automation system that meets federal certification standards. There are two components to the Child Support Automation System; Child Support Enforcement (CSE) and 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. The program also provides funding for the local electronic data processing maintenance and operation costs. SDU provides services to collect child support payments from non-custodial parents and to disburse these payments to custodial parties.

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. Ongoing costs for the Child Support Automation System is approximately $118.79 million ($103.8 million CSE and $14.97 million SDU).

Staff Comment: Informational item included for discussion.

3. Revenue Stabilization

Background: The 2009-10 Governor's Budget proposed an augmentation of $18.7 million ($6.4 million General Fund) for local child support agencies (LCSAs) to maintain revenue generating caseworker staffing levels in order to stabilize child support collections. The Legislature approved the Department of Child Support Services (DCSS) request and directed that 100 percent of the new funds be utilized to maintain revenue generating caseworker staffing levels. DCSS issued specific claiming instructions to the LCSAs to ensure that the funds were used in compliance with legislative intent, which specified that the revenue stabilization funds should be distributed to counties based on their performance in two federal performance measures – Collections on current support and cases with collections in arrears. All LCSAs submitted plans and implementation began in 2009. Collection data for 2011-12 indicates that the revenue stabilization funding continues to have the expected positive impact on child support collections for California's families and the General Fund.

DCSS was able to maintain 234 of the 235 revenue generating caseworker staff originally retained in 2009-10 with the appropriated funds. According to DCSS, the retained staff generated a total of $2.3 million in distributed collections and the net General Fund assistance

associated with retaining the caseworker staff was $9 million. The DCSS calculates that the ongoing contribution to the General Fund associated with the revenue stabilization funds appropriated in 2009 will be $2.5 million.

Staff Comment: Informational item included for discussion.

B. 5160 Department of Rehabilitation (DOR)

1. Department Overview & Changes in Appeals Process

The Department of Rehabilitation's mission is to work in partnership with consumers and other stakeholders to provide services and advocacy resulting in employment, independent living, and equality for individuals with disabilities. With a proposed 2013-14 budget of $414.3 million ($56.6 million GF), the department offers programs related to vocational rehabilitation, assistive technology, independent living, supported employment, services for individuals with traumatic brain injuries, and workforce development. Overall, around 84 percent of the Department's budget is composed of federal funding. The total number of authorized positions proposed for DOR for 2013-14 is 1,823 (no change from 2012-13).

The 2012-13 budget eliminated the Rehabilitation Appeals Board process for reviewing appeals filed by applicants for, or consumers of, DOR services. The associated responsibilities were instead transferred to impartial hearing officers through an interagency contract with the Office of Administrative Hearings. Related trailer bill language required the hearing officers to be trained regarding the vocational rehabilitation program, as well as how to protect the rights of appellants at administrative hearings, with emphasis on assisting, where appropriate, appellants represented by themselves (or an inexperienced advocate) to develop the administrative record. The department indicates that the transition in the appeals process has been effective and hearing decisions rendered pursuant to the new process have been completed within statutorily required timeframes.

Staff Comment & Recommendation: This is an informational item and no action is required.

Questions:

1. Are there any recent or pending significant changes in the department's budget or program implementation?

2. Please describe how the recent transition in the appeals process is working and whether any concerns have been raised by consumers, advocates, or other stakeholders.

3. Has the required training for impartial hearing officers, particularly with respect to assisting appellants without experienced representatives, been implemented?

2. Traumatic Brain Injury Program

Budget Issue: With approximately $850,000 in 2012-13 funding, the Department of Rehabilitation administers the Traumatic Brain Injury (TBI) program. The program's services are delivered by seven providers located throughout the state and include coordinated post-acute care, such as supported living, community reintegration, and vocational supports, to help impacted individuals lead productive and independent lives. TBI Fund revenues stem from penalties paid for various violations of California's Vehicle Code, including the seatbelt law. Recent penalty funding and corresponding TBI funds are summarized below:

TOTAL STATE PENALTY FUND AND TBI FUND REVENUE

State Fiscal Year	State Penalty Fund	TBI Fund
SFY 06-07	$ 167,589,106	$ 1,105,546
SFY 07-08	$ 167,483,359	$ 1,104,936
SFY 08-09	$ 162,260,219	$ 1,070,492
SFY 09-10	$ 157,883,929	$ 1,041,716
SFY 10-11	$ 165,532,414	$ 1,091,926
SFY 11-12 *	$ 137,101,778	$ 960,000
SFY 12-13 *	$ 46,129,679	$ 849,000

* Estimated Revenue

The Department of Rehabilitation has been administering the TBI program since it was transferred from the Department of Mental Health, pursuant to Chapter 439, Statutes of 2009 (AB 398, Monning). The legislation also directed DOR to monitor and evaluate the performance of service providers, and to establish requirements and processes for continuing participation in the program.

Background on TBI: California is home to the highest number of individuals impacted by TBI in the nation, with over 350,000 current survivors and an estimated 30,000 hospitalizations for TBI each year. Generally these injuries are caused by an external force's impact on the brain, frequently from a fall or motor vehicle accident. Symptoms resulting from TBI can include short and long-term effects that hinder the person's ability to function.

Staff Comment & Recommendation: This item is included for oversight purposes and no action is required.

Questions:

1. How has the transition of the TBI program to DOR been working? What feedback has the department heard from stakeholders?

2. How are the recent declines in TBI Fund revenues impacting the services provided through the program?

C. 5180 Department of Social Services, In-Home Supportive Services (IHSS) [& 0530 Office of Systems Integration (OSI)]

Overview: With a proposed 2013-14 budget of $6.2 billion ($1.8 billion GF) for services and administration, the IHSS program provides personal care services to approximately 420,000 qualified low-income individuals who are aged (over 65), blind, or who have disabilities. 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 average annual cost of services per IHSS client is estimated to be around $12,000 for 2012-13.

In contrast to recent years, the Governor's budget does not include new proposals for reductions to IHSS. At the same time, as discussed below, there are several significant prior reductions that are currently enjoined as a result of ongoing litigation, for which a settlement agreement has recently been reached by the parties.

Program Structure and Employment Model: County social workers determine IHSS eligibility and perform case management after conducting a standardized in-home assessment of an individual's ability to perform activities of daily living. Based on authorized hours and services, IHSS recipients are responsible for hiring, firing, and directing their IHSS provider(s). In the majority of cases, recipients choose a relative to provide care.

In 2012, there were around 380,000 IHSS providers with hourly wages varying by county and ranging from $8.00 to $12.20 per hour. Prior to July 1, 2012, county public authorities or nonprofit consortia were designated as "employers of record" for collective bargaining purposes on a statewide basis, while the state administered payroll and benefits. Pursuant to 2012-13 trailer bill language, however, collective bargaining responsibilities in the eight counties participating in the Coordinated Care Initiative (CCI), which is also discussed below, will shift to an IHSS Authority administered by the state.

Recent Changes to IHSS: Changes to IHSS that were adopted in the past four budgets and have taken effect are summarized in the following chart.

Policy	Estimated GF Savings (in 000s, if available)[1]	Other Notes
Enhanced federal funding from Community First Choice Option	$107,000 in 2013-14	2012-13 savings were $201 million, but are expected to decline under fed. rule changes.
Requirement for health care provider to certify need	$63,500 in 2013-14	
Across-the-board cut of 3.6% of authorized service hours in 2010-11 through 2012-13	$60,000 in 2012-13	Governor's budget sunsets reduction as scheduled on 7/1/13.
Increases to out-of-pocket costs for some consumers	$45,000	
Program integrity measures (background checks, criminal exclusions, training, etc.)		
Reductions in administrative funding		

1. Recent Settlement of Litigation Related to Prior Reductions

Budget Issue: As summarized in the chart below, several reductions to the IHSS program made in the last four state budgets were enjoined by federal courts from taking effect.

Policy	Est. GF Savings in First Year (in 000s)	Name of Lawsuit Under Which Policy Is Enjoined from Taking Effect
Loss of eligibility for individuals with assessed needs below specified thresholds	$92,000	*Oster (V.L.) v. Lightbourne, et al. (Oster I)*
Across-the-board cut of 20% of authorized hours, with exceptions (impacts about 300,000 recipients)	$243,000	*Oster (V.L.) v. Lightbourne, et al. (Oster II)*
Reduction in state participation in provider wages (from maximum of $12.10 to $10.10 per hour)	$65,500	*Dominguez v. Schwarzenegger, et al.*

In March 2013, the Administration and plaintiffs in those cases (labor unions and disability rights advocates) announced that they had reached a comprehensive settlement agreement.

[1] Savings are annual in the first year of implementation, unless otherwise specified.

The agreement, which has received preliminary approval from the presiding federal judge, requires that the Administration and plaintiffs support passage of legislation, no later than May 24, 2013, to codify its tenets, which include the repeal of the reductions described above and replacement with the policies described in the chart and summary that follows.

Policy Included in Settlement	Est. GF Savings in First Year (in 000s)	Effective Dates
Across-the-board cut of 8% (no exceptions, so impacts all recipients)	$160,100	12 months after it takes effect, with a target date to begin July 1, 2013
Across-the-board cut of up to 7% (no exceptions, so impacts all recipients)	$158,800	Upon expiration of the 8% cut and in any future years that it is not "triggered off" (see below)

As referenced above, the settlement agreement also includes a provision to "trigger off" the ongoing reduction of up to seven percent–in whole or in part–as a result of enhanced federal funding received pursuant to an "assessment" (likely a fee or tax) on home care services, including IHSS. The proposed legislation stemming from the agreement includes no additional details regarding the assessment mechanism beyond a requirement for the Department of Health Care Services (DHCS) to submit a proposal for its implementation to the federal government by October 2014.

Background on Prior Sales Tax on Support Services: In 2010-11, the budget also included savings[2] that would have resulted from enhanced federal funding obtained as a match on revenues the state expected to receive and use to fund IHSS from extending the sales tax to support services, including IHSS. IHSS providers would have received a supplemental payment equal to the amount of their new tax liability. DHCS submitted its plan to implement this funding mechanism to the federal government, but the state has still not received a formal response and as a result, the law has not yet been implemented.

Appeals and Reassessments Under the Settlement: Under the proposed legislation to codify the settlement, if an IHSS recipient appeals the eight or seven percent reductions on their face, his/her request can be administratively denied. At the same time, the settlement agreement reiterates that IHSS recipients retain their rights under existing law to request a reassessment of service hours based on a change in personal circumstances. The department estimates that in response to the eight percent reduction proposed for 2013-14, ten percent of IHSS recipients will appeal the reduction itself and have their requests administratively denied. The department estimates that an additional 25 percent will request reassessments and that around 19 percent will receive additional authorized hours that will make up for some or all of the reduction.

[2] The last estimate from the department indicates that, if authorized, this policy would result in an estimated $95.5 million GF in the first year.

Relationship of Proposed Reductions to Existing 3.6 Percent Reduction: The settlement agreement intends to avoid any time lapse between the elimination of an existing 3.6 percent reduction that is scheduled to sunset on June 30, 2013 and implementation of the 8 percent reduction. In effect, the agreement intends for recipients to experience an additional 4.4 percent reduction on top of the existing 3.6 percent reduction implemented in 2012-13 (and two prior years) for a total eight percent reduction beginning July 1, 2013. Similarly, from the perspective of recipients, the seven percent reduction would implement an additional 3.4 percent reduction on top of the existing 3.6 percent reduction (or at that time, a one percent restoration from the reduction of eight percent).

Staff Comment & Recommendation: Staff recommends holding this item open.

Questions:

1. Please briefly summarize the prior reductions at issue and the terms of the settlement agreement.

2. When can we expect to hear more details about the "assessment" on home care services included as part of the settlement agreement? How might it work?

2. Community First Choice Option (CFCO)

Budget Issue: The Governor's budget includes savings of $168 million GF in 2013-14 due to the state's continued operation of the IHSS program under the Community First Choice Option (CFCO) waiver that was created by passage of the Affordable Care Act (federal health care reform). CFCO provides states with an additional six percent in federal funding for services and supports provided to individuals who are at risk of out-of-home placement. This is a reduced amount of savings when compared with the implementation of CFCO in 2012-13 because the federal government has clarified that, effective July 1, 2013, the eligibility requirements for the waiver are narrower than the criteria the state originally used in developing its plan. In its pending application to the federal government regarding how to implement the changes, the department proposes to include recipients who meet specified eligibility criteria for intermediate and skilled nursing levels of care. The department estimates that this includes approximately 41 percent of IHSS recipients.

The Administration additionally requests, in an April Finance Letter, $381,000 ($190,000 GF) and authority for three permanent positions to handle workload associated with new CFCO quality assurance/quality improvement requirements. The department indicates that the requested staff would have responsibility for: 1) training and technical assistance, 2) monitoring (including visits), and 3) enhanced analysis and reporting.

Staff Comment & Recommendation: Staff recommends that the Subcommittee approve the April Finance Letter.

Questions:

1. Please briefly describe the CFCO waiver, the criteria for eligibility beginning in 2013-14, and the need for the requested positions.

2. To the extent that the CFCO waiver created new service-related requirements (e.g., for back-up planning or training of recipients) which were implemented across-the-board under the state's initial waiver application, will all IHSS recipients continue to receive those benefits once the new, narrower CFCO eligibility criteria is applied?

3. Coordinated Care Initiative (CCI)-Related Changes to IHSS

Budget Issue: As discussed in greater detail during the Subcommittee hearing on April 4, 2013 (background materials available online at: http://sbud.senate.ca.gov/subcommittee3), the Governor's budget includes continuation of the Coordinated Care Initiative (now called Cal MediConnect), which is intended to integrate medical, behavioral, long-term supports and services (LTSS), and home- and community-based services through a single health plan for persons eligible for both Medicare and Medi-Cal (dual eligibles) in eight demonstration counties. Approximately 65 percent of IHSS recipients reside in the demonstration counties.

Related to CCI, a 2012-13 budget trailer bill (SB 1036, Chapter 45, Statutues of 2012) created IHSS Maintenance of Effort (MOE) funding requirements for counties, which replaced the previously existing county share of non-federal funding of 35 percent. As a result, the Governor's budget for 2013-14 includes increases of $17.5 million GF in 2012-13 and $47.1 million GF in 2013-14 to reflect costs estimated to shift from counties to the state.

SB 1036 also shifted collective bargaining responsibilities from local county public authorities (PAs) or non-profit consortia in the demonstration counties to a new California IHSS Authority (Statewide Authority), with specified members and an advisory committee. The department anticipates that this shift will begin in February 2014 and be complete in January 2015. Subcommittee #5 is additionally reviewing a budget change proposal that includes $563,000 GF and authority for permanent positions for the Department of Human Resources (CalHR) to implement the state's new collective bargaining responsibilities.

Finally, the Governor's budget includes a request for $884,000 ($442,000 GF) and seven limited-term positions at DSS (through 2014-15), to address workload associated with CCI. DSS states that these positions will allow the department to certify agency providers, create an appeal process, establish a fee structure, review and approve contracts, oversee the counties' activities associated with CCI, and engage with stakeholders.

Related Request to Extend Timeframe for Developing New PA Funding Methodology: The California Association of Public Authorities (CAPA) is requesting an extension to trailer bill language originally enacted in 2011 that requires DSS to work with the PAs (via CAPA) on a new rate methodology for PA administrative funding. The current language requires the new

methodology to take effect with the 2013-14 year. Given the intersection with CCI and other priorities related to the IHSS program, however, the new methodology is not yet developed.

Staff Comment & Recommendation: Staff recommends amending the statutory language regarding the revision of public authority rates so that it does not include a specified timeframe. While changes continue to be necessary, especially in light of shifting responsibilities between the state and counties under the Cal MediConnect demonstration, the exact timing of those changes in demonstration counties and/or statewide is evolving. Staff also recommends approving the requested resources and limited-term positions at DSS.

Questions:

1. Please briefly summarize the recent changes to IHSS financing and collective bargaining and the impacts of those changes in 2013-14.

4. Draft Federal Labor Regulations That Could Impact IHSS

Budget Issue: The United States Department of Labor (US-DOL) has proposed draft amendments to regulations interpreting the Fair Labor Standards Act (FLSA) that may impact the applicability of federal labor laws, including those governing overtime requirements, to the IHSS program. The Administration estimates that application of the proposed rules in their current publicly available form could create upwards of $300 million (approximately half GF) in new IHSS-related costs unless IHSS program rules were amended in response.

Background: The Fair Labor Standards Act (FLSA) is the primary federal statute dealing with minimum wage, overtime pay, child labor, and related issues. Under current law and regulations, the provisions of the FLSA do not apply to certain employees. One such exemption is the "Companionship Services Exemption" for domestic service employees who: 1) provide babysitting services on a casual basis, or 2) provide "companionship services" to individuals who are unable to care for themselves. The term "companionship services" is defined in federal regulation to mean services that provide fellowship, care, and protection for a person who, because of advanced age or physical or mental disability, cannot care for his or her own needs. These services may include household work, such as meal preparation, bed making, washing of clothes, and other similar services that can be provided through IHSS. General housework may also be included, subject to some limitations. Current regulations also exempt employees of third-party agencies and live-in domestic service employees who provide companionship services from coverage.

The U.S. Department of Labor (US-DOL) has recently proposed to repeal both the companion-care and live-in exemptions for workers employed by third-party employers. The last public draft of the regulatory changes would also substantially narrow the activities exempted for families who employ companion care providers directly. Under the proposed rules, employers would either need to newly pay covered overtime costs or make changes in scheduling to reduce or eliminate overtime costs that would be incurred.

On January 15, 2013, the US-DOL filed its proposed rule changes with the Office of Information and Regulatory Affairs [a division of the Office of Management and Budget (OMB)]. The regulations are confidential until the OMB completes its review. The OMB cannot amend a rule; their authority only allows them to finalize/publish the regulation or return it back to the sponsoring department. The timing of the OMB's pending decisions with respect to these regulations is unknown.

Staff Comment & Recommendation: This is an informational item and no action is necessary.

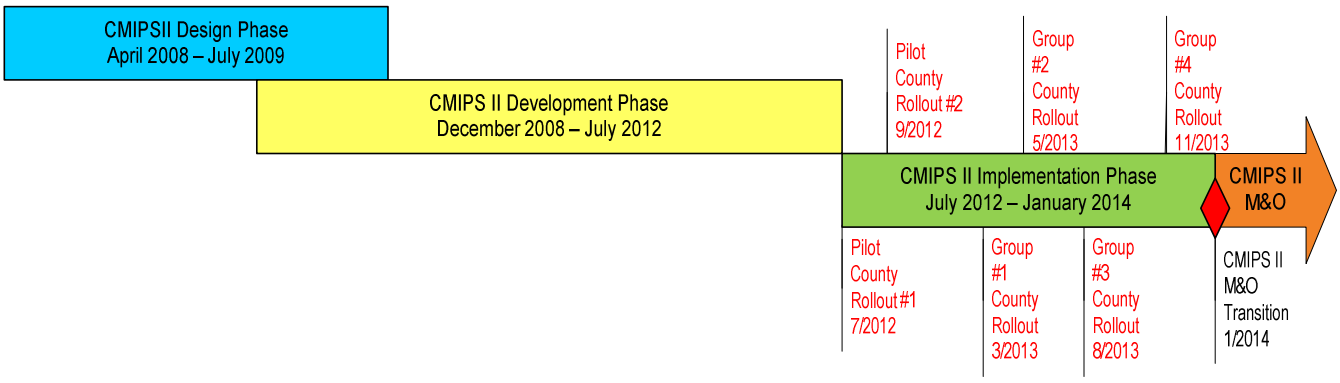
Questions:

1. Please briefly summarize the potential impacts of the pending regulations and any additional information regarding the anticipated timing of information regarding their status.

5. Case Management, Information & Payrolling System (CMIPS) II

Budget Issue: The Governor's budget proposes $510,000 ($255,000 GF) and the two-year extension of authority for four existing, limited-term positions at DSS to work with the Office of Systems Integration (OSI), the vendor, and the counties to support the continued roll-out, and then maintenance of, the Case Management, Information, and Payrolling System (CMIPS) II. Total proposed funding for combined DSS and OSI CMIPS II staffing of 36 positions in 2013-14 includes $3.4 million ($1.7 million GF).

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. The CMIPS II system will provide, according to the department, an enhanced, efficient, and more user-friendly Interface system to support the IHSS programs, as well as hold approximately 30 percent more data. The anticipated schedule for the CMIPS II roll-out is summarized in the chart below:



The Administration indicates that the requested position extensions are needed to ensure a smooth transition from the existing Legacy CMIPS to the CMIPS II replacement system. As the new system is implemented across the state, these staff would also maintain CMIPS II by providing ongoing technical assistance and support services (e.g., oversight and maintenance of governmental interfaces for sharing of information, enhanced data extraction, and change management and configuration management activities).

Staff Comment & Recommendation: Staff recommends that the Subcommittee approve the requested resources and position extensions.

Questions:

1. Please briefly describe the need to continue the requested positions.

2. The initial counties implementing CMIPS II experienced some significant challenges associated with the transition. Please summarize what those challenges were, how they have been addressed, and whether there are continuing concerns.

D. 5180 Department of Social Services, Community Care Licensing (CCL)

1. Overview

Budget Issue: With a total proposed budget of about $104 million (approximately $24 million GF), CCL oversees the licensure or certification of approximately 78,000 facilities, and has responsibility for protecting the health and safety of the individuals served by those facilities. The facilities licensed by CCL include child care centers; family child care homes; foster family and group homes; adult residential facilities; and residential care facilities for the elderly. CCL does not license skilled nursing facilities (licensed by the Department of Health Care Services) or facilities that provide alcohol and other drug treatment.

Additional Background: DSS is required to conduct pre- and post-licensing inspections for new facilities (including when a previously licensed facility changes hands). In addition, the department must conduct unannounced visits to licensed facilities under a statutorily required timeframe. Prior to 2003, these routine inspection visits were required annually for all facilities except family child care homes (which received at least triennial inspections). In 2003, a human services budget trailer bill (AB 1752, Chapter 225, Statutes of 2003) reduced the budget for CCL by $5.6 million and reduced the frequency of these inspections. As a result, CCL must visit a small number of specified facilities and conduct random, comprehensive visits to at least 10 percent of the remaining facilities annually. Ultimately, the Department must visit all facilities at least once every five years (which is less frequently than is required in most states). In addition, there is a "trigger" by which annually required inspections increase if citations increase by 10 percent from one year to the next. Finally, CCL is required to respond within 10 days to complaints and may conduct related onsite investigations.

After the 2003 changes and because of other personnel reductions, CCL fell significantly behind in meeting the new requirements for several years. The department indicates that currently, they are able to respond to and investigate complaints within the required 10-day timeframe 99 percent of the time and to comply with annually required inspections 91 percent of the time, as well as random inspection requirements 86 percent of the time.

Staff Comment & Recommendation: This is an informational item and no action is necessary.

Questions:

1. Please briefly summarize the mission of CCL and how the division is doing with respect to meeting its required duties.

2. To what do you attribute recent improvements in the division's performance of those duties?

2. Budget Change Proposal Related to Tracking Registered Sex Offenders

Budget Issue: The Governor's budget requests $470,000 ($385,000 GF) and authority for four permanent positions (two investigators, one assistant government program analyst and one staff information systems analyst) to implement a matching and investigations system intended to detect and remedy the illegal presence of registered sex offenders in DSS-licensed facilities that serve children or adults. The department indicates that this workload is currently being performed by redirected staff, but that this is not sustainable given the other critical licensing activities and investigations CCL is responsible for conducting.

Background: The Bureau of State Audits (BSA) published a report in 2008, and a subsequent report in July 2011, that concluded that the department can and should do more to ensure that licensees and county child welfare services (CWS) agencies prevent registered offenders from inappropriate contact with minors and adults residing in licensed facilities. In 2011, the BSA found over 1,000 addresses in the Department of Justice Sex Offender Registry that matched addresses of DSS or county-licensed homes of children in the CWS system. According to the department, the current rate of validated matches is around four percent of those initially identified (or 40 registered offenders).

Staff Comment & Recommendation: Staff recommends that the Subcommittee approve the requested resources and positions.

Questions:

1. Please briefly summarize the need for the requested positions.

E. 4170 Department of Aging

1. Overview & Sequestration

Department Overview: With a proposed 2013-14 budget of $196.2 million ($32.2 million GF) and 115.5 authorized positions, the California Department of Aging (CDA) administers programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities throughout the State. The department administers funds allocated under the federal Older Americans Act, the Older Californians Act, and through the Medi-Cal program.

The department contracts with the network of Area Agencies on Aging, who directly manage a wide array of federal and state-funded services that help older adults find employment, support older adults and individuals with disabilities to live as independently as possible in the community, promote healthy aging and community involvement, and assist family members in their caregiving. CDA also contracts directly with agencies that operate the Multipurpose Senior Services Program through the Medi-Cal home and community-based waiver for the elderly, and certifies Community Based Adult Services centers for the Medi-Cal program.

Sequestration: According to the department, the four largest and most critical programs that are supported by federal funding and affected by the recent sequestration reductions are the: 1) Congregate Nutrition, 2) Home Delivered Nutrition, 3) Supportive Services, and 4) Long Term Care Ombudsman programs. The Congregate and Home Delivered Nutrition programs provide meals to individuals aged 60 and older at congregate meal sites, or at home for those who are homebound due to illness, disability or isolation. Supportive Services programs are designed to provide assistance to keep individuals in the community. Services include assistance with care-management, chore, personal care and transportation. The Long Term Care (LTC) Ombudsman, through its 35 local programs, investigates and resolves complaints made by, or on behalf of, individual residents in long-term care facilities (nursing homes and residential care and assisted living facilities for the elderly) and advocates for the rights of all residents of long-term care facilities.

The department estimates that sequestration may reduce the federal funding for these critical programs for Federal Fiscal Year (FFY) 2013 as follows:

Program	Estimated Reduction	Percent
Congregate Nutrition	3,533,757	8.1
Home Delivered Nutrition	936,436	4.3
Supportive Services	1,782,516	5.2
LTC Ombudsman	109,347	5.2

Staff Comment & Recommendation: This is an informational item, and no action is required.

Questions:

1. Please briefly summarize the department's most critical roles and programs.

2. How is the department implementing reductions due to federal sequestration?

2. Multi-Purpose Senior Services Program (MSSP)

Budget Issue: The budget proposes $40.5 million ($20.2 million GF) for local assistance and $2.6 million ($1.2 million GF) for state operations related to the MSSP program. The budget also continues to assume that MSSP, along with other long-term care supports and services, will be integrated into Medi-Cal managed care as a part of the Coordinated Care Initiative (CCI) or Cal MediConnect.

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 to around 12,000 individuals. The program operates under a federal Medicaid Home and Community-Based, Long-Term Care Services waiver.

MSSP As Part of the CCI: As discussed in greater detail during the Subcommittee hearing on April 4, 2013 (background materials available online here: http://sbud.senate.ca.gov/subcommittee3), the Governor's budget includes CCI, which is intended to integrate medical, behavioral, long-term supports and services (LTSS), and home- and community-based services through a single Medi-Cal health plan for persons eligible for both Medicare and Medi-Cal (dual eligibles) in eight demonstration counties. Additionally, CCI will integrate LTSS into Medi-Cal managed care for individuals eligible for Medi-Cal, but not Medicare.

For recipients in non-demonstration counties, the MSSP program's current eligibility process and programmatic requirements will continue without changes. In the eight participating counties, the demonstration sites (through managed care plans) are expected, under the state's Memorandum of Understanding (MOU) with the federal government, to contract with existing MSSP sites to provide care coordination to the plans' enrollees until March 31, 2015 or 19 months after the commencement of beneficiary enrollment into a participating plan, whichever is later. During this period, the plans must allocate to MSSP providers the same level of funding those providers would have otherwise received under their MSSP contract with CDA. Beneficiaries enrolled in MSSP in seven counties with passive enrollment will have an

effective enrollment date no sooner than October 1, 2013. Los Angeles County will instead enroll all MSSP beneficiaries January 1, 2014. Passive enrollment based on MSSP status supersedes the county-specific phase-in detailed above.

The MSSP Site Association recommends that the beginning date for enrollment of MSSP beneficiaries into the demonstration be delayed by three months so that these particularly frail recipients would not be among the first to be enrolled. The Association further recommends that requirements related to the provision of person-centered care coordination to enrollees in the demonstration who are not MSSP recipients, but who have similar needs, be defined to be consistent with the current MSSP model.

Staff Comment & Recommendation: Staff recommends holding this item open pending the May Revision.

Questions:

1. How will the transition to receiving LTSS through managed care work for current MSSP clients and those currently awaiting services?

2. How is the Administration engaging MSSP sites and staff as the Coordinated Care Initiative is being implemented?

3. Looking ahead a few years, does the Administration intend for MSSP to 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?

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

April 25, 2013
Hearing Outcomes

Staff: Jennifer Troia & Brady Van Engelen

VOTE-ONLY ITEMS

A. 4170 Department of Aging (CDA)

1. Chronic Disease Self-Management Education (CDSME) Grant Program

2. Supplemental Nutrition Assistance Program Nutrition Education Obesity Prevention Program (SNAP-Ed)

3. New Freedom Transportation Grant - Request for Extension

Approved Items 1-3 (on a 3-0 vote)

B. 4185 California Senior Legislature

1. Budget Change Proposal for Administrative Staff

Approved (3-0)

C. 5180 Department of Social Services

1. Community Care Licensing - Fingerprinting Fees

Approved (3-0)

2. County Match-Waiver for CalFresh Administration

Approved (2-1, Emmerson no) the proposed extension, with the understanding that the counties will again be expected to fully fund CalFresh administration in the near future.

3. Transfer of Temporary Assistance to Needy Families Funding to California Student Aid Commission

Approved (2-1, Emmerson no) the portion of the proposed TANF transfer that is necessary to meet (but not exceed) the state's required MOE level of spending. According to the Department of Finance, this amount will be determined in conjunction with the May Revision of the Governor's budget.

DISCUSSION ITEMS

A. 5180 Department of Social Services, In-Home Supportive Services (IHSS)

1. Recent Settlement of Litigation Related to Prior Reductions

Held open.

2. Community First Choice Option (CFCO)

Approved (3-0) the April Finance Letter.

3. Coordinated Care Initiative (CCI)-Related Changes to IHSS

Voted (2-1, Emmerson no) to amend the statutory language regarding the revision of public authority rates so that it does not include a specified timeframe and to approve the requested resources and limited-term positions at DSS.

5. Case Management, Information & Payrolling System (CMIPS) II

Approved (3-0) the requested resources and position extensions.

B. 5180 Department of Social Services, Community Care Licensing (CCL)

2. Budget Change Proposal Related to Tracking Registered Sex Offenders

Approved (3-0) the requested resources and limited-term positions.

C. 4170 Department of Aging

2. Multi-Purpose Senior Services Program (MSSP)

Held open.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

May 2, 2013

9:30 AM or Upon Adjournment of Session
(whichever is later)

Room 4203, State Capitol
(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 916-651-1505. Requests should be made one week in advance whenever possible. Thank you.

0530 California Health and Human Services Agency

1. Office of the Patient Advocate

Budget Issue. The Office of the Patient Advocate (OPA) requests $184,000 (Office of Patient Advocate Trust Fund) and 1.0 two-year limited-term position to develop a Complaint Data Reporting System, as required by AB 922 (Monning, Statutes of 2011). This includes $67,000 for ongoing technical/statistical support from the National Committee for Quality Assurance and $12,000 to cover expenses associated with the design, translation, printing, promotion, and dissemination of the annual complaint reports and annual stakeholder preview sessions.

With approval of this request, OPA indicates that the following milestones will be completed:

- January - Summer 2013 – Conduct a complaint data assessment, convene an interagency workgroup, and initiate the development of the uniform reporting format.
- Fall 2013 – Initiate submission of the complaint data (retroactive to January 2013).
- January 2014 – Begin to conduct preliminary data analysis and quality assurance review.
- June 2014 – Analyze the first reporting year of complaint data, prepare online complaint report design/display, and design report.
- Summer 2014 – Schedule stakeholder preview of data.
- Fall 2014 – Issue the first report online and hold kickoff summit meeting, disseminate printed copies throughout remainder of the year.
- Repeat the cycle annually ongoing

The current year activities (January – June 2013) are being performed by a position on loan from the Department of Managed Health Care (DMHC). This DMHC position is funded with federal grant funds from the Center for Consumer Information and Insurance Oversight (as part of the Consumer Assistance Program grant). In July 2013, this position would be an OPA employee under this proposal.

Background. AB 922 designates OPA as a central resource to ensure that consumers get information on how to obtain health care coverage for which they are eligible or entitled and how to receive timely assistance in resolving problems when they have difficulty accessing care or have other programs with their health plans or providers.

AB 922 requires that OPA, by January 2013, expand its current audience of commercially covered consumers to serve all publicly and privately covered Californians as well as the uninsured. OPA is specifically mandated to provide the following services:

1. Publicly report and analyze aggregate data on consumer complaints regarding health coverage.
2. Render assistance to consumers regarding problems with their health care coverage or services, including assistance with procedures, rights, and responsibilities related to the filing of complaints, grievances and appeals.
3. Develop protocols and procedures for assisting in the resolution of consumer complaints, including the referral of complaints to the appropriate regulator or health coverage program.
4. Develop, in consultation with specified health coverage programs, education and informational guides to be made available to the public online and through public outreach and education programs.
5. Provide outreach and education about health care coverage options and coordinate with other state and federal agencies engaged in outreach and education regarding the implementation of federal health care reform.
6. Operate a toll-free telephone number that can route callers to the proper regulating body or public program, their health plan, or local consumer assistance program.
7. Operate an Internet website, social media and up-to-date communication systems to provide information regarding consumer assistance programs.

Complaint Data Reporting. AB 922 requires OPA to launch a new project focused on collecting, analyzing and reporting aggregated complaint data from California's two health insurance regulators and three other state agencies. These state entities include Department of Managed Health Care (DMHC), Department of Insurance (CDI), Department of Health Care Services (DHCS), Managed Risk Medical Insurance Board (MRMIB), and the California Health Benefit Exchange (Exchange).

With the new mandate to collect, analyze and report complaint data from multiple sources, OPA will need to establish and maintain an ongoing Complaint Data Reporting Project to standardize health care complaint data (more than 30 data elements per complaint) for annual submission by five state entities; and provide for the analysis of the aggregated data set for public reporting. The availability of new aggregated complaint data will increase the state's capability to identify systematic problems through better monitoring of trends and to address emerging problems with timely and appropriate enforcement or other needed policy or program changes.

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

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

1. Please provide an overview of this proposal.

2. Please provide an update on implementation of activities specified in AB 922.

3. How is OPA preparing for implementation of the federal health care reform?

2. Aging and Disability Resource Connection Program Continuation

Budget Issue. The California Health and Human Services Agency (CHHS) requests an increase of $250,000 in federal fund budget authority and extension of two limited-term positions until June 30, 2014, to support the Aging and Disability Resource Connection (ADRC) model of streamlining consumer access to community-based long-term services and supports (LTSS) in California. These positions will improve collaboration between community-based Aging and Disability Resource Connection (ADRC) partnerships and Money Follows the Person (MFP) Lead Organizations.

The positions will be fully funded with federal grant funds via an Interagency Agreement with the Department of Health Care Services.

Background. The California ADRC model offers consumers, regardless of age, disability or income level, access to comprehensive information and a "no wrong door" access to services. The ADRC model brings together multiple local agencies to provide a coordinated system of long-term services and supports (LTSS) through partnership between Area Agencies on Aging and Independent Living Centers, as well as other community partners who serve people with long-term chronic conditions and/or disability.

Growth in the ADRC partnership model has been incremental since 2004, when California launched the first two ADRCs. Today, seven regional ADRCs serve 11 of California's 58 counties: San Diego, San Francisco, Del Norte, Orange, Riverside, Nevada, Butte, Colusa, Glenn, Tehama and Plumas. In January 2013, CHHS awarded the Alameda County ADRC partnership $100,000 in federal funds to support development and implementation of a new ADRC Program in a Duals Demonstration county, bringing the total number of ADRC partnerships to eight.

The mission of ADRCs is to empower consumers to consider all options, make informed decisions, and access community LTSS that help them meet their personal goals for independence – regardless of the source of financing (Med-Cal, Medicare, private insurance, federal or state-funded programs, or private pay).

According to CHHS, approval of this request enables CHHS to maintain the state oversight infrastructure that currently supports ADRC replication and ADRC designation, technical assistance to existing and newly forming ADRC partnerships, collaboration with DHCS and Medi-Cal Money Follows the Person Lead Organizations and Minimum Data Set (MDS) 3.0 Local Contact Agencies (LCAs).

Current federal grants that have supported the California ADRC initiatives expire September 30, 2013.

Background—Money Follows the Person. 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.

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

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

1. Please provide an overview of this proposal.

2. Please describe in more detail how this proposal will further goals of the Money Follows the Person program.

3. CMS State Innovation Models Grant

Budget Issue. CHHS requests an increase of $1.8 million federal funds in 2013-14 as a result of being awarded a Center for Medicare and Medicaid Services Innovation (CMMI) State Innovation Models (SIM) Grant. It is proposed that these funds would be used to develop innovative models that improve the delivery of health care, lower health care costs, and promote better overall health for Californians.

A current year request for increased federal fund expenditures of $850,000, as a result of this grant, was submitted to the Joint Legislative Budget Committee in March.

CHHS proposes to contract with the UC Davis Institute for Population Health Improvement for this project.

Background. CMS is providing nearly $300 million to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation with the aim of improving health system performance and lowering costs for residents of participating states. The projects will be broad-based and focus on people enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

California intends to utilize existing state and national initiatives, including capitated payment models, accountable care organizations, bundled episode payments, the Coordinated Care Initiative for dual-eligible Medi-Cal and Medicare beneficiaries, and the state's Section 1115 Medi-Cal Bridge to Health Care Reform Waiver, to inform their model design.

California's design process will involve a broad range of advocacy groups that will address its diverse population in order to develop a model that reflects California's complex health care and financing environment. This design process will enable California to apply for a CMMI SIM Testing Grant, anticipated to be announced later in 2013.

The SIM Design Grant complements the goals of the Governor's Let's Get Healthy California Task Force Report, which outlines a ten-year blueprint to make California the healthiest state in the nation and reduce health care costs. The Task Force's goals and priorities will be used as a basis for the State Health Care Innovation Plan. In anticipation of this grant, the California Health and Human Services Agency formed six private sector work groups in line with the Let's Get Healthy California six strategic goals; the work groups will develop private sector implementation strategies and policy recommendations for the State Health Care Innovation Plan. Health care payment reforms under California's SIM initiative will maximize the value of existing expenditures rather than invest new funds to reform care delivery.

The six strategic goals and workgroups that will inform this process are:
1. Healthy Beginnings – Laying the foundation for a healthy life.
2. Living Well – Preventing and managing chronic disease.
3. End of Life – Maintaining dignity and independence.

4. Redesigning the health system – Efficient, safe, and patient centered care.
5. Creating Healthy Communities – Enabling healthy living.
6. Lowering the Cost of Care – Making coverage affordable and aligning financing to health outcomes.

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

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

1. Please provide an overview of this proposal.

4260 Department of Health Care Services

1. Adult Dental Services

Budget Issue. Senator Steinberg, Subcommittee #3 and several other Senators, are seeking to restore Adult Dental Services as a benefit in the Medi-Cal Program. Presently, only certain "federally required adult dental services" (FRADS) are offered to most adult enrollees. Generally, FRADS primarily involves the removal of teeth.

Through technical assistance discussions with DHCS, the California Dental Association and others, three options have emerged for consideration. It should be noted these fiscal estimates are preliminary may need to be updated at the time of the Governor's May Revision. Specific Medi-Cal dental procedure codes for these options are available.

The three options are as follows:

Option 1: Restore but not Replace Teeth (increase of $70 million GF).

Through option one, adults would receive a basic level of dental health that is within the standards of care. This involves restoring but not replacing existing teeth and providing basic preventive services to maintain these teeth. The DHCS dental consultants believe this is the bare minimum that must be done if dental benefits are brought back.

Preventive and diagnostic services (exams, oral prophylaxis, fluorides, and radiographs) would be provided. Teeth needing repair would be addressed through restorations (amalgams, composite and stainless steel crowns). Root canal treatments could be considered on a case-by-case basis.

Additional procedures regarding periodontics, implants and dentures would *not* be included in this option.

Option 2: Full Mouth Dentures *plus* Option 1 (increase of $90 million GF).

Under option two, full mouth dentures would be provided in addition to the services described under option one. This option would *not* allow for partial dentures.

Option 3: Full Restoration of All Adult Dental Benefits (increase of $166 million GF).

Option three restores all optional procedures for adults that were eliminated through ABX3 5, Statutes of 2009. This would include preventive, diagnostic, and restorative procedures, as well as root canals, laboratory processed crowns, periodontics, implants and partial dentures.

Background. Adult Dental Services, with the limited exception of "federally required adult dental services" (FRADS) and dental services to pregnant women and nursing home patients,

were eliminated as an “optional” Medi-Cal benefit in 2009 due to the state’s fiscal crisis. Generally, FRADS primarily involves the removal of teeth and treating the affected area.

Subcommittee Staff Comment and Recommendation—Hold Open. The elimination of Adult Dental Services created a dramatic impact on the oral health and overall health of millions of Medi-Cal enrollees. Failure to provide Adult Dental Services prevents many individuals from receiving services needed to preserve teeth for eating, overall health and even employment. Without care, dental disease progresses and the pain and infection that results often leads to increased emergency room use.

With the expansion of Medi-Cal to certain childless adults, under federal health care reform, the state could take advantage of the 100 percent federal funding (for the first three years) for these new enrollees. The federal government would be paying for 100 percent of the costs associated with the restoration of Adult Dental Services for the newly eligible under one of these options.

It is recommended to hold this item open until after the May Revision when the Legislature has a better understanding of the state’s fiscal situation.

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

1. Please provide a brief description of the three options, and from a technical assistance perspective, the pros and cons of each.

2. What additional cost may there be if partial dentures were included in option two?

2. Affordable Care Act (ACA) – MAGI Medi-Cal Verification Plan

Oversight Issue. On March 26, 2013, DHCS submitted California's Modified Adjusted Gross Income (MAGI)-based Medi-Cal Eligibility Verification Plan to the federal government. This plan describes the state's planned policies and procedures to verify enrollee information (e.g., income and residency) that would be used to determine MAGI-Medi-Cal eligibility.

Several stakeholders have raised questions and concerns about California's plan that suggest the state is not maximizing available electronic resources to verify key eligibility data factors for MAGI Medi-Cal, thereby, (1) making it more difficult and cumbersome for people to enroll in Medi-Cal and (2) not complying with federal requirements to only require paper documentation when electronic data matches are unavailable.

Background– ACA Envisions Simplified Medi-Cal Enrollment. The federal ACA envisions simplified Medi-Cal eligibility and enrollment policies and procedures. For example, federal law emphasizes the use of electronic verification and permits the request of paper documentation only in instances when electronic data is not available or establishing the electronic data match would not be cost effective or would have an impact on program integrity.

MAGI Medi-Cal eligibility factors that must be verified include: income, residency, age, social security numbers, citizenship, immigration status, household composition, pregnancy, caretaker relative, Medicare, application for other benefits, deceased status, and deprivation.

Federal law also provides some flexibility to states regarding verification policies within certain parameters, including:

- ***Self-Attestation of Information.*** Most significantly, federal law allows states to accept self-attestation without documentation for many eligibility criteria, except as prohibited by law (e.g., verification is required for citizenship and immigration status information). States may verify non-financial information, including state residency, age, date of birth, and household size, using means other than self-attestation, as long as the agency still complies with other sections of the law that specify the reliance on electronic data.

  DHCS does not plan to use self-attestation for MAGI Medi-Cal except where it is required by federal law (pregnancy) and for the caretaker relative factor.

- ***Post-Enrollment Eligibility Verification.*** Federal law also offers states the option to conduct post-enrollment verification on self-attested data, whereby applicants can enroll in MAGI Medi-Cal or exchange programs based on self-attestation information, with the state or exchange, following up by verifying the information afterwards.

  DHCS does not propose to conduct post-enrollment eligibility verification. All information must be verified prior to a person being enrolled into MAGI Medi-Cal.

- ***Reasonable Compatibility.*** For instances when information obtained from a data source is not consistent with what was provided by an applicant, states can generally define their own standard of "reasonable compatibility" between the two pieces of information as specified. For income information, if *both* the self-attested and verified information are either below, above, or at the income threshold or standard in question, this information must be considered reasonably compatible for MAGI Medi-Cal. For exchange programs the reasonable compatibility standard for income is slightly different and can include using a threshold test.

  In situations where information provided by applicants is not reasonably compatible with an electronic data source (and when an electronic data source is not planned to be used), DHCS plans to request paper documentation. DHCS is not proposing to first ask for a reasonable explanation from the individual, stating that it views this as akin to self-attestation.

CalHEERS. The state is currently designing and building CalHEERS, the state's enrollment system for MAGI Medi-Cal and Covered California health insurance programs. This new IT system, among other things, will interface with other federal and state electronic databases to verify individual application information for MAGI Medi-Cal and Covered California programs. These other electronic resources include:

- ***Federal Services Data Hub (FDSH).*** The federal government will establish a Federal Data Services Hub (FDSH) that states may use to verify certain information, or obtain information, from federal sources including the Social Security Administration, Department of Homeland Security, and Internal Revenue Service. Data elements expected to be verifiable through FSDH include income, age/date of birth, Social Security number, citizenship, immigration status, incarceration status, and other health coverage. According to federal regulation, a state must use FDSH to the extent that information related to Medicaid eligibility is available. While states may obtain information through another mechanism subject to federal approval, California is not proposing to do this. According to DHCS, several states are currently in testing with FSDH, including California.

- ***Statewide Automated Welfare System (SAWS).*** SAWS is made up of three county-based computer systems, or "consortia"—LEADER, C-IV, and CalWIN—and is considered an eligibility determination and case management system for county administration of health and human services programs, including CalWORKs, CalFresh, and Medi-Cal. Each county in the state utilizes one of the consortia. SAWS contains a variety of data elements, including income, demographic, eligibility, program participation, and case management information.

- ***Medi-Cal Eligibility Data System (MEDS).*** MEDS is a statewide database that stores client information, such as Medi-Cal eligibility, demographics, and enrollment in other programs like CalWORKs and CalFresh. MEDS generates a Client Index Number (CIN), which is a unique number assigned to an individual for purposes of tracking benefits receipt across programs and counties, among other things.

- ***Income and Eligibility Verification System (IEVS).*** IEVS is mandated by the federal government, among other functions, it obtains, uses, and verifies information pertinent to the determination of eligibility and share of cost for Medicaid benefits by cross-checking data supplied by applicants against other databases, such as those at EDD and FTB, as well as federal databases, including data from the Social Security Administration.

DHCS Not Maximizing Federal Flexibilities and Electronic Verification. As proposed in the MAGI Medi-Cal verification plan, data verification will be required on most eligibility factors as self-attestation will only be allowed when it is required by the federal government. This does not take advantage of opportunities to streamline the Medi-Cal enrollment process.

Additionally, it appears that DHCS has not explored all options to electronically verify a person's residency information. Legislative staff have repeatedly asked DHCS for its analysis of the feasibility of electronically verifying residency information against FDSH, SAWS, and MEDS (for examples) and have not received a response from the Administration. These systems could have an enrollee's address information and both FDSH and MEDS are already identified a databases to verify other eligibility factors (e.g., income and other health coverage).

Consequently, under the proposed process, individuals will *always* have to submit additional information prior to being determined eligible for MAGI Medi-Cal.

Subcommittee Staff Comment and Recommendation—Hold Open. It appears that DHCS's plan for MAGI Medi-Cal verifications may be inconsistent with the federal policy to only require paper documentation when electronic data matches are unavailable.

Furthermore, DHCS's policy decisions regarding verifications place additional burdens on individuals applying for Medi-Cal coverage and could increase county eligibility processing costs (compared to the county eligibility processing costs when this information is electronically verified), as county eligibility workers would generally be required to process (i.e., "touch") residency verification information for every MAGI Medi-Cal case.

It is recommended to hold this item open as more information becomes available.

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

1. Please provide an overview of DHCS's proposed MAGI Medi-Cal verification plan. What were DHCS's guiding principles when developing this plan?

2. Has CMS provided any feedback on this plan? What is the timeline for the approval of this plan?

3. Please provide an overview of how DHCS considered county eligibility processing costs as part of its MAGI Medi-Cal verification plan design process.

3. ACA – "Mandatory" Medi-Cal Expansion – LAO Analysis

Budget Issue. The Legislature was notified of the Administration's revised estimates related to the "mandatory" Medi-Cal expansion under the ACA in a Spring Finance Letter. These revised estimates project that the General Fund costs of the mandatory expansion will be $188.7 million in 2013-14, $659.6 million in 2014-15, and $729.1 million in 2015-16, when costs are fully phased in. (The January Budget included $350 million General Fund in 2013-14 as a placeholder for the costs.)

This revised estimate was discussed in great detail at the March 14th Subcommittee #3 hearing (see: http://sbud.senate.ca.gov/sites/sbud.senate.ca.gov/files/SUB3/03142013Sub3CalHEERS_EMSA_OSHPD_DPH.pdf).

The Administration's estimate, particularly in the out years, is significantly higher than other models, including the LAO's estimate and CalSIM (which was created by the UCLA Center for Health Policy and Research and UC Berkeley Labor Center for Labor Research and Education). See chart below for a high-level overview of these various estimates.

Table: Already Eligible/Mandatory Medi-Cal Expansion Estimates*

	DHCS	LAO Moderate	CalSIM Base	CalSIM Enhanced
Medical inflation	5%	5.1% Medicaid/ 4.2% CHIP**	2.30%	2.30%
Caseload growth rate	3%	1%	0.07%	0.07%
Take-up rate	N/A	20%	10%	40%
Full take-up achieved	Sept. 2014	July 2016	2018	2016
Total number eligible but not enrolled	N/A	2.5 million	2.5 million	2.5 million
Average monthly enrolled into Medi-Cal (Caseload)				
2013-14	239,283	154,016	200,000	440,000
2014-15	814,960	410,447		
2015-16	858,000	488,218	230,000	490,000
Medi-Cal Per Member Per Month (PMPM)				
2013-14	$136	$125	$135	$150
2014-15	$143	$131	$138	$153
2015-16	$150	$136	$141	$157
Healthy Families Program (HFP) PMPM				
2013-14	$93	$104	$129	$129
2014-15	$98	$109	$132	$132
2015-16	$103	$113	$135	$135
General Fund costs				
2013-14	$188,436,000	$103,844,679	$143,000,000	$378,000,000
2014-15	$661,461,000	$289,528,711		
2015-16	$732,111,000	$358,553,824	$125,000,000	$380,000,000

* For the purpose of creating this chart, certain generalizations were made for ease of comparison (e.g., the CalSIM estimates are based on a calendar year; whereas, the Administration's and LAO's estimates are based on the state fiscal year).
**CHIP is the Children's Health Insurance Program (formerly the Healthy Families Program and now the Targeted Low-Income Children's Program under Medi-Cal).

LAO Analysis. The Subcommittee requested that the LAO perform a detailed analysis of the revised estimates. The LAO's analysis can be found at: http://www.lao.ca.gov/laoapp/main.aspx

According to the LAO, the Administration's fiscal estimates are likely too high. One of the key variations between the LAO's estimate and the Administration's estimate relates to differing underlying assumptions about the number of additional enrollees under the mandatory expansion. The LAO is unclear on the basis for some of the Administration's assumptions in developing its estimates of additional enrollment, and finds that the Administration's enrollment estimates are likely high—particularly in the short term.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open to continue more in-depth discussions regarding these assumptions.

The Subcommittee has requested the LAO to provide an overview of its comprehensive review of the Administration's estimate.

4. ACA – Medi-Cal Enhanced Federal Funding for Prevention Services & Adult Vaccines

Budget Issue. The Governor's January budget does not assume any savings associated with an increase in the federal funding percentage for Medi-Cal for preventative services and adult vaccines as provided under the ACA.

Background. Effective January 1, 2013, the ACA established a one percentage point increase in the Federal Medical Assistance Percentages (FMAP) for Medi-Cal for preventative services and adult vaccines in states that meet certain requirements. In order to qualify for the one percentage point FMAP increase for these services, a state must cover all preventative services assigned a grade A or B by the United States Preventive Services Task Force (USPSTF) and all approved vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). Also, states may not impose beneficiary cost-sharing on such services. The increased FMAP would apply to the applicable services in both fee-for-service (FFS) and managed care.

Medi-Cal currently covers all specified preventive services assigned a grade A or B by the USPSTF and approved adult vaccines recommended by the ACIP and does not impose cost-sharing for these services.

DHCS submitted its state plan amendment (SPA) to the federal government at the end of March indicating that it seeks this FMAP increase. If this SPA is approved, the state would be able to claim the enhanced FMAP retroactively back to January 1, 2013.

Prevention services that would be eligible for this increase in FMAP include: breast cancer screening, colorectal cancer screening, depression screening, HIV screening, and osteoporosis screening, and tobacco use counseling.

Subcommittee Staff Comment and Recommendation—Hold Open. Discussions with DHCS indicate that at least $2.5 million in General Fund savings would be realized as a result of this increased FMAP. This estimate is based on an analysis of only fee-for-service data. It is expected that additional savings would be realized as this analysis is performed on managed care data. It is recommended to hold this item open as more details become available and as the Administration considers its May Revise estimate.

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

1. Please provide an overview of this ACA provision.

2. When does DHCS anticipate having an estimate for the managed care-related savings as a result of this ACA provision?

5. ACA – Medi-Cal Enrollment Assistance and Outreach Grants

Issue. An effective and targeted outreach and enrollment strategy will be necessary to maximize Medi-Cal enrollment under the ACA. The Governor's budget does not include any funds earmarked for this purpose.

As part of its commitment to full and complete implementation of ACA in California, The California Endowment (TCE) Board of Directors has approved providing $26.5 million to the state for the purpose of Medi-Cal in-person enrollment assistance payments and targeted outreach and enrollment grants to community-based organizations. These funds could be used to draw down a federal match; thereby, providing $53 million (total funds) for these purposes.

Specifically, TCE has committed to providing:

- **Medi-Cal Enrollment Assistance - $14 million.** This funding would be used for Medi-Cal in-person enrollment assistance payments of $58 per approved Medi-Cal application.

- **Medi-Cal Outreach and Enrollment Grants to Community-Based Organizations- $12.5 million.** This funding would be used to target outreach and enrollment strategies aimed at persons with behavioral health needs; homeless persons; young men of color; persons who are in county jail or state prison, on state parole or county probation, and post-release community supervision; families of mixed-immigration status; school-age children through their educational institutions; and persons with limited English proficiency.

Covered California has received a federal grant and TCE funding for outreach and enrollment activities targeted at those individuals with incomes over 138 percent of the federal poverty level that could qualify for Covered California's health coverage programs. However, these outreach and enrollment strategies may not target individuals who would qualify for Medi-Cal and would not pay for enrollment into the Medi-Cal program.

Subcommittee Staff Comment and Recommendation. It is recommended to adopt placeholder trailer bill language to require DHCS to accept these contributions and seek matching federal funds for these purposes. See Subcommittee staff handout for placeholder language (found at end of agenda).

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

1. Please provide an overview of this issue.

6. Managed Care Organization Gross Premiums Tax

Budget Issue. The Administration proposes to reauthorize the gross premiums tax (GPT) on Medi-Cal managed care plans permanently on a retroactive basis starting July 1, 2012. Reauthorizing this tax would generate General Fund savings of $131 million in 2012-13 and $232 million in 2013-14. The Administration proposes to continue to use 50 percent of the gross premium tax revenue to draw down federal funds and make plans whole and 50 percent of the revenue to offset General Fund spending. Revenue projections for the Gross Premiums Tax fund are $364.6 million in 2012-13 and $485.0 million in 2013-14.

One of the components of the Administration's proposed $1 billion reserve, is $364 million from the gross premiums tax ($131 million from 2012-13 and $232 million from 2013-14).

In addition, the proposed trailer bill language includes a $125 million General Fund loan to the Managed Risk Medical Insurance Board as the GPT has been a funding source for the Healthy Families Program. Consequently, the Administration proposes to implement this trailer bill in the current year.

Background. In 2005, California enacted a quality improvement fee (QIF) on Medi-Cal managed care organizations.[1] Based on federal rules, the fee was assessed on all premiums paid to legal entities providing health coverage to Medi-Cal enrollees. When the fee was established, 75 percent of the revenue generated was matched with federal funds and used for payments to managed care organizations and the remaining 25 percent was retained by the state General Fund. Under this arrangement, the managed care organizations received a rate adjustment (i.e., on the net, health plans gained).

Effective October 1, 2007, as part of the implementation of the state's new managed care rate methodology, this arrangement changed and 50 percent of the revenue generated by the QIF was matched with federal funds and used for payments to managed care organizations and the remaining 50 percent was retained by the state General Fund.[2] Under this allocation, managed care plans were made whole in that they were reimbursed the amount of QIF they paid, but no longer realized a net benefit.

Changes in federal law resulted in this fee sunsetting on October 1, 2009, as it no longer complied with federal requirements. New federal law required that provider fees be "broad based" and uniformly imposed throughout a jurisdiction, meaning that they cannot be levied on a subgroup of providers, such as only those enrolled in Medicaid programs.

Gross Premiums Tax (GPT). Assembly Bill 1422 (Chapter 157, Bass, Statutes of 2009) extended the 2.35 percent premium tax imposed on all types of insurance to include all

[1] Assembly Bill 1762 (Committee on Budget, Chapter 230, Statutes of 2003)

[2] "Financing Medi-Cal's Future: The Growing Role of Health Care-Related Provider Fees and Taxes," California HealthCare Foundation, November 2009.

comprehensive health plans contracting with Medi-Cal. The revenues from this tax were directed to fund health coverage for children through the Healthy Families Program, provide a cost-of-living increase to health plans participating in Healthy Families, and increase Medi-Cal capitation rates to health plans. Under this arrangement, 50 percent of the revenue was matched with federal funds to make health plans whole and 50 percent of the revenue was used to maintain the Healthy Families Program. This tax expired December 31, 2010 and was extended twice until it expired on June 30, 2012.

It should be noted that because the GPT is an existing tax on a broad group of insurers, the overwhelming majority of which are not health care insurers, it can be extended to Medi-Cal managed care plans without being considered a fee under federal law. As such, the state does not have to meet federal requirements for provider fees to obtain federal matching funds, using this source of revenues as the state match.

Last Year's Proposal. Last year, the Administration proposed to permanently extend the GPT. It was estimated that about $187 million from the GPT would be directed to the Healthy Families Program (and that Medi-Cal managed care plans would receive a rate adjustment to make them whole). The Senate Budget and Fiscal Review Committee approved a two-year extension of this tax; however, this proposal was not voted on by the Legislature. Consequently, this tax expired on July 1, 2012.

The 2012 Budget Act assumed reauthorization of the GPT, and, based on this assumption appropriated no General Fund to cover the Healthy Families Program. On January 7, 2013, the Administration notified the Joint Legislative Budget Committee of an unanticipated cost funding request of $15 million General Fund from the Managed Risk Medical Insurance Board. These requested funds would be used to cover the capitation and administrative vendor costs for the month of December 2012 for the Healthy Families Program.

Subcommittee Staff Comment and Recommendation—Hold Open. Key issues to consider when evaluating this proposal:

- ***Gross Premium Tax Brings In Additional Federal Funding to State.*** With the expiration of the GPT, the state is foregoing hundreds of millions of dollars in additional federal funding for the Medi-Cal program as the revenue from the gross premiums tax can be used as a match for federal funding for Medi-Cal.

- ***State Has One of Lowest Capitation Rates in Country.*** Medi-Cal capitation rates are among the lowest Medicaid rates in the country.[3] With the implementation of the ACA's Medicaid expansion, discussed earlier, it will be important to ensure that Medi-Cal rates are at a level to ensure provider participation in the program in order to ensure access to services. Consequently, as part of these discussions, it will be important to consider the cumulative impact of the AB 97 rate reductions, the managed care efficiencies proposal, and Medi-Cal expansion when evaluating this reauthorization and the

[3] "Public Partner: The California Health Benefit Exchange Aligned with Medi-Cal," California HealthCare Foundation, October 2011.

allocation of the revenues generated from this tax. For example, should the revenues from the GPT be used to offset General Fund expenditures in Medi-Cal or should they be used to increase rates to Medi-Cal managed care plans given their important role in the Medi-Cal expansion. As noted above, when the QIF was first assessed on managed care organizations, it was used to provide a rate increase to managed care plans.

- ***GPT Revenue Does Not Account for Medi-Cal Expansion.*** The Administration's January estimated GPT revenues do not include the impact of the Medi-Cal expansion (related to health care reform). Accordingly, GPT revenues will be higher than projected in the Governor's budget as more people will be covered by Medi-Cal managed care. For the "mandatory" Medi-Cal expansion, the Administration projects an additional $4 million General Fund offset in 2013-14 and $14 million General Fund offset in 2014-15. These numbers are not reflected in the January budget.

- ***Permanent Extension Makes Evaluation Difficult.*** A permanent extension of this tax would make it difficult to periodically evaluate its effectiveness and its impact on Medi-Cal managed care.

Additionally, the Administration has proposed to adopt this trailer bill language in the current year to provide funding for HFP; however, the Administration has indicated that this proposal will change in the May Revision. Consequently, it is recommended to hold this item open. The Administration should submit a General Fund deficiency request to the Joint Legislative Budget Committee for current year funding for HFP.

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

1. Please provide an overview of this proposal.

2. Does the Administration plan to submit a deficiency request to the Joint Legislative Budget Committee for the current year funding for the Healthy Families Program?

7. Managed Care Efficiencies

Budget Issue. The Governor's budget includes a decrease of $135 million General Fund in the Medi-Cal program as a result of implementing additional efficiencies in managed care. DHCS proposes to look for new ways to improve quality and the efficiency of the health care delivery system and develop payment systems that promote quality of care and improve health outcomes.

The Administration indicates that this proposal does not require statutory authority, but it has not provided details on how this proposal may be implemented. Discussions with DHCS indicate that potential proposals may include changes regarding potentially preventable hospital admissions and emergency room visits and readmissions.

DHCS indicates that the basis for the amount of $135 million is that this is the amount of AB 97 retroactive savings that should be recouped from Medi-Cal managed care plans. However, since the state is legally not able to recoup from managed care plans for a retroactive period, it is submitting this proposal to achieve equivalent savings.

LAO Recommendation. The LAO recommends against approval of this proposal unless the Administration can provide additional detail about the proposal, including:

- How it plans to incorporate efficiency adjustments into managed care plan rates.
- How the changes will reduce General Fund costs.
- How the changes would potentially impact the quality of care and access to care for Medi–Cal enrollees.

Subcommittee Staff Comment and Recommendation—Hold Open. It is anticipated that more information on this proposal will be forthcoming in the May Revision. Consequently, it is recommended to hold this item open.

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

1. Please provide an overview of this proposal.

8. 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 certain Medi-Cal managed care enrollees 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.

This proposal would only apply to those beneficiaries in the Family and Child aid code categories. It would not apply to Seniors and Persons with Disabilities (SPDs) and beneficiaries dually eligible for Medicare and Medi-Cal (duals). However, DHCS would have the option of adding additional Medi-Cal managed care populations in future years.

This proposal would result in $2 million ($1 million General Fund) savings in 2013-14. These savings come from the reduction in the number of health assessments and reduced mailing costs to implement annual open enrollment offset by one-time system update costs.

Background. Currently, beneficiaries in Two-Plan Model and Geographic Managed Care counties can change plans at the beginning of any month.

DHCS contends that a 12-month lock-in with an open enrollment period would bring Medi-Cal managed care in line with the health care industry and 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).

Under annual open enrollment, beneficiaries would receive a written notice prior to the end of an enrollment year, allowing them to change Medi-Cal plans during the open enrollment period. If the beneficiary does not elect to change Medi-Cal plans, he or she would be required to remain in their Medi-Cal plan for one year until the next enrollment period.

A new beneficiary would have the option to change to an alternate Medi-Cal plan within the first 90 days following the first time the beneficiary enrolls in a Medi-Cal plan and then be

subject to the annual open enrollment period for each year thereafter. Beneficiaries with fluctuating Medi-Cal eligibility would be re-enrolled into the Medi-Cal plan previously selected until the next annual open enrollment period.

Subcommittee Staff Comment and Recommendation—Hold Open. The Legislature has denied similar proposals in the last few years because it found that it is important to ensure that Medi-Cal enrollees have the ability to change health plans at any time to ensure that his or her health needs are met. This is still the case and potentially even more important given that there are still ongoing managed care transitions to (e.g., the Healthy Families Program transition to Medi-Cal and the rural managed care expansion).

Additionally, the proposed trailer bill language provides DHCS with substantial authority to determine if this policy should be implemented for seniors and persons with disabilities.

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

1. Please provide an overview of this proposal.

9. Diagnosis Related Groups Payment System – Update & Position Request

Budget Issue. DHCS requests conversion of one limited-term position to permanent in order to meet the workload requirements for the Diagnostic Related Groups Payment Systems Program (DRG), which will be implemented on July 1, 2013. The total cost of this position is $121,000 ($61,000 General Fund).

This position will be responsible for researching and developing DRG studies and analyses, as well as monitoring DRG base rates, developing reconciliation processes and providing information to providers and stakeholders.

Background. There are three main "types" of hospitals: private hospitals, Designated Public Hospitals (DPH), and Non-designated Public Hospitals (NDPH). These three types of hospitals are currently reimbursed for inpatient care using either 1) rates negotiated by the Selective Provider Contracting Program (SPCP), or 2) a cost based reimbursement methodology. DPHs are reimbursed based on certified public expenditures (CPEs).

The reimbursement methodology for private and NDPH hospitals will be changing in the near future. Per AB 1467 (a 2012 budget trailer bill), starting July 1, 2012, and subject to federal approval, NDPHs will be reimbursed based on CPEs, as discussed in more detail in the next item of the agenda. Starting July 1, 2013, private hospitals will be reimbursed using a new DRG methodology. SB 853 (Statutes of 2010) directed DHCS to move to a DRG payment method.

The DRG payment system, which will replace the current payment system for private hospitals, operates on a reimbursement related to the recipient's assigned diagnosis or diagnoses. Diagnoses and procedures must be documented in the patient's medical record. They are then coded in the claim using International Classification of Diseases (ICD-9-CM / ICD-10-CM) nomenclature. The coding process is extremely important since it essentially determines what DRG and reimbursement will be assigned for a patient. Each DRG category is designed to be "clinically coherent", and all patients assigned to a specific DRG are deemed to have a similar clinical condition requiring similar interventions. The payment system is based on paying the average cost for treating patients in the same DRG.

The DRG payment system is intended to help ensure and improve access by providing higher DRG-based payments for sicker patients and by setting payments based on acuity, to improve transparency and fairness compared to the contract-based system (which has confidential negotiated rates), to reward hospitals that reduce costs and complete coding of diagnoses and procedures, and to allow for future implementation of quality factors in payments.

California's DRG model is the All Patient Refined model and was developed by 3M and the National Association of Children's Hospitals and is intended to be suitable for all-patient populations, especially obstetrics, newborns, NICU babies, general pediatrics, and children with complex medical needs.

DHCS has indicated that it has submitted its state plan amendment to CMS to implement this change.

Transition Period. With the implementation of DRGs, DHCS proposes a three-year transition period. Medicare had a similar transition period when it moved to DRGs. The transition period is intended to limit an individual hospital's change in payment from baseline to a plus or minus of 5 percent in year one, 10 percent in year two, and 15 percent in year three. With full implementation of the DRG payment method occurring in year four. DHCS contends that this will provide hospitals with time to make adjustments as needed.

Stakeholder Concerns with DRG Implementation. Concerns have been raised by the hospital industry that the state is not ready to implement the DRG payment methodology. Specifically, for example, hospitals are concerned that the dataset (from 2009) being used to establish the baseline rate is outdated and flawed, that more time is needed to system test these changes with pilot hospitals, and a lack of transparency on how certain policy and casemix adjustor factors were determined.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a status update on DRG implementation.

2. Has testing with pilot hospitals begun? What has been the experience?

3. Please comment on the concerns raised by the hospital industry specifically addressing data validity and a lack of transparency on policy decisions and adjustment factors.

10. Non-Designated Public Hospital Program – Position Request

Budget Issue. DHCS requests permanent expenditure authority and the conversion of six limited-term 1115 Bridge to Reform Waiver positions to permanent to implement and maintain the new Non-Designated Public Hospital (NDPH) program, implemented as part of the 2012 budget. The six positions requested are existing limited-term positions that were originally approved to work on the 1115 Bridge to Reform Waiver. The cost of these positions is $827,000 ($414,000 General Fund and $413,000 federal funds).

The six positions include the following:

- **Four Health Program Specialist I positions** – Responsible for all the administrative functions of implementing the payment mechanism for these facilities. Their duties would include development of waiver language and implementation of waiver provisions, development of Medi-Cal State Plan amendments and development and implementation of the cost reporting mechanisms for the CPEs.
- **One Medical Consultant II position** – Utilize medical training and knowledge to develop and assess the policies performance measures applicable for the 46 NPDHs participating in the NDPH-Delivery System Reform Incentive Pool program.
- **One Auditor III position** (4 total auditor positions are needed, three are being redirected internally) – Responsible for auditing the cost-reporting information.

Background. AB 1467 (a 2012 budget trailer bill) requires DHCS to change the reimbursement process for the 46 NDPHs to a Certified Public Expenditure (CPE) methodology. Under the CPE methodology, the NDPHs certify the cost of providing inpatient services to FFS Medi-Cal beneficiaries and receive as reimbursement the federal share of those expenditures. This is the same inpatient FFS reimbursement methodology under which the Designated Public Hospitals (DPHs) are reimbursed.

This change in the NDPH reimbursement methodology results in a net loss of funding for the NDPHs, therefore, AB 1467 also requires DHCS to seek approval of an amendment to the 1115 Bridge to Reform Waiver from CMS to increase Safety Net Care Pool Uncompensated Care (SNCP) and Delivery System Reform Incentive Pool (DSRIP) funding. The additional funds will 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.

Prior to AB 1467, NDPHs received either 1) the California Medical Assistance Commission (CMAC) negotiated per diem rates, if they were a contract facility or 2) cost-based reimbursement, if they were a non-contract facility, for hospital inpatient costs for services rendered to Medi-Cal fee-for-services (FFS) beneficiaries. In addition, qualified NDPHs received supplemental reimbursement under the Non-Designated Public Hospital Supplemental Fund. The reimbursement for both their FFS rates and the NDPH supplemental fund was paid with 50 percent federal financial participation (FFP) and 50 percent General Fund. Additionally, NDPHs received other supplemental payments under the Non-Designated

Public Hospital Intergovernmental Transfer Program established in 2011 by AB 113 (Monning, Chapter 20, Statutes of 2011).

DHCS indicates that the increased workload associated with implementing AB1467 requires 1) conversion of six limited-term positions to permanent. Four of these staff will be redirected to NDPH work in the Safety Net Financing Division (SNFD), one position will be redirected to NDPH work in the Director's Office, and one position will be redirected to NDPH work in the Audits and Investigations Division (A&I). A&I needs four positions for NDPH work, but three of these positions are already being redirected internally.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide an overview of this proposal.

2. Has this proposal been approved by CMS?

11. Hospital Quality Assurance Fee Extension

Budget Issue. The Governor's January budget includes $620 million in General Fund savings in 2013-14 as a result of the Hospital Quality Assurance Fee (QAF). This includes $310 million as a result of the existing fee, which sunsets on December 31, 2013, and $310 million as a result of the proposed extension of this fee.

One of the components of the Administration's proposed $1 billion budget reserve is $310 million from extending hospital QAF.

The budget projects that $3.1 billion in hospital QAF revenue will be generated in 2013-14.

As with past extensions of this fee, it is proposed that the budget score the savings resulting from this fee and that this fee be extended in a policy bill. SB 239 (Hernandez and Steinberg) has been introduced for this purpose.

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 extensions. 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).

The table below summarizes the supplemental payments to hospitals, funding for children's health care coverage, and state administrative costs under SB 335. The figures for 2013-14 represent only six months of information, as the hospital QAF under SB 335 expires on December 31, 2013.

Table: Summary of Hospital Quality Assurance Fee, as authorized under SB 335 (Hernandez, Statues of 2011)

Year	Private	NDPH (2)	DPH (3)	Children Health Care Coverage	Admin. Cost	Total
2011-12						
Inpatient FFS	$2,236,944,675					$2,236,944,675
Outpatient FFS	$634,335,739					$634,335,739
Managed Care	$1,366,566,780		$80,000,000			$1,446,566,780
Grants		$18,600,000	$50,000,000	$340,000,000	$1,000,000	$409,600,000
LIHP OON ER (1)	$172,800,000					$172,800,000
Subtotal	**$4,410,647,194**	**$18,600,000**	**$130,000,000**	**$340,000,000**	**$1,000,000**	**$4,900,247,194**
2012-13						
Inpatient FFS	$2,457,121,764					$2,457,121,764
Outpatient FFS	$723,777,454					$723,777,454
Managed Care	$1,237,253,340		$80,000,000			$1,317,253,340
Grants		$18,600,000	$43,000,000	$537,000,000	$1,000,000	$599,600,000
LIHP OON ER (1)	$172,800,000					$172,800,000
Subtotal	**$4,590,952,558**	**$18,600,000**	**$123,000,000**	**$537,000,000**	**$1,000,000**	**$5,270,552,558**
2013-14 (six months)						
Inpatient FFS	$1,395,593,507					$1,395,593,507
Outpatient FFS	$381,615,414					$381,615,414
Managed Care	$651,550,502					$651,550,502
Grants		$9,300,000	$0	$310,000,000	$500,000	$319,800,000
LIHP OON ER (1)	$86,400,000					$86,400,000
Subtotal	**$2,515,159,423**	**$9,300,000**	**$0**	**$310,000,000**	**$500,000**	**$2,834,959,423**
Total	**$11,516,759,175**	**$46,500,000**	**$253,000,000**	**$1,187,000,000**	**$2,500,000**	**$13,005,759,175**

Notes:

(1) LIHP OON ER: Low Income Health Program Out-Of-Network ER Supplemental Payments for Private Hospitals

(2) NDPH: Non-designated Public Hospital

(3) DPH: Designated Public Hospital

DPHs provide Intergovernmental Transfers to fund a portion of the LIHP OON ER Supplemental Payments for Private Hospitals

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide an overview of this proposal.

12. Oversight on Nursing Home Referrals to Community-Based Services

Oversight Issue. AB 1489 (a 2012 budget trailer bill) requires DHCS, in collaboration with the Department of Public Health, to provide the Legislature an analysis of the appropriate sections of the Minimum Data Set, Section Q and nursing facilities referrals made to designated local contact agencies (LCA) by April 1, 2013. Additionally, this analysis should also document the LCA's response to referrals from nursing facilities and the outcomes of those referrals.

The Legislature has not yet received this report.

Background. 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.

Subcommittee Staff Comment and Recommendation—Hold Open. The Legislature has not yet received this report. It is recommended to hold this item open.

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

1. Please provide an overview of this issue.

2. What is the status of the report? When will the Legislature receive this report?

3. How does the Administration ensure that nursing facilities make the appropriate referrals to local contact agencies?

4. Please describe other tools the department is developing to facilitate the referral of nursing home residents to community-based services.

13. Medi-Cal Adult Quality Care Improvement Project – Federal Grant

Budget Issue. DHCS has been awarded a federal grant of $2 million by the Centers for Medicare and Medicaid Services (CMS), for the period of December 2012 to December 2014, with funding made available under the Affordable Care Act (ACA).

For the DHCS project, titled *Medi-Cal Adult Quality Care Improvement (MAQCI): Diabetes Management, Maternal Health and Birth Outcomes, and Mental Health Medication Management,* DHCS requests six two-year, limited-term positions over the life of the grant, $530,000 expenditure authority in 2012-13, $937,000 in 2013-14, and $533,000 in 2014-15 to increase DHCS capacity for reporting on quality measures and performing associated quality improvement activities.

A current year request for increased federal fund expenditures of $530,000, as a result of this grant, was submitted to the Joint Legislative Budget Committee in March.

Background. DHCS will undertake coordinated activities to improve capacity for standardized collection and reporting of data on the quality of health care provided to approximately four million adults covered by Medi-Cal. These activities will focus on collection, analyzing and reporting on 16 of the 26 Initial CMS Core Adult Quality Measures that describe the quality of care in three major areas: (1) Diabetes management; (2) Maternal health and birth outcomes; and (3) Mental health medication management.

Each of these three areas is of critical importance to DHCS because they: (1) are linked to significant morbidity and mortality when care is suboptimal; (2) represent significant health care costs; and, (3) have available, evidence-based interventions to improve quality, outcomes, and population health.

The core MAQCI staff will be in the Office of the Medical Director (OMD), and include: (1) the Project Manager (Research Scientist Supervisor I), who will be responsible for the overall project including the deliverables, contracts, activities, and staff supervision; (2) the Project Assistant (Staff Services Analyst), who will assist the Project Manager and will have primary responsibilities to manage the contracts (Interagency Agreements), budget and compilation of reports due to CMS; and (3) four Research Scientists (levels II and III), who will work with programs to analyze the data and develop the quality measures and reporting methods. In addition to coordinating quality measure development within DHCS, the OMD will manage interagency agreements and contracts with external organizations that will: (1) contribute to the preparation of the quality measures; (2) provide technical support for staff development in the area of clinical quality; and, (3) provide assistance with the implementation of the identified QI projects.

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

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

1. Please provide an overview of this proposal.

2. Please describe how the department plans to incorporate this project with other quality measurement projects.

14. Every Woman Counts Program Fiscal Estimate Information

Budget Issue. The budget proposes $48.6 million (about $14 million General Fund) for the Every Woman Counts (EWC) program and projects that 313,548 will be served in 2013-14. This is an increase of $9.7 million and 11,788 compared to the current year.

Background. The EWC program 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.

The 2012 budget transferred EWC from the Department of Public Health (DPH) to DHCS as this program more closely aligned with the responsibilities of DHCS to provide direct health care services to individuals and, as federal health care reform is implemented, the transferring of these programs to DHCS could 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.

EWC Fiscal Information. The EWC budget documentation does not include previously included fiscal information, such as expenditures for various clinical service activities, that was provided when DPH completed the estimate. This information provided transparency as to how much EWC funding was allocated for office visits and consults, screening mammograms, diagnostic mammograms, case management, and other services.

Subcommittee Staff Comment and Recommendation. It is recommended to:

- **Hold open** the EWC funding proposal as updated information will be provided at May Revision.

- **Adopt placeholder trailer bill language** to require supplemental EWC fiscal information regarding clinical service activity expenditures be included in budget documents to ensure that the Legislature and stakeholders have the information necessary to make informed decisions.

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

1. Please provide an overview of the EWC program and budget.

15. AB 97 (Statutes of 2011) – Medi-Cal Provider Rate Reductions

Budget Issue. The January budget assumes implementation of the AB 97 Medi-Cal provider rate reductions and the resulting ongoing annual savings of about $855.4 million ($428 million General Fund).

However, since the January budget, certain provider associations have petitioned for a rehearing of the December 13, 2012 Ninth Circuit Court decision that vacated the preliminary injunction of these rate reductions. Consequently, most of these rate reductions are not in effect.

Background. As a result of the state's fiscal crisis, AB 97 (Chapter 3, Statutes of 2011) required the department to implement a 10 percent Medi-Cal provider payment reduction starting June 1, 2011. This 10 percent rate reduction applies to all providers with certain exemptions and variations, exempted providers include: distinct part adult subacute, distinct part pediatric subacute, hospital inpatient, hospital outpatient, crucial access hospitals, federal rural referral centers, federally qualified health centers/rural health clinics, services provided by the Breast and Cervical Cancer Treatment program, Family Planning, Access, Care, and Treatment programs, hospice services, payments funded by intergovernmental transfers and certified public expenditures, in-home supportive services, and pediatric day health centers. (Some of these exemptions are specified in AB 97 and others are a result of an access and utilization assessment.)

Other provider types have a varied implementation of the 10 percent rate reduction, for example, not all Intermediate Care Facility/Developmentally Disabled (ICF/DD) providers receive a 10 percent rate reduction, as a calculation based on cost data is performed each year to determine which ICF/DD facilities receive the reduction.

Additionally, AB 97 requires the 10 percent rate reduction for distinct part skilled nursing facilities to apply to the rates in effect in 2008-09 and freezes rates for rural swing beds to the 2008-09 level

Federal Approval and Access Monitoring. On October 27, 2011, the federal CMS approved California's State Plan Amendment (SPA) containing this proposal to reduce Medi-Cal provider reimbursement rates for various healthcare services. Prior to implementing the provider rate reductions, CMS required DHCS to (1) provide data and metrics that demonstrated that beneficiary access to these services (based on geographic location) would not be impacted and (2) develop and implement a healthcare access monitoring system (for ongoing evaluation).

Consequently, DHCS developed an access monitoring plan that contains 23 measures that will be reported annually, with a subset of four measures to be reported on a quarterly basis. The first annual report will be available in June 2013 and the last quarterly monitoring report was posted on October 2012. The 23 access measures were selected to provide a comprehensive

portrayal of healthcare access in the Medi-Cal program. See following table for listing of the 23 measures.

Table: Medi-Cal Access Monitoring Metrics

Beneficiary Measures
1. Percent Change in Medi-Cal Enrollment 2. Percent Change in Dental Enrollment
Provider Availability
3. Primary Care Practitioner Supply Ratios 4. Provider Participation Rates 5. Concentration of Medi-Cal Beneficiaries among Providers 6. Dental Provider Ratios 7. Pharmacy Participation Rates 8. Long Term Care (LTC) Provider Participation Rates 9. Ratio of Medi-Cal LTC Occupied Bed Days to State-wide LTC Occupied Bed Days 10. Medi-Cal LTC Bed Vacancy Rates 11. Medi-Cal Beneficiary with a Usual Source of Care 12. Medi-Cal Beneficiary and Provider Language Discordance
Service Use and Outcomes
13. Percent of Enrollees with at least one Physician Visit during the Past 12 Months 14. Mean Number of Physician Visits during the Past 12 Months 15. Percentage of Children with at least One Dental Visit During the Last 12 Months 16. Service Rates per 1,000 Member Months 17. Emergency Department Visits 18. Medi-Cal Beneficiary Perceived Timely Access to Care 19. Timely Prenatal Care 20. Preventable/Avoidable Hospitalization Rates 21. Rate of Low Birth Weight for Full Term Births 22. Percent Preterm Births 23. Help Line Calls Categorized by Reason for Call and Geographic Location

Court Injunctions. After CMS approval of the rate reductions, a U.S. District Court issued preliminary injunctions preventing DHCS from implementing most of the provider payment reductions. On December 13, 2012, a Ninth Circuit Court of Appeals panel reversed the district court's decisions and vacated the preliminary injunctions. On January 28, 2013, the California Medical Association, California Hospital Association, California Dental Association, California Pharmacists Association, National Association of Chain Drug Stores, California Association of Medical Product Suppliers, AIDS Healthcare Foundation, and American Medical Response

petitioned the court for a rehearing and; consequently, the state is currently prohibited from implementing the reductions.

Retroactive Savings. Federal approval of the AB 97 rate reductions was obtained in October 2011; however, since the state has been prevented from implementing most of these rate reductions due to court injunctions, there is a retroactive period of savings (generally from June 1, 2011 to present) in addition to the ongoing out-year savings achieved by these rate reductions.

The total amount of fee-for-service savings to be recouped is $998.6 million from the retroactive period. Retroactive savings to managed care cannot be applied.

Federal CMS regulations require that the state pay providers “using rates determined in accordance with the methods and standards specified in an approved State plan” (42 C.F.R. §447.253(i)) and since this reduction is specified in the approved State plan, the state is obligated to pay this rate or would have to use state funds to make up the difference.

See following table for a summary of the AB 97 savings.

Table: Summary of AB 97 Savings as Projected in January Budget

Provider Type	Retroactive Savings Period	Total Retroactive Savings	2013-14 Annual Savings
Nursing Facilities	6/1/11-6/30/12	$327,692	$338,080
ICF/DD	8/1/12-1/31/13	$423,847	$1,010,543
ICF/DD-Habilitative	8/1/12-1/31/13	$2,961,067	$7,059,827
ICF/DD-Nursing	8/1/12-1/31/13	$1,894,921	$4,517,903
Freestanding Pediatric Subacute	6/1/11-2/28/13	$5,549,351	$3,387,923
Distinct Part Nursing Facilities*	6/1/11-5/31/13	$72,160,485	$38,261,127
Phase 1 Providers	6/1/11-12/20/11	$31,322,606	$70,726,223
Physician (services for persons > 21 yrs.)*	6/1/11-5/31/13	$132,757,891	$72,831,847
Medical Transportation*	6/1/11-5/31/13	$29,365,407	$15,842,365
Medical Supplies & Durable Medical Equip.*	6/1/11-5/31/13	$37,549,012	$20,296,763
Dental*	6/1/11-5/31/13	$90,620,783	$45,310,391
Clinics*	6/1/11-5/31/13	$61,571,171	$33,335,772
Pharmacy*	6/1/11-5/31/13	$528,547,024	$271,942,284
Phase 3 Providers	6/1/11-8/31/12	$3,569,620	$3,087,640
Managed Care			$267,490,240
Total Savings		**$998,620,877**	**$855,438,928**
General Fund Savings		**$499,310,438**	**$427,719,464**

Notes:
(1) *Enjoined provider
(2) ICF/DD – Intermediate Care Facility/Developmentally Disabled

(3) The November 2012 Estimate assumed that the AB 97 injunction would be lifted in March 2013 and the reductions for fee-for-services providers will be implemented June 2013 and April 2013 for managed care providers. There is no recoupment for managed care.
(4) In April, DHCS withdrew the State Plan Amendment to implement payment reductions for Freestanding Pediatric Subacute facilities. The May 2013 Estimate will reflect this change.
(5) Phase I includes all subject providers, including the PDHC program, except for the enjoined providers and the Child Health and Disability Prevention (CHDP) program.
(6) Phase III includes the CHDP program providers.

Generally, DHCS has proposed to recoup the retroactive savings over a 24 month period. However, DHCS has indicated that it is willing to work with individual providers to develop a schedule to recoup the savings (as long as it falls within the federal CMS requirements regarding recoupments).

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as estimates will be revised to reflect when DHCS is able to implement these reductions and changes on how AB 97 is implemented (e.g., exempting Freestanding Pediatric Subacute facilities).

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

1. Please provide an overview of this issue.

2. What is the status of the rehearing of the December 13, 2012 Ninth Circuit Court decision?

3. Please explain how DHCS continually performs access monitoring to ensure that these provider rate reductions do not impact access to services.

4. How does DHCS assess the impact of these rate reductions on (1) particular geographic areas and (2) specialty services (e.g., pediatric dental surgery centers)?

Subcommittee Staff Handouts

ACA – Medi-Cal Enrollment Assistance and Outreach Grants Placeholder Trailer Bill Language (agenda item number 5 under 4260 Department of Health Care Services)

Medi-Cal Assister Language

Of the amount appropriated in the Medi-Cal General Fund and Federal Fund items, $14 million shall be used for Medi-Cal in-person enrollment assistance payments of $58 per approved Medi-Cal application and payment processing costs.

(a) Entities and persons that are eligible for this fee shall be those trained and eligible for in-person enrollment assistance payments by the California Health Benefits Exchange. The payments may be made by the State Department of Health Care Services or through the California Health Benefits Exchange in-person assistance payment system.

(b) The Department shall accept contributions by private foundations in the amount of at least $14 million for this purpose and shall immediately seek an equal amount of federal matching funds.

(c) Enrollment assistance payments shall be made only for Medi-Cal applicants newly eligible for coverage pursuant to the federal Patient Protection and Affordable Care Act or those who have not been enrolled in the Medi-Cal program during the previous 12 months prior to making the application.

(d) The commencement of enrollment assistance payments shall be consistent with those of the California Health Benefits Exchange.

(e) The department or the California Health Benefits Exchange shall provide monthly and cumulative payment updates and number of persons enrolled through in-person assistance payments on their website.

Medi-Cal CBO Grant Language

Of the amount appropriated in the Medi-Cal General Fund and Federal Funds items, $12.5 million shall be used for Medi-Cal outreach and enrollment grants to community-based organizations (CBOs).

(a) The grants shall be apportioned geographically according to the estimated number of persons who are eligible for Medi-Cal but not enrolled and who will be newly Medi-Cal eligible as of January 1, 2014. The department may determine the number of grants and the application process.

(b) The department shall give special consideration to outreach and enrollment proposals targeting the following populations:

a. persons with behavioral health needs;
b. homeless persons;
c. young men of color;

d. persons who are in county jail or state prison on state parole or county probation and post-release community supervision;
e. families of mixed-immigration status;
f. school-age children through their educational institutions; and
g. persons with limited English proficiency.

(c) The Department shall accept contributions by private foundations in the amount of at least $12.5 million for this purpose and shall immediately seek an equal amount of federal matching funds.

(d) The department shall begin the payment for the CBO grant outreach program by January 1, 2014.

(e) Grantees may not receive in-person assister payments for potential Medi-Cal enrollees assisted under the terms of this grant.

(f) Data shall be collected and made publicly available by the department that identifies outreach, enrollment, retention and utilization activities from CBO grantees using a web-based reporting system that would compile, by grantee, demographic and geographic information of population assisted with enrollment, outreach activity numbers by type of strategy, enrollment applications completed, successful enrollment in Medi-Cal and assistance with retention of coverage at annual renewal.

Michelle Baass 651-4103
Senate Budget & Fiscal Review

OUTCOMES: Senate Subcommittee #3 on Health & Human Services
Thursday, May 2 (Room 4203)

0530 California Health and Human Services Agency

1. Office of the Patient Advocate

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

2. Aging and Disability Resource Connection Program Continuation

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

3. CMS State Innovation Models Grant

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

4260 Department of Health Care Services

1. Adult Dental Services

- Held open.

2. Affordable Care Act (ACA) – MAGI Medi-Cal Verification Plan

- Held open.

3. ACA – "Mandatory" Medi-Cal Expansion – LAO Analysis

- Held open.

4. ACA – Medi-Cal Enhanced Federal Funding for Prevention Services & Adult Vaccines

- Held open.

5. ACA – Medi-Cal Enrollment Assistance and Outreach Grants

- Motion - Adopt placeholder trailer bill language to require DHCS to accept these contributions and seek matching federal funds for these purposes.
- Vote – 2-1 (Senator Emmerson voting no.)

6. Managed Care Organization Gross Premiums Tax

- Held open.

7. Managed Care Efficiencies

- Held open.

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

- Held open.

9. Diagnosis Related Groups Payment System – Update & Position Request

- Held open.

10. Non-Designated Public Hospital Program – Position Request

- Held open.

11. Hospital Quality Assurance Fee Extension

- Held open.

12. Oversight on Nursing Home Referrals to Community-Based Services

- Held open.

13. Medi-Cal Adult Quality Care Improvement Project – Federal Grant

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

14. Every Woman Counts Program Fiscal Estimate Information

- Motion:
  - **Hold open** the EWC funding proposal as updated information will be provided at May Revision.
  - **Adopt placeholder trailer bill language** to require supplemental EWC fiscal information regarding clinical service activity expenditures be included in budget documents to ensure that the Legislature and stakeholders have the information necessary to make informed decisions.
- Vote – 2-0 (Senator Emmerson absent.)

15. AB 97 (Statutes of 2011) – Medi-Cal Provider Rate Reductions

- Held open.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

May 9, 2013

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

Room 4203
(John L. Burton Hearing Room)

Agenda Part I: Human Services

Staff: Jennifer Troia

PLEASE NOTE:

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling 916-651-1505. Requests should be made one week in advance whenever possible. Thank you.

ISSUES RECOMMENDED FOR VOTE-ONLY

A. 4300 Department of Developmental Services (DDS)

1. Sonoma Developmental Center (SDC)

As discussed in the Subcommittee agenda for April 11, 2013, four out of 10 of SDC's Intermediate Care Facility (ICF) units were recently withdrawn from federal certification by DDS in response to a notice that the federal government was moving to decertify the larger group of ICF facilities at SDC. The federal government's concerns, and DDS's resulting actions, came on the heels of findings last year regarding multiple instances of abuse, neglect, and lapses in caregiving at SDC. One of the corrective actions included in the Governor's budget is a $2.4 million increase ($1.3 million GF) that would allow SDC to hire approximately 36 additional direct care staff. The addition of these staff members would correspondingly allow staff who serve as shift leads to focus on supervision, without being counted toward required ratios of direct care staff-to-clients.

Recommendation: Staff recommends that the Subcommittee take the following actions:

1) Approve the proposed resources and authority for 36 new positions on a two-year, time-limited basis, to be reevaluated consistent with the client census and an updated status regarding staff vacancies at the facility at the end of that period.

2) Staff also recommends that the Subcommittee direct the department to provide quarterly briefings to update legislative staff regarding implementation of corrective actions and the Program Improvement Plan for the facility, as well as its staffing (e.g., the use of overtime and the ratio of licensed-to-unlicensed staff, where relevant) and the collaboration between DDS and regional centers regarding required assessments of residents' needs. These briefings shall begin in July 2013.

2. Lanterman Developmental Center

As discussed in the Subcommittee agenda for April 11, 2013, the Lanterman Developmental Center (LDC) is in the process of transitioning its residents into community-based placements as part of a closure process. As part of the Governor's budget for the facility, the Administration assumes continuation of $8.2 million ($4.4 million GF) in enhanced funding for 88 staff positions that would otherwise have been eliminated as the number of facility residents declined, pursuant to the standard ratios of staff-to-residents. These positions were approved as enhanced staffing related to closure activities as part of the 2012-13 budget.

Recommendation: Staff recommends that the Subcommittee take the following actions:

1) Given the anticipated timeline for closure of the facility, approve enhanced funding for the 88 enhanced positions on an 18 month, limited-term basis. It is worth noting that some of these positions may cease to be needed prior to the expiration of that term and that some may require a longer duration. The more specific timing for the expiration of authority for these positions should be refined as part of the 2014-15 budget process.

2) Direct the department to provide quarterly briefings to Legislative staff on the meeting of milestones and timelines as previously outlined by the department. These briefings shall begin in July 2013 and may coincide with the briefings mentioned above related to the Sonoma DC.

3) Finally, adopt uncodified trailer bill language to reflect the department's anticipated timeframe for closure of the facility of the Fall of 2014 (no later than December 31, 2014).

B. 5180 Department of Social Services

1. Continuum of Care Reform (CCR) for Child Welfare Services

As described in the Subcommittee agenda for April 11, 2013, the 2012-13 budget included trailer bill language (in SB 1013, Chapter 35, Statutes of 2012) requiring the department to develop, in consultation with a stakeholder workgroup, recommended revisions to the current rate-setting system, services, and programs serving children and families in foster care settings, with a particular focus on foster family agencies and group homes. SB 1013 also requires the department to develop performance standards and outcome measures for providers of foster care. The department is authorized to temporarily make some changes through all-county letters and required to report on recommendations that necessitate statutory changes by October 1, 2014. The Governor's budget for 2013-14 proposes $249,000 ($166,000 GF) and authorization to make one limited-term position (otherwise scheduled to expire on June 30, 2013) permanent, as well as funding for two years of consultant services, to support the department's CCR work.

Recommendation: Staff recommends that the Subcommittee approve the requested resources and position and adopt placeholder trailer bill language to clarify some of the concrete reforms that should take effect in the shorter term, including:

1) Limitations on, and/or levels of review needed for, placements in group homes, particularly for children as young as six to twelve years old;

2) A requirement for the department to update the Legislature regarding the outcomes of the assessments and planning regarding transitions to family settings for children and youth who have been in group homes for longer than one year; and

3) Encouragement for the department to ensure that education, qualification and training requirements for direct care staff in group homes are consistent with the intended role of group homes as short-term placements focused on crisis intervention, and behavioral stabilization, with specific treatment goals.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

Outcomes of May 9, 2013 Hearing

Staff: Jennifer Troia

A. 4300 Department of Developmental Services (DDS)

1. Sonoma Developmental Center (SDC)

1) Approved (2-1, Emmerson no) the proposed resources and authority for 36 new positions on a two-year, time-limited basis, to be reevaluated consistent with the client census and an updated status regarding staff vacancies at the facility at the end of that period.

2) Directed (3-0) the department to provide quarterly briefings to update legislative staff regarding implementation of corrective actions and the Program Improvement Plan for the facility, as well as its staffing (e.g., the use of overtime and the ratio of licensed-to-unlicensed staff, where relevant) and the collaboration between DDS and regional centers regarding required assessments of residents' needs. These briefings shall begin in July 2013.

2. Lanterman Developmental Center

1) Given the anticipated timeline for closure of the facility, approved (2-1, Emmerson no) enhanced funding for the 88 requested positions on an 18 month, limited-term basis. Noted that some of these positions may cease to be needed prior to the expiration of that term and that some may require a longer duration. The more specific timing for the expiration of authority for these positions should be refined as part of the 2014-15 budget process.

2) Directed (3-0) the department to provide quarterly briefings to Legislative staff on the meeting of milestones and timelines as previously outlined by the department. These briefings shall begin in July 2013 and may coincide with the briefings mentioned above related to the Sonoma DC.

3) Finally, adopted (2-0, Emmerson abstained) uncodified trailer bill language to reflect the department's anticipated timeframe for closure of the facility of the Fall of 2014 (no later than December 31, 2014).

B. 5180 Department of Social Services

1. Continuum of Care Reform (CCR) for Child Welfare Services

1) Approved (2-1, Emmerson no) the requested resources and position.

2) Adopted (2-1, Emmerson no) placeholder trailer bill language to clarify some of the concrete reforms that should take effect in the shorter term, including:

a) Limitations on, and/or levels of review needed for, placements in group homes, particularly for children as young as six to twelve years old;

b) A requirement for the department to update the Legislature regarding the outcomes of the assessments and planning regarding transitions to family settings for children and youth who have been in group homes for longer than one year; and

c) Encouragement for the department to ensure that education, qualification and training requirements for direct care staff in group homes are consistent with the intended role of group homes as short-term placements focused on crisis intervention, and behavioral stabilization, with specific treatment goals.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

May 9, 2013

9:30 AM or
Upon Adjournment of Session
(whichever is later)

Room 4203, State Capitol
(John L. Burton Hearing Room)

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.

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VOTE ONLY

4140 Office of Statewide Health Planning and Development (OSHPD)

1. Healthcare Workforce Development – Spring Finance Letter

Budget Issue. OSHPD is requesting an extension of its three limited-term positions responsible for proactive Health Professional Shortage Area (HPSA), Medically Underserved Area (MUA), and Medically Underserved Population (MUP) designations; and the extension of its one limited-term position responsible for continuing the implementation of the healthcare reform work plan, through an increase in the California Health Data and Planning Fund (CHDPF) expenditure authority of $286,000 in 2013-14.

Background. OSHPD has traditionally processed HPSA, MUA, and MUP applications in a reactive fashion; community clinics or stakeholders submit their application to OSHPD and staff validates the information in the HPSA, MUA, and MUP applications and makes a recommendation to the federal government.

The 2011-12 budget authorized three positions to perform these designations on a proactive basis. The proactive process allows OSHPD to prepare the aforementioned applications by identifying which areas of the state meet the federal criteria for designation and preparing designation applications on behalf of communities. However, OSHPD was unable to fill these four positions until February 2012. The proposed one-year extension provides an opportunity to continue its effort to complete these proactive designations.

According to OSHPD, California's communities receive almost $1.5 billion in federal, state, and private funding for programs for which one of the pre-requisites for participation is a HPSA, MUA, or MUP designation. Increasing the number of these designations also increases the ability of clinics to take advantage of Rural Health Clinic and Federally Qualified Health Center status, thereby increasing federal funds to the state's clinics.

Additionally, the Affordable Care Act (ACA) includes provisions on health workforce. OSHPD's role is to understand the issues around California's health care infrastructure and workforce and developing programs and engaging in activities that expand and equitably distribute California's health workforce. OSHPD has been involved in guiding the implementation of health workforce provision of the ACA and developed a health care reform implementation work plan. One of the limited-term positions requested to be extended is responsible for continuing the implementation of the healthcare reform work plan.

Subcommittee Staff Comment and Recommendation—Approve.

2. Mental Health Workforce Education and Training – Spring Finance Letter

Budget Issue. OSHPD requests that $2.2 million in unexpended Mental Health Services Act (MHSA) (Proposition 63) Workforce and Education Training (WET) be reappropriated through 2017-18 for WET programs. OSHPD also requests budget bill language to allow for appropriations to be available through 2017-18.

The 2012-13 WET appropriation was $22.8 million, of which OSHPD has expended $20.6 million, leaving $2.2 million in yet unexpended funds which OSHPD is requesting to be reappropriated. According to OSHPD, there are a variety of program-specific reasons for the funds not being fully expended, including: 1) the Mental Health Loan Assumption Program (MHLAP) designates funding for every county, although some counties do not have professionals with qualifying educational loans in certain years; 2) sometimes students drop out of the stipend program; and, 3) OSHPD did not receive a sufficient number of applications to expend all of the Song-Brown funding.

Of the $2.2 million proposed to be reappropriated, $632,000 will be allocated to the MHLAP through 2017-18. OSHPD expects the applicant pool to increase as counties recruit providers to meet increased demand (in part associated with federal health care reform implementation). The remaining $1.5 million will be used to implement the second 5-year WET plan, and the priorities identified in that plan. (The 5-year WET plan was discussed in this subcommittee on March 14, 2013.)

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve the following budget bill language:

4140-001-3085--For support of Office of Statewide Health Planning and Development, for payment to Item 4140-001-0121, payable from the Mental Health Services Fund……11,471,000
Provisions:
1. Notwithstanding subdivision (a) of Section 1.80 or any other provision of law, the funds appropriated in this item for the purposes provided for in Welfare and Institutions Code sections 5820, 5821 and 5822, shall continue to be available for expenditure and encumbrance until June 30, 2018.

4140-101-3085--For local assistance, Office of Statewide Health Planning and Development, for payment to Item 4140-101-0001, payable from the Mental Health Services Fund..... 12,650,000
Provisions:
1. Notwithstanding subdivision (a) of Section 1.80 or any other provision of law, the funds appropriated in this item for the purposes of the workforce, education, and training (WET) programs established pursuant to Sections 5820, 5821, and 5822 of the Welfare and Institutions Code ~~for contracts with accredited physician assistant programs, as well as contracts with hospitals or other health care delivery systems located in California,~~ in support of the Mental Health Services Act ~~that meet the standards of the California Healthcare Workforce Policy Commission, established pursuant to Article 1 (commencing with Section 128200) of Chapter 4 of Part 3 of Division 107 of the Health and Safety Code,~~ shall continue to be available ~~for the 2014-15, 2015-16, and 2016-17 fiscal years~~ until June 30, 2018.

4150 Department of Managed Health Care (DMHC)

1. Consumer Assistance Program Federal Grant Reappropriation

Budget Issue. DMHC requests to reappropriate $1 million in federal authority from 2012-13 to 2013-14 for workload associated with the federal consumer assistance grant. The reappropriation amount reflects the amount of contractual, personnel services, and associated indirect costs necessary in 2013-14 to extend the four positions through June 30, 2014.

Background. On August 24, 2012, DMHC was awarded a second federal consumer assistance grant in the amount of $4.6 million in support of implementation of the Affordable Care Act (federal health care reform). These federal funds are being used to continue to enhance the current consumer assistance activities with a more focused approach on education and outreach to uninsured individuals and families and seniors and persons with disabilities.

Staff Recommendation—Approve.

ISSUES FOR DISCUSSION

4150 Department of Managed Health Care

1. Health Benefit Exchange

Budget Issue. DMHC requests three 18-month limited-term positions (July 1, 2013 through December 31, 2014) for the DMHC's Division of Licensing (DOL) and five 12-month limited-term positions (January 1, 2014 through December 31, 2014) for the DMHC's Help Center (HC) to address workload associated with enrolling consumers into licensed managed care plans and licensure/expansion of health plans participating in the California Health Benefit Exchange. Reimbursement authority of $622,000 for 2013-14 and $394,000 for 2014-15 is also requested, as these costs will be reimbursed by the Covered California.

The limited-term positions are as follows:

Division of Licensing

- 2.0 Attorneys
- 1.0 Associate Health Program Advisor

Help Center

- 3.0 Consumer Assistance Technicians
- 2.0 Staff Services Analysts

Background. The Affordable Care Act (ACA) (federal health care reform) requires states to establish a Health Benefit Exchanges to facilitate the purchasing of health coverage. In California, the Exchange is known as Covered California. Covered California is charged with creating a new insurance marketplace in which individuals and small businesses will be able to purchase competitively priced health plans using federal tax subsidies and credits beginning in 2014.

It is anticipated that six million Californians will enroll in managed care plans licensed by the DMHC beginning in 2014 via Covered California. An increase is expected in the number of enrollee inquiries, correspondence and complaints the DMHC will receive from this new population. Also, new and existing health care service plans will seek to enter the managed care marketplace as a Qualified Health Plan (QHP) which will precipitate new license applications and expansion of the scope of existing licenses. New entrants and expansion proposals will require DMHC to establish and maintain the legal framework for department approval of new types of plans and products, and to provide legal analysis relating to QHP certification standards. The Exchange coordination and QHP certification process will also require DMHC to initiate and maintain tracking of QHP regulatory filings, revisions to plan operations during the QHP contract term, and assist health plans in adhering to filing

guidelines specific to QHP regulatory filings and to serve as a primary liaison with Exchange plan management staff.

Covered California was awarded a two-year federal grant on January 17, 2013 to assist with continued development and implementation of the Exchange. Covered California will enter into an Interagency Agreement (IA) with DMHC to reimburse DMHC for its services performed related to Exchange activities. DMHC proposed to begin this work starting in January 1, 2013 to address the immediate workload; however, the IA with Covered California has not yet been finalized. DMHC anticipates that this agreement will be completed in time for these positions to start July 1, 2013.

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

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

1. Please provide an overview of this budget proposal.

2. Please provide an update on finalizing the agreement with Covered California to begin this work.

2. Implementation of the Affordable Care Act

Budget Issue. DMHC requests to convert 13.0 limited-term positions, set to expire June 30, 2013, to permanent and add one new permanent position; and $1,841,000 for 2013-14 and $1,932,000 for 2014-15 and ongoing to address permanent workload resulting from implementation of the federal Affordable Care Act (ACA).

The positions requested are:

Help Center

- 1.0 Attorney
- 1.0 Research Program Specialist I

Division of Licensing

- 4.0 Attorney III
- 2.0 Attorneys

Division of Financial Oversight

- 1.0 Corporation Examiner IV Supervisor
- 4.0 Corporation Examiners

Office of Technology and Innovation

- 1.0 Staff Programmer Analyst

Background. The DMHC is a health care consumer protection organization that helps California consumers resolve problems with their health plans and works to provide a stable and financially solvent managed care system. The DMHC ensures California's strong patient rights laws are followed and that all health plan members get the right care at the right time. The DMHC operates under a body of statutes collectively known as the Knox-Keene Health Care Service Plan Act of 1975 (KKA), as amended.

The ACA, federal health care reform, fundamentally alters the availability and structure of health insurance, brings coverage for the first time to millions of Californians and brings new coverage options for millions of enrollees who receive care through KKA-licensed health plans and contracted medical groups.

Because the ACA requires all Americans to obtain health care insurance, and based on the proportionate number of current health care plan members served by plans regulated by DMHC (versus the California Department of Insurance or other entities), DMHC estimates that approximately 6.16 million consumers (88 percent of the uninsured) will soon join health plans under DMHC jurisdiction.

Consequently, DMHC was approved for 13.0 two-year limited-term positions in the 2011-12 budget to address the resulting workload. However, DMHC indicates that its experience over

the last year has proven that this workload is not limited to two years, but is continuous and has permanently increased. This workload includes:

- **Help Center.** As mentioned previously, DMHC estimates that approximately six million consumers will soon join health plans under DMHC jurisdiction. These consumers will look to the Help Center for assistance in accessing care, learning about health care options, dealing with non-compliance issues affecting their care, responding to denials and delays in receiving care, and reporting a myriad of health care complaints for resolution. DMHC maintains that it is imperative that the Help Center maintain an infrastructure to proactively assess and effectively respond to consumer issues resulting from health care reform implementation.

- **Division of Licensing.** Provides legal analysis of health plan license filings attributable to the ACA. DMHC indicates that this workload is not "one-time" because the health care marketplace will continue to change after 2014 and license filings reflecting these changes will occur.

- **Division of Financial Oversight.** Addresses the medical loss ratio (MLR) workload associated with the rebate requirements of commercial plans. DMCH has the authority to impose and enforce an 85 percent MLR in the large group market and an 80 percent MLR in the small group and individual markets. If a health plan does not meet its specified MLR, DMH is require to ensure the plan provides appropriate rebates to consumers.

- **Office of Technology and Innovation.** Addresses the workload associated with new ACA reporting requirements and the expansion of information needed from health plans.

LAO Findings and Recommendation. The LAO recommends approval of all positions on a permanent-basis except the Division of Licensing positions. The LAO recommends approving these positions as two-year limited-term positions (instead of permanent positions) because it finds that the degree to which the licensing workload would be ongoing is still unclear at this time.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal. Subcommittee staff finds that the workload associated the changing health care market place under the ACA and with six million more Californians receiving health coverage through health plans under DMHC's jurisdiction is ongoing and permanent.

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

1. Please provide an overview of this budget proposal.

2. Please respond to the LAO's findings and recommendation.

3. Network Adequacy Assessments for Healthy Families Program Transition

Budget Issue. DMHC requests four limited-term positions, effective July 1, 2013 through December 31, 2014; and $546,000 for 2013-14 and $262,000 for 2014-15 to address the increased workload attributable to the network adequacy assessments required for each of the four phases of the Healthy Families Program (HFP) transition to Medi-Cal.

The limited-term positions requested are as follows:

Division of Licensing

- 1.0 Attorney III
- 1.0 Health Plan Specialist I
- 1.0 Associate Governmental Program Analyst

Office of Technology and Innovation

- 1.0 Staff Programmer Analyst

Background. AB 1494 (a 2012 budget trailer bill) provides for the transition of HFP subscribers to the Medi-Cal program, commencing January 1, 2013. The HFP transition to Medi-Cal will occur in four phases over an approximate one year period, as follows:

- Phase 1 (Phase 1 has been broken down into to three sub-phases beginning January 1, 2013, March 1, 2013, April 1, 2013, and May 1, 2013). Individuals enrolled in a HFP health plan that is also a Medi-Cal health plan.
- Phase 2 (April 1, 2013). Individuals enrolled in a HFP health plan that is a subcontractor of a Medi-Cal health plan.
- Phase 3 (August 1, 2013). Individuals enrolled in a HFP plan that is not a Medi-Cal health plan and does not contract or subcontract with one of the Medi-Cal managed care plans in the county.
- Phase 4 (September 1, 2013). Individuals residing in a county that is not currently a Medi-Cal managed care county.

The DMHC's role in the HFP transition to Medi-Cal consists of performing network adequacy assessments prior to each transition phase, as well as ongoing monitoring for one year after the completion of each transition phase.

As part of this transition, the DMHC received a one-time augmentation of $400,000 in 2012-13. Of that amount, $250,000 is used for consultant services and $150,000 to fund one attorney position. The current year workload includes network adequacy assessments to determine health plan's readiness to include HFP enrollees in their Medi-Cal managed care networks but does not include the costs for monitoring workload as each phase of the transition occurs.

In order to manage the new workload associated with the transition of the HFP to Medi-Cal, DMHC indicates that the Division of Licensing (DOL) will require four limited-term positions effective July 1, 2013 through December 31, 2014.

Quarterly monitoring will be specific to each transition phase will begin three months after the start of each transition phase. The duration of the monitoring will last for one year after the beginning of each phase. With Phase 4 scheduled to transition September 1, 2013, the last monitoring report to DHCS should be completed by December 30, 2014.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal as ongoing monitoring of this transition is critical.

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

1. Please provide an overview of this budget proposal.

2. Has DMHC begun the quarterly monitoring for Phase 1a?

4260 Department of Health Care Services

1. Transparency of Medi-Cal State Plan Amendments and Waiver Amendments

Oversight Issue. Proposed State Plan Amendments (SPAs) are important documents that explain to the federal government how the state plans to change the Medi-Cal program. Similarly, waiver amendments and waiver renewals are documents that explain to the federal government how the state plans to change (or renew) a Medi-Cal waiver.

Proposed SPAs, wavier amendments, and waiver renewals are not available on the DHCS website and in the past have not been routinely shared with the Legislature or the public.

Consequently, the affected stakeholders may not have an opportunity to assess the accuracy of the state's representations to the federal government about a proposed change.

Background. When California wants to make significant changes to its Medicaid program (Medi-Cal), it must take one of two steps: either (1) amend its State Medicaid Plan; or (2) receive an exemption or Medicaid waiver from portions of Title XIX of the Social Security Act by the U.S. Department of Health and Human Services (DHHS).

State Plan. The state's Medi-Cal program is governed by the requirements set forth in the state's Medicaid State Plan. The State Plan is a comprehensive written document created by California that describes the nature and scope of its Medicaid (Medi-Cal) program. It serves as a contractual agreement between California and the federal government. The State Plan contains all information necessary for the federal Centers for Medicare and Medicaid Services (CMS) to determine if the state can receive federal financial participation (i.e., federal funding). Changes to the State Plan are submitted as amendments. The SPAs must be approved by CMS.

Waivers. Waivers allow states to wave certain Medicaid requirements and to use federal Medicaid funds in ways that are not otherwise allowed under federal rules. The federal government has the discretion to approve or reject waiver proposals. California has multiple Medi-Cal waivers. Waiver amendments are proposals to change an existing approved waiver.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language. DHCS has indicated that it is in the process of posting this information and is looking at ways to improve its communication and transparency. Given the importance of these documents and the importance for stakeholders, including Legislative staff, to have a complete understanding of how DHCS proposes to implement changes to the Medi-Cal program, it is recommended to adopt placeholder trailer bill language to require DHCS to post on its website proposed SPAs, waiver amendments, and waiver renewals that it has submitted to the federal government. This would provide legislative staff and stakeholders with the opportunity to review and comment on the state's implementation of policy.

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

1. Please provide an overview of this item.

2. Please provide a brief overview of projects DHCS is undertaking to improve its transparency and communication with stakeholders.

2. Maximizing Federal Reimbursement for Parolees and State Hospital Patients

Oversight Issue. There are potential opportunities for the state to maximize federal Medicaid reimbursement. These include:

- **Parolee Mental Health Care – LAO Report.** The LAO recently released a report highlighting opportunities for the state to maximize federal reimbursements that could be available for parolee mental health treatment. Specifically, the LAO recommends that the California Department of Corrections and Rehabilitation (CDCR):

  1. Provide increased Medi-Cal application assistance for mentally ill parolees to ensure that all eligible parolees are enrolled.

  2. Develop a process, in collaboration with DHCS, to claim federal reimbursement for the costs assisting inmates with benefits applications.

  3. Develop a process, in collaboration with DHCS, to claim federal reimbursement for mental health treatment services provided to parolees.

  The LAO estimates that if these steps were taken, the state could achieve $6 million General Fund savings in 2013-14 and $28 million annually upon full implementation in 2014-15.

- **Parolee Substance Use Treatment – LAO Finding.** In the LAO's parolee mental health care report, it notes that it is possible that federal reimbursements could also be available for substance use treatment services provided to parolees. An analysis of whether the substance use treatment services offered to parolees are consistent with the services covered by Medi-Cal would be necessary.

- **Off-Site Inpatient Medical Services for State Hospital Patients.** Just as the state is able to claim federal Medicaid reimbursement for off-site inpatient medical services provided to prison inmates, the state could potentially claim federal Medicaid reimbursement for off-site inpatient medical services provided to eligible state hospital patients. The Department of State Hospitals spends about $10 million General Fund annually on off-site inpatient medical services of state hospital patients.

Subcommittee Staff Comment and Recommendation—Hold Open. These issues will be discussed in more detail in Subcommittee #5. Subcommittee staff recommends DHCS continue to work with CDCR and Subcommittee #5 staff on developing a plan to maximize federal Medicaid reimbursement for services provided to eligible parolees. Given Medi-Cal expansion to certain childless adults, under federal health care reform, it is likely that thousands of additional parolees could be eligible for Medi-Cal beginning in 2014 (with the federal match at 100 percent for the first three years).

The Subcommittee has requested the LAO to provide an overview of its report.

3. Medi-Cal Coverage of County Medical Parole and Compassionate Release

Budget Issue. DHCS requests one permanent position to implement SB 1462 (Leno, Statues of 2012) which provides Medi-Cal to eligible county inmates on medical parole and inmates granted compassionate release.

The annual cost for this position is $103,000 total funds ($51,000 reimbursement from counties, and $52,000 federal funds).

Background. SB 1462 authorizes under certain conditions the release of prisoners from a county correctional facility on medical probation and the granting of compassionate release. SB 1462 requires a county that chooses to implement these provisions to pay the non-federal share of a prisoner's Medi-Cal costs.

The bill also authorizes a county sheriff to request that a court grant medical probation or resentence certain individuals in lieu of jail time. If the medical condition of the probationer improves to the extent that the person no longer qualifies for medical probation, the probationer may be returned to the sheriff's custody. In addition, SB 1462 requires a county that chooses to implement these provisions to pay the non-federal share of a prisoner's Medi-Cal costs.

Implementation of SB 1462 will require DHCS to develop a process to allow counties who voluntarily participate in this program to receive federal funds for eligible Medi-Cal services, and to require counties to pay the non-federal share of the services provided.

Subcommittee Staff Comment and Recommendation—Hold Open. No concerns have been raised regarding the requested position. However, DHCS indicates that statutory changes are necessary to ensure the cost neutrality of SB 1462. Subcommittee staff recommends that DHCS work with the author's office to ensure that the proposed changes comply with the intent of SB 1462.

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

1. Please provide an overview of this budget proposal.

4. Medi-Cal Managed Care Expansion to Rural Counties

Budget Issue. The Governor's budget includes $2.7 million General Fund savings in 2013-14 and $3.6 million in 2012-13 as a result of the expansion of Medi-Cal managed care into 28 rural counties across the state.

The Governor's budget assumed this expansion would occur on June 1, 2013; however, this transition has been delayed until September 1, 2013.

Background. AB 1467 (a 2012 budget trailer bill) expands Medi-Cal managed care into 28 rural counties across the state (Medi-Cal currently operates under a fee-for-service model in these counties). About 396,000 Medi-Cal enrollees will be transitioned to managed care under this expansion.

DHCS is currently in the process of assessing plan readiness and finalizing plan contracts. General notices about this change will be sent to the impacted enrollees on June 1. More specific notification about health plans will be sent to enrollees on July 1.

See table below for specific information on Medi-Cal eligibles in the 28 counties and health plan information.

Table: Summary of Medi-Cal Eligibles and Plans in Rural Managed Care Expansion

County Model	County	Family & Children	Healthy Families	Medi-Cal-Only Seniors & Persons with Disabilities	Dual Eligible
County Organized Health System (COHS) Model Partnership Health Plan	Del Norte	4,602	487	1,375	1,368
	Humboldt	15,093	2,731	4,408	4,843
	Lake	9,754	1,370	2,626	2,901
	Lassen	2,906	208	641	747
	Modoc	1,144	106	273	383
	Shasta	22,830	3,244	6,509	7,453
	Siskiyou	6,001	581	1,597	2,047
	Trinity	1,492	202	462	590
Subtotal		**63,822**	**8,929**	**17,891**	**20,332**
COHS Model Anthem Blue Cross	San Benito	6,530	1,759	713	752
Total 9 COHS Counties		**70,352**	**10,688**	**18,604**	**21,084**
Regional Model (18 contiguous counties) Anthem Blue Cross & California Health and Wellness	Alpine	112	6	26	41
	Amador	2,842	375	460	715
	Butte	30,205	2,858	7,740	8,771
	Calaveras	4,314	580	781	979
	Colusa	2,909	1,606	307	629
	El Dorado	11,176	2,623	2,239	2,978
	Glenn	4,370	1,165	744	971
	Inyo	2,170	270	283	514
	Mariposa	1,747	150	300	487
	Mono	858	387	87	117
	Nevada	6,887	2,289	1,308	1,924
	Placer	17,892	5,062	3,895	5,280
	Plumas	1,781	222	409	638
	Sierra	260	27	69	127
	Sutter	14,599	3,148	2,324	3,528
	Tehama	10,510	1,239	2,027	2,727
	Tuolumne	4,740	861	1,104	1,479
	Yuba	12,588	1,740	2,679	2,665
Subtotal		**129,960**	**24,608**	**26,782**	**34,570**
Imperial Model Plans California Health and Wellness	Imperial	39,668	3,952	4,466	11,302
Total 19 Non-COHS Counties		**169,628**	**28,560**	**31,248**	**45,872**
TOTAL		**239,980**	**39,248**	**49,852**	**66,956**

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open as the May Revision will include updated fiscal estimates reflecting the delay of this managed care expansion.

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

1. Please provide an update on this issue.

4265 Department of Public Health

1. Suspension of Tuberculosis Control Mandate

Budget Issue. The Governor proposes to suspend the tuberculosis control (TB) mandate in 2013-14. There is no statewide cost estimate for this mandate; consequently, this proposal would not result in any budgetary savings in 2013-14. It is anticipated that the statewide cost estimate would be available sometime this year.

The Administration contends that the procedures required under the TB control mandate are best practices and locals would continue to follow these procedures even if they are not specifically reimbursed for them.

Background. TB is a contagious bacterial disease that is spread through airborne particles. DPH is the lead state agency for TB control and prevention activities. However, the primary responsibility for TB control resides with local health officers (LHOs). The LHOs have broad statutory responsibility to protect the public from the spread of TB.

The DPH provides about $6.7 million General Fund to LHOs for TB control through a formula that is based on the number of TB cases in each jurisdiction.

The Commission on State Mandates determined (on October 27, 2011) that the following TB control laws constitute state-reimbursable mandates:

- **For LHOs.** Reviewing treatment plans submitted by health facilities within 24 hours of receipt and notifying the medical officer of a state parole region when there are reasonable grounds to believe that a parolee with TB has ceased TB treatment.
- **For Local Detention Facilities.** Notifying and submitting a written treatment plan to LHOs when an inmate with TB is discharged and notifying the LHO and medical officer of the local detention facility when a person with TB is transferred to a facility in another jurisdiction.
- **For Counties and Cities with Designated LHOs.** Providing counsel to non-indigent TB patients, who are subject to a civil detention order, for purposes of representing the TB patients in court hearings reviewing civil detention orders.

LAO Findings and Recommendation. The LAO finds that the activities required by the TB control mandate likely reduce the spread of TB, as the LHOs have more experience with TB cases than a typical medical professional. Additionally, the LAO finds that since there is no statewide cost estimate for this mandate, it is difficult to evaluate the benefits of the mandated activities compared to the costs. (LAO thinks it is reasonable to assume the costs would be in the magnitude of a few million dollars.)

Consequently, the LAO recommends rejecting the Governor's proposal. Rejecting the Governor's proposal would have no fiscal effect in 2013-14, but would add an unknown

amount (for the 2013-14 costs) to the total reimbursement for prior-year costs that the state must provide in the future. The LAO also recommends that the Legislature consider modifying existing TB control funding to address the mandate costs and direct the Administration to work with local governments to examine how the funding stream could be repurposed to fund the mandated activities.

Subcommittee Staff Comment and Recommendation—Reject. Subcommittee staff concurs with the LAO that it is difficult to evaluate the benefits of the mandated activities compared to the costs since there are no statewide cost estimates. Consequently, staff recommends rejecting the proposal. As statewide cost information becomes available, the Legislature and Administration will have the information necessary to understand how this mandate could interact with existing state funding for TB control.

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

1. Please provide an overview of this proposal.

2. Drinking Water Program - US EPA Notice of Noncompliance

Oversight Issue. On April 19, 2013, DPH received a notice of noncompliance from the US Environmental Protection Agency (EPA) regarding its Safe Drinking Water State Revolving Fund (SDWSRF) program. US EPA's key findings of noncompliance are:

- **Noncompliance with Expeditious and Timely Use of Funds.** As of October 1, 2012, the SDWSRF had an unspent balance of $455 million in federal funds. This sum was the largest unliquidated obligation of any state in the nation. States are required to make timely loans or grants using all available drinking water funds to eligible water systems. EPA found that California has failed to meet this standard.

- **Noncompliance with Technical Capability to Operate the SDWSRF Program.** EPA found that DPH has inadequate personnel and resources to manage the SDWSRF program and that DPH has not provided EPA the required quarterly schedule of cash forecasts.

DPH must submit a corrective action plan within 60 days of receipt of the notice of noncompliance.

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 over 200 public water system projects and executed about $1.5 billion in funding agreements.

DPH Response to Notice of Noncompliance. DPH indicates that it has been working to address these concerns identified by EPA. Specifically, DPH notes that it has developed a SDWSRF cash flow model and revised the claims submittal process. Additionally, DPH proposes to overcommit SDWSRF funds next year, eliminate the $20 million cap for SDWSRF projects, and create a small water system unit (discussed in the next agenda item) to address the specific challenges facing small water systems.

DPH indicates that these actions, among others, would improve the pace at which funding for projects is committed and dispersed. It plans to double its dispersements in the current year and budget year, as compared to 2006-07 to 2008-09. DPH cites that since October 1, 2012, it has dispersed $80 million.

Concerns with Drinking Water Program. Over the past several years, the Legislature has focused oversight efforts on the provision of safe drinking water throughout the state, and in particular to small, disadvantaged communities mainly in rural areas. The Legislature, starting in 2008, has held numerous oversight hearings discussing groundwater and drinking water legislation, with a focus on providing clean drinking water, and looking at the root causes of water quality degradation. The conclusion of these hearings, as well as various reports, is that the majority of the water supply in California is safe and clean. However, where there are gaps

in some areas, the provision of water is a challenge, particularly in small, disadvantaged and rural communities.

As discussed at the April 11, 2013 Senate Budget Subcommittee #2 hearing, there are hints that the Administration is considering a shift that would place the Department of Public Health (DPH) drinking water programs under the Cal-EPA. This would allow for the combination of the two federally-funded infrastructure loan programs (drinking water and wastewater at the State Water Resources Control Board), and could bring efficiencies in the administration of water programs, particularly in rural areas.

Subcommittee Staff Comment—Oversight Item. This is an informational item. Subcommittee staff finds that DPH has taken steps and has plans for future activities to improve its ability to more quickly fund drinking water projects. However, there is more work to be done to address the benchmarks set by EPA. Subcommittee staff recommends that DPH keep the Subcommittee updated on its corrective action plan and communications with EPA.

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

1. Please provide an overview of this issue.

2. Please describe steps DPH has taken or proposes to take to address these issues of noncompliance.

3. One of the key areas of noncompliance identified by EPA was inadequate personnel and resources to manage the SDWSRF program. How does DPH plan to address this concern?

3. Small Water Systems Technical Assistance Positions

Budget Issue. DPH requests seven permanent positions and $2.7 million in contract funds to address small community water systems that are currently not in compliance with primary drinking water quality standards.

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 over 200 public water system projects and executed about $1.5 billion in funding agreements.

There are approximately 2,300 small community water systems in California (water systems that serve less than 1,000 service connections). Of these, approximately 181 are not in compliance with one or more health-based drinking water standards. In comparison, for the 677 large community water systems statewide, 35 are not in compliance with primary drinking water standards.

Approximately 57,000 individuals (<1 percent of the State's population) are served by small water systems that fail one or more health-based standards. Predominantly, these individuals are located in disadvantaged communities and/or are served by small water systems in rural areas. These water systems typically cannot charge rates sufficient for maintenance and operation, or to undertake infrastructure repairs and upgrades. At the same time, the standards for public water systems have grown increasingly complex and more stringent.

With this proposal, DPH would create a small water system support unit to provide a higher level of assistance to these small systems. In addition, DPH will increase funding for contracts with third party technical assistance providers that have specialized skills to assist small water systems in solving their drinking water problems.

There are 181 non-compliant small community water systems in the state. These systems are to be brought up to a level of technical, managerial, and financial capacity to enable them to sustain compliance into the future. DPH has established an implementation plan to achieve the program goal. The purpose of the implementation plan is to define the specific steps DPH will take to bring these targeted small systems into sustainable compliance with primary drinking water standards. It includes the use of DPH staff and coordination with county drinking water programs, technical assistance providers, and stakeholders to accomplish its goal. This comprehensive approach will address the specific violations and reduce the numbers of primary drinking water standard violations in California.

Small water systems have the most difficulties navigating the complex process for SDWSRF funding. They have limited access to the types of professionals that large water systems typically use to prepare applications and manage the process, such as engineers, environmental consultants, accountants (to provide audits and financial data), and

administrative staff. Consequently, it is more labor intensive for DPH to work with these systems and provide greater oversight and assistance.

Subcommittee Staff Comment and Recommendation—Approve. Small water systems face unique challenges and require additional state support and technical assistance; consequently, it is recommended to approve this proposal.

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

1. Please provide an overview of this proposal.

2. Please address how this proposal addresses concerns raised by the US EPA regarding the SDWSRF (previous agenda item).

4. Office of Health Equity Update

Oversight Issue. At the March 14, 2013 Subcommittee #3 hearing, this committee heard an update from DPH regarding the Office of Health Equity (OHE). Generally, DPH had not made significant progress on any major responsibilities including the appointment of a Deputy Director, the selection of the Advisory Committee, the development of the Interagency Agreement with the Department of Health Care Services (DHCS), and the finalization of the California Reducing Disparities (CRDP) Strategic Plan.

Background. The Governor's 2012 budget proposed the creation of a new Office of Health Equity (OHE) at DPH. The OHE would be created by consolidating the following entities:

- Office of Multicultural Health at DPH
- Office of Women's Health at the Department of Health Care Services (DHCS)
- Office of Multicultural Services at the Department of Mental Health (this department was eliminated in 2012)
- Health in All Policies Task Force at DPH
- Healthy Places Team at DPH

Concerns were raised by various stakeholders during last year's budget process finding that the Administration's 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. As a result, Legislative staff and stakeholders worked together to strengthen the administration's proposal. This modified proposal was approved by the Legislature and included in AB 1467 (a 2012 budget trailer bill).

Subcommittee Staff Comment—Oversight Item. It appears that DPH has made some progress regarding its OHE responsibilities. It has made a recommendation to the Governor's Office for a Deputy Director (this position is appointment by the Governor and confirmed by the Senate), sent acceptance letters to 25 individuals selected to be part of the Advisory Committee and is working on selecting the first meeting date, is meeting with key stakeholders this week regarding the CRDP Strategic Plan, and is sending the Interagency Agreement to DHCS for review this week.

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

1. Please provide an update on the OHE activities.

Michelle Baass 651-4103
Senate Budget & Fiscal Review

OUTCOMES: Senate Subcommittee #3 on Health & Human Services
Thursday, May 9 (Room 4203)
Agenda Part 2

VOTE ONLY

4140 Office of Statewide Health Planning and Development (OSHPD)

1. Healthcare Workforce Development – Spring Finance Letter

- Motion – Approve proposal.
- Vote – 3-0

2. Mental Health Workforce Education and Training – Spring Finance Letter

- Motion – Approve the following budget bill language:

4140-001-3085--For support of Office of Statewide Health Planning and Development, for payment to Item 4140-001-0121, payable from the Mental Health Services Fund……11,471,000
Provisions:
1. Notwithstanding subdivision (a) of Section 1.80 or any other provision of law, the funds appropriated in this item for the purposes provided for in Welfare and Institutions Code sections 5820, 5821 and 5822, shall continue to be available for expenditure and encumbrance until June 30, 2018.

4140-101-3085--For local assistance, Office of Statewide Health Planning and Development,
for payment to Item 4140-101-0001, payable from the Mental Health Services Fund..... 12,650,000
Provisions:
1. Notwithstanding subdivision (a) of Section 1.80 or any other provision of law, the funds appropriated in this item for the purposes of the workforce, education, and training (WET) programs established pursuant to Sections 5820, 5821, and 5822 of the Welfare and Institutions Code ~~for contracts with accredited physician assistant programs, as well as contracts with hospitals or other health care delivery systems located in California,~~ in support of the Mental Health Services Act ~~that meet the standards of the California Healthcare Workforce Policy Commission, established pursuant to Article 1 (commencing with Section 128200) of Chapter 4 of Part 3 of Division 107 of the Health and Safety Code,~~ shall continue to be available ~~for the 2014-15, 2015-16, and 2016-17 fiscal years~~ until June 30, 2018.

- Vote – 3-0

4150 Department of Managed Health Care (DMHC)

1. Consumer Assistance Program Federal Grant Reappropriation

- Motion – Approve proposal.
- Vote – 3-0

ISSUES FOR DISCUSSION

4150 Department of Managed Health Care

1. Health Benefit Exchange

- Motion – Approve proposal.
- Vote – 3-0

2. Implementation of the Affordable Care Act

- Motion – Approve proposal.
- Vote – 2-1 (Senator Emmerson voting no.)

3. Network Adequacy Assessments for Healthy Families Program Transition

- Motion – Approve proposal.
- Vote – 3-0

4260 Department of Health Care Services

1. Transparency of Medi-Cal State Plan Amendments and Waiver Amendments

- Motion – Adopt placeholder trailer bill language to require DHCS to post on its website proposed SPAs, waiver amendments, and waiver renewals that it has submitted to the federal government. This would provide legislative staff and stakeholders with the opportunity to review and comment on the state's implementation of policy.
- Vote – 3-0

2. Maximizing Federal Reimbursement for Parolees and State Hospital Patients

- Held open.

3. Medi-Cal Coverage of County Medical Parole and Compassionate Release

- Held open.

4. Medi-Cal Managed Care Expansion to Rural Counties

- Held open.

4265 Department of Public Health

1. Suspension of Tuberculosis Control Mandate

- Motion – Reject proposal.
- Vote – 3-0

2. Drinking Water Program - US EPA Notice of Noncompliance

- Oversight item.

3. Small Water Systems Technical Assistance Positions

- Motion – Approve proposal.
- Vote – 3-0

4. Office of Health Equity Update

- Oversight item.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

May 20, 2013

1:00 P.M. or Upon Adjournment of Session

Room 4203
(John L. Burton Hearing Room)

Staff: 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 916-651-1505. Requests should be made one week in advance whenever possible. Thank you.

ISSUES RECOMMENDED FOR VOTE-ONLY

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

1. Case Management, Information, and Payrolling System (CMIPS) II

(Issues 302, 308)

As discussed in greater detail in the agenda for the Subcommittee's hearing on April 25, 2013, CMIPS and the replacement system currently being rolled out, CMIPS II, are the automated, statewide systems that handle payroll functions for In-Home Supportive Services providers. The Administration requests a variety of changes to the OSI CMIPS II budget, with a net effect of a $1.6 million decrease (a decrease of $2.2 million, partially offset by an increase of $584,000 to support the 4.5 positions). The changes include:

- Shifts of funds between budget years to reflect delays that have occurred;
- Authority for 4.5 additional positions, including:
    - Three new, permanent positions;
    - Authority to convert one existing position to a permanent position; and
    - The redirection of half the time (0.5 of a position) for an existing full-time position assigned to the Child Welfare Services (CWS)-New System;
- Increases in prime vendor contract costs for software and licensing purchases, as well as the costs of systems changes associated with the Coordinated Care Initiative and Community First Choice Option;
- A decrease in the costs associated with interfaces;
- Decreases in costs for county staff and travel; and
- Increases in data center costs.

Additionally, the Administration requests a decrease of $23.9 million ($12.1 million GF and $11.8 million reimbursements) in the budget for DSS, to reflect the revised project schedule.

Recommendation: Approve the requested changes, with a technical adjustment to also reflect the corresponding decrease in funding associated with the repurposing of the half-time position from CWS-NS to CMIPS II.

2. Los Angeles Eligibility, Automated Determination, Evaluation and Reporting (LEADER) Replacement System (LRS)

(Issue 343)

The Administration requests a net increase to DSS's budget of $10.7 million (a decrease of $20.1 GF and $23.1 million Federal Trust Fund, offset by an increase of $53.8 million reimbursements) to reflect a full year of design, development, and implementation activities for the LRS project and enhanced federal financial participation and cost allocation relief that was available related to health care reform. The system being replaced, 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.

Recommendation: Approve the requested adjustments.

B. 4170 Department of Aging (CDA)

1. Health Insurance Counseling Program

(Issue 500)

The Administration requests that Item 4170-101-0890 be increased by $660,000 and that Item 4170-101-0001 be amended to reflect this change. The federal Centers for Medicare and Medicaid Services will award a one-time, $1 million grant to CDA to provide training for Health Insurance Counseling Program staff and one-on-one dual-eligibility health insurance counseling connected with the Cal MediConnect initiative. There is no requirement for the state to match the grant funds. The adjustments reflect the estimated 2013-14 grant expenditures. The remaining funding will be expended in 2014-15, and the Administration also proposes budget bill language to allow for this carryover.

Recommendation: Approve the requested expenditure authority and budget bill language.

C. 4300 Department of Developmental Services (DDS)

1. May Revision Caseload and Estimates Updates

The Administration requests the following technical adjustments in the May Revision:

- Workload Adjustments (Issues 507, 509, and 510): The Administration requests to increase Item 4300-003-0001 by $903,000 and reimbursements by $486,000, as well as to increase Item 4300-004-0001 by $43,000 and reimbursements by $20,000, to reflect adjustments in Level-of-Care and Non-Level-of-Care Staffing. These adjustments are due to refinements in caseload estimates based on more recent data.

- Workload Adjustments (Issues 512, 513, 514, and 518): The Administration requests to increase Item 4300-101-0001 by $7.7 million and reimbursements by $26.0 million to reflect adjustments in caseload, Intermediate Care Facility/Developmentally Disabled (ICF/DD) operational costs, and the delayed inclusion of developmental services in the 1915 (k) State Plan Amendment.

- Provider Payment Restoration Adjustment (Issues 516 and 517): The Administration requests to increase Item 4300-101-0001 by $294,000 and reimbursements by $183,000 to reflect adjustments for the operations and provider payments restoration previously included in January (and adopted by this Subcommittee on April 11, 2013).

- Annual Family Program Fee Adjustment (Issue 501): The Administration requests to increase Item 4300-101-0001 by $3.3 million and to decrease Item 4300-101-0172 by $3.3 million. This adjustment reflects a revised, lower estimate of fees to be collected. The underlying request was held open by this Subcommittee on April 11, 2013.

- Quality Assurance Fees (Issues 515): The Administration requests to increase Item 4300-101-0001 by $414,000 reimbursements to reflect updated day treatment and transportation costs for ICF/DD residents.

The caseload estimates included in the May Revision anticipate that the number of consumers with developmental disabilities in the community, who are served by regional centers, will increase from 256,224 in the 2012-13 fiscal year to 265,097 in 2013-14, while the number of consumers residing in state-operated facilities will be 1,209 by the end of 2013-14 (June 30, 2014).

Recommendation: Approve the requested technical adjustments, subject to additional conforming changes made by other Legislative actions.

2. Proposal to Reappropriate Previously Authorized Funds for Developmental Center Repairs

(Issue 505)

The Administration requests to add Item 4300-492 to provide for a one-year extension of the liquidation period for approximately $322,600 that was initially appropriated in Item 4300-003-0001 by the Budget Act of 2010. DDS is in the process of completing two special repair contracts at the Sonoma Developmental Center (one to replace a main sewer line and one to replace flooring); however, the projects will not be completed prior to June 30, 2013 (when the funds are otherwise scheduled to revert). Both projects are estimated to instead be completed in August 2013.

Recommendation: Adopt May Revision request to reappropriate this funding.

D. 5175 Department of Child Support Services

1. Enrollment Caseload Population Estimate

The Governor's May Revision includes a request to decrease the amount of the department's General Fund support by $276,000 and to offset the reduction with a $276,000 increase in Federal Trust Funds.

Background: As noted in the April 25, 2013 Subcommittee hearing, there are federal incentives tied to a list of performance measures that apply to the process of establishing parentage, the collection of child support, and the overall cost of collecting child support. Additional gains have been made by the state in nearly every category. Most notably, there have been significant increases on collections in current support and collections on arrears.

The additional gains made by the state have led to an increase in Federal Performance Basic Incentive funds. The table below represents the state's ranking as it compares to other states and territories.

Measure	2012 Rank	2011 Rank	2010 Rank
Paternity Establishment	7	2	2
Cases with Support Orders	14	20	25
Current Support Paid	28	37	41
Cases Payment on Arrears	22	25	31
Cost Effectiveness	49	49	50

Staff Comment: This request is budget neutral and will not impact the department's overall budget. The decrease in General Fund support stems from an increase an additional Federal Trust funds being made available.

Recommendation: Adopt May Revision request.

E. 5180 Department of Social Services

1. May Revision Caseload and Estimates Updates

The May Revision proposes a net decrease of $324.8 million (decreases of $123.6 million GF, $497,000 Child Support Collections Recovery Fund, and $212.6 million reimbursements, offset by an increase of $11.8 million Federal Trust Fund), due to the impact of caseload and workload changes since the Governor's Budget, as displayed in the following table:

Program	Item	Change from Governor's Budget
California Work Opportunity and Responsibility to Kids (CalWORKs)	5180-101-0001 5180-101-0890 5180-601-0995	-$96,069,000 $60,074,000 -$83,000
Supplemental Security Income/State Supplementary Payment (SSI/SSP)	5180-111-0001	-$30,404,000
In-Home Supportive Services (IHSS)	5180-111-0001 5180-611-0995	$24,374,000 -$237,259,000
Other Assistance Payments	5180-101-0001 5180-101-0890 5180-601-0995	-$8,065,000 $171,000 $14,000
County Administration and Automation Projects	5180-141-0001 5180-141-0890 5180-641-0995	-$13,270,000 -$26,495,000 $27,312,000
Community Care Licensing	5180-151-0001 5180-151-0890	-$1,102,000 -$45,000

Program	Item	Change from Governor's Budget
Realigned Programs		
Adoption Assistance Program	5180-101-0890	-$1,534,000
Foster Care	5180-101-0890 5180-101-8004 5180-141-0890	-$15,876,000 -$497,000 $437,000
Child Welfare Services (CWS)	5180-151-0001 5180-151-0890 5180-651-0995	$904,000 -$4,920,000 $76,000
Title IV-E Waiver	5180-153-0001 5180-153-0890	$15,000 $16,000
Adult Protective Services	5180-651-0995	-$2,615,000

The updated caseload estimates for the largest programs are summarized below:

Program	January estimate for 2012-13	January estimate for 2013-14	May estimate for 2012-13	May estimate for 2013-14
CalWORKs	563,505	572,133	561,912	558,750
SSI/SSP	1,291,022	1,308,026	1,287,136	1,298,697
IHSS	422,945	418,890	442,769	448,225

Additionally, the Administration requests the following technical adjustments (Issues 309, 403):

- An increase of $13.7 million GF to reflect fewer cases transferring from the state-only Kinship Guardianship Assistance Payment (Kin-GAP) program to the Federal Kinship Guardianship Assistance Payment program. The Governor's Budget included an estimated 45.5 percent (of total Kin-GAP caseload) would remain in state-only Kin-GAP. However, the May Revision estimates that 60.5 percent will instead remain in state-only Kin-GAP.

- An increase of $224.3 million ($95.6 million GF and $128.7 million reimbursements) to reflect decreased savings from the IHSS health care certification requirement. Updated caseload data indicates more applicants are securing certification than previously assumed.

- A net decrease of $15.7 million (a decrease of $43.2 million GF offset by an increase of $27.5 million reimbursements) is requested to reflect increased General Fund savings from the Community First Choice Option program. The increased savings is primarily attributable to a revised methodology based on updated information regarding the average monthly hours of recipients with higher needs.

Recommendation: Approve May Revision caseload estimate changes and the changes related to Kin-GAP, IHSS health care certification, and implementation of the Community First Choice Option, subject to additional conforming changes made by other Legislative actions.

2. In-Home Supportive Services (IHSS): Across-the-Board Reductions

(Issues 311, 313)

The Administration requests a decrease of $444.3 million ($176.4 million GF and $268.0 million reimbursements) to reflect the net savings associated with implementation of an eight-percent across-the-board reduction to IHSS recipient hours, pursuant to a recent settlement agreement in the *Oster* and *Dominguez* lawsuits (described further in the analysis of SB 67, a current-year budget trailer bill that recently passed out of the Senate). The eight-percent reduction would begin July 1, 2013, followed by a one-percent restoration after 12 months. The Administration also proposes $9.8 million ($3.5 million GF) for administration costs associated with the eight percent reduction. The savings described above already take these offsetting costs into account. SB 67 is awaiting action in the Assembly.

The Administration also proposes a corresponding increase of $461.6 million ($180.3 million GF and $281.3 million reimbursements) to remove savings associated with a previously enacted 20-percent across-the-board reduction that was triggered by lower than anticipated revenues. Under the settlement agreement that led to the recent passage of SB 67 by the Senate, that 20-percent reduction would be repealed.

Recommendation: Approve the requested technical adjustments to local assistance funding to conform to the policies recently passed by the Senate in SB 67. Hold open the requested funding for state operations costs associated with the changes.

3. Resource Family Approval Project

(Issue 401)

The Administration requests a decrease of $207,000 ($101,000 GF, $36,000 Federal Trust Fund, and $70,000 reimbursements) and two positions to withdraw the Governor's January Budget request for Resource Family Approval Project resources. The prior proposal assumed that $70,000 of the costs would be funded with 2011 Local Revenue Fund. However, the Administration subsequently determined that those funds would not be made available by the counties. As described in additional detail in the Subcommittee agenda for April 11, 2013, the project would consolidate three separate approval processes for foster parents, adoptive parents, and relative caregivers into a single comprehensive approval process**.** The May Revision proposes corresponding trailer bill language to suspend the project. The Legislative Analyst's Office (LAO) recommends rejecting the May Revision proposal to suspend the project, and instead directing the department to consider opportunities to replace the $70,000 budgeted in January from county reimbursements, either by redirecting existing resources or proposing alternative funding sources.

Recommendation: Reject May Revision request and instead approve the necessary funding (anticipated to be approximately $171,000 GF and $36,000 Federal Trust Fund), along with two positions, for the project to move forward. Correspondingly, require the department to update the Subcommittee on its progress in implementing the project during 2014-15 budget hearings.

4. Budget Bill Language: Community Care Licensing Title XX Funding

(Issue 402)

The Administration requests to add provisional language to Item 5180-001-0279 that authorizes up to $2.1 million Child Health and Safety Fund (CHSF) for the Community Care Licensing (CCL) program to backfill a reduction in the Social Services Block Grant (Title XX) related to federal sequestration. Sufficient reserves are available in the CHSF to backfill the reduction in 2013-14.

Recommendation: Approve the request provisional language.

5. Temporary Assistance for Needy Families (TANF) Transfer to California Student Aid Commission

(Issue 314)

The Administration requests a decrease of $18.7 million GF in the proposed amount of TANF block grant expenditures swapped with General Fund expenditures between the Cal Grant and CalWORKs programs. A corresponding increase of $18.7 million GF is proposed in the California Student Aid Commission budget (see Item 7980-101-0001, Issue 018). The remaining amount of the total transfer of TANF funding to CSAC (and corresponding General Fund resources to support CalWORKs) would be $924 million.

Recommendation: Hold this item open. It is worth noting that the Administration's May Revision proposal is inconsistent with the prior action of the Subcommittee, on April 25, 2013, to approve the portion of the proposed TANF transfer that is necessary to meet (but not exceed) the state's required MOE level of spending. At the time, the Administration indicated that the Subcommittee's action would be reflected in the May Revision. However, the Administration has subsequently indicated that maintaining the larger amount of the transfer is tied to its proposal to realign certain human services programs in connection with the financing of health care reform implementation.

6. Budget Bill Language: General Fund Loan Authority

(Issues 304, 345)

The Administration requests that Provision 1 of Item 5180-141-0001 be amended to increase existing General Fund loan authority by $13 million to manage cash flow issues related to increased reimbursement payments from counties in the event of timing delays in the receipt of reimbursements.

Additionally, the Administration requests that Provision 2 of Item 5180-151-0001 be amended to include reimbursement payments as an allowable use of existing General Fund loan authority within that provision. Provision 2 currently authorizes a loan of up to $50 million GF to cover the federal share of costs for programs when federal funds have not been received. This amendment would address cash flow problems for payments to private vendors and other departments by allowing the existing loan authority to cover delays in reimbursements from other state entities and counties as well.

Recommendation: Approve the requested budget bill language.

DISCUSSION ITEMS

A. 4300 Department of Developmental Services (DDS)

1. Sonoma Developmental Center

Summary: The May Revision reflects a $7.4 million GF increase in 2012-13, and a $15.7 million GF increase in 2013-14, to backfill federal funding lost due to the loss of federal certification for four residential units within the Sonoma Developmental Center (SDC) (Issue 511). The 2012-13 funding was also included in SB 68, a current-year budget bill that was passed by the Senate earlier this month. SB 68 is currently awaiting action in the Assembly.

The May Revision additionally requests $300,000 ($200,000 GF) in 2012-13, and $2.5 million ($1.7 million GF) in 2013-14, to fund a contract with an Independent Consultative Review Expert (ICRE), as required by the Program Improvement Plan the state entered into with the federal certification agency.

Finally, the May Revision includes proposed budget bill language intended to address costs that may be necessary to implement the action plan identified by the ICRE as a part of the state's Program Improvement Plan. The proposed language allows the Department of Finance to authorize expenditure of up to $10 million GF, and to notify the Legislature within 10 working days of such authorization. The department indicates that the, as yet unidentified, costs might include costs associated with implementing recommendations related to additional staffing or training.

Background: With approximately 500 total residents, SDC is authorized for around 1,500 state staff positions and has a 17 percent staff vacancy rate. The Governor's January budget proposed a $2.4 million increase ($1.3 million GF) to allow the facility to hire approximately 36 additional direct care staff. The addition of those staff members would correspondingly allow staff who serve as shift leads to focus on supervision, without being counted toward required ratios of direct care staff-to-clients. This Subcommittee previously approved that requested funding, but with authorization for the positions for a limited-term of two years.

As discussed in greater detail in the Subcommittee agenda for April 11, 2013, four out of 10 of SDC's Intermediate Care Facility (ICF) units, with approximately 111 consumers who reside in

them, were recently withdrawn from federal certification by DDS, in response to notice that the federal government was otherwise moving to decertify all of the ICF units at SDC. The federal government's concerns, and DDS's resulting withdrawal of these units from certification, came on the heels of findings last year regarding multiple instances of abuse, neglect, and lapses in caregiving at SDC. The Program Improvement Plan, referenced above, covers changes required for the remaining six ICF units to retain certification, as well.

LAO Recommendation: The LAO recommends that the Legislature approve funding for the ICRE contract, indicating that it is "critical to continue progress towards recertification" of the four units. The LAO also recommends that the Legislature deny the administration's provisional budget bill language because "…it is premature to assume any level of costs associated with implementation of the action plan to be developed by the ICRE. There is uncertainty regarding the level of additional staffing, training, overtime or patient safety costs that may result from the action plan. Furthermore, the costs to implement the action plan may be minor and absorbable. If DDS requires additional funding to implement the action plan, it can utilize the deficiency funding process or seek additional expenditure authority through a supplemental appropriations bill."

Staff Comment & Recommendation: Hold this item open.

Questions:

1. What are the major steps and the timelines associated with the Program Improvement Plan?

2. When does the department anticipate that all residential units within the facility will again be certified to receive federal financial participation?

3. What costs does the department anticipate might be included in the up to $10 million additional expenditure authority proposed in the May Revision? How was that figure arrived at?

2. Additional Trailer Bill Language Proposals

Summary: The 2012-13 budget included trailer bill language (in AB 1472, Chapter 25, Statutes of 2012) associated with a $200 million GF reduction that made a variety of policy changes. These changes included, among several other provisions, a series of policies intended to redesign services for individuals with challenging needs by significantly restricting the statutory criteria for admissions to developmental centers (DCs), limiting the use of locked mental health facilities and out-of-state placements, and strengthening 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). They also included a requirement for regional centers to conduct comprehensive assessments of the service needs of all individuals residing in DCs. Disability Rights California proposes the following clean-up to these provisions:

1. Clarification that existing restrictions on use of Institutions for Mental Disease (IMDs) should apply irrespective of the age of the individual with a developmental disability. This is recommended because a reference in last year's trailer bill to the lack of federal funding for the placements that were restricted may have unintentionally created distinctions between when children under the age of 18 or adults over the age of 65 can be placed in these institutions (because federal funding may actually be available in some instances when individuals of those ages are placed in these institutions) versus the more restrictive circumstances under which individuals between the ages of 18 and 65 can now be placed there;

2. Clarification that comprehensive assessments of the needs of DC residents that regional centers are required, under existing law, to conduct within a specified timeframe should specifically identify the community-based services and supports that would enable the individual to move to a community-based setting (including specification that those services and supports should be considered for development in Community Placement Plans, if they are not already available), along with a requirement for regional centers to submit those assessments to the court and other parties to specified hearings in response to the request of an adult who is seeking release from a DC;

3. Notification of clients' rights advocates when placements in IMDs are made, when the required assessments of DC residents' needs are being shared at Individual Program Plan team meetings in which the team will be identifying the least restrictive placement setting that can meet a consumer's needs, and when courts are holding specified hearings in response to the request of an adult who is seeking release from a DC, along with clarification that the clients' rights advocate may attend those hearings; and

4. A statement that these requirements shall be construed in a manner that "affords an adult requesting release all rights under Welfare and Institutions Code section 4502, including the right to treatment and habilitation services and supports in the least restrictive environment and the Americans with Disabilities Act of 1990 (P.L. 101-336), as amended in 2008 (P.L. 110-325), including the right to receive services in the most integrated setting appropriate."

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

Questions:

1. Please summarize the proposed changes to existing law.

3. Federal Sequestration

Summary: The May Revision requests a reduction of $3.4 million in the federal grant for Early Start services due to federal sequestration (Issue 506). The Administration proposes, however, to backfill $600,000 of this amount with General Fund resources in order to maintain the expenditures for direct services. The remaining $2.8 million decrease would be absorbed by reductions in administrative costs.

The May Revision also requests to increase Item 4300-101-0001 by $11.9 million, and decrease reimbursements by $11.9 million, to backfill the estimated loss of federal funding resulting from the Title XX Block Grant for Social Services and Elder Care, associated with sequestration (Issue 499).

Staff Comment & Recommendation: Staff recommends approving the requested resources to backfill the loss of federal funding associated with sequestration.

Questions:

1. Please briefly summarize the reductions associated with sequestration, their potential consequences, and the rationale for the proposed backfill of those resources with General Fund.

B. 5160 Department of Rehabilitation (DOR)

1. Client Assistance Program

(Issue 500)

The Administration requests that Item 5160-001-0890 be decreased by $909,000, and that Item 5160-001-0001 be amended, to reflect this change. This adjustment reflects the transfer of responsibilities for administering the federally-funded Client Assistance Program from DOR to Disability Rights California (DRC). The Administration indicates that designating DRC as the grant recipient will reduce program administrative costs by an estimated $198,000 annually, allowing additional funding to become available for direct services. The amount of the requested decrease represents nine months of the federal grant period beginning October 1, 2013. The total federal fiscal year 2013 grant award is $1.2 million.

Staff Comment & Recommendation: Approve the requested transfer of responsibilities, with a technical adjustment to make the changes to Program 10 - Vocational Rehabilitation Services (not Program 30 – Independent Living).

C. 5180 Department of Social Services (DSS)

California Work Opportunities and Responsibility to Kids (CalWORKs)

1. Early Engagement Redesign Proposal

(Issue 340)

Summary: The Administration requests an increase of $48.3 million GF to improve early engagement and barrier removal processes and supports within the CalWORKs program, and to expand subsidized employment opportunities for CalWORKs Welfare-to-Work participants. The increased funding is intended to allow counties to perform more robust appraisals in order to identify the services that can best benefit program participants, including family stabilization services, barrier removal, and employment services. Correspondingly, with respect to the subsidized employment component of the proposal, the Administration proposes trailer bill language to significantly expand the number of slots available to participants. Finally, the Administration proposes a one-time increase of $600,000 GF to support necessary automation changes associated with the proposal.

Context for the Proposal: As discussed in greater detail in the Subcommittee agenda for March 21, 2013, CalWORKs is the state's version of the federal Temporary Assistance for Needy Families program, which provides cash assistance and welfare-to-work services to eligible low-income families with children. In the last several years, CalWORKs has sustained very significant reductions, as well as programmatic restructuring. One of the largest policy changes was the implementation, beginning January 2013, of a new, prospective 24-month limit on adult eligibility for assistance under state work participation rules. Adults may continue to receive cash assistance and services for up to a total of 48 months, but only if they comply with federal work participation rules after the 24-month clock is exhausted (unless granted an extension). Federal rules are more restrictive than state rules and place a heavier emphasis on employment, as opposed to education, training, or barrier-removal activities (e.g., limited English proficiency, limited educational attainment, substance abuse, mental health, or domestic violence). At the same time, the state work participation rules that apply before the 24-month clock has expired were changed to be more flexible with respect to allowable welfare-to-work activities. That flexibility was intended to help CalWORKs families overcome barriers to employment and self-sufficiency.

The 2012-13 trailer bill that made these programmatic changes, SB 1041 (Chapter 47, Statutes of 2012), also included a requirement for DSS, in consultation with a workgroup including specified stakeholders, to identify best practices and other strategies to improve efforts to engage clients in welfare-to-work as early and effectively as possible, and to assist them in removing barriers to success so that the initial months during which adults are subject to welfare-to-work requirements are as meaningful an opportunity as possible. The statute also indicates that this may require evaluating and restructuring the basic program flow for clients. Given the urgency of needing these reforms to be in place as soon as, or only shortly after, the new 24-month time limit took effect on January 1, 2013, DSS was required to report to the Legislature by January 10, 2013, regarding the recommendations developed, including those that would be implemented through administrative changes and those that would require statutory changes. The May Revision proposals described above are the Administration's response to this unfinished conceptual component of the 2012-13 budget agreement related to changes in CalWORKs.

Additional Details Regarding the Proposal: The Administration's proposal includes the following three main issues:

1. **Robust Appraisal** ($9.4 million GF in 2013-14): The Governor proposes to make the up-front appraisal of clients' needs more comprehensive by introducing a new appraisal tool intended to more effectively identify barriers to employment. The goal is to allow caseworkers to connect participants with services and welfare-to-work activities that best align with their needs. The Administration plans to acquire an Online Work Readiness Assessment (OWRA) tool, which was developed by the federal government and is available to states free-of-charge. Under the Governor's proposal, customization of the tool and training regarding its use would be completed by January 1, 2014, at which point the tool would be rolled out in all 58 counties. The May Revision includes one-time automation costs of $600,000 GF, and one-time training costs of $2.2 million GF. Once the tool is rolled out, the May Revision assumes that county workers will spend one hour with new participants using the tool, at a cost of $6.6 million in 2013-14. The Administration does not, however, propose any statutory changes to incorporate a requirement to use this new tool into the state law underlying the existing flow of welfare-to-work processes.

2. **Family Stabilization** ($10.8 million in 2013-14): The May Revision proposes a new approach for assisting families that are experiencing acute crisis situations (e.g., homelessness or severe and immediate substance abuse, mental health challenges, or domestic violence). This approach would involve creating family "stabilization plans" and providing more intensive case management. The May Revision assumes that initially the number of participants requiring a stabilization plan will roughly equal the number of clients estimated to be accessing substance abuse, mental health, and domestic violence services currently, but also that this number will increase somewhat over time, as the new appraisal tool becomes more fully and effectively utilized. The May Revision would provide counties with an additional $10.8 million in the employment services component of the single allocation in 2013-14 to allow for additional caseworker contact and follow-up with these participants. Again, however, the Administration does not propose any statutory changes to incorporate these elements into the law governing the administration of CalWORKs.

3. **Enhanced Subsidized Employment** ($28.1 million in 2013-14): The Governor proposes to substantially increase the role of subsidized employment by building on the state's experience with recent federal American Recovery and Reinvestment Act (ARRA) funding. The proposal would establish a fixed number of subsidized employment positions that would be fully funded by the state, representing greater state support than is currently available under the state's subsidized employment program [originally established by Chapter 589, Statutes of 2007 (AB 98, Niello)]. The May Revision assumes that initially 250 enhanced subsidized employment positions would be available beginning in November 2013, eventually increasing to 8,250 positions in June 2014. The Administration does propose statutory changes to implement this component of its proposal.

LAO Recommendations: The LAO indicates that, "The Governor's proposal has merit and warrants serious consideration. The proposal constructively builds on the work of the early engagement workgroup and we believe that it could result in improved services for CalWORKs

recipients. However, the proposal also raises some concerns. In general, the proposal lacks needed detail on county implementation. Several important decisions about how the proposal would be implemented would be left either to the administration or to individual counties, and we think these decisions warrant legislative input. The proposal, in its current form, also does not adequately provide for data collection and reporting that would be valuable to the Legislature for oversight and policy making purposes. Finally, while the expansion of subsidized employment does have its policy merits, we believe it would be appropriate to approach the creation of fully state-funded subsidized positions more cautiously by limiting the expansion proposed by the Governor until there is more conclusive evidence on the long-term effectiveness of this welfare-to-work activity."

Staff Comment & Recommendation: Staff recommends holding this issue open and notes that while the Administration's proposal includes several very helpful concepts and ideas, additional details and associated statutory changes may be critical to ensuring that the intended reforms that were included as part of last year's budget agreement are fully realized.

Questions:

1. Please summarize the proposal and its main components.

2. How does the Administration intend to ensure meaningful, statewide changes to the program in the absence of changes to the statutorily governed welfare-to-work flow and other laws governing the CalWORKs program?

2. Semi-Annual Reporting in CalWORKs and CalFresh

Summary: The Administration proposes trailer bill language that it indicates would align CalWORKs and CalFresh reporting rules, as required in Chapter 501, Statutes of 2011 (AB 6), and allow Semi-Annual Reporting (SAR) to be implemented in a manner that is consistent with federal reporting rules.

Background: Counties are required to annually re-determine eligibility for CalWORKs and CalFresh benefits. Existing law additionally requires the county to re-determine recipient eligibility and grant amounts on a quarterly basis, and to determine the grant amount that a recipient is entitled to receive for each month of the quarterly reporting period. Recipients are also required to report to the county specified changes that could affect the amount of aid to which they are entitled. The statutes enacted in AB 6 require counties to change the regular reporting period to a semi-annual, rather than quarterly, period no later than October 1, 2013. AB 6 also required DSS, in conjunction with the Department of Community Services and Development, to implement, by January 1, 2013, a utility assistance initiative to give CalFresh beneficiaries a nominal Low-Income Home Energy Assistance Program (LIHEAP) service benefit out of the federal LIHEAP block grant.

AB 6 mandates a maximum amount of compatibility between CalWORKs and CalFresh so as to reduce administrative inefficiencies and to create ease-of-use for clients. The department

indicates that CalFresh requested waivers from Federal Nutrition Services (FNS) to implement SAR as prescribed in AB 6, but several of these waivers were denied. Therefore, in order to more closely align with federal requirements for periodic recipient reporting, annual re-certifications, and prospective budgeting, the department proposes statutory changes to address the following concerns:

1. Policies contained in AB 6, with respect to the averaging of income and prospective budgeting in order to determine the appropriate grant amounts, are inconsistent with FNS policies.

2. It was assumed, upon implementation of SAR, that the number of eligibility reports required in a 12-month period would decrease from four to two. However, FNS regulations only allow for one periodic report in a 12-month period, in addition to the annual recertification. The requirement that a second periodic report be submitted, in addition to the annual recertification, is not consistent with FNS' rules and would also result in duplicative reporting.

3. AB 6 requires households that receive the LIHEAP benefit to have a Standard Utility Allowance (SUA) used in the computation of their CalFresh benefit. However, FNS rules prohibit recipients from being eligible for both the SUA deduction and a deduction tied to homelessness. As a result of applying the SUA, instead of the homeless shelter deduction, a number of homeless recipients would receive less CalFresh benefits.

4. Further, for many CalFresh cases, a ten cent LIHEAP benefit will be the only cash benefit issued on their EBT card. Current EBT regulations require that when a cash account becomes inactive (no debit transaction for 135 days), a notice must be sent to the recipient that their cash benefits will be inaccessible after 180 days of inactivity. Due to the small amount of the benefit, the department anticipates that a large portion of LIHEAP recipients will not access the benefit, and the counties will be required to mail them notices. Because of the small amount of money involved, versus the high cost of processing and mailing the notices ($745,000 GF), DSS is proposing to modify the notice requirement for LIHEAP to instead be triggered when the EBT cash account is in an inactive status and the balance is one dollar ($1.00) or more.

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

Questions:

1. Please briefly summarize the rationale for the proposal and its ties to the department's budget.

Affordable Care Act Implementation

3. Realignment of Human Services Programs Associated with Health Reform

Summary: As will be discussed in greater detail in future agendas related to health issues, the May Revision proposes a state-based approach to the optional expansion of Medicaid to medically indigent adults, authorized under the Affordable Care Act (ACA). Counties currently receive about $1.5 billion annually in 1991 realignment funds for health care, primarily for services for indigent adults-some of the same individuals who will receive Medi-Cal (California's Medicaid program) services under the ACA. The Administration is proposing that over time, as the state assumes more responsibility for health care, counties will take on more financial responsibility for certain human services programs. The Administration estimates that $300 million in 2013-14, $900 million in 2014-15, and $1.3 billion in 2015-16 in 1991 realignment funding will shift from local health programs to local human services programs, including primarily CalWORKs and CalWORKs-related child care programs (Stages One, Two, and Three), and, if necessary, CalFresh administration costs. The Administration indicates that the actual amount shifted would, however, be based on each county's experience with implementing the optional expansion. The Administration has not yet provided detailed trailer bill language outlining the fiscal and/or programmatic changes being proposed.

The state currently spends approximately $2.3 billion on CalWORKs and CalWORKs-related child care programs. In addition to assuming higher costs through the Medi-Cal expansion, the Administration also proposes for the state to take on an expanded financial role in In-Home Supportive Services (IHSS) and California Children's Services (CCS), for which counties currently spend approximately $1 billion in 1991 realignment funds. The timing of these proposed changes is not yet clear.

Additional Details Regarding the Human Services Realignment Proposals: The Administration proposes for counties to assume greater financial responsibility for CalWORKs and CalWORKs-related child care programs. In the budget year, counties would assume a portion of CalWORKs and related child care costs in the form of a required maintenance of effort. Over time, counties would have flexibility to reinvest savings and any revenue growth in "self-sufficiency services". Eligibility, grant levels, and rates would continue to be set by the state. In the budget year, the counties would also reimburse the Department of Education (CDE) for costs associated with the CalWORKs child care programs administered by that department. In 2014-15, the state would begin to transition Stage Two and Three contracts with Alternative Payment Programs, which administer CalWORKs child care programs, from the CDE to the counties.

Technically, the Administration proposes to establish an account within 1991 realignment for CalWORKs, and a separate subaccount for CalWORKs child care. The Administration also recommends giving consideration to developing a statewide approach for allocating a portion of growth funds to support increases in the Earned Income Disregard and increases in the income eligibility exit point for cash aid, and a portion for reinvestment in such services as family stabilization, subsidized employment, and expanded child care. Counties could be provided flexibility to redirect savings resulting from caseload decline, as well as revenue

growth, to the single allocation for program support, or, on an annual one-time basis, to the CalWORKs Child Care subaccount. However, counties would not be allowed to spend less on child care than in the base year or to reduce the number of slots from the base year. Child care funds would have to be spent on child care services for current or former CalWORKs recipients who meet the income, age, and other eligibility requirements established by the state. Further, counties would be protected from "significant changes in caseload or revenues which have been caused by economic factors beyond county control." In the event that state policy changes, outside of county control, increase the cost of operating a program component, the state would provide funding to meet those costs. Again, however, the Administration has not yet provided specific trailer bill language proposals to effectuate these concepts.

LAO Recommendations: The LAO analysis identifies two primary concerns with this realignment proposal: 1) the new realignment proposal adds significant complexity to the already complicated issue of implementing the optional expansion of Medi-Cal, and 2) there are potentially increased county costs and state mandates, particularly given that forecasting future costs for caseload-driven programs is very difficult, and that ensuring that redirected funds would be sufficient to cover costs would also be difficult. The LAO recommends that the Legislature instead consider building upon an existing arrangement created under the 2011 realignment plan that uses county funding to offset state General Fund costs for CalWORKs grants. This approach would not fundamentally increase county financial responsibility for supporting CalWORKs or change the state's authority over, or programmatic responsibility for, CalWORKs. As a result, it would be a much simpler to implement, particularly in the near term.

Staff Comment & Recommendation: Staff recommends holding this issue open, and notes, consistent with the LAO's comments, that the underlying proposals are complex and that the Administration has not yet provided significant amounts of detail necessary in order to evaluate the proposals at this late date.

Questions:

1. Please summarize the proposal, including both the potential benefits and the risks to the state, counties, and the human services programs at issue.

2. Please characterize the feedback the Administration has received from stakeholders thus far with respect to these proposals.

3. When does the Administration intend to submit detailed trailer bill language related to these proposals?

4. Other Requests Related to Implementation of the Affordable Care Act

(Issues 341, 342, 380)

Summary: The Administration requests an increase of $76.8 million ($5.9 million GF and $71.0 million reimbursements) for enhanced call center functionality to support the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS)/ACA implementation and interface development, as well as implementation of interactions between the Statewide Automated Welfare System (SAWS) consortia and CalHEERS. The call center expansion would allow the current county infrastructure to interface with CalHEERS centralized customer service centers. Increased funding would also allow for modifications to the SAWS consortia system to allow for interfaces between CalHEERS and SAWS, as required by ACA guidelines. Additionally, the Administration requests an increase of $379,000 in reimbursements to support two new, limited-term positions (expiring June 30, 2015), and one existing position, to analyze social services program impacts associated with federal health care reform.

Staff Comment & Recommendation: Staff recommends approving the requested resources and positions.

Questions:

1. Please briefly summarize the requests.

In-Home Supportive Services (IHSS)

5. Coordinated Care Initiative – Statewide Authority

(Issue 385)

Summary: The Administration requests an increase of $518,000 ($259,000 GF and $259,000 reimbursements) to support the creation and implementation of the Statewide Authority, the entity required to assume IHSS provider collective bargaining responsibilities from counties that transition IHSS benefits to managed care plans under the Coordinated Care Initiative (CCI) demonstration project. This request includes four positions to implement and support the CCI's California IHSS Authority (Statewide Authority) and Statewide Advisory Committee.

Background: As discussed in greater detail during the Subcommittee hearings on April 4 and April 25, 2013, the Governor's budget (and May Revision) include continuation of the Coordinated Care Initiative (now called Cal MediConnect), which is intended to integrate medical, behavioral, long-term supports and services, and home- and community-based services through a single health plan for persons eligible for both Medicare and Medi-Cal (dual eligibles) in eight demonstration counties.

Related to CCI, a 2012-13 budget trailer bill (SB 1036, Chapter 45, Statutes of 2012) shifted collective bargaining responsibilities from local county public authorities or non-profit consortia in the demonstration counties to the new Statewide Authority, with specified members and an advisory committee. The Governor's January budget included a related budget change

proposal requesting $563,000 GF, and authority for permanent positions for the Department of Human Resources (CalHR), to implement the state's new collective bargaining responsibilities.

Finally, the Governor's January budget included a request for $884,000 ($442,000 GF), and seven limited-term positions at DSS (through 2014-15), to address workload associated with CCI. DSS stated that these positions would allow the department to certify agency providers, create an appeal process, establish a fee structure, review and approve contracts, oversee the counties' activities associated with CCI, and engage with stakeholders. This Subcommittee approved those requested resources and positions on April 25, 2013.

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

Questions:

1. Please briefly describe the requested positions and their responsibilities.

2. Could the previously authorized positions related to CCI also be relied upon to address the proposed workload associated with the Statewide Authority?

Child Welfare Services

6. Moratorium on Applications for Group Homes with Rate Classification Levels of One Through Nine

Summary: The Administration requests trailer bill language to extend through 2013-14 an existing moratorium, without exceptions, on applications and requests for rate changes for group homes with rate classification levels (RCL) of one through nine. The Administration indicates that the moratorium has been helpful in ensuring that the use of group homes is increasingly focused on meeting the higher-level needs of foster youth. While the underlying moratorium, which also applies to higher RCL facilities, is ongoing, the current disallowance of exceptions to the moratorium for RCL one through nine facilities would otherwise sunset on June 30, 2013.

Background: Beginning in 2010-11, the budget has included around $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 2013-14, the average group home grant per child, per month is $7,934. In response to this increased cost, as well as other significant policy concerns about the use of group home placements in California, and 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. The 2012-13 budget made this moratorium permanent, and additionally limited exceptions to higher-level group homes [licensed at a Rate Classification Level (RCL) of 10 or over, on a scale of one to 14] for an initial period of one year.

Staff Comment & Recommendation: Staff recommends approving the requested extension of the disallowance of exceptions to the moratorium for facilities with an RCL of one to nine. This action would also be consistent with the Subcommittee's actions on May 9, 2013 related to the Continuum of Care reform efforts (e.g., the adoption of limitations on the use of group homes and/or requirement for additional levels of review prior to group home placements, particularly for children as young as ages six to twelve).

Questions:

1. Please briefly summarize the proposal and identify how it is consistent with the Continuum of Care reform efforts previously discussed by the Subcommittee.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

May 20, 2013

Hearing Outcomes

Staff: Jennifer Troia

Note: All actions below were approved with a 2-0 vote (including Senators Monning and DeSaulnier). Senator Emmerson was absent.

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

1. Case Management, Information, and Payrolling System (CMIPS) II

(Issues 302, 308)

Approved the requested changes, with a technical adjustment to also reflect the corresponding decrease in funding associated with the repurposing of the half-time position from CWS-NS to CMIPS II.

2. Los Angeles Eligibility, Automated Determination, Evaluation and Reporting (LEADER) Replacement System (LRS)

(Issue 343)

Approved the requested adjustments.

B. 4170 Department of Aging (CDA)

1. Health Insurance Counseling Program

(Issue 500)

Approved the requested expenditure authority and budget bill language.

C. 4300 Department of Developmental Services (DDS)

1. May Revision Caseload and Estimates Updates

Approved the requested technical adjustments noted, subject to additional conforming changes made by other Legislative actions.

2. Proposal to Reappropriate Previously Authorized Funds for Developmental Center Repairs

(Issue 505)

Adopted May Revision request to reappropriate this funding.

3. Backfill of Specified Federal Funding Losses Due to Sequestration and Redistribution

(Issues 499, 506)

Approved the requested resources to backfill the loss of federal funding.

D. 5160 Department of Rehabilitation (DOR)

1. Client Assistance Program

(Issue 500)

Approved the requested transfer of responsibilities, with a technical adjustment to make the changes to Program 10 - Vocational Rehabilitation Services (not Program 30 – Independent Living).

E. 5175 Department of Child Support Services

1. Enrollment Caseload Population Estimate

Adopted May Revision request.

F. 5180 Department of Social Services

1. May Revision Caseload and Estimates Updates

Approve May Revision caseload estimate changes and the changes related to Kin-GAP, IHSS health care certification, and implementation of the Community First Choice Option, subject to additional conforming changes made by other Legislative actions.

2. In-Home Supportive Services (IHSS): Across-the-Board Reductions

(Issues 311, 313)

Approved the requested technical adjustments to local assistance funding to conform to the policies recently passed by the Senate in SB 67. Held open the requested funding for state operations costs associated with the changes.

3. Resource Family Approval Project

(Issue 401)

Rejected May Revision request and instead approved the necessary funding (anticipated to be approximately $171,000 GF and $36,000 Federal Trust Fund), along with two positions, for the project to move forward. Correspondingly, required the department to update the Subcommittee on its progress in implementing the project during 2014-15 budget hearings. Adopted only the technical aspects of the related trailer bill language (i.e., to update outdated references to the project's former status as a pilot).

4. Budget Bill Language: Community Care Licensing Title XX Funding

(Issue 402)

Approved the requested provisional language.

5. Budget Bill Language: General Fund Loan Authority

(Issues 304, 345)

Approved the requested budget bill language.

6. Requests (other than Realignment) Related to Implementation of the Affordable Care Act

(Issues 341, 342, 380)

Approved the requested resources and positions.

7. Moratorium on Applications for Group Homes with Rate Classification Levels of One through Nine

Approved the requested extension of the disallowance of exceptions to the moratorium for facilities with an RCL of one to nine.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

May 21, 2013

9:30 AM

Room 4203, State Capitol
(John L. Burton Hearing Room)

Agenda Part 1
(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

0530 Office of Systems Integration

1. CalHEERS Adjustment (DOF Issue 444)

Budget Issue. The May Revision requests an increase of $3.7 million in reimbursement authority to provide project management services for the design, development, implementation, and operation and maintenance for the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) project. The increase reflects changes in state/program partner personnel costs, negotiated service center costs, and expanded system costs for CalHEERS.

Subcommittee Staff Comment and Recommendation—Approve.

4140 Office of Statewide Health Planning and Development

1. Mental Health Reappropriation (DOF Issue 304 and 306)

Budget Issue. The May Revision requests a reappropriation of previously approved Mental Health Services Act Workforce, Education, and Training (WET) funds ($7.8 million). These funds are requested to be reappropriated through 2017-18; consistent with the Mental Health Services Act. Of these funds, $7.5 million will be used for purposes identified in the WET five-year plan that is in development and about $330,000 will be used for scholarship and loan repayment programs.

Subcommittee Staff Comment and Recommendation—Approve.

4150 Department of Managed Health Care (DMHC)

1. Medi-Cal Dental Managed Care Program Oversight

Budget Issue. DMHC requests to convert two limited-term positions to permanent to address the increased workload attributable to the expanded oversight of the Medi-Cal Dental Managed Care (DMC) plans and the transition of the Healthy Families Program (HFP) children to the Medi-Cal DMC program.

DMHC also requests $130,000 for consultant services to provide specialized dental expertise for the dental plan surveys. DMHC indicates that consultants provide specialized dental expertise beyond the scope of the health care service plan analyst classifications and will support DMHC in evaluating the specific elements related to dental care.

Total cost of this request is $378,000 (on an ongoing-basis) and would be funded by 50 percent Managed Care Fund and 50 percent federal funds (through reimbursement from the Department of Health Care Services seeking the federal match).

Subcommittee Staff Comment and Recommendation—Approve. This issue was heard on April 4, 2013. No issues have been raised.

3. Medi-Cal Managed Care Rural Expansion

Budget Issue. DMHC requests 3.5 positions and $510,000 for 2013-14 and $470,000 for 2014-15 and ongoing, to address workload attributable to the expansion of Medi-Cal managed care into 28 rural counties, as mandated by AB 1468 (a 2012 budget trailer bill).

This request also includes $130,000 for consultant services to perform annual medical surveys of health plans. DMHC indicates that consultants provide specialized medical expertise beyond the scope of the health care service plan analyst classifications and will support DMHC in evaluating the specific elements related to this managed care expansion.

The proposal will be funded by 50 percent Managed Care Fund and 50 percent reimbursement from the Department of Health Care Services (DHCS) seeking the federal match.

Subcommittee Staff Comment and Recommendation—Approve. This issue was heard on April 4, 2013. The Administration addressed Subcommittee staff concerns with a supplemental request, described in the next agenda item.

4. Medi-Cal Managed Care Rural Expansion Supplemental – May Revision (DOF Issue 501)

Budget Issue. DMHC requests a 0.8 two-year limited term position and $298,000 for 2013-14 and $290,000 for 2014-15 to address workload attributable to an additional three plans that are now part of the Medi-Cal managed care expansion into 28 rural counties. This request includes $195,000 for consultant services to perform annual medical surveys of the three additional plans.

The proposal will be funded by 50 percent Managed Care Fund and 50 percent reimbursement from the Department of Health Care Services seeking the federal match. The position requested would be assigned to the Help Center and assist with annual medical surveys of the

five plans for the first two years. The DMHC is asking for a 0.8 limited-term position to augment the previously requested permanent positions listed in the agenda item above.

Subcommittee Staff Comment and Recommendation—Approve. The Governor's January budget included a request to address workload based on providing consumer assistance and conducting annual medical surveys of two plans for the Medi-Cal Managed Care Rural Expansion (see previous agenda item).

Subsequently, DMHC learned that DHCS has contracted with an additional three plans, for a total of five plans. Accordingly, this limited-term supplemental proposal augments DMHC's previously submitted request to allow the DMHC to conduct five surveys annually during the first two years.

4260 Department of Health Care Services

1. Medi-Cal Estimate Update – Technical Adjustments (DOF Issue 200)

May 2013 Medi-Cal Estimate. It is requested that the technical 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 increased by $579,114,000 and reimbursements be decreased by $907,993,000
2. Item 4260-101-0236 be decreased by $30,000
3. Item 4260-101-0890 be increased by $4,353,324,000
4. Item 4260-101-3168 be increased by $1,419,000
5. Item 4260-101-3213 be increased by $436,646,000
6. Item 4260-104-0001 be increased by $3,531,000
7. Item 4260-105-0001 be decreased by $29,140,000
8. Item 4260-106-0890 be decreased by $8,202,000
9. Item 4260-107-0890 be decreased by $164,000
10. Item 4260-113-0001 be increased by $28,086,000
11. Item 4260-113-0890 be increased by $41,275,000
12. Item 4260-117-0001 be increased by $2,317,000
13. Item 4260-117-0890 be increased by $4,709,000

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. Continuation of 1115 Waiver Activities - Position Request

Budget Issue. DHCS requests to extend 18 limited-term positions through the end of the 1115 Waiver, which expires on October 31, 2015. DHCS also requests $1 million per year, for three years, in contract funds for actuary services and $10,000 for actuarial and auditing training.

The 2013-14 cost for this proposal is $3.165 million ($1.3 million General Fund, $1.7 million federal funds, and $107,000 reimbursement from counties).

Subcommittee Staff Comment and Recommendation—Approve. This issue was heard on April 4, 2013. No issues have been raised.

3. Continuation of LIHP & DSRIP Activities - Position Request

Budget Issue. DHCS requests the extension of 26 limited-term positions and contract funds to continue the workload associated with the Low Income Health Program (LIHP) and Delivery System Reform Incentive Pool (DSRIP) components of the 1115 Bridge to Reform Demonstration Medicaid Waiver.

The cost for this request is $2.7 million ($260,000 General Fund, $1.4 million federal funds, and $1.1 million in reimbursements from counties).

Subcommittee Staff Comment and Recommendation—Approve. This issue was heard on April 4, 2013.

4. Assisted Living Waiver – Position Request

Budget Issue. DHCS requests to extend two limited-term positions for three years to work on the Assisted Living Waiver (ALW) program. These positions are set to expire on June 30, 2013. The total cost of these positions is $235,000 ($117,000 General Fund and $118,000 federal funds).

Subcommittee Staff Comment and Recommendation—Approve. This issue was heard on April 4, 2013.

5. Security Oversight of MEDS – Position Request

Budget Issue. DHCS requests the authority to establish five permanent, and two limited-term, full-time positions for $822,000 ($371,000 General Fund and $451,000 federal funds) to provide Medi-Cal Eligibility Data System (MEDS) program and systems management oversight

of county California Department of Social Services (CDSS) program administrators, as well as quality control to ensure compliance with federal requirements.

The request is for seven new positions, four Associate Governmental Program Analysts (AGPA), one Staff Information Systems Analyst (SISA), one Systems Software Specialist, and one Staff Programmer Analyst.

Subcommittee Staff Comment and Recommendation—Approve. This issue was heard on April 4, 2013.

6. HIPPA – Position Request

Budget Issue. DHCS requests the establishment of three permanent and two limited-term positions (three-year) in the Office of Health Insurance Portability and Accountability Act of 1996 (HIPAA) Compliance (OHC).

The total cost for these positions is $682,000 ($235,000 General Fund and $447,000 federal funds).

Subcommittee Staff Comment and Recommendation—Approve. This issue was heard on April 4, 2013.

7. Public Assistance Reporting Information System (PARIS) Interstate – Position Request

Budget Issue. DHCS requests one full-time permanent Associate Governmental Program Analyst (AGPA) to operate the Public Assistance Reporting Information System (PARIS) Interstate program on a statewide basis.

This proposal does not seek new General Fund resources, as funding for the new staff will come from redirection of program savings of $102,000 ($51,000 General Fund and $51,000 federal funds) resulting from the implementation of PARIS Interstate.

Subcommittee Staff Comment and Recommendation—Approve. This issue was heard on April 4, 2013. Additionally, DHCS now anticipates implementing PARIS-Federal and PARIS-Interstate on a statewide-basis starting January 1, 2014.

8. Medi-Cal Electronic Health Records – Position Request

Budget Issue. DHCS' Office of Health Information Technology (OHIT) requests the extension of 11 limited-term positions for the administration of the Medi-Cal Electronic Health Record (EHR) Incentive Program.

Total cost for these positions is $1.3 million ($1.2 million federal funds and $93,000 reimbursement from outside entities, and [$38,000 General Fund]). DHCS is not requesting any additional General Fund in this proposal, as the $38,000 General Fund cost associated with these positions is covered by the General Fund support specified in AB 1467 (a 2012 budget trailer bill) for support costs associated with this program.

Subcommittee Staff Comment and Recommendation—Approve. This issue was heard on April 4, 2013.

9. 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 certain Medi-Cal managed care enrollees 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.

This proposal would only apply to those beneficiaries in the Family and Child aid code categories. It would not apply to Seniors and Persons with Disabilities (SPDs) and beneficiaries dually eligible for Medicare and Medi-Cal (duals). However, DHCS would have the option of adding additional Medi-Cal managed care populations in future years.

Subcommittee Staff Comment and Recommendation—Reject. This proposal was discussed at the May 2nd Subcommittee hearing. The Legislature has denied similar proposals in the last few years because it found that it is important to ensure that Medi-Cal enrollees have the ability to change health plans at any time, to ensure that his or her health needs are met. This is still the case and potentially even more important given that there are still ongoing managed care transitions (e.g., the Healthy Families Program transition to Medi-Cal and the rural managed care expansion).

Additionally, the proposed trailer bill language provides DHCS with substantial authority to determine if this policy should be implemented for seniors and persons with disabilities.

10. Diagnosis Related Groups Payment System – Position Request

Budget Issue. DHCS requests conversion of one limited-term position to permanent in order to meet the workload requirements for the Diagnostic Related Groups Payment Systems Program (DRG), which will be implemented on July 1, 2013. The total cost of this position is $121,000 ($61,000 General Fund).

This position will be responsible for researching and developing DRG studies and analyses, as well as monitoring DRG base rates, developing reconciliation processes and providing information to providers and stakeholders.

Subcommittee Staff Comment and Recommendation—Approve. This issue was heard on May 2, 2013.

11. Breast and Cervical Cancer Treatment Program Resources – Position Request (DOF Issue 006)

Budget Issue. The May Revision requests the extension of six full-time limited-term positions for the Breast and Cervical Cancer Treatment Program (BCCTP), until December 31, 2014. (These positions expire December 31, 2013.)

The total cost of these positions would be $369,000 ($185,000 General Fund and $184,000 federal funds).

Since the program's inception in 2002, BCCTP has received 45,744 applications; the active BCCTP caseload has continued to increase from 5,000 cases in the first year of operation to 14,500 active cases as of March 1, 2013. Of these active cases, there are 5,337 federal cases that are overdue for an annual redetermination and another 1,324 federal cases that are currently due for an annual redetermination, which amounts to almost 7,000 cases needing a redetermination.

According to DHCS, the ongoing workload associated with initial eligibility determinations, annual redeterminations, and the processing of requests by applicants for retroactive coverage makes it essential that these six positions be extended.

Subcommittee Staff Comment and Recommendation—Approve.

12. Federal Authority for Mental Health Services Technical Adjustment (DOF Issue 008 and 108)

Budget Issue. The May Revision requests a technical adjustment to align federal fund authority for mental health services grants with the actual amount of grant funding received from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). This is a technical adjustment.

Subcommittee Staff Comment and Recommendation—Approve.

13. Family Health Programs Adjustments (DOF Issue 211)

Budget Issue. The May Revision requests adjustments to the California Children's Services (CCS), Child Health and Disability Prevention Program (CHDP), and the Genetically Handicapped Person's Program (GHPP).

These changes reflected revised expenditure estimates based on caseload adjustments, the use of federal Safety Net Care Pool funding and medical rebate funding, to offset General

Fund, and other technical changes in program expenditures. (Approximately $65 million is still available for Designated State Health Programs in the Safety Net Care Pool.)

Caseload projections are estimated to be 20,062 for CCS (a 44.6 percent decrease over the revised current year forecast), 26,547 for CHDP (a 12.7 percent increase over the revised current year forecast), and 944 for GHPP (a 4.9 percent increase over the revised current year forecast).

Subcommittee Staff Comment and Recommendation—Approve.

14. Drug Medi-Cal Legal Representation – Position Request

Budget Issue. DHCS requests to make one limited-term staff counsel position permanent to provide ongoing legal services to the Drug Medi-Cal (DMC) Program.

The cost of this position is $182,000 ($73,000 General Fund and $109,000 federal funds).

Subcommittee Staff Comment and Recommendation—Approve. This issue was heard on April 18, 2013.

15. Long Term Care Quality Assurance Fund – Borrowable for Cash Flow

Budget Issue. The May Revision proposes trailer bill language to make the funds available in the Long Term Care Quality Assurance Fund borrowable for General Fund cash flow purposes.

The Administration notes that this is common practice and assists with General Fund cash flow management.

Subcommittee Staff Comment and Recommendation—Approve.

4265 Department of Public Health

1. Genetic Disease Screening Program (DOF Issue 504)

Budget Issue. The May Revision requests a technical adjustment to reflect a rate increase for contracted laboratories, offset by lower costs, to provide follow-up services in the Prenatal Screening Program.

Subcommittee Staff Comment and Recommendation—Approve.

2. Nursing Home Administrator's State License Examining Fund (DOF Issue 502)

Budget Issue. The May Revision proposes to abolish the Nursing Home Administrator's State License Examining Fund and shift expenditures to the Licensing and Certification Fund, as required by AB 1710 (Yamada, Statutes of 2012).

Background—AB 1710. AB 1710 eliminates the Nursing Home Administrator's State License Examining Fund and shifts expenditures to the Licensing and Certification Fund in order to integrate nursing home administrator fees into the L&C's fee and workload methodology.

Subcommittee Staff Comment and Recommendation—Approve.

4280 Managed Risk Medical Insurance Board

1. Caseload Updates (Technical Adjustments)

Budget Issue. The May Revision requests the following:

- **County Health Initiative Matching (CHIM) Caseload Update (DOF Issue 106)** – An increase of $45,000 in the CHIM fund and $88,000 in federal funds due to a slight increase in projected enrollment. This county funded program allows the use of matching federal dollars to provide health coverage for children between 250 percent and 400 percent of the federal poverty level (FPL) and who otherwise meet federal eligibility criteria.

- **Healthy Families Program Caseload Update (Issue 104)** – A net increase of $6.7 million General Fund (and other technical budget adjustments) as a result of the increased enrollment months for infants linked to the Access for Infants and Mothers (AIM) program, the transfer of Single Point of Entry related costs to the Department of Health Care Services (DHCS), and increased Healthy Families Program (HFP) administrative vendor costs.

- **Access for Infants and Mothers Program Caseload Update (Issue 105)** - An increase in $2.2 million federal funds (and corresponding technical adjustments) to reflect the net effect of a decrease in estimated caseload, an increase in administrative vendor costs, an increase in capitation and lump-sum birth event and post-partum rates, and an increase in costs associated with covering beneficiaries under a single statewide health care service plan.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding these adjustments.

4560 Mental Health Services Oversight and Accountability Commission

1. Proposition 63 Evaluation Master Plan (DOF Issue 001)

Budget Issue. The May Revision requests $947,000 and six positions to begin implementation of the Mental Health Services Act (MHSA, Proposition 63) Evaluation Master Plan.

The MHSOAC is mandated to evaluate the outcomes of investments made through the MHSA. On March 28, 2013, the MHSOAC approved an Evaluation Master Plan which prioritizes possibilities for evaluation investments and activities over a three to five year course of action.

The MHSOAC Evaluation Master Plan is the result of findings from interviews with approximately 40 key informants, along with county visits. The plan focuses on individual, system, and community outcomes; provides specific evaluation activities and a general system by which to prioritize those and future evaluation activities; and identifies strategies for successful completion of all items described and prioritized in the plan. While the major focus of the plan is on the MHSA, the scope of the plan is broader.

Subcommittee Staff Comment and Recommendation—Approve. These needed resources were discussed in detail at the April 18th Subcommittee hearing. No issues have been raised.

ISSUES FOR DISCUSSION

4280 Managed Risk Medical Insurance Board (MRMIB)

1. Pre-Existing Condition Insurance Plan (PCIP) Update

Issue. MRMIB has recently been notified that the federal government plans to take over the administration of PCIP on July 1, 2013. MRMIB is in the process of assessing the implication of this change. Its preliminary assessment indicates that deductibles under the federally-administered program will be higher and there will be a change in premiums (some individuals may have a lower premium and some individuals may have a higher premium). MRMIB anticipates sending notices to PCIP subscribers by the end of this week.

Background. As a result of the federal Affordable Care Act (ACA), California, via MRMIB, 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. After that date, there will no longer be a need for high-risk pools because federal rules will not allow insurers to reject persons with pre-existing conditions or charge them higher rates than those without such conditions.

The federally-funded 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 six months. The California PCIP is run by the Managed Risk Medical Insurance Board (MRMIB).

The federal government notified all state-administered PCIPs to close to new enrollments after March 2, 2013. As the contractor that operates PCIP in California for CMS, MRMIB has closed PCIP enrollment except for persons coming into California with PCIP from another state and for persons who applied prior to March, but whose application was missing information.

Approximately 16,500 individuals are enrolled in PCIP. California has the largest PCIP program in the nation. California's PCIP has incurred costs of about $529 million of its $761 million allocation.

Subcommittee Staff Comment—Informational Item.

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

1. Please provide an overview of this issue and its implications.

2. How is MRMIB planning for the transition of these subscribers?

4140 Office of Statewide Health Planning and Development

1. Grant for Workforce Development (DOF Issue 303 and 305)

Budget Issue. The California Endowment (TCE) has committed $52 million, over four years, to OSHPD for health care workforce development programs. The May Revision proposes that these funds be allocated to (1) $31 million ($14 million in 2013-14, $9 million in 2014-15, $7.9 million in 2015-16, and $82,000 in 2016-17) and one staff person for the Health Professions Education Foundation for health professional scholarship and loan repayments and (2) $21 million ($7 million dollars in 2013-14, 2014-15 and 2015-16) for the Song-Brown Program to provide funding to health professional training institutions to train Family Practice Physicians, Family Nurse Practitioners, and Primary Care Physician Assistants.

Background. On January 18, 2013, TCE announced its commitment of $225 million to help California implement the Affordable Care Act (ACA). TCE is dedicating $90 million to "fund efforts to expand the primary care health workforce" and of that, TCE is investing $52 million in OSHPD healthcare workforce development programs.

As a result of the TCE's grant to OSHPD, the Health Professions Education Foundation will award approximately 625 more scholarships and loan repayments to students and practitioners providing direct patient care in underserved communities over 2013-14, 2014-15 and 2015-16, and Song-Brown will fund 68 health professions programs that will result in 4,166 physicians, family nurse practitioners (FNP) and physician assistants (PA) trained in primary care and providing direct patient care in underserved communities each year in 2013-14, 2014-15 and 2015-16.

The Health Professions Education Foundation was established in 1987, it is the state's only non-profit, public-benefit corporation statutorily created to provide financial assistance to students and providers in exchange for providing direct patient care in a California medically underserved area (MUA). Housed in OSHPD, the Foundation supports the participation of Californians from underserved and economically disadvantaged communities and increases access to health providers in those communities.

The Song-Brown Program provides grants to California health professions education institutions (HPEIs) providing clinical training to family practice medical residents, and primary care family nurse practitioners and physician assistant students. Residents and students of Song-Brown funded HPEIs are required to complete training in underserved areas, such as health professional shortage areas, medically underserved areas, medically underserved populations, and primary care shortage areas, as well as multicultural and rural communities.

Subcommittee Staff Comment and Recommendation—Approve.

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

1. Please provide an overview of this proposal.

4265 Department of Public Health (DPH)

1. AIDS Drug Assistance Program (ADAP) Caseload and Estimate Update (DOF Issue 506)

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
AIDS Drug Rebate Fund	$264,158	$243,809	-$20,349
Federal Funds – Ryan White	105,179	79,141	-$26,038
Reimbursements-Medicaid Waiver	66,339	66,339	-
Total	**$435,676**	**$389,289**	**-$46,387**

Two issues impacting the ADAP program are:

a. **ADAP and Health Care Reform.** The transition of ADAP clients to Medi-Cal or Covered California as a result of the federal Affordable Care Act (ACA).

b. **Changes to OA-Pre-Existing Condition Insurance Plan (PCIP).** The implications of the transition of the administration of the Pre-Existing Conditions Insurance Plan from the state to the federal government.

ADAP and Health Care Reform. For the most part, the May Revision projects a reduction in expenditures for ADAP a result the movement of ADAP clients to the Low Income Health Program (LIHP) and the movement of ADAP clients to Medi-Cal expansion and Covered California, under implementation of the federal Affordable Care Act (ACA). See following tables for details.

Table: DPH Projection of ADAP Client Transition to Medi-Cal (in millions)

Client Population	Clients	Estimated Savings	Notes
ADAP to LIHP to Medi-Cal Expansion	9,140	$84.3	Assumes 85% of ADAP clients who transition to LIHP prior to December 31, 2013 will transition to Medi-Cal Expansion on January 1, 2014, and the remainder will return to ADAP.
ADAP-only directly to Medi-Cal Expansion	612	$6.0	Assumes approximately 64% (85% of 75%) of ADAP-only clients who are eligible for Medi-Cal Expansion transition to Medi-Cal in 2013-14. Assumes that those who transition will apply on their birth month starting October 2013-June 2014.
OA-PCIP to Medi-Cal Expansion	101	$1.0	Assumes 85% of OA-PCIP clients will transition to Medi-Cal Expansion on January 1, 2014, and the remainder will become ADAP-only clients.
Total	**9,853**	**$91.3**	

Table: DPH Projection of ADAP Client Transition to Covered California (in millions)

Client Population	Clients	Estimated Savings	Notes
ADAP to LIHP to Covered California	225	$2.0	Assumes 85% of ADAP clients who transition to LIHP prior to December 31, 2013 will transition to Covered California on January 1, 2014, and the remainder will return to ADAP.
ADAP-only directly to Covered California	195	$1.5	Assumes 3.4% (85% of 4%) of ADAP-only clients who are eligible for Covered California transition in 2013-14. Assumes that 50% of those who transition will do so as of January 31, 2014, another 25% will transition in February 2014 and the remaining 25% will transition in March 2014.
OA-PCIP to Covered California	159	$1.3	Assumes 85% of OA-PCIP clients will transition to Covered California on January 1, 2014, and the remainder will become ADAP-only clients.
Subtotal	**579**	**$4.8**	
Admin Cost		~$1	Cost for contractor to administer premium payment workload for 2,692 OA-HIPP clients.
Total	**579**	**$4.1**	

Changes to OA-Pre-Existing Condition Insurance Plan (PCIP). OA-PCIP was implemented in November 2011 to pay monthly PCIP premiums. Clients who co-enroll in OA-PCIP and ADAP also receive assistance with drug co-pays and deductibles. OA-PCIP was implemented as a cost-containment measure because it is cheaper to pay monthly insurance premiums and medication co-pays and deductibles than the full-cost of a client's HIV-related medication.

The Managed Risk Medical Insurance Board (MRMIB) has recently been made aware that the federal government does not plan to renew its contract with MRMIB to administer the PCIP program. Consequently, it appears that current PCIP clients would transition to a federally-administered PCIP program. It is likely that the premiums, medication co-pays, and deductibles under the federally-administered program will be higher than under MRMIB's administered PCIP program. Consequently, OA-PCIP expenditures would be higher.

Subcommittee Staff Comment and Recommendation—Adjust expenditures and adopt placeholder trailer bill language. It is recommended to adjust ADAP expenditures to reflect that only 70 percent of ADAP clients (instead of 85 percent) would transition to Medi-Cal or Covered California in the budget year.

As discussed in previous Subcommittee hearings, there is much uncertainty regarding the rate at which individuals would transition to Medi-Cal or Covered California. Given the state's experience with take-up into new health care coverage programs (it took five-years for the Healthy Families Program to achieve its enrollment), it is prudent to ensure that ADAP has expenditure authority to continue to provide assistance.

Additionally, because of this and the uncertainty with OA-PCIP related-costs, it is recommended to adopt placeholder trailer bill language to keep the Legislature informed of any potential risk of the ADAP program's inability to provide services within its appropriation:

> Given the uncertainty within which persons diagnosed with HIV/AIDS from federal Ryan White HIV/AIDS Treatment Extension Act of 2009 funded programs may transition to Medi-Cal or other health insurance coverage, the State Department of Public Health shall report to the Joint Legislative Budget Committee by October 1, 2013, on whether any of the projections or assumptions used to develop the AIDS Drug Assistance Program (ADAP) estimated budget for the Budget Act of 2013 may result in an inability of ADAP to provide services to eligible ADAP clients. If this occurs before October 1, 2013, and ADAP is unable to provide services to eligible ADAP clients, the State 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 respond to the following questions.

1. Please provide an overview of this proposal.

2. Please provide an update on discussions regarding the implications of the transition of the administration of the Pre-Existing Conditions Insurance Plan from the state to the federal government.

2. Licensing and Certification (L&C) – Position Request (DOF Issue 502)

Budget Issue. The May Revision proposes an increase of 21 positions that would be supported with existing budget resources and would assist with the state survey workload.

Additionally, L&C proposes to contract for an organizational assessment of its effectiveness and performance. The assessment would evaluate L&C's resources, workload mandates and performance, workload management processes, organizational culture, and propose opportunities for L&C to implement operational efficiencies and best practices.

Background—CMS Concerns with L&C. On June 20, 2012, the federal Centers for Medicare and Medicaid (CMS) sent a letter to DPH expressing its concern with the ability of DPH to meet many of its current Medicaid survey and certification responsibilities. In this letter, CMS states that its analysis of data and ongoing discussions with DPH officials reveal the crucial need for California to take effective leadership, management and oversight of DPH's regulatory organizational structure, systems, and functions to make sure DPH is able to meet all of its survey and certification responsibilities.

The letter further states that "failure to address the listed concerns and meet CMS' expectations will require CMS to initiate one or more actions that would have a negative effect on DPH's ability to avail itself of federal funds."

In this letter, CMS acknowledges that the state's fiscal situation in the last few years, and the resulting hiring freezes and furloughs, has impaired DPH's ability to meet survey and certification responsibilities.

Subcommittee Staff Comment and Recommendation—Approve. As discussed at the March 14th Subcommittee hearing, concerns have been raised by the federal CMS and consumer advocates indicating that L&C has insufficient staff to address its workload. It is recommended to approve these positions and to request L&C keep the Subcommittee updated on its organizational assessment.

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

1. Please provide an overview of this proposal.

2. Please provide an update on the L&C's efforts to address CMS's concerns.

3. Infant Botulism Program / BabyBIG Program

Issue. In December 2011, the Governor issued and executive order, which directed the Department of Finance (DOF) to modify the budget process to increase efficiency and focus outcomes. In May 2012, DOF selected DPH as one of four state departments to pilot zero-based budgeting (ZBB) for 2013-14. DPH initiated its ZBB efforts in September 2012, focusing on three of its programmatic areas: (1) the Women, Infants and Children (WIC) Division, (2) the BabyBIG program, and (3) DPH contracting functions.

Background—Zero Based Budgeting (ZBB). DPH took a hybrid approach to its ZBB efforts by combining different elements of traditional, performance-based, and zero-based budgeting methods. As a starting point, the ZBB teams used prior year and current year budget information to build a "baseline budget." Each ZBB team also identified performance goals or metrics so it could better link program spending with program outcomes. Finally, the ZBB teams identified the various functions performed in their respective programs and calculated the cost to perform these functions.

Background—BabyBIG. The Infant Botulism Treatment and Prevention Unit (BabyBIG program) was established under Chapter 674, Statutes of 1995, to ensure the production and distribution of the orphan drug BabyBIG, which is a human-derived botulism antitoxin approved by the U.S. Food and Drug Administration (FDA) for the treatment of infant botulism. This orphan drug (i.e., medication for treatment of a rare medical condition) was originally developed by DPH staff, who now work with several contractors to produce, test, and distribute BabyBIG across the country and internationally.

ZBB BabyBIG Findings. The ZBB effort identified the following preliminary findings regarding the BabyBIG program:

- ***Need to Consider Entire Product Cycle Costs*** – The BabyBIG production cycle takes roughly five years from pre-production to post-production activities. During this period, the program's operating costs fluctuate significantly depending on the type of activities performed during the fiscal year. BabyBIG has an annual appropriation which remains largely fixed; any increase or decrease to the program's appropriation requires an approved budget change request. Ideally, the appropriation covers all anticipated costs associated with the expenditures incurred during a peak production year, eliminating the need for ongoing budget change requests.

- ***BabyBIG Expenses Must Be Carefully Monitored*** – Since BabyBIG's production costs fluctuate significantly, but its annual appropriation does not, it is absolutely critical for BabyBIG to carefully monitor spending and stagger costs from one budget cycle to the next.

- ***Pre-Production and Production Costs Have Increased Significantly*** – In the course of their analysis, the BabyBIG ZBB Team determined that the cost to produce Lot 6 will be 83 percent greater than that of Lot 5, which was produced in 2010. Without the ZBB

process, the BabyBIG program would not have been able to explain the reasons why production costs increased or whether these cost increases were justifiable.

- ***The Current BabyBIG Fee Will Not Cover Production Costs*** – In the course of their analysis, the BabyBIG ZBB Team calculated that the current fees cannot cover the cost to produce Lot 6. The department will need to raise its current fee, as the actual cost per treatment is anticipated to increase significantly with the production of Lot 6.

- ***Collection of More Blood Plasma Is Critical*** – The amount of BabyBIG produced is limited by the volume of the raw material (human plasma from vaccinated donors) collected. While there are numerous barriers in identifying and obtaining additional donors, the BabyBIG ZBB team identified some options that can be explored to increase plasma collection.

- ***Demand for BabyBIG May Exceed Vaccine Supply*** – The ZBB Team's analysis of BabyBIG utilization suggests that the amount produced in Lots 5 and 6 may be insufficient to meet BabyBIG demand.

- ***Prevention Efforts Could Be Cost-Effective*** – BabyBIG treatment is expensive; however, treatment with BabyBIG saves money. The BabyBIG ZBB Team's analysis suggests that a relatively small investment in prevention activities could reduce the incidence of infant botulism. Increased program activity to identify and implement effective prevention strategies may be warranted.

ZBB Recommendations – The BabyBIG ZBB Team has the following recommendations:

- ***Strengthen Administrative Support*** – Currently, the BabyBIG program is largely administered by the scientists who developed BabyBIG. These same scientists are responsible for contract negotiation with pharmaceutical firms, budgeting, fiscal forecasting, and trend analysis. The BabyBIG ZBB Team recommends that the program reallocate one of its vacant positions for quality control to focus on program administration, particularly in the area of contract negotiation and execution.

- ***Raise BabyBIG Vaccine Fee*** – BabyBIG should increase its vaccine fee to cover the anticipated cost to produce Lot 6. As a result of its in-depth fiscal analysis, the BabyBIG ZBB Team has determined that implementation of a fee increase in 2013 can be done with a two-phased approach. Specifically, the BabyBIG ZBB Team recommends an initial 20 percent fee increase in 2013, followed by another fee increase once the full cost of Lot 6 production is calculated. This phased approach will help payers adjust to the rising cost and will ensure continuity of product development regardless of external, inflationary costs that CDPH cannot control.

- ***Produce More Blood Plasma*** – The BabyBIG ZBB Team recommends that the BabyBIG program actively take measures to identify ways to collect more blood plasma. The collection of more blood plasma may sharply reduce the average cost per vaccine and will help ensure that supply keeps up with demand.

- ***Monitor Utilization*** – Given the recent spike in BabyBIG utilization, the program must carefully monitor utilization at the statewide, national, and international levels to determine if the increase last year was an anomaly or part of a new trend. This utilization review should be conducted quarterly as part of an internal estimate process.

- ***Develop Criteria and Policies for BabyBIG Distribution*** – Currently, BabyBIG is distributed on a first-come, first-serve basis. Given the risk that Lot 6 may not produce a sufficient supply of BabyBIG vaccine, the BabyBIG ZBB Team recommends that the program identify some criteria or policies to determine how it will distribute BabyBIG. The program may choose to continue its first-come, first-serve policy, but it may also want to investigate other options, including (1) prioritization for domestic use over international use, (2) severity of symptoms, (3) lower dosage, or (4) other considerations.

- ***Increase Prevention Efforts Through Partnerships*** – The BabyBIG ZBB Team recommends that the program collaborate with federally-funded programs like the Maternal Child Adolescent Health (MCAH); Women, Infant & Children, and Nutrition Education & Obesity Prevention (NEOP) programs to identify ways to educate parents on the ways to prevent infant botulism.

- ***Investigate Handling Fee*** – Federal law prevents BabyBIG from charging a higher fee for residents of other states. However, the BabyBIG ZBB Team recommends that the program investigate whether it may charge a handling or distribution fee to other states. In addition, the BabyBIG ZBB Team recommends that the program consider charging a higher fee to international clients. Taking these measures may mitigate the fee increase for California BabyBIG vaccine users.

- ***Consider Continuous Appropriation for BabyBIG*** – The BabyBIG program is unique insofar as it has a lengthy production cycle in which costs from year-to-year fluctuate significantly. In order to better manage and monitor its production costs and prevent the need for BCPs from year-to-year, the BabyBIG ZBB Team recommends that the program consider a continuous budget appropriation, which would allow it to carry forward unspent monies from one fiscal year to the next.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is apparent that the ZBB efforts regarding the BabyBIG program have identified areas for improvement that could facilitate better policies, improve service delivery, and improve public health outcomes. It is important that these preliminary findings and recommendations be acted upon and not “sit on a shelf.”

Consequently, it is recommended to adopt placeholder trailer bill language requiring DPH to submit a plan to the Legislature on how it will address these findings and implement changes, as it is important to ensure that an adequate supply of the vaccine is available to meet demand.

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

1. Please provide a brief overview of the ZBB process and the findings and recommendations for the BabyBIG program.

4. Women, Infants, and Children (WIC) Program (DOF Issue 505)

Budget Issue. For the WIC program, the May Revision projects an expenditure decrease of $62 million as a result of Maximum Allowable Departmental Reimbursement (MADR) rate limitations directed by the US Department of Agriculture (USDA) and a net decrease of $80 million in federal funds as a result of the change in the level of final WIC grants to states. Of this reduction, $44.6 million is due to sequestration.

No change in the number of individuals served by WIC is projected as a result of these expenditure and revenue changes.

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.

Maximum Reimbursement Rate Methodology. The maximum amount that vendors are reimbursed for WIC food is based on the mean price per redeemed food instrument type by peer group with a tolerance for price variances (referred to as MADR). Effective May 25, 2012, USDA directed CA WIC to remove 1-2 and 3-4 cash register WIC vendors from the MADR-determination process and instead set MADR for these vendors at a certain percentage higher than the average redemption value charged by vendors with five or more registers in the same geographic region. The USDA was concerned that California was paying 1-2 and 3-4 cash register stores up to 50 percent more than prices paid to other vendors.

CA WIC submitted a plan to USDA to address price competitiveness, MADR methodology and cost containment on October 3, 2012. It is still working on a final methodology with USDA and plans to incorporate the methodology in the November 2013 estimate for the 2014-15 fiscal year.

In the meantime, USDA has directed MADR limitations to be 15 percent for 1-2 cash register vendors and 11 percent for 3-4 cash register vendors above the average redemption value charged by vendors with five or more cash registers in the same geographic region.

Subcommittee Staff Comment and Recommendation—Approve.

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

1. Please provide an update on the WIC estimate and adjustments.

2. Please describe the impact of sequestration on WIC.

4260 Department of Health Care Services

1. ACA Implementation Activities Related to Medi-Cal – Position Request (DOF Issue 010)

Budget Issue. The May Revision requests to make 12 existing limited-term positions permanent and to extend nine existing two-year limited-term positions to continue to support the implementation of the ACA.

The annual cost of the 21 requested positions is $2.3 million ($893,000 General Fund and $1.4 million in federal funds).

Background. DHCS is responsible for California's Medicaid program (Medi-Cal), and is responsible for implementing and maintaining new Medicaid program changes relating to the ACA. The requested positions would be responsible for the following ACA-related workload:

- **Medi-Cal Eligibility Expansion and Interactions with Covered California and Other State Departments**
  - Office of Legal Services (1 position) – Review and respond to federal proposed rulemaking, follow federal case law, establish benchmark benefits, develop parity for mental health services, review eligibility statutes and regulations and amend accordingly, establish protocol and procedures for working with Covered California, contract with counties for new eligibility workload, develop necessary interagency agreements, and contract monitoring.
  - Information and Technology Services Division (1 position) – Provide technical analysis and support information technology changes needed to implement the ACA. This includes changes to MEDS and CalHEERS.

- **Enhancements to California Medicaid Management Information Systems (CA-MMIS)**
  - Information Technology Management Branch (3 positions) – Develop business rules and design, develop, and implement CA-MMIS changes required by the ACA.

- **Changes to Medicaid Drug Rebate Provisions**
  - Pharmacy Benefits Division's Policy Branch (3 positions) - Implement ACA-related changes regarding pharmacy benefits.
  - Pharmacy Benefits Division's Drug Rebate Branch (5 positions) – Implement ACA requirement that the state capture claims data and rebates from managed care organizations for drugs provided to Medi-Cal beneficiaries.
  - Capitated Rates Development Division (1 position) – Analyze, monitor, and respond to the financial impacts that the prescription drug rebate program changes have on the capitation rates paid by DHCS to Medi-Cal managed care plans and assist in the development of capitation rates.

- **Program Integrity – Enhanced Provider Screening**
  - Provider Enrollment Division (5 positions) – Implement enhanced provider screening under the program integrity requirements of the ACA.

- **Cross-Cutting ACA Issues Requiring Rates, Regulations, and/or System Changes**
  - Mental Health Services Division (1 position) – Research, establish, and implement California's mental health and substance use disorder essential health benefits; establish enhanced coordination and integration of mental health, substance use, and primary care services; and implement federal parity requirements.
  - Benefits Division (1 position) – Collaborate with other divisions to ensure implementation of ACA provisions, develop State Plan Amendments, convene stakeholder meetings, and serve as the lead with external partners.

DHCS contends that without the positions noted above, it would not be able to implement the ACA. It also states that it cannot redirect existing positions to perform this workload without impacting other high-priority workload.

Subcommittee Staff Comment and Recommendation—Approve.

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

1. Please provide an overview of this proposal.

2. Withdraw Managed Care Efficiencies Proposal (DOF Issue 216)

Budget Issue. The May Revision proposes to withdraw the proposal to implement $135 million in General Fund savings as a result of managed care efficiencies.

Background. The Governor's January budget included a decrease of $135 million General Fund in the Medi-Cal program as a result of implementing additional efficiencies in managed care. DHCS proposed to look for new ways to improve quality and the efficiency of the health care delivery system and develop payment systems that promote quality of care and improve health outcomes.

The Administration indicated that this proposal did not require statutory authority, but it did not provide details on how this proposal may be implemented.

Subcommittee Staff Comment and Recommendation—Approve withdrawal of proposal. It is recommended to approve the withdrawal of this proposal and make the corresponding adjustments in the budget. As discussed at the May 2nd Subcommittee hearing, it was unclear how the Administration planned to implement this proposal and it was unclear how this proposal would have impacted quality and access to care.

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

1. Please provide an overview of this issue.

3. ACA - Medi-Cal Enhanced Federal Funding for Prevention Services & Adult Vaccines

Budget Issue. The May Revision includes $2.5 million General Fund savings associated with an increase in the federal funding percentage for Medi-Cal preventive services and adult vaccines as provided under the ACA. The proposed savings only reflect the Medi-Cal fee-for-service delivery system and does not include the Medi-Cal managed care delivery system.

Additionally, the May Revision proposes trailer bill language to exempt preventive services and adult vaccines from copayment or cost sharing, in order to implement these savings. The ACA ensures that cost sharing cannot be required for these services.

Background. Effective January 1, 2013, the ACA established a one percentage point increase in the Federal Medical Assistance Percentages (FMAP) for Medi-Cal for preventative services and adult vaccines in states that meet certain requirements. In order to qualify for the one percentage point FMAP increase for these services, a state must cover all preventative services assigned a grade A or B by the United States Preventive Services Task Force (USPSTF) and all approved vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). Also, states may not impose beneficiary cost-sharing on such services. The increased FMAP would apply to the applicable services in both fee-for-service (FFS) and managed care.

Medi-Cal currently covers all specified preventive services assigned a grade A or B by the USPSTF and approved adult vaccines recommended by the ACIP and does not impose cost-sharing for these services.

DHCS submitted its state plan amendment (SPA) to the federal government at the end of March indicating that it seeks this FMAP increase. If this SPA is approved, the state would be able to claim the enhanced FMAP retroactively back to January 1, 2013.

Prevention services that would be eligible for this increase in FMAP include: breast cancer screening, colorectal cancer screening, depression screening, HIV screening, and osteoporosis screening, and tobacco use counseling.

Subcommittee Staff Comment and Recommendation—Adjust savings and approve placeholder trailer bill language. The May Revision does not account for the savings in Medi-Cal managed care associated with this increase in federal funding percentage. DHCS acknowledges that these savings are not included and indicates that it is working on developing this estimate.

It is recommended to score an additional $10 million in General Fund savings attributable to the increase in federal funds for these services for Medi-Cal managed care plans. Given that about 80 percent of the Medi-Cal caseload is under managed care, these savings generally reflect a corresponding proportion of savings that should be recognized in the budget.

It is also recommended to adopt the placeholder trailer bill language necessary to exempt these services from cost-sharing in order to be eligible for this enhanced federal funding percentage.

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

1. Please provide an overview of this ACA provision and the proposal.

4. Eliminate Sunset Date for Specialty Provider Contracting

Budget Issue. The May Revision proposes trailer bill language to eliminate the sunset date for specialty provider contracting. The elimination of this sunset date achieves ongoing $6.9 million General Fund savings.

Background. AB 1183 (Statutes of 2008) allows DHCS to enter into contracts with providers who distribute and provide care for specialty drugs and services. This law allows DHCS to restrict payment of specialty drugs and services to a limited number of providers. AB 1183 also included an annual reporting requirement after the first and second years after implementation and a sunset provision of July 1, 2013.

According to DHCS, most chain and non-specialty retail pharmacies are unwilling or incapable of providing the drugs currently provided by specialty pharmacy providers. If the specialty provider contracting provisions sunset, beneficiaries in need of blood factor, drugs used for HIV, cancer, hepatitis, inborn errors of metabolism, pulmonary hypertension, transplants, for example, would be forced to obtain these services through utilization of hospital emergency departments, extended stays in acute and sub-acute care settings, or via increased medical interventions in acute care settings. Additionally, DHCS notes that provision of these services in an outpatient pharmacy setting has been demonstrated to be less costly on the national level.

This proposal would remove the July 1, 2013, sunset date and allow DHCS to continue to contract with providers of specialty drugs and services. Also, the proposal would delete the annual reporting requirements which DHCS has already met.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised with this proposal.

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

1. Please provide an overview of this proposal.

5. Laboratory Rate Methodology Stakeholder Process Extension

Issue. AB 1467 and AB 1494 (2012 budget trailer bills) allowed DHCS to develop a new rate reimbursement methodology for clinical laboratory and laboratory services. The proposed methodology would develop rates that are based on the lowest amounts other payers are paying for similar clinical laboratory services.

Until the implementation of the new methodology, payments for clinical laboratory services would be subject to an additional 10 percent reduction (on top of the 10 percent payment reductions pursuant to AB 97 (2011)). (The Family Planning, Access, Care, and Treatment Program is exempt from the payment reduction specified in AB 1494.)

As required by AB 1467, DHCS has been working with stakeholders on the development of the new rate methodology; however, this process has taken longer than anticipated and the new rate methodology has not yet been approved by the federal CMS.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt placeholder trailer bill language to extend the time period for which laboratory service providers have to submit data reports specifying their lowest amounts other payers are paying. This is necessary as the process to develop the new rate methodology has taken longer than anticipated. This proposal has no impact on the General Fund savings anticipated with the change in methodology.

DHCS has indicated that it has no concerns with this proposed trailer bill language.

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

1. Please provide an overview of this proposal.

6. Dense Breast Notification – Medi-Cal and Every Woman Counts Program (DOF Issue 211)

Budget Issue. The budget includes a total of $11.9 million General Fund to implement the dense breast notification and supplemental screening required by SB 1538 (Simitian, Statutes of 2012)--$3.6 million for the Medi-Cal program and $8.3 million for the Every Woman Counts (EWC) program.

Background. SB 1538 requires health facilities, administering mammograms to women 40 years and over, to notify patients whose breasts are categorized as being heterogeneously or extremely dense. The notification informs patients that they may benefit from supplementary screening due to the level of dense breast tissue seen on the mammogram.

Data indicates that about 50 percent of women over age 40 have dense breasts. Of this population, DHCS projects that (1) 50 percent would request a supplementary screening test and (2) 100 percent would require case management services under the EWC program.

Subcommittee Staff Comment and Recommendation—Adjust expenditures. DHCS's assumptions regarding the number of women who would request a supplementary screening test and require EWC case management services are high. For example, Connecticut is the only other state that requires similar dense breast notification. In its first year of implementation, according to a study by the Yale Cancer Center, only 20 percent of women who received the notification requested a supplementary screening.

Additionally, EWC case management services would only be necessary for women who receive a positive screen on their supplementary screening test and not for all women who receive a supplementary screening, as projected by DHCS. Data suggests that only 10 to 15 percent of women who obtain a supplementary screening test receive a positive screen.

Consequently, it is recommended to adjust these program budgets to reflect that only 30 percent of women who receive a dense breast notification obtain a secondary screening and only 10 percent of this population (for the EWC program) requires case management services. This results in about a $5 million General Fund savings.

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

1. Please provide an overview of this proposal.

7. Integration of Medi-Cal Managed Care Screenings and Referrals into EPSDT Performance Outcome System

Issue. DHCS is in the process of developing a performance outcome system for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program mental health services for children, as required by SB 1009 (a 2012 budget trailer bill). As currently designed, this performance outcome system is focusing on the Medi-Cal specialty mental health services provided by the counties.

As discussed at the April 18th Subcommittee hearing, the measuring and evaluating of Medi-Cal managed care plan screenings for mental disorders and referrals (to Medi-Cal fee-for-service providers and county mental health plans) has not been incorporated into the EPSDT performance outcome system.

DHCS has indicated that it agrees that screening and assessments of children and youth for mental health needs is critical and that it is looking at how it can strengthen managed care plans' screenings of children for these needs as well as their referrals for these services.

Background—EPSDT. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit is Medicaid's (Medi-Cal in California) comprehensive preventive child health service designed to assure the availability and accessibility of health care services and to assist eligible individuals and their families to effectively use their health care resources.

The EPSDT program assures that health problems, including mental health and substance use issues, are diagnosed and treated early before they become more complex and their treatment more costly.

Under the EPSDT benefit, eligible individuals must be provided periodic screening (well child exams), as defined by statute. One required element of this screening is a comprehensive health and developmental history, including assessment of physical and mental health development. Early detection of mental health and substance use issues is important in the overall health of a child and may reduce or eliminate the effects of a condition if diagnosed and treated early. If, during a routine periodic screening, a provider determines that there may be a need for further assessment, an individual should be furnished additional diagnostic and/or treatment service.

On March 27, 2013, the federal Centers for Medicare and Medicaid Services (CMS) issued an Informational Bulletin to help inform states about resources available to help them meet the needs of children under EPSDT, specifically with respect to mental health and substance use disorder services.

Background—EPSDT Performance Outcome System. SB 1009 (a 2012 budget trailer bill) requires DHCS, in collaboration with the California Health and Human Services Agency, and in consultation with the Mental Health Services Oversight and Accountability Commission, to

create a plan for a performance outcome system for EPSDT program mental health services for children.

SB 1009 also requires that by no later than September 1, 2012, a stakeholder advisory committee shall be convened for the purpose of developing this plan and requires DHCS to provide a plan, including milestones and timelines for EPSDT mental health outcomes by no later than October 1, 2013.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt placeholder trailer bill language to incorporate the measuring and evaluating of Medi-Cal managed care plans screenings for mental health needs and their referrals for these services (to both Medi-Cal fee-for-service providers and county mental health plans) into the EPSDT performance outcome system. This effort would be informed by stakeholders and a plan for the incorporation of these factors into the outcome system would be due to the Legislature by October 1, 2014.

Understanding how children are screened and access mental health care is fundamental to understanding how well EPSDT benefits are provided.

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

1. Please provide an overview of this proposal.

8. Behavioral Health Services Needs Assessment and Services Plan

Issue. Concerns have been raised that the process DHCS is using to develop its Behavioral Health Services Plan has not been transparent. Stakeholder involvement is important to ensure that this plan has meaning and accounts for variations across counties.

Background. The state's Medi-Cal Section 1115 "Bridge to Reform" Waiver Special Terms and Conditions requires the state to complete a Behavioral Health Services Needs Assessment that includes an accounting of the services available throughout the state, as well as information on service infrastructure, capacity, utilization patterns, and other information necessary to determine the current state of behavioral health service delivery in California. (Behavioral health includes mental health and substance use disorder services.)

The waiver special terms and conditions also require the completion of a Behavioral Health Services Plan, no later than October 1, 2012. This service plan will describe California's recommendations for serving the Medi-Cal expansion population, under federal health care reform, and demonstrate the state's readiness to meet the projected mental health and substance use disorder needs.

Behavioral Health Services Needs Assessment. DHCS contracted out to conduct a Mental Health and Substance Use System Needs Assessment. The primary purpose of the Needs Assessment was to review the needs and service utilization of current Medi-Cal recipients and identify opportunities to ready Medi-Cal for the expansion of enrollees and the increased demand for services resulting from health reform.

The Needs Assessment was completed in February 2012.

Behavioral Health Services Plan. The Needs Assessment was to facilitate DHCS's development of a Behavioral Health Services Plan. The Services Plan would describe California's recommendations for serving the Medi-Cal expansion population, under federal health care reform, and demonstrate the State's readiness to meet the mental health and substance use disorder needs of this population. The Services Plan was due to the federal CMS on October 1, 2012. However, since federal guidance on the Medicaid Benchmark Benefit and Medicaid Behavioral Health Parity was not available in October 2012, the state and CMS agreed that the state could submit an outline of the Services Plan in October 2012 and that the state would have until April 1, 2013 to submit the Services Plan.

On April 1, 2013, DHCS submitted a letter to CMS and a draft Medicaid Alternative Benefit Plan Options Analysis prepared by Mercer. This Options Analysis was developed on behalf of DHCS to provide information on the Medicaid expansion benefit options. DHCS has not been able to complete the Services Plan because a decision on the Medicaid benefit package and delivery system has not been made.

DHCS has indicated that it will submit the final Service Plan to CMS by October 1, 2013.

Subcommittee Staff Comment—Adopt placeholder trailer bill language. It is recommended to adopt the following placeholder trailer bill language to require the Administration to consult with stakeholders prior to the submittal of the Behavioral Health Services Plan to the federal CMS:

> Commencing no later than August 1, 2013, the State Department of Health Care Services shall convene a series of stakeholder meetings to receive input from clients, family members, providers, counties, and representatives of the Legislature concerning the development of the Behavioral Health Services Plan, as required by the Section 1115 Bridge to Reform Demonstration Special Terms and Conditions paragraph 25.d.

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

1. Please provide an update on the development of the Behavioral Health Services Plan.

Michelle Baass 651-4103
Senate Budget & Fiscal Review

OUTCOMES: **Senate Subcommittee #3 on Health & Human Services**
Tuesday, May 21 (Room 4203)
Agenda Part 1

VOTE ONLY

0530 Office of Systems Integration

1. CalHEERS Adjustment (DOF Issue 444)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

4140 Office of Statewide Health Planning and Development

1. Mental Health Reappropriation (DOF Issue 304 and 306)

- Motion – Approve request to appropriate previously approved funds that were reverted.
- Vote – 2-0 (Senator Emmerson absent.)

4150 Department of Managed Health Care (DMHC)

1. Medi-Cal Dental Managed Care Program Oversight

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

3. Medi-Cal Managed Care Rural Expansion

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

4. Medi-Cal Managed Care Rural Expansion Supplemental – May Revision (DOF Issue 501)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

4260 Department of Health Care Services

1. Medi-Cal Estimate Update – Technical Adjustments (DOF Issue 200)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

2. Continuation of 1115 Waiver Activities - Position Request

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

3. Continuation of LIHP & DSRIP Activities - Position Request

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

4. Assisted Living Waiver – Position Request

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

5. Security Oversight of MEDS – Position Request

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

6. HIPPA – Position Request

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

7. Public Assistance Reporting Information System (PARIS) Interstate – Position Request

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

8. Medi-Cal Electronic Health Records – Position Request

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

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

- Motion – Reject proposal.
- Vote – 2-0 (Senator Emmerson absent.)

10. Diagnosis Related Groups Payment System – Position Request

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

11. Breast and Cervical Cancer Treatment Program Resources – Position Request (DOF Issue 006)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

12. Federal Authority for Mental Health Services Technical Adjustment (DOF Issue 008 and 108)

- Motion – Approve proposal.

- Vote – 2-0 (Senator Emmerson absent.)

13. Family Health Programs Adjustments (DOF Issue 211)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

14. Drug Medi-Cal Legal Representation – Position Request

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

15. Long Term Care Quality Assurance Fund – Borrowable for Cash Flow

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

4265 Department of Public Health

1. Genetic Disease Screening Program (DOF Issue 504)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

2. Nursing Home Administrator's State License Examining Fund (DOF Issue 502)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

4280 Managed Risk Medical Insurance Board

1. Caseload Updates (Technical Adjustments)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

4560 Mental Health Services Oversight and Accountability Commission

1. Proposition 63 Evaluation Master Plan (DOF Issue 001)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

ISSUES FOR DISCUSSION

4280 Managed Risk Medical Insurance Board (MRMIB)

1. Pre-Existing Condition Insurance Plan (PCIP) Update

- Informational Item.

4140 Office of Statewide Health Planning and Development

1. Grant for Workforce Development (DOF Issue 303 and 305)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

4265 Department of Public Health

1. AIDS Drug Assistance Program (ADAP) Caseload and Estimate Update (DOF Issue 506)

- Motion – Approve staff recommendation:

Subcommittee Staff Comment and Recommendation—Adjust expenditures and adopt placeholder trailer bill language. It is recommended to adjust ADAP expenditures to reflect that only 70 percent of ADAP clients (instead of 85 percent) would transition to Medi-Cal or Covered California in the budget year.

As discussed in previous Subcommittee hearings, there is much uncertainty regarding the rate at which individuals would transition to Medi-Cal or Covered California. Given the state's experience with take-up into new health care coverage programs (it took five-years for the Healthy Families Program to achieve its enrollment), it is prudent to ensure that ADAP has expenditure authority to continue to provide assistance.

Additionally, because of this and the uncertainty with OA-PCIP related-costs, it is recommended to adopt placeholder trailer language to keep the Legislature informed of any potential risk of the ADAP program's inability to provide services within its appropriation:

Given the uncertainty within which persons diagnosed with HIV/AIDS from federal Ryan White HIV/AIDS Treatment Extension Act of 2009 funded programs may transition to Medi-Cal or other health insurance coverage, the State Department of Public Health shall report to the Joint Legislative Budget Committee by October 1, 2013, on whether any of the projections or assumptions used to develop the AIDS Drug Assistance Program (ADAP) estimated budget for the Budget Act of 2013 may result in an inability of ADAP to provide services to eligible ADAP clients. If this occurs before October 1, 2013, and ADAP is unable to provide services to eligible ADAP clients, the State Department of Public Health shall provide notification to the Joint Legislative Budget Committee within 15 calendar days of this determination.

- Vote – 2-0 (Senator Emmerson absent.)

2. Licensing and Certification – Position Request (DOF Issue 502)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

3. Infant Botulism Program / BabyBIG Program

- Motion – staff recommendation:

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is apparent that the ZBB efforts regarding the BabyBIG program have identified areas for improvement that could facilitate better policies, improve service delivery, and improve public health outcomes. It is important that these preliminary findings and recommendations be acted upon and not "sit on a shelf."

Consequently, it is recommended to adopt placeholder trailer bill language requiring DPH to submit a plan to the Legislature on how it will address these findings and implement changes, as it is important to ensure that an adequate supply of the vaccine is available to meet demand.

- Vote – 2-0 (Senator Emmerson absent.)

4. Women, Infants, and Children (WIC) Program (DOF Issue 505)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

4260 Department of Health Care Services

1. ACA Implementation Activities Related to Medi-Cal – Position Request (DOF Issue 010)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

2. Withdraw Managed Care Efficiencies Proposal (DOF Issue 216)

- Motion – Approve proposal to withdraw the managed care efficiency proposal.
- Vote – 2-0 (Senator Emmerson absent.)

3. ACA - Medi-Cal Enhanced Federal Funding for Prevention Services & Adult Vaccines

- Motion – Approve staff recommendation:

Subcommittee Staff Comment and Recommendation—Adjust savings and approve placeholder trailer bill language. The May Revision does not account for the savings in Medi-Cal managed care associated with this increase in federal funding percentage. DHCS acknowledges that these savings are not included and indicates that it is working on developing this estimate.

It is recommended to score an additional $10 million in General Fund savings attributable to the increase in federal funds for these services for Medi-Cal managed care plans. Given that about 80 percent of the Medi-Cal caseload is under managed care, these savings generally reflect a corresponding proportion of savings that should be recognized in the budget.

It is also recommended to adopt the placeholder trailer bill language necessary to exempt these services from cost-sharing in order to be eligible for this enhanced federal funding percentage.

- Vote – 2-0 (Senator Emmerson absent.)

4. Eliminate Sunset Date for Specialty Provider Contracting

- Motion – Approve proposal to withdraw the managed care efficiency proposal.
- Vote – 2-0 (Senator Emmerson absent.)

5. Laboratory Rate Methodology Stakeholder Process Extension

- Motion – Approve staff recommendation:

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt placeholder trailer bill language to extend the time period for which laboratory service providers have to submit data reports specifying their lowest amounts other payers are paying. This is necessary as the process to develop the new rate methodology has taken longer than anticipated. This proposal has no impact on the General Fund savings anticipated with the change in methodology.

DHCS has indicated that it has no concerned with this proposed trailer bill language.

- Vote – 2-0 (Senator Emmerson absent.)

6. Dense Breast Notification – Medi-Cal and Every Woman Counts Program (DOF Issue 211)

- Motion – Approve staff recommendation:

Subcommittee Staff Comment and Recommendation—Adjust expenditures. DHCS's assumptions regarding the number of women who would request a supplementary screening test and require EWC case management services are high. For example, Connecticut is the only other state that requires similar dense breast notification. In its first year of implementation, according to a study by the Yale Cancer Center, only 20 percent of women who received the notification requested a supplementary screening.

Additionally, EWC case management services would only be necessary for women who receive a positive screen on their supplementary screening test and not for all women who receive a supplementary screening, as projected by DHCS. Data suggests that only 10 to 15 percent of women who obtain a supplementary screening test receive a positive screen.

Consequently, it is recommended to adjust these program budgets to reflect that only 30 percent of women who receive a dense breast notification obtain a secondary screening and only 10 percent of this population (for the EWC program) requires case management services. This results in about a $5 million General Fund savings.

- Vote – 2-0 (Senator Emmerson absent.)

7. Integration of Medi-Cal Managed Care Screenings and Referrals into EPSDT Performance Outcome System

- Motion – Approve staff recommendation:

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt placeholder trailer bill language to incorporate the measuring and evaluating of Medi-Cal managed care plans screenings for mental health needs and their referrals for these services (to both Medi-Cal fee-for-service providers and county mental health plans) into the EPSDT performance outcome system. This effort would be informed by stakeholders and a plan for the incorporation of these factors into the outcome system would be due to the Legislature by October 1, 2014.

Understanding how children are screened and access mental health care is fundamental to understanding how well EPSDT benefits are provided.

- Vote – 2-0 (Senator Emmerson absent.)

8. Behavioral Health Services Needs Assessment and Services Plan

- Motion – Approve staff recommendation:

Subcommittee Staff Comment—Adopt placeholder trailer bill language. It is recommended to adopt the following placeholder trailer bill language to require the Administration to consult with stakeholders prior to the submittal of the Behavioral Health Services Plan to the federal CMS:

> Commencing no later than August 1, 2013, the State Department of Health Care Services shall convene a series of stakeholder meetings to receive input from clients, family members, providers, counties, and representatives of the Legislature concerning the development of the Behavioral Health Services Plan, as required by the Section 1115 Bridge to Reform Demonstration Special Terms and Conditions paragraph 25.d.

- Vote – 2-0 (Senator Emmerson absent.)

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

May 21, 2013

9:30 a.m.

Room 4203, State Capitol
(John L. Burton Hearing Room)

AGENDA Part 2
(Joe Stephenshaw)

4440 Department of State Hospitals

Vote Only

Items to be Heard

Vote Only

Issue 1 – CONVERT CONTRACT TO CIVIL SERVICE POSITIONS

Governor's Proposal. The May Revision proposes authority for 22 new permanent positions and funding to be transferred from contracts in the Sex Offender Commitment Program and the Mentally Disordered Offender Program.

Background. The Department of State Hospitals (DSH) states that this transfer from contracted positions to state civil service will allow the affected programs to hire civil service psychologists to meet the current workload, and comply with Government Code (GC) Section 19130(b)(3).

Recommendation. Approve as proposed.

Issue 2 –PERSONAL DURESS ALARM SYSTEM PROJECTS - REAPPROPRIATION

Governor's Proposal. The May Revision proposes the reappropriation of unencumbered funds for the Personal Duress Alarm System (PDAS) projects.

Background. DSH explains that the unencumbered funds from 2012-13 resulted from initial implementation delays with the PDAS at Napa State Hospital, which caused upgrade delays at Metropolitan and Patton State Hospitals in the current fiscal year. The 2012 Budget Act included $22.8 million General Fund for the PDAS, and the remaining balance, $5.4 million, of that amount is to be reappropriated to the budget year.

Recommendation. Approve as proposed.

California Department of State Hospitals (4440)

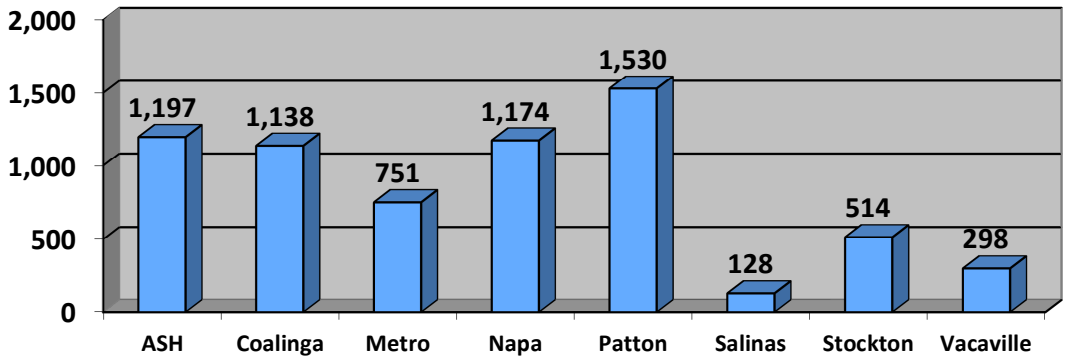
The California Department of State Hospitals (DSH) operates five state hospitals throughout California, including: Atascadero State Hospital (San Luis Obispo County), Coalinga State Hospital (Fresno County), Metropolitan State Hospital (Los Angeles County), Napa State Hospital (Napa County), and Patton State Hospital (San Bernardino County). Each state hospital provides inpatient treatment services for Californians with serious mental illnesses. Additionally, the department operates two correctional programs, Salinas Valley Psychiatric Program and Vacaville Psychiatric Program, and is in the process of opening a third correctional program at the California Health Care Facility in Stockton in the budget year.

The majority of the state hospital population, approximately 92 percent, is forensic-or penal code-related. Major categories of state hospital patients include:

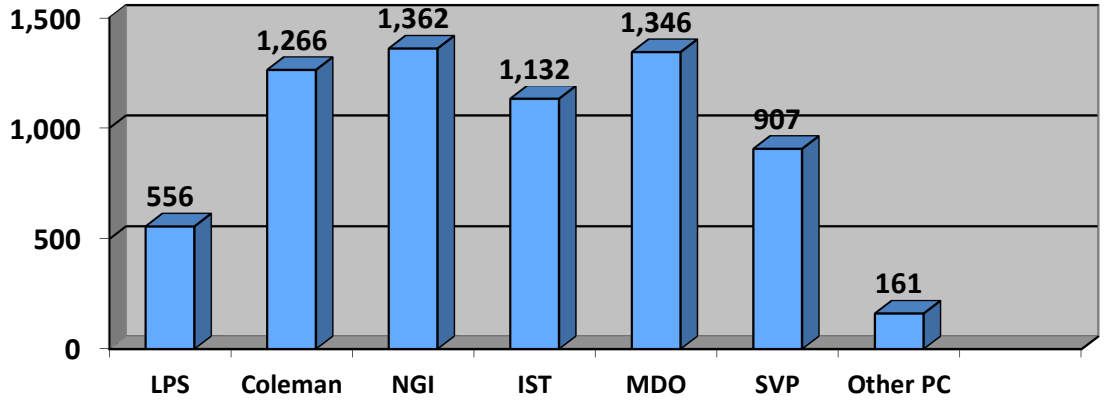
- Judicial commitments directly from superior courts - Not Guilty by Reason of Insanity (NGI) and Incompetent to Stand Trial (IST)
- Civil commitments as Sexually Violent Predators (SVPs)
- Referrals/transfers from California Department of Corrections and Rehabilitation (CDCR), including Mentally Disordered Offenders (MDOs) and Parolees
- Civil commitments from counties under the Laterman-Petris-Short Act

As of the May Revision, DSH projects providing inpatient mental health treatment services to approximately 6,730 patients in 2013-14.

Estimated State Hospital Population
2013-14



Estimated Patient Casepoad by Commitment
2013-14



Issue 1 – CONTINUED ACTIVATION OF THE CALIFORNIA HEALTH CARE FACILITY AND ASSOCIATED REDUCTIONS AND RETENTIONS

Governor's Proposal. The May Revision contains four proposals related to staffing at the three CDCR psychiatric facilities, including:

1. $4.2 million GF (partial year, $8.4 million full year) and 44.3 positions (partial year, 59 full year) to increase the staff at the California Health Care Facility (CHCF) in Stockton to adjust relief factors for staff at CHCF, consistent with existing hospital standards, and ensure sufficient staffing ratios for appropriate treatment.
2. A decrease of $22.6 million GF and 164.2 positions at the Salinas Valley Psychiatric Program (SVPP) and the Vacaville Psychiatric Program (VPP) to reflect the migration of 450 beds to the CHCF.
3. $8.4 million GF and 117.2 positions to be retained at VPP and SVPP to improve treatment for patients at these two facilities.
4. $1.4 million GF and 19.0 positions to be transferred from VPP and SVPP to Sacramento.

Background. The *Coleman* federal court monitors the provision of mental health care of California's prison inmates, as the result of a class-action lawsuit brought against the California Department of Corrections and Rehabilitation (CDCR) asserting that they were not providing adequate mental health care to inmates. Because of remedies required by the *Coleman* court, when inmates require inpatient mental health care, they are referred to DSH, which places them in either the SVPP or the VPP.

In November 2009, the CDCR, working collaboratively with the Federal Receiver overseeing inmate medical care, filed a Long-Range Integrated Strategy Plan to reduce overcrowding and provide for increased medical and mental health treatment beds. Construction of the CHCF was included in the long-range plan and is key to ultimately satisfying both the *Coleman* and *Plata* (medical) courts.

The CHCF is currently under construction, with intake of inmates scheduled for July 22 of this year. The facility will include 1,722 beds of all security levels and will provide all necessary support and rehabilitation program spaces. CHCF establishes specialized housing with necessary treatment for a population of seriously and chronically, medically and mentally ill inmates. Within CHCF, DSH will be responsible for 514 licensed and Joint Commission accredited beds, which will be known as the Stockton Psychiatric Program (SPP). These beds will include 432 intermediate level-of-care beds for high-level (custody level IV) inmates and 82 acute level-of-care beds, which will serve inmates of all custody levels.

The Governor's budget included $114.9 million and 931 positions for DSH's beds at CHCF. DSH states that it has undertaken outreach and education efforts to affected staff at Vacaville and Salinas, thereby providing information about employment opportunities at SPP. The hiring plan has been phased in over a two-year period to

accommodate building activations, licensing and patient movement plans. DSH expects to fill all positions by December 2013. The January budget did not include the savings from staff reductions at VPP and SVPP, and DSH indicated that this savings would be reflected in the May Revision.

The subcommittee reviewed this issue and proposal on April 18, 2013 and approved of the requested resources for CHCF of approximately $100 million GF.

May Revise

The May Revision has four proposals related to the activation of the new CHCF in Stockton:

1) **An increase in staff at CHCF (Stockton).** DSH proposes 59 additional staff above the 931 included in the CHCF staffing plan, and $8.4 million GF for full year resources. According to DSH, they took a closer look at staffing needs and made an assessment that a higher level of staffing is appropriate and necessary.

2) **The expected transfer of staff from Vacaville and Salinas to Stockton.** Based strictly on current staffing levels and the number of "beds" transferring from Vacaville and Salinas to Stockton (described as the "Blueprint"), the reduction of staff at VPP and SVPP would be 486.5 (full year positions) for savings of $45.2 million.

3) **An increase in retained staff at Vacaville and Salinas.** Rather than taking the full reduction in staff and savings, as could be projected based on patient migration to Stockton, DSH is proposing to retain approximately 234.2 full-year positions at VPP and SVPP, thereby reducing savings by $22.3 million (to $22.9 million). DSH expects to lay-off 133 despite this proposed retention.

4) **Centralization of Psychiatric Program Administration.** DSH is proposing to transfer 19 positions and $1.4 million from VPP and SVPP to Sacramento for oversight of fiscal, personnel and risk management.

	Reduction Based on Current Staffing				**May Revision Proposal**			
	Full-Year		Half-Year		Full-Year		Half-Year	
	Position Reduction	Funding Reduction	Position Reduction	Funding Reduction	Position Reduction	Funding Reduction	Position Reduction	Funding Reduction
Salinas	-271.5	-$24.8	-135.8	-$12.4	-189.5	-$16.1	-94.8	-$9.1
Vacaville	-215.0	-$20.4	-107.5	-$10.2	-62.8	-$6.9	-31.3	-$5.1
Total	**-486.5**	**-$45.2**	**-243.3**	**-$22.6**	**-252.3**	**-$22.9**	**-126.1**	**-$14.2**

The proposed retention of staff includes the following positions:

- Patient Treatment Teams (30 registered nurses)
- Patient Admission and Discharge (21 positions, various classifications)
- Patient Escorts and Staff Relief (167 Medical Technical Assistants)

- Centralized Administration (19 positions, various classifications)

Staff Comment. DSH reports that the staffing levels for the three CDCR programs included in these May Revise proposals are based on the department's assessment of staffing needs. However, staff has not been provided with sufficient information to determine whether the department's requests are justified. In addition, it is unclear why the proposed staffing augmentations contained in these requests could not have been included in the Governor's Budget or April Finance Letters, allowing the Legislature appropriate time to review.

The subcommittee approved of the resources for Stockton earlier this year with the expectation that substantial savings would be contained in the May Revise, as patients and staff transfer from VPP and SVPP. Instead, DSH has reinvested a significant portion of those savings into increased staff. It is surprising and unclear as to the reasons that this need for additional staff was unknown to DSH prior to the May Revision.

Recommendation. Approve the decrease of $22.6 million GF and 164.2 positions at the Salinas Valley Psychiatric Program and the Vacaville Psychiatric Program to reflect the migration of 450 beds to the DSH - Stockton. Hold open the remaining proposals.

Issue 2 – PATIENT MANAGEMENT AND BED UTILIZATION

Governor's Proposal. The May Revision proposes $1.8 million General Fund and 18 positions to establish a Patient Management Unit.

Background. The proposed Patient Management Unit will be dedicated to managing patient bed needs in order to maximize the utilization and capacity of state hospitals. The unit is planned to increase patient security by providing improved placements. It will also help to reduce wait lists by identifying all available beds throughout the hospital system, by maintaining a centralized patient population data repository to track patient referrals, transfers, wait lists, rejections, and demographics. This unit will be responsible for coordination of county bed purchases and the coordination of county placements for new admissions, establishment and oversight of patient placement resolution and appeal processes, management of patient data and liaison functions between DSH, California Department of Corrections and Rehabilitation and county clinicians.

The department currently is in the process of transforming the state's hospitals into an actual hospital system, from its historical mode of operation which has been as a collection of distinct, independent facilities. Within this vein, current practice is for judges or courts throughout the state to refer patients specifically to the hospital that is geographically closest, regardless of the availability of space at that, and the other hospitals, at any given time. The referrals also lack any consideration of the fact that the facilities are not all the same and have varying abilities to meet different types of patient needs.

The proposed unit includes four positions dedicated to data collection and management and research. DSH states that these positions, in addition to other responsibilities, would be responsible for taking on research projects to help the state better understand the state hospitals' population and answer questions, such as what are the causes of the increase in the wait list.

Staff Comment. Currently, there is no coordination between the facilities with regard to waiting lists, patient referrals, space available, and the redirection of referrals to more appropriate facilities. Nevertheless, Legislative staff lack sufficient time to fully evaluate the workload justification for the proposed number and types of staff being proposed for the new unit.

Recommendation. Hold open.

Issue 3 – ACTIVATION OF ADDITIONAL INTERMEDIATE CARE AND ACUTE UNITS

Governor's Proposal. The May Revision proposes $22.1 million ($16 million General Fund and $6.1 million reimbursements) and 173 positions to increase treatment capacity by 155 beds.

Background. DSH has indicated a steady increase in the waiting list for state hospital beds, from an average of 250 per week to the current size of approximately 382. In response, DSH is proposing to activate four new units and the conversion of one unit at three state hospitals, for a total increase of 155 beds, to address the wait lists for Incompetent to Stand Trail (IST) and Mentally Disordered Offender (MDO) commitments.

DSH has indicated to staff that they began implementing this expansion in February of this year. DSH will absorb current year (2012-13) costs, and this request for $22.1 million is for the budget year, 2013-14. The specific number of new beds, their location and intended patient type is described in the table below:

HOSPITAL	# NEW BEDS	POPULATION SERVED
Atascadero	35	IST
Coalinga	35	MDO
Coalinga	50	SVP
Metropolitan	35	LPS
Atascadero (conversion)	35	IST
Vacaville (temporary activation)	37	PC 2684
TOTAL	**155**	

IST - Incompetent to Stand Trial
MDO - Mentally Disordered Offender
SVP - Sexually Violent Predator
LPS – Lanterman-Petris-Short (Civil Commitments)

Staff Comment. Staff recognizes that DSH must address the size and growth of the patient waitlist and this proposal appears to be a step in the right direction. However, DSH has reported that they started implementing this plan in February of this year. As such, it is not clear why the department has chosen to wait until the May Revision to provide this request to the Legislature, allowing staff little time to evaluate the merits.

Recommendation. Hold open.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

May 23, 2013

Upon Adjournment of Appropriations

Room 4203
(John L. Burton Hearing Room)

Staff: Jennifer Troia

Agenda Part I

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.

ISSUES RECOMMENDED FOR VOTE-ONLY

A. 4300 Department of Developmental Services (DDS)

1. Regional Center Payments for Out-of-Pocket Health Insurance Costs

As discussed in the Subcommittee agenda for April 11, 2013, the Governor's budget includes increases of $15 million GF in 2012-13, and $9.9 million GF in 2013-14, to support payments by regional centers of health insurance co-pays and co-insurance payments tied to accessing services identified as necessary in the consumer's Individual Program Plan (IPP). The administration also proposes trailer bill language to specify the conditions under which regional centers would be authorized to make such co-payments going forward, and prohibits payment by regional centers of insurance deductibles.

Recommendation: Approve the proposed resources and trailer bill language, subject to the changes mentioned below, and any additional refinement in the trailer bill process:

1) Clarify that the trailer bill language is intended to cover co-insurance, as well as co-pays;

2) Clarify that the use of the word "parent" also includes guardians or caregivers; and

3) Include placeholder language to require data collection related to coverage by regional centers of co-payments and co-insurance.

2. Proposal to Eliminate Sunset Date for Annual Family Fee

As discussed in the Subcommittee agenda for April 11, 2013, the administration proposes trailer bill language to eliminate the sunset date on the required payment of annual fees of $150 or $200 by families with children under the age of 18, living at home, who receive services from regional centers beyond eligibility determination, needs assessment, and service coordination. As under existing law, the fees would only apply under specified circumstances. The department has also indicated that it is working with regional centers to increase implementation of the existing requirements.

Recommendation: Approve the proposal to make the annual family fee permanent. Additionally, direct the department to continue to work with each regional center to ensure that the fee will be implemented as intended, and to update the Subcommittee on those efforts.

3. Additional Trailer Bill Language Proposals

As discussed in the Subcommittee agenda for May 20, 2013, Disability Rights California has proposed trailer bill language to:

1) Clarify that restrictions on the use of Institutions for Mental Disease (IMDs), that were adopted in trailer bill language last year, were intended to apply irrespective of the age of the individual with a developmental disability.

2) Clarify that comprehensive assessments of the needs of developmental center (DC) residents that regional centers are required to conduct, under existing law, should specifically identify community-based services and supports that would enable the individual to move to a community-based setting (including specification that those services and supports should be considered for development in Community Placement Plans, if they are not already available), along with a requirement for regional centers to submit those assessments to the court and other parties to specified hearings, in response to the request of an adult who is seeking release from a DC;

3) Require notification of clients' rights advocates when placements in IMDs are made; when the required assessments of DC residents' needs are being shared at Individual Program Plan team meetings in which the team will be identifying the least restrictive placement setting that can meet a consumer's needs; and when courts are holding specified hearings in response to the request of an adult who is seeking release from a DC, along with clarification that the clients' rights advocate may attend those hearings; and

4) State that these requirements shall be construed in a manner that "affords an adult requesting release all rights under Welfare and Institutions Code section 4502, including the right to treatment and habilitation services and supports in the least restrictive environment and the Americans with Disabilities Act of 1990 (P.L. 101-336), as amended in 2008 (P.L. 110-325), including the right to receive services in the most integrated setting appropriate."

Recommendation: Approve placeholder trailer bill language, consistent with the proposals described above.

B. 5180 Department of Social Services

1. Proposed Changes Related to State Hearings

As discussed in the Subcommittee agenda for March 21, 2013, the Governor's budget requested $3.4 million ($1.3 million GF) to establish 21 new, permanent state staff positions to handle an increased state hearings caseload. The General Fund resources are proposed to be redirected from the payment of penalties for late hearing decisions. The department indicates that these late decisions are a result of caseload growth and that the amount of penalties has increased since 2006, totaling $1.1 million for 2011-12, and is projected to be as high as $1.8 million yearly over the next three years. Correspondingly, the Governor proposes trailer bill language to limit, for a period of three years, the department's exposure to those court-mandated penalties. Advocates have expressed concern with the administration's proposal to have the Legislature and Governor make those changes to the penalty structure, rather than having the parties propose any potential changes to the court that continues to retain jurisdiction over the litigation which established the penalty structure.

As discussed in the Subcommittee agenda for May 20, 2013, the May Revision additionally proposes an increase of $9.8 million ($3.5 million GF) for administration costs associated with anticipated state hearings workload related to proposed across-the-board reductions in In-Home Supportive Services (IHSS) hours. The proposed $176.4 million GF savings related to the reduction in 2013-14 is already net of these anticipated costs, which the administration indicates could be used to fund up to 24, temporary administrative law judge positions and corresponding support staff.

> **Recommendation:** In response to the Governor's January and May proposals, approve funding and authority for 24 new, permanent administrative law judges, and corresponding funding for 17 administrative support staff. The fiscal effect of this action should be determined by the administration, after consultation with Subcommittee staff. Additionally, defer, to a court-based process related to the underlying litigation that established the penalty structure, the potential for funding, through temporary penalty relief, state hearings resources necessary to get to timely decisions.

2. CalWORKs Early Engagement Proposal

As discussed in greater detail in the Subcommittee agenda for May 20, 2013, the May Revision requests an increase of $48.3 million GF in 2013-14, to improve early engagement and barrier removal processes and supports within the CalWORKs program, and to expand subsidized employment opportunities for CalWORKs Welfare-to-Work participants. The increased funding is intended to allow counties to perform more robust appraisals in order to identify the services that can best benefit program participants, which could include family stabilization services, barrier removal services, and employment services. Correspondingly, with respect to the subsidized employment component of the proposal, the Administration proposes trailer bill language to expand the number of slots available to participants. Finally, the administration proposes a one-time increase of $600,000 GF to support necessary

automation changes associated with the proposal.

> **Recommendation:** Approve the overall amount of funding associated with the administration's proposal and adopt the administration's subsidized employment-related language, as placeholder language, subject to refinement. Additionally, adopt placeholder trailer bill language to: 1) require the statewide use of the proposed tool for conducting more robust appraisals, 2) provide a framework and add specificity regarding the services that will be available as family stabilization services, and 3) make related changes to existing law regarding the flow of welfare-to-work services.

3. Human Services Realignment Proposals Associated with Health Care Reform

As discussed in greater detail in the Subcommittee agenda for May 20, 2013, the administration is proposing that over time, as the state assumes more responsibility for health care, counties will take on more financial responsibility for certain human services programs. The administration estimates that $300 million in 2013-14, $900 million in 2014-15, and $1.3 billion in 2015-16 in 1991 realignment funding will shift from local health programs to local human services programs. The administration indicates that the actual amount shifted would, however, be based on each county's experience with implementing the optional expansion of Medi-Cal. The administration has not yet provided detailed trailer bill language outlining the fiscal and/or programmatic changes being proposed.

> **Recommendation:** Reject the programmatic aspects of the administration's human services realignment proposal. To the extent that the Senate takes actions with respect to health care reform that result in an amount of 1991 realignment funding that could become available to offset General Fund, adopt instead a fiscally-based transaction (e.g., tied to funding for CalWORKs grants, CalFresh administration, or other programs).

4. Temporary Assistance for Needy Families (TANF) Transfer to Student Aid Commission

The 2012-13 budget redirected an unprecedented amount of California's federal Temporary Assistance to Needy Families (TANF) block grant funding ($804 million) away from CalWORKs and to the California Student Aid Commission (CSAC) to be used for expenditures in the Cal Grants program, which provides financial aid for students obtaining a higher education. The funds were swapped, dollar-for-dollar, to redirect an equal amount of General Fund monies that would have been spent on Cal Grants to instead be spent on CalWORKs. The Governor's budget proposes to make the same swap in 2013-14, but at an even higher level ($924.2 million in the May Revision). This would mean that more than half of the Cal Grants program would be supported by federal TANF funding.

> **Recommendation:** Consistent with the prior action of this Subcommittee, reduce the TANF transfer to CSAC to eliminate any amount of the transfer that is tied to the creation of excess Maintenance of Effort (MOE) funding. The final amount of the change should be determined by the administration, after consultation with Subcommittee staff and the LAO. This will also require making conforming, technical

changes to replace a corresponding amount of TANF funds, previously budgeted under CSAC, with General Fund. The overall budget impact of the change should be neutral to the General Fund at the statewide level.

5. Trailer Bill Language Related to Implementation of AB 6 (Chapter 501, Statutes of 2011)

As discussed in greater detail in the agenda for the Subcommittee hearing on May 20, 2013, the May Revision proposes trailer bill language intended to more closely align state law established by AB 6 with federal requirements regarding eligibility reporting and Low-Income Home Energy Assistance Program (LIHEAP) policies, and to make other changes regarding the deductions available to recipients. Advocates have additionally suggested these two changes to the administration's proposed language:

1) On page 2, subsection (c), amend to read:

> "(c) …In the event a complete certificate is not received by the 15th day of the month in which the certificate is due, a personal contact shall be made with the family by a county worker, and the certificate shall then be completed with the assistance of the eligibility worker, if needed…"

2) On page 6, strike subdivision (b)(2) of section 11265 to align CalWORKs and CalFresh requirements with the denial of a federal waiver related to CalFresh policy.

> **Recommendation:** Adopt the administration's proposed trailer bill language, along with the changes recommended by advocates, as placeholder language, subject to refinement in the trailer bill process.

6. Coordinated Care Initiative – Statewide Authority

As discussed in the Subcommittee agenda for May 20, 2013, the administration is requesting an increase of $518,000 ($259,000 GF and $259,000 reimbursements) and four positions (two permanent and two limited-term) to support the creation and implementation of the California In-Home Supportive Services Authority (Statewide Authority) and Statewide Advisory Committee. The Statewide Authority is the entity required to assume In-Home Supportive Services (IHSS) provider collective bargaining responsibilities from counties that transition IHSS benefits to managed care plans under the Coordinated Care Initiative.

Additionally, stakeholders propose the following trailer bill language intended to make technical changes to the budget trailer bill from last year (SB 1036, Chapter 45, Statues of 2012) that established the Statewide Authority:

> Section 110032 of the Government Code is amended to read:
>
> 110032. After the applicable mediation procedure has been exhausted, factfinding has been completed and made public, and no resolution has been reached by the parties, the Statewide Authority may declare an impasse and implement any or all of its last, best, and final offer. Any

proposal in the Statewide Authority's last, best, and final offer that, if implemented, would conflict with existing statutes or require the expenditure of funds shall be presented to the Legislature for approval. The unilateral implementation of the Statewide Authority's last, best, and final offer shall not deprive a recognized employee organization of the right each year to meet and confer on matters within the scope of representation, whether or not those matters are included in the unilateral implementation, prior to the adoption of the annual budget or as otherwise required by law.

Recommendation: Approve the requested resources and positions, and adopt placeholder trailer bill language as clean-up to SB 1036.

7. Foster Family Home and Small Family Home Insurance (FSH) Fund

As discussed in the Subcommittee agenda for April 11, 2013, the Administration proposes, in a Spring Finance Letter, to reduce the previously proposed 2013-14 funding for the FSH Fund by $140,000 GF. The letter also proposes a one-time transfer of $2.3 million from the FSH Fund to the General Fund to return excess surplus funds, as identified by the administration, that have accumulated because recent expenditures have been lower than budgeted.

Recommendation: Approve the requested adjustments.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

May 23, 2013

Agenda Part I Outcomes

A. 4300 Department of Developmental Services (DDS)

1. Regional Center Payments for Out-of-Pocket Health Insurance Costs

Approved (2-1, Emmerson no) the proposed resources and trailer bill language, subject to the changes mentioned below, and any additional refinement in the trailer bill process:

1) Clarification that the trailer bill language is intended to cover co-insurance, as well as co-pays;

2) Clarification that the use of the word "parent" also includes guardians or caregivers; and

3) Inclusion of placeholder language to require data collection related to coverage by regional centers of co-payments and co-insurance.

2. Proposal to Eliminate Sunset Date for Annual Family Fee

Approved (3-0) the proposal to make the annual family fee permanent. Additionally, directed the department to continue to work with each regional center to ensure that the fee will be implemented as intended, and to update the Subcommittee on those efforts.

3. Additional Trailer Bill Language Proposals

Adopted (3-0) placeholder trailer bill language, consistent with the proposals described above.

B. 5180 Department of Social Services

1. Proposed Changes Related to State Hearings

Approved (2-1, Emmerson no) funding and authority for 24 new, permanent administrative law judges, and corresponding funding for 17 administrative support staff. The fiscal effect of this action should be determined by the administration, after consultation with Subcommittee staff. Additionally, defer, to a court-based process related to the underlying litigation that established the penalty structure, the potential for funding, through temporary penalty relief, state hearings

resources necessary to get to timely decisions.

2. CalWORKs Early Engagement Proposal

Approved (2-1, Emmerson no) the overall amount of funding associated with the administration's proposal and adopt the administration's subsidized employment-related language, as placeholder language, subject to refinement. Additionally, adopted placeholder trailer bill language to: 1) require the statewide use of the proposed tool for conducting more robust appraisals, 2) provide a framework and add specificity regarding the services that will be available as family stabilization services, and 3) make related changes to existing law regarding the flow of welfare-to-work services.

3. Human Services Realignment Proposals Associated with Health Care Reform

Rejected (3-0) the programmatic aspects of the administration's human services realignment proposal. To the extent that the Senate takes actions with respect to health care reform that result in an amount of 1991 realignment funding that could become available to offset General Fund, adopted instead a fiscally-based transaction (e.g., tied to funding for CalWORKs grants, CalFresh administration, or other programs).

4. Temporary Assistance for Needy Families (TANF) Transfer to Student Aid Commission

Consistent with the prior action of this Subcommittee, voted (2-1, Emmerson no) to reduce the TANF transfer to CSAC to eliminate any amount of the transfer that is tied to the creation of excess Maintenance of Effort (MOE) funding. The final amount of the change should be determined by the administration, after consultation with Subcommittee staff and the LAO. This will also require making conforming, technical changes to replace a corresponding amount of TANF funds, previously budgeted under CSAC, with General Fund. The overall budget impact of the change should be neutral to the General Fund at the statewide level.

5. Trailer Bill Language Related to Implementation of AB 6 (Chapter 501, Statutes of 2011)

Adopted (2-1, Emmerson no) the administration's proposed trailer bill language, along with the changes recommended by advocates, as placeholder language, subject to refinement in the trailer bill process.

6. Coordinated Care Initiative – Statewide Authority

Approved (2-1, Emmerson no) the requested resources and positions, and adopted placeholder trailer bill language as clean-up to SB 1036.

7. Foster Family Home and Small Family Home Insurance (FSH) Fund

Approved (3-0) the requested adjustments.

SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Bill Monning

Senator Mark DeSaulnier
Senator Bill Emmerson

May 23, 2013

Upon Adjournment of Appropriations Committee

Room 4203, State Capitol
(John L. Burton Hearing Room)

Agenda Part 2
(Michelle Baass)

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VOTE ONLY

4150 Department of Managed Health Care

1. Coordinated Care Initiative

Budget Issue. DMHC requests to extend 13.0 limited term positions, set to expire June 30, 2013, and add 3.5 new limited term positions to address the workload associated with the transition of dual eligible enrollees in eight counties into managed health care under the Coordinated Care Initiative (CCI). These positions would expire on June 30, 2016.

DMHC also requests $334,000 for consultant services to perform triennial medical plan surveys and financial audits. DMHC indicates that consultants provide specialized medical expertise beyond the scope of the health care service plan analyst classifications and will support DMHC in evaluating the specific elements related to the care for dual eligible beneficiaries.

This proposal would be funded by 50 percent Managed Care Fund and 50 percent reimbursement from the Department of Health Care Services (DHCS) seeking a federal match.

Subcommittee Staff Comment and Recommendation—Approve. This issue was heard on April 4, 2013. No issues have been raised.

4260 Department of Health Care Services

1. Medi-Cal Coverage of County Medical Parole and Compassionate Release

Budget Issue. DHCS requests one permanent position to implement SB 1462 (Leno, Statutes of 2012), which provides Medi-Cal to eligible county inmates on medical parole and inmates granted compassionate release. The annual cost for this position is $103,000 total funds ($51,000 reimbursement from counties, and $52,000 federal funds).

Subcommittee Staff Comment and Recommendation—Approve and adopt placeholder trailer bill language. It is recommended to approve the position and adopt placeholder trailer bill language to ensure the cost neutrality (i.e., no General Fund impact) of SB 1462.

This issue was heard on May 9, 2013.

2. Non-Designated Public Hospital Program – Position Request

Budget Issue. DHCS requests permanent expenditure authority and the conversion of six limited-term 1115 Bridge to Reform Waiver positions to permanent to implement and maintain the new Non-Designated Public Hospital (NDPH) program, implemented as part of the 2012 budget. The six positions requested are existing limited-term positions that were originally approved to work on the 1115 Bridge to Reform Waiver. The cost of these positions is $827,000 ($414,000 General Fund and $413,000 federal funds).

Subcommittee Staff Comment and Recommendation—Reject. It is recommended to reject this request since the Administration is not proceeding with changes to the NDPH program because federal CMS approval was not obtained (this issue is discussed in more detail later in the agenda). This position request was heard on May 2, 2013.

3. Eliminate Physician and Clinic Seven Visit Cap

Budget Issue. The Administration has indicated that it is withdrawing its state plan amendment (SPA) that caps the number of physician visits and clinic visits, including Federally Qualified Health Centers and Rural Health Clinics (FQHCs/RHCs), allowed per Medi-Cal beneficiary, at seven per year, as it became apparent that the federal CMS would not approve this SPA. It made the decision to withdraw the SPA after the May Revision.

Background. AB 97 (a 2011 budget trailer bill) capped the number of physician visits and clinic visits, including Federally Qualified Health Centers and Rural Health Clinics (FQHCs/RHCs), allowed per Medi-Cal beneficiary, at seven per year. The cap on the number of physician and clinic visits is for adults, 21 years of age or older, that do not meet the statutory exemptions or exceptions criteria.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt placeholder trailer bill language to remove this cap in statute since it would not be approved by the federal CMS.

4. Eliminate Contractor Costs to Survey Drug Price Information

Budget Issue. The May Revision includes $500,000 General Fund to hire a contractor to survey drug price information from Medi-Cal pharmacy providers and update maximum allowable ingredient costs and average acquisition costs on an ongoing basis. AB 102 (a 2011 budget trailer bill) authorizes DHCS to develop a reimbursement methodology for drugs based on a new benchmark. To assist in developing this benchmark, DHCS had anticipated hiring a contractor to conduct surveys.

On May 15th, DHCS notified stakeholders that it has placed on hold the procurement for an average acquisition cost study vendor while it awaits and considers further federal CMS guidance regarding national pricing benchmarks.

Subcommittee Staff Comment and Recommendation—Reduce "Other Administration" expenditures by $500,000 General Fund. Since the state has put the procurement for a survey on hold, it is recommended to reduce DHCS's other administration expenditures by $500,000.

5. CCI Long Term Care Division - Position Request

Budget Issue. DHCS's Long-Term Care Division requests the extension of one full-time limited-term position (a Health Program Manager III) for a three-year term. This position would continue work related to the implementation of the Duals Demonstration Project/Coordinated Care Initiative (CCI).

The cost for this position is $150,000 ($75,000 General Fund and $75,000 federal funds).

Background. SB 208 (Statutes of 2010) directed DHCS to establish pilot projects in up to four counties to develop effective health care models to provide services to persons who are dually eligible under both the Medi-Cal and Medicare programs (the Dual Demonstration). SB 1008 (a 2012 budget trailer bill) authorized CCI and expanded the Dual Demonstration to an additional four counties and included the integration of long-term supports and services (LTSS), including the Multi-Purpose Senior Services Program and In-Home Supportive Services, into a Medi-Cal managed care benefit.

The position requested to be extended in this proposal would help facilitate LTSS integration into managed care health plans participating in the Duals Demonstration. In addition, this position would work with the California Department of Aging and the California Department of Social Services, on developing the universal LTSS assessment process and tool.

Subcommittee Staff Comment and Recommendation—Approve.

4560 Mental Health Services Oversight and Accountability Commission

1. Guidelines for Prevention and Early Intervention Projects

Issue. The Mental Health Services Oversight and Accountability Commission (OAC) is responsible for developing guidelines for prevention and early intervention (PEI) projects.

AB 1467 (a 2012 budget trailer bill) implemented changes to the Mental Health Services Act (MHSA, Proposition 63) and gave the Department of Health Care Services authority to issue

regulations regarding the MHSA. This is technical clean-up language regarding last year's trailer bill that transferred and consolidated community mental health.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt placeholder trailer bill language to clarify the responsibility of OAC regarding PEI guidelines.

ISSUES FOR DISCUSSION

4260 Department of Health Care Services

1. Medi-Cal Baseline Caseload and Budget – May Revision Update

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

Governor's May Revision. The May Revision proposes total expenditures of $69.2 billion ($16.1 billion General Fund) for 2013-14 which represents *an increase* of $9.4 billion (total funds), or 15.7 percent more than the current-year.

Medi-Cal caseload is projected to be 9,117,000, which represents a 15.5 percent increase compared to current year (and reflects the Administration's assumptions on take-up regarding Medi-Cal expansion).

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

	2012-13 Revised	2013-14 Proposed	Difference	Percent
Benefits	$55,901.3	$64,829.5	$8,928.2	16%
County Administration (Eligibility)	3,564.4	3,976.9	412.5	11.6%
Fiscal Intermediaries (Claims Processing)	312.7	355.7	43.3	13.8%
Total-Local Assistance	**$59,778.4**	**$69,162.1**	**$9,383.7**	**15.7%**
General Fund	$15,251.1	$16,072.3	$821.1	5.4%
Federal Funds	$35,918.0	$42,325.4	$6,407.4	17.8%
Other Funds	$8,609.3	$10,764.3	$2,155.0	25.0%

LAO Comment. Based on its review of recent caseload data, the LAO finds that the Administration's revised estimates of Medi-Cal caseload, which are unrelated to the federal Affordable Care Act, are reasonable.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve adjustments in caseload and budget, with any changes to technically conform as appropriate to other actions that have been or will be taken.

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

1. Please provide a high-level overview of the changes to the Medi-Cal budget from the January budget.

2. ACA – "Optional" Medi-Cal Expansion

Special Legislative Session on Health Care Reform. The Legislature has special session bills SBX1 1 (Hernandez and Steinberg) and ABX1 1 (Perez) that implement the expansion of Medi-Cal coverage in California to low-income adults with incomes between 0 and 138 percent of the federal poverty level (FPL), establishes the Medi-Cal benefit package for this expansion population, and requires the existing Medi-Cal program to cover the essential health benefits (EHB) contained in the federal Affordable Care Act (ACA). Additionally, these bills implement a number of Medi-Cal ACA provisions to simplify the eligibility, enrollment, and renewal processes for Medi-Cal. (SBX1 1 and ABX1 1 are identical bills.)

Budget Issue. In the May Revision, the Administration has finally made a proposal regarding the "optional" Medi-Cal expansion for newly eligible childless adults, with incomes up to 138 percent of the federal poverty level, as provided under the federal Affordable Care Act (ACA):

- **State-Based Expansion.** The Governor has concurred with the Legislature (as specified in SBX1 1 and ABX1 1) to implement this expansion on a statewide-basis. The Governor's January budget proposed two-options, a state-based option and a county-based option.

- **Benefit Package.** The Administration proposes that Medi-Cal benefit package for these newly eligible individuals would be the same as the current Medi-Cal benefit package, including county-administered specialty mental health services and county-supported substance use disorder services.

  Long-term care services would be covered, provided that the federal government approves the retention of an asset test for these services. At a county's option, existing enrollees and newly eligible individuals could receive an enhanced benefit package for substance use disorders.

  In contrast, SBX1 1 and ABX1 1 provide a more comprehensive benefit package in that these bills propose that the Medi-Cal benefit package cover the EHB contained in the ACA. For example, SBX1 1 and ABX1 1 provide enhanced substance use disorder services as part Medi-Cal. Whereas, the Administration's proposal allows counties to provide enhanced substance use disorder and could lead to county differences in these services.

- **Mechanism to Capture County Savings.** The May Revision estimates that counties would save $300 million in 2013-14, $900 million in 2014-15, and $1.3 billion in 2015-16 as individuals who were previously uninsured would gain health coverage through Medi-Cal expansion or through health coverage available through Covered California (California's Health Benefit Exchange).

  The Administration indicates that these are only estimates and it proposes that a mechanism be developed to determine the level of county savings based on *actual*

experience. These savings would be withheld from counties health realignment funding and would be "trued-up" once actual data became available. This mechanism is discussed in more detail below.

- **County Savings on Indigent Care Redirected to Support Human Services Programs at the Local Level.** The May Revision proposes to redirect the previously specified county savings on indigent care to support human services programs at the local level. These programs include CalWORKs, CalWORKs-related child care programs, and CalFresh (formerly Food Stamps). This issue was discussed at the Subcommittee hearing on May 20th.

- **Pregnant Women Shift to Covered California.** The May Revision includes a decrease of $26.4 million General Fund in 2013-14 to reflect that pregnant women with incomes between 100 percent and 200 percent of the federal poverty level, who are currently eligible for Medi-Cal, would instead receive health coverage through Covered California, beginning in 2014.

  The May Revision proposes for the state to cover all cost sharing not covered by the federal advance premium tax credits and any Medi-Cal benefits that are not provided under the coverage obtained via Covered California.

- **Newly Qualified Immigrants Shift to Covered California.** The May Revision includes a decrease of $5.4 million General Fund in 2013-14 to reflect that individuals, who would otherwise have been eligible under Medi-Cal as newly qualified immigrants, would instead receive coverage through Covered California, beginning in 2014.

  The May Revision proposes for the state to cover all cost sharing not covered by the federal advance premium tax credits and any Medi-Cal benefits offered under the expansion benefit package that are not provided under the coverage obtained via Covered California.

- **County Administrative Costs.** The May Revision includes an increase of $71.9 million in 2013-14 for increased county costs to implement the ACA. This includes additional resources to process new applications and redeterminations, develop training materials, train county eligibility workers, and support planning and implementation activities. The Administration proposes to base future appropriations on a time study of resource needs, beginning in 2015-16. This item will be discussed in more detail later in the agenda.

The cost to implement this expansion is $1.5 billion ($21 million General Fund and $1.5 billion federal funds) in 2013-14. Under the ACA, the federal government will pay for 100 percent of the costs for this population for the first three years (2014-2016), with funding gradually decreasing to 90 percent in 2020.

Mechanism to Determine County Savings. The Administration proposes to establish a single mechanism to determine the level of county savings resulting from implementation of the ACA that is based on actual experience.

This mechanism will determine savings on a county by county basis. Each county's savings will be determined by measuring actual county costs for providing Medi-Cal and uninsured services and the revenues received for such services, including federal funds, as well as an established baseline of health realignment and other county contribution to health services. To the extent that the combination of revenues for services and realignment/county contribution exceeds the county's costs, the amount of that excess will be considered savings and will be redirected to human services programs.

Additionally, given the cost-basis of this mechanism, the Administration proposes to include appropriate incentives for cost containment and maximizing enrollment into coverage for counties. Therefore a cap on cost growth will be included in the determination of county costs used in this calculation; this cap will be based on historical county cost trends.

The intention of this mechanism is that the counties maintain funding for services to the uninsured at today's level of service and reimbursement, since other support for the safety net will be provided through the coverage expansion at the state level.

Finally, it is proposed that this mechanism be time-limited until such point that stability has occurred with respect to the shifting health care costs and responsibilities between the counties and the state at which time the shift of county fiscal and programmatic responsibility for human services will be finalized. The Administration estimates that this could be in eight to ten years.

Maintaining County Safety Net. The Administration acknowledges that the state has an interest in maintaining a strong public safety net to ensure access to health care services, particularly in the Medi-Cal program. As a part of the optional Medi-Cal expansion, the Administration indicates that it will work with the county safety net in an effort to ensure that those providers have a viable patient base of beneficiaries as well as adequate rates for services provided to that population. In addition, the Administration has committed to maximizing federal funding through the development and procurement of a future Medicaid Waiver to replace the existing Waiver that expires in 2015.

Subcommittee Staff Comment and Recommendation—Hold open. It is recommended to hold this item open. Significant concerns have been raised by various stakeholders regarding this proposal and the withholding of $300 million in county realignment funds in the budget year.

Counties and other stakeholders contend that there are too many unknowns in regards to how individuals might receive coverage and counties need to maintain adequate funding for ongoing indigent care, public health responsibilities, and infrastructure development.

Additionally, concerns have been raised that the proposed mechanism treats all counties in the same manner regardless of if they have a public hospital (12 counties), are a County Medical Services Program (CMSP) county (35 counties), or provide indigent care under a different system (11 counties).

This proposal is unclear and there are many unanswered questions. No data has been provided to support withholding $300 million in county indigent care realignment funding in the budget year. Additionally, trailer bill language to implement this proposal has not yet been received.

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

1. Please provide an overview of this proposal.

2. What is the timeline for finalizing the details of this mechanism?

3. What is the basis of the $300 million in county savings on indigent care?

3. ACA – MAGI Income Conversion – State True-Up on General Fund Savings

Issue. The state is currently developing its modified adjusted gross (MAGI) income conversion standard. This standard will define what Medi-Cal population would be eligible for claiming enhanced federal funding (100 percent starting in 2014 for three years and decreasing to 90 percent in 2020).

It is anticipated that certain currently eligible individuals (in the parent/caretaker relative eligibility category) could be eligible for claiming of enhanced federal funding depending on where the income conversion standard is set, and; consequently, the state could achieve General Fund savings as federal funds cover a higher percentage of these costs.

Background—MAGI Conversion Standard. The Affordable Care Act (ACA) changes the way income will be counted for determining Medi-Cal eligibility. Historically, states have calculated eligibility using net income standards incorporating various disregards. Disregards vary by state, eligibility category, and income source. For example, when counting income for parents and children, states typically disregard $90 of earnings per worker in a household and disregard at least $50 in child support payments received.

In addition to income disregards, states may also deduct certain expenses from counted income and may augment these deductions. In the case of determining eligibility for parents and children, states commonly deduct between $175 and $200 of monthly child care expenses (based on the age of the child) from counted income.

After 2014, states will assess eligibility using MAGI for most populations, and current state-specific disregards will be replaced by a general disregard of five percent of the current federal poverty level (FPL) for the applicable family size.

The transition to MAGI involves converting current net income eligibility standards to MAGI standards. Federal guidance sets out two options for a state to use a standardized MAGI conversion methodology (1) a federal methodology using state-adjusted data or (2) a state-developed alternative methodology that must be approved by CMS.

As explained in CMS guidance, the primary objective in establishing a methodology to convert from the current net income standard and eligibility group to the converted MAGI standard and eligibility group is to produce no change in aggregate eligibility, though some individuals will likely gain or lose eligibility, or move from one eligibility group to another. The conversion process should not systematically increase or decrease eligibility overall.

Implications of MAGI Conversion Standard. The MAGI conversion standard will define the "entry point" to where the state can claim enhanced federal financial participation (100 percent starting in 2014) for the newly eligible individuals. Importantly, the state may be able to set the MAGI conversion standard at a level that could allow the state to claim enhanced federal funding (100 percent) for certain currently eligible parent/caretaker relatives.

Consequently, the state would receive enhanced federal funding (100 percent) for this already eligible population.

This conversion level would be effective January 1, 2014 and would immediately be applied to the state's claiming for federal financial participation.

Develop State True-Up Mechanism to Keep General Fund Savings in Health Programs. It is estimated that there are over a million individuals eligible under the parent/caretaker relative category.

If a portion of these individuals exceed the MAGI conversion standard and are eligible for enhanced federal funding the state could achieve hundreds of millions of dollars in General Fund savings as federal funds cover a greater share of the Medi-Cal costs for these individuals.

It is critical that the Legislature maintain oversight of the implications of this conversion standard and direct the resulting state savings to health, mental health, and substance use disorder services.

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is too soon to tell at what level California's MAGI conversion standard will be set. However, it is likely that it would be set at a level that would include some individuals (in the parent/caretaker relative eligibility category) that are currently receiving Medi-Cal.

It is recommended to adopt placeholder trailer bill language to require the Administration to develop a "true-up" mechanism to identify the General Fund savings as a result of the state receiving an enhanced federal matching rate for currently enrolled individuals that exceed the MAGI conversion standard. This language would direct the General Fund savings to be used to invest in health, mental health, and substance use disorder services.

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

1. Please provide an overview of this proposal.

2. When does the Administration plan to submit its proposed MAGI conversion standard methodology to CMS?

4. ACA – County Eligibility Processing Costs

Budget Issue. The budget includes three components (for a total of about $100 million General Fund) to address the increased county costs as a result of the ACA-related workload at county human services departments:

1. The May Revision includes an increase of $143.8 million ($71.9 million General Fund) in 2013-14 for increased county costs to implement the ACA. This includes $65 million to process new applications and redeterminations, $4 million to develop training materials, train county eligibility workers, and $2.9 million support planning and implementation activities. The Administration proposes to base future appropriations on a time study of resource needs, beginning in 2015-16.

2. A $30.8 million ($15.4 million General Fund) cost of doing business increase for county staff who perform tasks as part of the Medi-Cal Eligibility process.

3. The ability to rollover unspent funding from the current year. It is estimated that $15 to $35 million General Fund might be available from the current year for the budget year.

Background. The state delegates various administrative functions to counties, such as intake and eligibility determinations of new Medi-Cal applications and ongoing eligibility case management activities. Generally, the state allocates funds to counties based on expected workload and costs.

County human services departments will play an important role in ensuring the successful implementation of health care reform. Starting in October, these departments will begin early enrollment of individuals and families into the new Medi-Cal expansion program as well as the coverage offered under Covered California. Counties anticipate receiving walk-in traffic at county offices throughout the state, as well as an increase in direct phone calls and applications through our online systems. Additionally, 32 counties will be receiving calls transferred from the main Covered California service center when the caller is identified as likely Medi-Cal eligible. The goal of all of these efforts is to maximize customer-friendly service and provide real-time enrollment decisions to as many applicants as possible.

LAO Findings. The LAO has expressed concerns regarding the proposed increase in funding for county eligibility processing given the uncertainty of how the simplification of the eligibility determination process (as required by the ACA) might reduce the average cost per enrollee across the entire Medi-Cal population. Additionally, the LAO notes that the Administration has provided very little detail to support these proposals.

Subcommittee Staff Comment and Recommendation—Modify. Concerns have been raised that county human services departments need additional funding, beyond what is proposed in the May Revision, to ensure a successful implementation of the ACA and to meet performance requirements for processing Medi-Cal applications.

The County Welfare Directors Association (CWDA) conducted its own cost analysis related to ACA implementation and believes that counties will need $120 million in order to implement the ACA efficiently and in a timely manner. Therefore, although CWDA supports the May Revision, they also believe that an additional approximate $20 million will be necessary for counties. In order to achieve this additional $20 million, CWDA request a one-time rollover of potential unspent funds from the current year CalWORKs single allocation, up to a maximum of $120 million General Fund, to county administration.

Counties have not received a cost-of-living adjustment for five years. They are key partners in ensuring the successful implementation of the ACA and the enrollment of millions of new individuals into Medi-Cal.

Consequently, it is recommended to do the following:

- **Approve** the proposed May Revision increases specified above for county administrative costs associated with the implementation of the ACA.

- **Adopt budget bill language** to allow a one-time rollover of potential unspent funds from the current year CalWORKs single allocation to county administration, up to a maximum of $120 million General Fund from all county administration proposals discussed in this item

- **Adopt uncodified placeholder trailer bill language** requiring the Department of Social Services to work together with counties, advocates for clients, and Legislative staff to ensure that there is no unintended impact of this action on clients' access to employment services or child care.

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

1. Please provide an overview of this proposal.

5. Managed Care Organization Tax

Budget Issue. The May Revision proposes a permanent reauthorization the managed care organization (MCO) tax, a tax on Medi-Cal managed care plans:

- In 2012-13, the tax rate would be equal to the gross premiums tax (2.35 percent) to generate $128.1 million General Fund savings. The current year revenues would be directed to the Healthy Families Program. The proposed trailer bill language also provides for a General Fund loan to the Managed Risk Medical Insurance Board to cover the costs of the Healthy Families Program until MCO tax revenue is received.

- In 2013-14, and beyond, the rate would be equal to the state sales and use tax rate (3.9375 percent) and would generate about $342.9 million in General Fund savings on an ongoing basis.

  In the budget year, it is projected that the MCO tax would generate $644 million in revenue. Half of these funds would be used to draw down federal Medi-Cal funds and then used to pay back Medi-Cal managed care plans. And the other half of these funds would be used to offset General Fund expenditures for Medi-Cal managed care rates for children, seniors and persons with disabilities, and dual eligibles.

Subcommittee Staff Comment and Recommendation—Hold open. It is recommended to hold this item open. Subcommittee staff and health plans have requested more information regarding managed care plan rates that has not yet been received.

Additionally, as has been previously been discussed in Subcommittee, a permanent extension of this tax does makes is it difficult to periodically evaluate its effectiveness and its impact on Medi-Cal managed care.

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

1. Please provide an overview of this proposal.

6. Coordinated Care Initiative

Budget Issue. The May Revision proposes changes to the Coordinated Care Initiative (CCI) resulting in $119.6 million General Fund savings in 2013-14. See table on following page for a summary of CCI savings.

The May Revision proposes the following changes to CCI:

- Delay the CCI start date from October 1, 2013 to no sooner than January 1, 2014.

- Implement a scheduled phasing-in of CCI enrollment. Los Angeles County would phase-in beneficiaries over 12 months (subject to discussions with the federal government). San Mateo County would enroll all beneficiaries over three months. Orange, San Diego, San Bernardino, Riverside, Alameda, and Santa Clara counties would phase-in over 12 months.

- Reflect a revised number of enrollees estimated at 456,000, which is almost half the size of the number of enrollees estimated in the 2012 budget. This includes a cap of no more than 200,000 participants in Los Angeles County.

The Administration indicates that trailer bill language regarding these changes (and potentially others) is forthcoming.

Background. The Coordinated Care Initiative (CCI) integrates medical, behavioral health, and long-term support and services for individuals who are eligible for both Medi-Cal and Medicare (dual eligibles) through a single health plan. The CCI also enrolls dual eligibles in managed care plans for their Medi-Cal benefits. The CCI is a demonstration project in eight counties. The state and federal government entered into a Memorandum of Understanding (MOU) regarding the CCI on March 27, 2013.

Table: Summary of Projected Coordinated Care Initiative Savings

	2013-14		2014-15 (8 counties)		Annual (8 counties)	
(Whole Dollars)	Total Funds	General Fund	Total Funds	General Fund	Total Funds	General Fund
SAVINGS						
Dual Medi-Cal Savings	159,740,728	79,870,364	192,945,500	96,472,750	-164,384,129	-82,192,065
Non Duals Medi-Cal Savings	275,681,883	137,840,942	-626,130	-313,065	-122,678,606	-61,339,303
Total	**435,422,612**	**217,711,306**	**192,319,371**	**96,159,685**	**-287,062,735**	**-143,531,367**
Payment Deferrals						
Defer Managed Care Payment	-437,827,767	-218,913,884	-304,870,977	-152,435,489	0	0
Delay 1 Checkwrite	39,640,925	19,820,463	92,640,370	46,320,185	0	0
Revenue						
Increased MCO Tax from CCI Population	-25,594,590	-25,594,590	-109,388,744	-109,388,744	-160,241,144	-160,241,144
Incremental Increase from shifting to MCO Tax at Sales Tax Rate	-115,180,445	-115,180,445	-124,394,881	-124,394,881	-219,811,908	-219,811,908
Savings Sub-Total	**-103,539,266**	**-122,157,151**	**-253,694,861**	**-243,739,243**	**-667,115,787**	**-523,584,419**
COSTS						
Increased DHCS Costs						
Administrative Costs	5,172,000	2,542,500	5,172,000	2,542,500	5,172,000	2,542,500
Costs Sub-Total	**5,172,000**	**2,542,500**	**5,172,000**	**2,542,500**	**5,172,000**	**2,542,500**
Net Impact to CA - Costs (Savings)	**-98,367,266**	**-119,614,651**	**-248,522,861**	**-241,196,743**	**-661,943,787**	**-521,041,919**

Subcommittee Staff Comment and Recommendation. It is recommended to do the following:

- **Adopt revised savings.** It is recommended to adopt the revised CCI savings.

- **Take no action on proposed trailer bill language.** Trailer bill language regarding this proposal has not yet been received. Consequently, since CCI has been delayed until no sooner than January 1, 2014, it is recommended that these changes be worked out via policy bill.

- **Adopt placeholder trailer bill language** regarding the extension of certain Medicare contracts (MIPPA/D-SNP/FIDE-SNP) with the federal CMS. Since the CCI implementation date has been delayed until at least January 1, 2014, it is important to maintain continuity of care for these dual eligibles. If these Medicare contracts are not extended then dual eligibles covered by these Medicare plans may have their care interrupted. Since these contracts must be extended by June 30, 2013, it is recommended to adopt placeholder trailer bill language.

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

1. Please provide an overview of the proposed changes to CCI.

2. Please discuss the revised CCI savings.

7. Healthy Families Program Transition to Medi-Cal

Budget Issue. As has been discussed in previous Subcommittee hearings, the state is in the process of transitioning children in the Healthy Families Program to Medi-Cal. The table below reflects the May Revision projected savings from this transition.

Table: Summary of Savings from Transition of Healthy Families Program to Medi-Cal

	2012-13 Revised	2013-14 Estimate	Ongoing
General Fund	$2,733	-$38,907	-$33,306
Federal Funds	$2,102	-$74,434	-$64,032
Total Funds	**$4,434**	**-$113,342**	**-$97,338**

The Administration is in the process of planning for phases 3 and 4 of this transition:

- **Phase 3** - Begins no sooner than August 1, 2013 and transitions about 111,000 children enrolled in a HFP plan that is not a Medi-Cal health plan and does not contract or subcontract with a Medi-Cal health plan into a Medi-Cal health plan in that county.

- **Phase 4** - Begins no earlier than September 1, 2013 and transitions about 40,000 children in HFP residing in a county that is not Medi-Cal managed care into the Medi-Cal fee-for-service delivery system.

Phase 3 Network Assessments Not Complete. As part of the transition, the Administration is required by AB 1476 (a budget trailer bill) to provide an implementation plan and network adequacy assessment in advance of a phase. On May 1st, the Phase 3 Implementation Plan and Network Adequacy Assessment Report were submitted to the Legislature. Among the key findings from the network adequacy assessment report are that of the 23 counties (included in the report) that would be transitioning in Phase 3:

- 11 counties require follow-up network adequacy assessments
- 7 counties still are working on subcontracting with a health plan. If this subcontract does not occur, additional follow-up would be necessary.
- 5 counties require no additional follow-up as the departments have deemed the Medi-Cal networks adequate

DHCS and the Department of Managed Health Care (DMHC) indicate that follow-up information is expected from the plans by early June and that DMHC would likely develop an addendum to this assessment prior to the transition.

Phase 4 Interaction with Rural Managed Care Expansion. Phase 4 of this transition is targeted to occur on the same date as Medi-Cal managed care is expanded in 28 counties. The rural managed care expansion was delayed from June 2013 to September 2013. The

delay was necessary to allow for all readiness activities to be completed, including the each health plans development of a sufficient provider network.

Subcommittee Staff Comment and Recommendation—Approve updated fiscal estimates. It is recommended to approve the updated estimates regarding the transition.

There is greater potential for interruptions in care for phases 3 and 4 of this transition. This is because the level of plan and provider overlap decreases in these phases. Since there is great uncertainty regarding the networks in phases 3 and 4 as Administration has not yet been able to confirm the adequacy of plan networks in 11 of the 23 counties transitioning in Phase 3 and expansion of rural managed care has already been delayed, it is important the Administration proceed cautiously in the final phases of this transition.

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

1. Please provide an update on the planning for Phases 3 and 4 of this transition.

2. Since the April Subcommittee hearing on this transition, how has the Administration worked with providers to educate them about this transition? What more needs to be done?

8. Add Applied Behavioral Analysis (ABA) Services to Medi-Cal Managed Care

Issue. In the fall of 2012 during the planning for the Healthy Families Program (HFP) transition to Medi-Cal, questions about the provision of Applied Behavioral Analysis (ABA) services in Medi-Cal for children with autism were raised.

Stakeholders requested specific information regarding the differences in services provided by HFP and Medi-Cal in order to identify issues prior to any transition and plan for their remedy. Senator Steinberg sent a letter to the California Health and Human Services Agency on November 29, 2012 requesting this specific information. However, the Administration did not respond to Senator Steinberg and did not provide stakeholders a clear representation for how the eligibility for this service differed between HFP and Medi-Cal.

On April 1, 2013 as HFP children in some counties were transitioned to Medi-Cal, families were given very short notice that their children would no longer be able to access ABA services once enrolled into a Medi-Cal managed care plan. This was in spite of months of awareness of this concern and clear feedback from consumer advocates that there was still confusion about this issue. Since April, it appears that DHCS may have addressed this on a case-by-case basis, but a thoughtful, systematic, and planned approach has not occurred.

Background. Pursuant to AB 88 (Thomson, Statutes of 1999) and SB 946 (Steinberg, Statutes of 2011), commercial insurance plans including HFP were required to pay for behavioral services (e.g., ABA) while health plans contracted with Medi-Cal were exempt from these provisions. Consequently, Medi-Cal does not currently have a set of services designated as "ABA." Currently, Medi-Cal pays for behavioral services for children under the Department of Developmental Services' Home and Community Based waiver provided through the regional centers. Not all HFP children receiving behavioral services qualify for these services in the regional centers because of eligibility and medical necessity criteria.

ABA is an intensive behavioral intervention therapy which is designed to promote positive social behaviors and reduce or ameliorate behaviors which interfere with learning and social interaction.

Subcommittee Staff Comment and Recommendation—Add ABA services to Medi-Cal managed care for children. It is recommended to augment the Medi-Cal budget by $50 million General Fund and adopt placeholder trailer bill language to add ABA services to Medi-Cal managed care for children ineligible for regional center services. This funding is intended for the budget year as a short-term solution to ensure that services are maintained from July through June 30, 2014. This is necessary to ensure that these services are appropriately continued during the transitions and changes to Medi-Cal under federal health care reform so as to not impact families (again) as transitions occur.

As specified in AB 1494 (a 2012 budget trailer bill), the Legislature intended for no disruptions in services for children transitioning from HFP to Medi-Cal and required that implementation

plans to be developed to ensure continuity of care. This did not occur as ABA services were disrupted.

In the long-term, SBX1 1 (Hernandez and Steinberg) and ABX1 1 (Perez) propose to make the current Medi-Cal benefit package for existing enrollees comparable to the Medi-Cal benefit package for the Medi-Cal expansion. Federal law requires that the benefit package for the Medi-Cal expansion include the Essential Health Benefits, which includes behavioral services.

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

1. Please provide an overview of this proposal.

9. Transition of AIM-linked Infants (DOF DHCS Issue 007 and MRMIB Issue 107)

Budget Issue. The May Revision proposes to transfer the AIM-linked infants, born to women whose income is from 250 to 300 percent of the federal poverty level (FPL), from the Managed Risk Medical Insurance Board to DHCS. AIM-linked infants, born to women whose income is up to 250 percent of FPL are transitioning, as described below, as part of the Healthy Families Program transition to Medi-Cal.

Children born to women in the AIM program whose income is up to 300 percent of the FPL are eligible for health, dental, and vision services for the first two years as AIM-linked infants. AIM-linked infants, whose mothers have incomes up to 250 percent of the FPL, are scheduled to transition to Medi-Cal beginning on August 1, 2013. The Administration proposes to transfer the remaining AIM-linked infants between 250 to 300 percent of the FPL to the DHCS on October 1, 2013.

It is important to note that because of ACA maintenance of effort requirements, the state must maintain the AIM program until 2019.

Summary of AIM-Linked Infant Transition. The Administration's plan for the transition of AIM-linked infants has multiple components, this includes:

- AIM-Linked Infants up to 250% FPL in Healthy Families Program Transition Phase 1, 2, and 3 Counties Transition to Medi-Cal August 1, 2013 with Phase 3 Counties.

- AIM-Linked Infants up to 250% FPL in Healthy Families Program Transition Phase 4 counties, will transition to Medi-Cal with Phase 4 on September 1, 2013.

- AIM-Linked Infants between 250-300% of FPL in ***ALL*** Counties will transition to DHCS on October 1, 2013. MRMIB and DHCS will work collaboratively to draft a Title XXI State Plan Amendment to establish a CHIP program under DHCS for AIM-linked Infants.

Table: Number of AIM-Linked Infants by Income Category

Under 200% FPL	200-250% FPL	251% FPL & Above	Total
2,883	6,649	1,886	11,418

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt the placeholder trailer bill language regarding the transition of AIM-linked infants (born to women whose income is from 250 to 300 percent FPL.)

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

1. Please provide an overview of this proposal.

10. Family Planning, Access, Care and Treatment Benefit Changes

Budget Issue. The May Revision proposes to implement benefit changes to the Family Planning, Access, Care and Treatment (FPACT) program. These changes result in $32.6 million ($9.7 million General Fund) savings.

Background. 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.

The Office of Family Planning at DHCS conducts on-going monitoring and utilization management of the FPACT program to evaluate the cost-effectiveness of services and identify opportunities to reduce program costs while maintaining the same quality of care.

According to DHCS, this ongoing monitoring and evaluation indicates that changes to the FPACT benefits should be made. Consequently, DHCS proposes to:

- Reduce chlamydia screening of women over 25 years of age,
- Decrease over-utilization of emergency contraception,
- Adopt a Medi-Cal Preferred List for oral contraceptives,
- Eliminate urine culture, and
- Discontinue brand name anti-fungal drugs.

Additionally, effective July 1, 2013, DHCS plans to eliminate mammograms and pregnancy test only benefit to maintain compliance with Federal rules. See following table for projected savings from these benefit changes.

Table: DHCS Proposed Savings as a Result of FPACT Benefit Changes

Benefit	Federal Matching Rate	Total Savings
Chlamydia Screening	90%	$16,586,000
Emergency Contraception	90%	$5,505,000
Medi-Cal List of Oral Contraceptives	90%	$4,000,000
Urine Culture	50%	$335,000
Brand Name Antifungal Drug	50%	$812,000
Pregnancy Test Only	90%	$325,000
Total Savings		**$32,605,000**

Subcommittee Staff Comment and Recommendation—Reject proposed benefit changes. It is recommended to reject this proposed benefit change to FPACT. DHCS has not provided any documentation to support these recommended benefit changes. Nor has it explained why these benefit changes would be cost effective, particularly given the enhanced federal matching rate.

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

1. Please provide an overview of this proposal.

2. Please discuss the evidence and data supporting DHCS's proposed benefit changes.

11. Federal Grant on Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Suicide Prevention Project (DOF Issue 009)

Budget Issue. The May Revision request an increase in federal authority of $928,000 in the budget year as a result of the state receiving a Garrett Lee Smith Memorial Act Grant from the Federal Substance Abuse and Mental Health Services Administration (SAMHSA).

This grant is to be used for the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) Youth Suicide Prevention Project. The grant provides $479,000 in fiscal year 2012-13, $449,000 in 2013-14, and $450,000 in 2014-15 for prevention, educational, and training resources in high schools to prevent suicide among LGBTQ youth. Due to startup delays, the 2012-13 funds were unspent. However, the SAMHSA has approved the rollover of these funds to 2013-14 for a combined total of $928,000.

According to DHCS, this grant will allow DHCS to build a system of suicide prevention in high schools in five California counties. The project will promote acceptance of culturally diverse students, particularly LGBTQ youth, increase the capacity of peer and adult gatekeepers to recognize warning signs and risk factors of suicide, and increase knowledge and use of LGBTQ resources specific to this target population. This grant will also increase the number of mental health professionals in California trained to recognize and manage suicide risk among LGBTQ youth.

DHCS will contract with three entities to implement the components of the LGBTQ Youth Suicide Prevention Project. These entities include the Trevor Project, Education Development Center, Inc. (EDC) and the Institute for Social Research (ISR) at the California State University, Sacramento.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this proposal. It is important for DHCS to coordinate and keep in communication with other state agencies and programs on these efforts as they complement the Office of Health Equity's work on the California Reducing Disparities Project and the LGBTQ community and the Mental Health Services Act' state level prevention programs.

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

1. Please provide an overview of this proposal.

2. How is DHCS working with other partners, including other state agencies, on maximizing coordination and communication on this important issue?

12. Medi-Cal Specialty Mental Health Services – May Revision Update

Budget Issue. The May Revision includes $1.8 billion federal funds and $33.4 million General Fund) for Medi-Cal Specialty Mental Health Services. See following table for funding summary.

Table: Medi-Cal Specialty Mental Health Services May Revision Summary (in millions)

	2013-14 January Budget		2013-14 May Revision	
	General Fund	**Federal Funds**	**General Fund**	**Federal Funds**
Healthy Families	$0	$17,018	$0	$18,77
Children	$39,261	$1,038	$39,385	$1,116
Adults	-$6,000	$672,441	-$6,000	$750,888
Total	**$33,261**	**$1,728**	**$33,385**	**$1,886**

Caseload. In the May Revision, it is projected that 276,466 adults (an 18 percent increase from the January budget) and 270,897 children (a 10 percent increase from the January budget) will receive Medi-Cal Specialty Mental Health Services (using the accrual methodology).

Background. California provides Medi-Cal "specialty" mental health services under a 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. Children's specialty mental health services are provided under the federal requirements of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for persons under age 21.

County Mental Health Plans are the responsible entity that ensures 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.

California's Medi-Cal Specialty Mental Health Services Waiver is effective until June 30, 2013.

The 2012 budget implemented the 2011 Realignment of Medi-Cal Specialty Mental Health for adults and children.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised with these revised estimates.

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

1. Please provide an overview of this issue

2. Please highlight key changes to this estimate compared to January.

3. Please comment on the revised (and increased) caseload projections.

13. Drug Medi-Cal – May Revision Update

Budget Issue. The May Revision includes $202.1 million ($92 million federal funds and $110 million local funds) for DMC. Since DMC was realigned in 2011, there is no longer General Fund support for this program. See following table for DMC funding summary.

Table: Drug Medi-Cal Program May Revision Summary (dollars in thousands)

	2013-14		
Service Description	**County Funds**	**Federal Funds**	**Total Funds**
Narcotic Treatment Program	$61,590	$61,501	$123,091
Outpatient Drug Free Treatment Services	$41,704	$23,490	$65,193
Day Care Rehabilitative Services	$9,563	$9,563	$19,126
Perinatal Residential Substance Abuse Services	$718	$718	$1,436
Naltrexone Treatment Services	$0	$0	$0
Annual Rate Adjustment	-$1,939	-$1,654	-$3,593
Drug Medi-Cal Program Cost Settlement	-$1,630	-$1,630	-$3,259
DRUG MEDI-CAL TOTAL	**$110,007**	**$91,988**	**$201,994**

Caseload. The May Revision projects an unduplicated DMC caseload of 63,205 individuals.

Background. The Drug Medi-Cal (DMC) program provides medically necessary substance use disorder treatment services for eligible Medi-Cal beneficiaries.

At the time this agenda was prepared, DHCS had not provided unduplicated May Revision DMC caseload information

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised with these revised estimates.

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

1. Please provide an overview of this issue

2. Please highlight key changes to this estimate compared to January.

14. Non-Designated Public Hospital Program Change in Reimbursement Methodology

Budget Issue. AB 1467 (a 2012 budget trailer bill) changed the non-designated public hospital (NDPH) reimbursement methodology to a certified public expenditure (CPE) methodology and eliminated NDPH supplemental payments. Additionally, under this change in methodology, DHCS would seek a state plan amendment (SPA) 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.

DHCS submitted a SPA to the federal CMS for this proposal; however, CMS has not approved the SPA and has raised major issues regarding the DSRIP component. Consequently, in the May Revision, DHCS proposes that NDPHs continue to receive payments under their current methodology until December 31, 2013 and then transition to a diagnosis related grouping on January 1, 2014. This proposed change results is a loss of $94.4 million General Fund in the current year and $94.4 million General Fund in the budget year.

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.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve DHCS's proposal to withdraw this proposed change in NDPH reimbursement methodology as it appears that CMS is not willing to approve the SPA. The budget should reflect that this methodology would not be incorporated in the budget year.

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

1. Please provide an overview of this proposal.

Michelle Baass 651-4103
Senate Budget & Fiscal Review

OUTCOMES: **Senate Subcommittee #3 on Health & Human Services**
Tuesday, May 21 (Room 4203)
Agenda Part 1

VOTE ONLY

0530 Office of Systems Integration

1. CalHEERS Adjustment (DOF Issue 444)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

4140 Office of Statewide Health Planning and Development

1. Mental Health Reappropriation (DOF Issue 304 and 306)

- Motion – Approve request to appropriate previously approved funds that were reverted.
- Vote – 2-0 (Senator Emmerson absent.)

4150 Department of Managed Health Care (DMHC)

1. Medi-Cal Dental Managed Care Program Oversight

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

3. Medi-Cal Managed Care Rural Expansion

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

4. Medi-Cal Managed Care Rural Expansion Supplemental – May Revision (DOF Issue 501)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

4260 Department of Health Care Services

1. Medi-Cal Estimate Update – Technical Adjustments (DOF Issue 200)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

2. Continuation of 1115 Waiver Activities - Position Request

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

3. Continuation of LIHP & DSRIP Activities - Position Request

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

4. Assisted Living Waiver – Position Request

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

5. Security Oversight of MEDS – Position Request

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

6. HIPPA – Position Request

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

7. Public Assistance Reporting Information System (PARIS) Interstate – Position Request

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

8. Medi-Cal Electronic Health Records – Position Request

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

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

- Motion – Reject proposal.
- Vote – 2-0 (Senator Emmerson absent.)

10. Diagnosis Related Groups Payment System – Position Request

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

11. Breast and Cervical Cancer Treatment Program Resources – Position Request (DOF Issue 006)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

12. Federal Authority for Mental Health Services Technical Adjustment (DOF Issue 008 and 108)

- Motion – Approve proposal.

- Vote – 2-0 (Senator Emmerson absent.)

13. Family Health Programs Adjustments (DOF Issue 211)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

14. Drug Medi-Cal Legal Representation – Position Request

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

15. Long Term Care Quality Assurance Fund – Borrowable for Cash Flow

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

4265 Department of Public Health

1. Genetic Disease Screening Program (DOF Issue 504)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

2. Nursing Home Administrator's State License Examining Fund (DOF Issue 502)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

4280 Managed Risk Medical Insurance Board

1. Caseload Updates (Technical Adjustments)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

4560 Mental Health Services Oversight and Accountability Commission

1. Proposition 63 Evaluation Master Plan (DOF Issue 001)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

ISSUES FOR DISCUSSION

4280 Managed Risk Medical Insurance Board (MRMIB)

1. Pre-Existing Condition Insurance Plan (PCIP) Update

- Informational Item.

4140 Office of Statewide Health Planning and Development

1. Grant for Workforce Development (DOF Issue 303 and 305)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

4265 Department of Public Health

1. AIDS Drug Assistance Program (ADAP) Caseload and Estimate Update (DOF Issue 506)

- Motion – Approve staff recommendation:

Subcommittee Staff Comment and Recommendation—Adjust expenditures and adopt placeholder trailer bill language. It is recommended to adjust ADAP expenditures to reflect that only 70 percent of ADAP clients (instead of 85 percent) would transition to Medi-Cal or Covered California in the budget year.

As discussed in previous Subcommittee hearings, there is much uncertainty regarding the rate at which individuals would transition to Medi-Cal or Covered California. Given the state's experience with take-up into new health care coverage programs (it took five-years for the Healthy Families Program to achieve its enrollment), it is prudent to ensure that ADAP has expenditure authority to continue to provide assistance.

Additionally, because of this and the uncertainty with OA-PCIP related-costs, it is recommended to adopt placeholder trailer language to keep the Legislature informed of any potential risk of the ADAP program's inability to provide services within its appropriation:

Given the uncertainty within which persons diagnosed with HIV/AIDS from federal Ryan White HIV/AIDS Treatment Extension Act of 2009 funded programs may transition to Medi-Cal or other health insurance coverage, the State Department of Public Health shall report to the Joint Legislative Budget Committee by October 1, 2013, on whether any of the projections or assumptions used to develop the AIDS Drug Assistance Program (ADAP) estimated budget for the Budget Act of 2013 may result in an inability of ADAP to provide services to eligible ADAP clients. If this occurs before October 1, 2013, and ADAP is unable to provide services to eligible ADAP clients, the State Department of Public Health shall provide notification to the Joint Legislative Budget Committee within 15 calendar days of this determination.

- Vote – 2-0 (Senator Emmerson absent.)

2. Licensing and Certification – Position Request (DOF Issue 502)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

3. Infant Botulism Program / BabyBIG Program

- Motion – staff recommendation:

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is apparent that the ZBB efforts regarding the BabyBIG program have identified areas for improvement that could facilitate better policies, improve service delivery, and improve public health outcomes. It is important that these preliminary findings and recommendations be acted upon and not "sit on a shelf."

Consequently, it is recommended to adopt placeholder trailer bill language requiring DPH to submit a plan to the Legislature on how it will address these findings and implement changes, as it is important to ensure that an adequate supply of the vaccine is available to meet demand.

- Vote – 2-0 (Senator Emmerson absent.)

4. Women, Infants, and Children (WIC) Program (DOF Issue 505)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

4260 Department of Health Care Services

1. ACA Implementation Activities Related to Medi-Cal – Position Request (DOF Issue 010)

- Motion – Approve proposal.
- Vote – 2-0 (Senator Emmerson absent.)

2. Withdraw Managed Care Efficiencies Proposal (DOF Issue 216)

- Motion – Approve proposal to withdraw the managed care efficiency proposal.
- Vote – 2-0 (Senator Emmerson absent.)

3. ACA - Medi-Cal Enhanced Federal Funding for Prevention Services & Adult Vaccines

- Motion – Approve staff recommendation:

Subcommittee Staff Comment and Recommendation—Adjust savings and approve placeholder trailer bill language. The May Revision does not account for the savings in Medi-Cal managed care associated with this increase in federal funding percentage. DHCS acknowledges that these savings are not included and indicates that it is working on developing this estimate.

It is recommended to score an additional $10 million in General Fund savings attributable to the increase in federal funds for these services for Medi-Cal managed care plans. Given that about 80 percent of the Medi-Cal caseload is under managed care, these savings generally reflect a corresponding proportion of savings that should be recognized in the budget.

It is also recommended to adopt the placeholder trailer bill language necessary to exempt these services from cost-sharing in order to be eligible for this enhanced federal funding percentage.

- Vote – 2-0 (Senator Emmerson absent.)

4. Eliminate Sunset Date for Specialty Provider Contracting

- Motion – Approve proposal to withdraw the managed care efficiency proposal.
- Vote – 2-0 (Senator Emmerson absent.)

5. Laboratory Rate Methodology Stakeholder Process Extension

- Motion – Approve staff recommendation:

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt placeholder trailer bill language to extend the time period for which laboratory service providers have to submit data reports specifying their lowest amounts other payers are paying. This is necessary as the process to develop the new rate methodology has taken longer than anticipated. This proposal has no impact on the General Fund savings anticipated with the change in methodology.

DHCS has indicated that it has no concerned with this proposed trailer bill language.

- Vote – 2-0 (Senator Emmerson absent.)

6. Dense Breast Notification – Medi-Cal and Every Woman Counts Program (DOF Issue 211)

- Motion – Approve staff recommendation:

Subcommittee Staff Comment and Recommendation—Adjust expenditures. DHCS's assumptions regarding the number of women who would request a supplementary screening test and require EWC case management services are high. For example, Connecticut is the only other state that requires similar dense breast notification. In its first year of implementation, according to a study by the Yale Cancer Center, only 20 percent of women who received the notification requested a supplementary screening.

Additionally, EWC case management services would only be necessary for women who receive a positive screen on their supplementary screening test and not for all women who receive a supplementary screening, as projected by DHCS. Data suggests that only 10 to 15 percent of women who obtain a supplementary screening test receive a positive screen.

Consequently, it is recommended to adjust these program budgets to reflect that only 30 percent of women who receive a dense breast notification obtain a secondary screening and only 10 percent of this population (for the EWC program) requires case management services. This results in about a $5 million General Fund savings.

- Vote – 2-0 (Senator Emmerson absent.)

7. Integration of Medi-Cal Managed Care Screenings and Referrals into EPSDT Performance Outcome System

- Motion – Approve staff recommendation:

Subcommittee Staff Comment and Recommendation—Adopt placeholder trailer bill language. It is recommended to adopt placeholder trailer bill language to incorporate the measuring and evaluating of Medi-Cal managed care plans screenings for mental health needs and their referrals for these services (to both Medi-Cal fee-for-service providers and county mental health plans) into the EPSDT performance outcome system. This effort would be informed by stakeholders and a plan for the incorporation of these factors into the outcome system would be due to the Legislature by October 1, 2014.

Understanding how children are screened and access mental health care is fundamental to understanding how well EPSDT benefits are provided.

- Vote – 2-0 (Senator Emmerson absent.)

8. Behavioral Health Services Needs Assessment and Services Plan

- Motion – Approve staff recommendation:

Subcommittee Staff Comment—Adopt placeholder trailer bill language. It is recommended to adopt the following placeholder trailer bill language to require the Administration to consult with stakeholders prior to the submittal of the Behavioral Health Services Plan to the federal CMS:

> Commencing no later than August 1, 2013, the State Department of Health Care Services shall convene a series of stakeholder meetings to receive input from clients, family members, providers, counties, and representatives of the Legislature concerning the development of the Behavioral Health Services Plan, as required by the Section 1115 Bridge to Reform Demonstration Special Terms and Conditions paragraph 25.d.

- Vote – 2-0 (Senator Emmerson absent.)

Senate Budget Subcommittee #3:
Health & Human Services

Senator Bill Monning, Chair

Senator Bill Emmerson, Vice-Chair
Senator Mark DeSaulnier

Informational Hearing:
Public Health Protections in a Free Market

AGENDA

Tuesday, September 24, 2013
10:00 am
California State Capitol, Room 3191
(Michelle Baass)

1. **Overview: Public Health Protections in a Free Market**

    a. Public Health Economics
        - Richard Scheffler, PhD, Professor of Public Health and Public Policy, University of California at Berkeley

    b. Public Policy as a Tool for Improving the Public's Health
        - Linda Rudolph, MD, MPH, Public Health Institute

2. **The Trend and Burden of Chronic Diseases and Injury in California**

    a. Ron Chapman, MD, MPH, Director, California Department of Public Health (CDPH)

3. **Effective and Successful Public Health Laws and Programs**

    a. California Tobacco Control Program
        - Ron Chapman, MD, MPH, Director, CDPH
    b. Injury Prevention Policies
        - Barbara Alberson, MPH, Senior Deputy Director, Policy and Planning, San Joaquin County Public Health Services
    c. Government As Protector of Public Health
        - Andrew Cheyne, CPhil, Research Director, Berkeley Media Studies Group

4. Opportunities for Additional Public Health Policy Interventions

a. Sugar-Sweetened Beverage Tax
   - Harold Goldstein, DrPH, Executive Director, California Center for Public Health Advocacy

b. Built Environments
   - Marice Ashe, JD, MPH, Founder and CEO, ChangeLab Solutions

c. Alcohol Harms and Minimum Pricing Policies
   - Thomas K. Greenfield, PhD, Center Director and Scientific Director, Alcohol Research Group

5. Public Comment

Speaker Biographies

Barbara Alberson. Ms. Alberson is a public health professional with more than 35 years of experience in the government sector. She recently joined San Joaquin County Public Health Services as a Senior Deputy Director for Policy and Planning. In this role, she will be guiding the department through the formal process to achieve national accreditation status. Ms. Alberson also oversees the department's Health Promotion and Chronic Disease Prevention program and public health activities that address the built environment. Previously, Ms. Alberson served as the Chief of the State and Local Injury Control Section in the California Department of Public Health. During that 23 year tenure, Ms. Alberson and her staff designed and implemented a comprehensive statewide injury and violence prevention program - now one of the largest and most productive of its kind in the nation. On the national level, Ms. Alberson has served as a consultant to many federal agencies and national associations, and as a member of America Walks, Safe States Alliance, and Directors of Health Promotion and Education; she was also a member of the Federal Highway Administration's National Safe Routes to School Task Force. Ms. Alberson serves as faculty for numerous national, regional, and state conferences each year. She earned her Bachelors of Arts from University of California at Los Angeles, and her Masters in Public Health from California State University at Northridge.

Marice Ashe. The founder and chief executive officer of ChangeLab Solutions, Marice Ashe has launched a number of groundbreaking efforts to improve public health through the use of law and policy. Under her leadership, ChangeLab Solutions builds the capacity of leaders across the nation to address a range of chronic diseases through practical policy solutions. ChangeLab Solutions' team of lawyers, city planners, architects, and policy specialists develop model laws and policies, consult on tough policy questions, and provide training and technical assistance to ensure strong policy initiatives and sustainable solutions. Ms. Ashe is a frequent speaker at public health conferences throughout the nation, and she consults with federal and state agencies on how best to incorporate legal and policy tools into public health strategies. Ms. Ashe graduated from University of Notre Dame, and received her Masters in Public Health and Juris Doctor from UC Berkeley.

Ron Chapman. On June 13, 2011, Ron Chapman, MD, MPH, was sworn in as director of the California Department of Public Health (CDPH). Dr. Chapman is a board-certified family physician who has dedicated his career to public health and medicine, caring for the uninsured and underinsured in California. Prior to becoming the director of CDPH, he was the chief medical officer of Partnership HealthPlan of California (PHC), a managed care Medi-Cal plan serving Yolo, Solano, Napa, and Sonoma counties. For six years prior to that, Dr. Chapman was the public health officer and deputy director of public health in Solano County, California. From 1998 to 2004, he worked at the California Department of Health Services as the founding chief of the Medicine and Public Health section. Dr. Chapman has a medical degree from the University of

Southern California, a Masters in Public Health from the University of Michigan and a Bachelor of Science from University of California, Irvine. He has completed fellowships in academic medicine at the University of California, San Francisco and graduated in the inaugural class of the California Health Care Foundation's Health Care Leadership Program. Before entering public health practice, Dr. Chapman was on the faculty at the University of California, Davis School of Medicine. He is the American Medical Association 2008 Dr. Nathan Davis Award winner for local government service. Dr. Chapman's primary interests are in the areas of care for the uninsured, the interface between public health and medicine, and chronic disease management.

Andrew Cheyne. Andrew Cheyne leads the research team at Berkeley Media Studies Group (BMSG). Combining his interest in political activism with his background in media analysis and social science scholarship, Andrew has guided the organization's research into a variety of contemporary issues at the forefront of public health. This work spans content analyses of how the news frames public health issues to assessments of industry marketing practices. He has been project director for a series of investigations into food and beverage marketing to children, focusing on the industry's use of cutting-edge digital techniques to target young people. Mr. Cheyne has also acted as the primary liaison between BMSG and a leading legal institute for a joint news-policy analysis of the tobacco industry's use of "personal responsibility" rhetoric as a strategic framing device to neutralize potential tobacco control policies. He is currently overseeing an inquiry into the food and beverage industry's use of corporate social responsibility tactics as a means to forestall meaningful public health intervention, and comparing these to similar practices employed by other industries such as Big Tobacco. Andrew holds a Bachelors of Art in American Studies from Northwestern University and a Master's and C.Phil. in political sociology from the University of California, San Diego.

Harold Goldstein. Harold Goldstein, DrPH is the Executive Director of the California Center for Public Health Advocacy, which he founded in 1999. CCPHA is a nationally recognized leader in advocating for public policies to address the social, economic, and community conditions that perpetuate the obesity epidemic. CCPHA has lead statewide campaigns resulting in enactment of state laws getting soda and junk food out of schools, getting first-ever funding for school physical education, establishing the nation's first state menu labeling law, and defining access to water as a basic human right. Harold has a Bachelors degree in physiology from UC Berkeley and both Masters and Doctorate degrees in public health from UCLA.

Thomas Greenfield. Educated at Caltech, MIT and the University of Michigan (PhD, Clinical Psychology), since 1999 Dr. Greenfield has directed the US National Institute on Alcohol Abuse and Alcoholism (NIAAA)-supported National Alcohol Research Center on the Epidemiology of Alcohol Problems at the Public Health Institute's Alcohol Research Group (ARG) in Emeryville, California (in its 33nd year). He also directs its 5-yearly National Alcohol Survey (NAS) series. Center studies have generated numerous contributions and spawned a large number of related independent NIH grants. Greenfield has collaborated with other scientists on age-period-cohort (APC) trend analyses of alcohol and drug use patterns. The Center and Greenfield's independent

grants have conducted numerous innovative analyses to improve alcohol consumption pattern and problem measures for use in the US and other countries. Greenfield's other funded research mostly supported by NIAAA has included epidemiology of alcohol consumption and problems of men and women in various cultures, populations and ethnic minority groups; ethnicity and long-term alcohol-related mortality (two R01s); long-term policy-analyses of prevention interventions; alcohol and mental health services research (funded by SAMSA, CMHS), and alcohol's relationship to sexual risk taking. Recently, working with economists Greenfield has been examining alcohol prices and expenditures, beverage quality substitution, and more recently alcohol externalities (harms experienced from other drinkers). Other studies have focused on federal alcohol policy development, public opinion and the role of research in policy making. Greenfield has authored and coauthored over 200 peer reviewed articles, chapters and other publications. He has served on the board of directors of the Public Health Institute and the International Council on Alcohol & the Addictions (ICAA) and on a number of editorial boards. In 2008 he received the American Public Health Association's ATOD Section Leadership Award and until recently served on NIAAA's Extramural Advisory Board.

Linda Rudolph. Linda Rudolph, MD, MPH, is the co-director of the Climate Change and Public Health Project in Public Health Institute's (PHI) Center for Climate Change and Public Health. She was recently recognized as a White House Champion for Change for her work in Climate Change and Health. She is also the principal investigator on a PHI project to advance the integration of Health in All Policies in local jurisdictions throughout California. Previously, Dr. Rudolph served as the Deputy Director of the California Department of Public Health (CDPH)'s Center for Chronic Disease Prevention and Public Health and the health officer and public health director for the City of Berkeley, CA. While at CDPH, Rudolph chaired the Strategic Growth Council Health in All Policies Task Force and the California Climate Action Team Public Health Work Group. Dr. Rudolph has also been the chief medical officer for Medi-Cal Managed Care, medical director for the California Division of Workers' Compensation, executive medical director for the Industrial Medical Council, staff physician in the CDPH Occupational Health program, and a physician for the Oil, Chemical, and Atomic Workers' International Union. Dr. Rudolph received her doctorate in medicine and clinical training in pediatrics and emergency medicine from the University of California at San Francisco. She holds a Master's in Public Health from the University of California at Berkeley. Rudolph is board certified in occupational medicine.

Richard Scheffler. Richard Scheffler is a Distinguished Professor of Health Economics and Public Policy at the University of California, Berkeley and holds the Chair in Healthcare Markets & Consumer Welfare endowed by the Office of the Attorney General for the State of California. He is Director of The Nicholas C. Petris Center On Health Care Markets and Consumer Welfare. At Berkeley, he serves as Co-Director of the Scholars in Health Policy Research Program funded by the Robert Wood Johnson Foundation; he is founding Co-Director of the National Institutes of Mental Health (NIMH) pre- and post-doctoral training programs. Professor Scheffler co-directs the NIH-Fogarty Mental Health & Policy Research Training for Czech Post Doctoral

Scholars program; the Agency for Healthcare Research and Quality (AHRQ) pre and postdoctoral training program; and the Edmund S. Muskie Fellowship Program. He served as President and Program Chair of the International Health Economics Association (iHEA) 4th World Congress San Francisco, June 2003. His research is on healthcare markets, health insurance, the health work force, mental health economics, and international health system reforms in Western and Eastern Europe. Professor Scheffler is the current recipient of the American Public Health Association's Carl Taube Award, which honors distinguished contributions to the field of mental health services research. He is a recipient of a senior scientist award from NIMH for work on mental health parity, the economics of the public mental health system in California, managed care in mental health, and the mental health work force. Professor Scheffler has been a Fulbright Scholar, a Rockefeller Scholar and a Scholar in Residence at the Institute of Medicine–National Academy of Sciences. Professor Scheffler has published over a hundred papers and edited and written six books. His forthcoming book is on the future of the health work force–University of California Press.

Senate Budget Subcommittee #3:
Health & Human Services

Senator Bill Monning, Chair

Senator Bill Emmerson, Vice-Chair
Senator Mark DeSaulnier

Public Health Protections in a Free Market

Informational Hearing Background Paper
September 24, 2013
10:00 am, Room 3191

Summary

As a protector of the public's health, California utilizes laws, regulations, and other public policies designed to protect the public's health and safety by targeting individual or private sector behaviors that present health or safety hazards to the population.[1] These behaviors, often referred to as externalities, include actions such as emitting air pollution, addressed by setting and enforcing air quality standards.

Legal and public policy tools to address these externalities and protect the public's health include incentives, taxation, regulation, and zoning laws. For example, California's Tobacco Control Program (funded by a cigarette tax) has had a powerful impact on reducing adult and youth smoking rates, incidence of lung cancer, and medical care costs in the state.

The top three leading attributable causes of death are tobacco, poor diet and physical inactivity, and alcohol consumption. These preventable behaviors and exposures also lead to millions of Californians living with diseases and injuries and are largely a result of imperfect market conditions that do not account for the true costs of consumption to society. Public policy proposals to address these imperfect market conditions, such as the sugar-sweetened beverage tax, have the potential to significantly improve public health.

Moreover, given that government, and ultimately the taxpayer, is responsible for financing a significant portion of health care costs associated with diseases and injury, through public programs such as Medicare and Medicaid, the need to address these public health concerns is even more important.

The purpose of this hearing is to discuss the role of government in protecting the public's health in a free market and consider when government is the appropriate agent to intervene for the public's health and safety.

Public Health Economics

Public health economics is the study of the economic role of government in public health, particularly, in addressing externalities and supplying public goods.[2] Externalities occur when consumers or producers do not bear the full costs of their consumption/production (negative externalities) or when there are benefits from consumption/production that go beyond the individual consumer/producer (positive externalities). A public good is a good or service that does not lend itself to market allocation because it costs nothing and it is generally difficult or impossible to exclude individuals from consuming it.

In a free market, individuals work, play, and consume what they want without restrictions. Sellers and buyers exchange goods and services at a price determined by supply and demand. Under ideal conditions, the entire economy functions without any central control or direction from the government.

However, perfect market conditions are useful for modeling and simulations, but do not occur in the real world.[3] Market conditions are manipulated, for example, by uninformed consumers. Information about the short- and long-term costs and benefits of consuming or producing some products is often limited and individuals make choices they later regret or the full costs of their consumption is often not borne by those making the consumption.

Mass media and other public education campaigns can provide information that can alter consumers' perceptions of the costs and benefits they received from consuming a given product, resulting in different consumption choices. For example, cigarette smoking in the U.S. rose rapidly in the first half of the twentieth century. It was not until the 1950s that strong evidence linking cigarette smoking to lung cancer first appeared in scientific literature. Consequently, individuals made choices to smoke without full information about the health risks (and associated health costs) from smoking.[4]

Similarly, negative externalities in production, such as air and water pollution from emissions and discharges that can cause various health consequences, are costs to society that are not reflected in the costs paid by producers.

These imperfect market conditions can justify government intervention to protect the public's health. Some legal interventions are more controversial than others and illustrate the challenge of balancing public goods and individual freedoms due to varying norms, expectations, and values that may inform both public opinion and decision-making by lawmakers in different jurisdictions.

Legal and Public Policy Tools to Protect the Public's Health

Federal, state, and local governments have various public policy interventions and tools that can be used to address imperfect market conditions and protect the public's health. These include: [5]

- taxation, incentives, and spending (e.g., cigarette and other "sin" taxes and allocation of the tax to combat the problem, may include pricing policies and financial incentives);
- altering the informational environment (e.g., food or drug labeling, and disclosure of health information);
- altering the built/physical environment (e.g., zoning, toxic waste);
- altering the natural environment (e.g., clean water, air);
- direct regulation (e.g., seat belts, helmets, gun safety device requirements, drinking water fluoridation, iodized salt; licensure of medical care providers and facilities);
- indirect regulation (e.g., tort litigation in tobacco); and
- deregulation (e.g., distribution of sterile injection equipment).

These tools can address market failures by changing the relative costs and benefits that influence the decisions consumers and producers make. Public policies can address the true price of a product, which includes not just the monetary cost of the product but other costs associated with obtaining and using the product.

Polices that increase the full price of unhealthy behaviors or reduce the full price of healthier behaviors have the potential to significantly improve public health.

Successful Public Policies that Have Protected and Improved the Public's Health

Examples of successful public policies that have been proven effective and of high value in addressing major causes of death, disease, and disability include the Tobacco Control Program and California's seat belt law.

Tobacco Control Program. The California Tobacco Control Program has had a powerful impact on reducing adult and youth smoking rates, incidence of lung cancer, and medical care costs in the state. In California, between 1989 and 2004, $1.8 billion was spent on the Tobacco Control Program, and $86 billion was saved in personal health care expenditures alone (and 3.6 billion fewer packs of cigarettes were bought).[6]

The Tobacco Control Program is funded with Proposition 99 funds. Proposition 99, the California Tobacco Health Protection Act of 1988, was approved by voters in November 1988. This initiative increased the state cigarette tax by 25 cents per pack and earmarked new revenues for programs to reduce smoking and to support tobacco-related research, among other programs.

Seat Belt Law. In 1986, California became one of the first states in the country to require individuals to wear seat belts in an automobile. According to the National Highway Traffic Safety Administration, the 2007 seat belt use rate (94.6 percent) in California resulted in a total cost savings of $8.9 billion and 1,791 lives saved.

Public Health Concerns that Merit Government Intervention

According to the California Department of Public Health, almost half of all deaths that occurred in the United States in 2000 can be attributed to a limited number of largely preventable behaviors and exposures. The top three leading attributable causes of death are tobacco, poor diet and physical inactivity, and alcohol consumption.

These preventable behaviors and exposures also lead to millions of Californians living with diseases and injuries. Chronic disease (e.g., heart disease, cancer, diabetes, chronic respiratory disease, and hypertension) accounts for 80 percent of health care costs in California.

Government Bears Costs For Public Health Externalities. These preventable diseases and injuries are largely a result of imperfect market conditions that do not account for the true costs of consumption to society. Moreover, given that government, and ultimately the taxpayer, is responsible for financing a significant portion of health care costs associated with diseases and injury, through public programs such as Medicare and Medicaid, the need to address these public health concerns is even greater.

Obesity. For example, the dramatic increase in the prevalence of obesity appears to be attributable to environmental conditions that indirectly discourage physical activity and directly encourage the consumption of greater quantities of low-nutrient foods.[7] Consequently, a clear economic rationale exists for public policy to correct the market failures caused by externalities related to obesity.

Additionally, obesity has been shown to promote many chronic diseases, including type 2 diabetes, cardiovascular disease, several types of cancer (endometrial, postmenopausal breast, kidney, and colon cancer,) musculoskeletal disorders, sleep apnea, and gallbladder disease.[8]

The economic costs of obesity, overweight, and physical inactivity are estimated to exceed $28 billion annually in California.[9] The percentage of deaths attributed to poor diet and physical inactivity increased 17 percent from 1990 to 2000 and is expected to

surpass tobacco as the leading cause of death in the near future. In 1984, 40 percent of Californians were overweight or obese; in 1995, 50 percent were overweight or obese; and in 2010, almost 60 percent were overweight or obese.

Additionally, Medicaid enrolls a more obese population and incurs greater obesity-related costs.[10] In California, it is estimated that $1.7 billion in Medi-Cal expenditures were related to obesity in 2003.

Nationwide, $550 billion could be saved between 2012 and 2030 if the obesity rate stayed the same or decreased.[11]

Public Policy Proposals to Address Public Health Concerns

As discussed earlier, there are various tools that can be used to address public health concerns. Research suggests that the following types of intervention could have the biggest impact addressing public health concerns.

"Sin" Taxes. When it comes to public health laws that target the demand side of the market, economists emphasize the concept of "full price" as the mechanism through which these policies influence health-related behaviors and their consequences.[12]

Behaviors such as smoking, alcoholism, poor nutrition, and inadequate physical inactivity contribute significantly to the burden of disease and the cost of its treatment. Research indicates that these behaviors are amenable to changes (increases) in taxes on tobacco, alcohol, sugary beverages, and fatty foods. Additionally, extensive economic research clearly demonstrates that higher taxes and prices lead to significant improvements in public health by reducing the use of harmful products.

These types of taxes attempt to recover the related public cost of an activity, increased health care costs, not covered by the private cost of that activity. Research[13] indicates that:

- Alcohol Tax – Doubling the tax on alcohol would reduce alcohol-related mortality by about 35 percent, traffic deaths by 11 percent, sexually transmitted diseases by 6 percent, violence by 2 percent, and crime in general by 1.4 percent.

- Cigarette Tax – A ten percent increase in cigarette prices generally reduces consumption by four percent. A reduction in the number of people who smoke or are exposed to secondhand smoke would have budgetary effects on a range of health care programs, including Medicaid and Medicare, as well as the private health insurance market.

- Sugar-Sweetened Beverage Tax – A 10 percent increase in the price of soda could result in a 10 to 12 percent decrease in consumption.[14] A reduction in the

consumption of sugar-sweetened beverages decreases the risk of obesity, diabetes, and heart disease.[15]

In addition to the resulting reduction of consumption of these products because of the increased price of the product, the revenue generated by these taxes can be used for public education campaigns and prevention programs to discourage behaviors and lead to further reductions in consumption.

Built Environment. From a public health perspective, built environment refers to physical environments that are designed with health and wellness as integral parts of the communities. This type of policy and land-use planning addresses the market failure of imperfect information as it disseminates information on the health impact of various land-use planning decisions and also stimulates the increase in supply of environments and communities that promote healthier eating and increased activity.

Research has indicated that the way neighborhoods are created can affect both the physical activity and mental health of the communities' residents.[16] Studies have shown that built environments that were expressly designed to improve physical activity are linked to higher rates of physical activity, which in turn, positively affects health.[17]

Access to healthy food is also an important component of the built environment. A higher density of convenience stores has been associated with obesity in children.[18] In contrast, improved access to community supermarkets and farmer's markets is correlated with a lower incidence of overweight individuals.[19]

Conclusion

The public health consequences that result from market failures are enormous. These market failures create a clear economic rationale for governments to intervene through laws, regulations, and other policies to improve public health. Economic theory suggests which types of policies are likely to be effective in addressing market failures and in improving public health.

From a state budget perspective, the need to address these concerns is particularly important since the state, and ultimately the taxpayer, is responsible for a significant portion of health care costs associated with preventable diseases and injury, through public programs such as Medicare and Medicaid.

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