Senate Budget and Fiscal Review

Subcommittee No. 3 2005 Agendas

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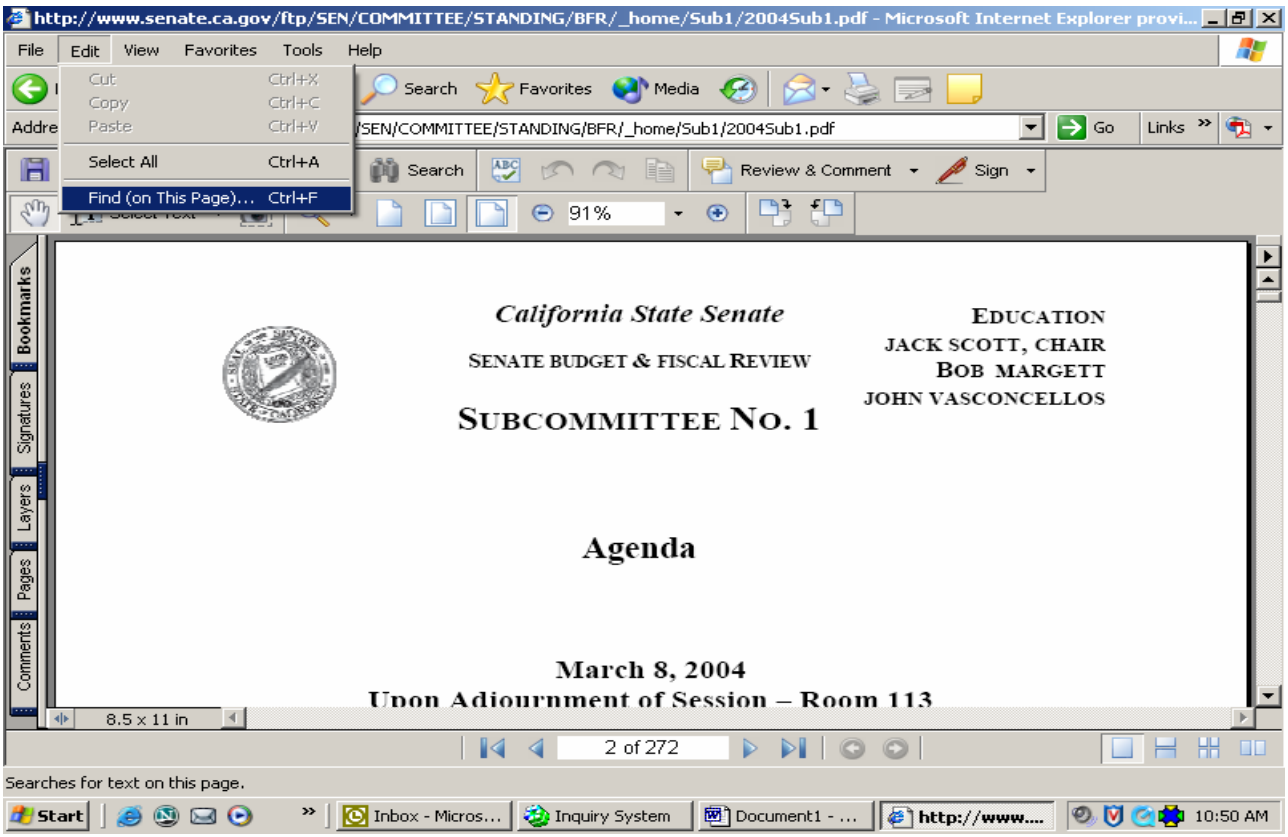

Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda
Health & Human Services

Chair, Senator Denise Ducheny

Senator Tom Torlakson
Senator George Runner

February 17, 2005

9:00 AM to 12:30 PM

Room 4203

Informational Hearing:
Governor's Proposed Medi-Cal Redesign

Hospital Financing, Managed Care, and Premiums

(PANEL DISCUSSIONS & PUBLIC COMMENT)

I. Panel to Discuss the Proposed Restructuring of Hospital Financing

Governor's Proposal for Restructuring Hospital Financing

- Tom McCaffery, Chief Deputy Director, Department of Health Services

Public Hospitals Perspective

- David Carroll, Director of Finance, CA Association of Public Hospitals & Health Systems
- William Walker, MD, Director, Health Care Agency for Contra Costa County
- Douglas Bagley, CEO, Riverside County Regional Medical Center

University of California Hospital Systems

- William Gurtner, Vice President, Clinical Services Development, University of California, Office of the President
- Claire Pomeroy, Vice Chancellor, Human Health Sciences, University of California Davis, and Dean, University of California Davis School of Medicine

Private Essential Access Hospitals Perspective

- Catherine K. Douglas, President & CEO, Private Essential Access Community Hospitals
- Carol Lee Thorpe, President, Community Services, Saint Francis Medical Center, Lynwood
- Bruce Satzger, President, Community Hospital of San Bernardino

II. Panel to Discuss the Proposed Expansion of Managed Care Panel

Governor's Proposal for Expansion of Managed Care

- Tom McCaffery, Chief Deputy Director, Department of Health Services

Perspective of the County Organized Healthcare Systems (COHS)

- Richard Chambers, CEO, CalOPTIMA & Chair of the CA Association of Health Insuring Organizations

Perspective of the Local Initiatives

- John R. Hackworth, PhD, CEO, Health Plan of San Joaquin
- Sylvia Gates Carlisle, M.D., Health Plan of San Joaquin
- Leona Butler, CEO, Santa Clara Family Health

Perspective of the California Association of Health Plans

- Joan Bovee, Legislative Advocate, California Association of Health Plans

Perspective of Other Representatives

- Ted Mazer, M.D., Private Practice
- Marilyn Holle, Senior Attorney, Protection and Advocacy, Inc.

III. Panel to Discuss the Proposed Use of Premiums

- Rene Mollow, Associate Director of Health Policy, Department of Health Services
- Angela M. Gilliard, Western Center on Law & Poverty, Inc.
- Deena Lahn, Policy Director, Children's Defense Fund--California
- Patricia Samuelson, M.D., Medical Director, Mercy Clinic--Norwood

IV. Additional Public Comment

- Public testimony as time permits on a first come basis. Written comments addressed to the Subcommittee are also welcomed.

Senate Budget & Fiscal Review,

Subcommittee #3
on Health and Human Services

Senator Denise Ducheny, Chair

Informational Hearing:

Governor's Proposed Medi-Cal Redesign:
Hospital Financing, Managed Care, and Premiums

February 17, 2005

Background Materials Prepared by
Senate Budget & Fiscal Review Committee
(Diane Van Maren)

Issue	Pages
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II. Proposed Hospital Finance Restructuring	**3 - 10**
III. Medi-Cal Managed Care Expansion	**11 - 16**
IV. Proposed Implementation of a Premium Payment	**16 - 21**

Summary and Analysis of
Administration's Medi-Cal Redesign Proposal
(Hospital Finance Restructuring, Managed Care and Premiums)

I. Key Components to the Administration's Proposal for Medi-Cal Redesign.

The Governor's Medi-Cal Redesign consists of six components, as shown in the table below. The proposal would require considerable state statutory change, as well as approval by the federal Centers for Medicare and Medicaid (CMS) for certain components that require a federal Waiver, such as the hospital finance restructuring component, managed care expansion, and the premium proposal.

The underlying fiscal assumptions offered by the Administration for each of these components are evolving with critical questions yet to be fully answered, particularly regarding the restructuring of hospital financing, expansion of Medi-Cal Managed Care, and the premium proposal.

Proposed Medi-Cal Redesign
2005-06 to 2008-09 General Fund Impact
(State Support & Local Assistance Amounts)
(Dollars in Thousands)

Proposed Redesign Component	2005-06	2006-07	2007-08	2008-09	Total
1. Medi-Cal Managed Care Expansion	$3,412	$40,098	$54,653	($85,487)	$12,675
2. Restructuring Hospital Financing	686	686	686	686	2,744
3. Capitating Dental Services	(24,843)	(25,325)	(25,325)	(25,325)	(100,818)
4. New Medi-Cal Premiums	6,847	(4,903)	(22,050)	(22,050)	(42,155)
5. Single Point of Entry Changes	2,126	(7,097)	(7,097)	(7,097)	(20,315)
6. County Performance Monitoring Standards	612	2,712	2,712	2,712	8,748
Totals	**($11,160)**	**$6,171**	**$3,579**	**($136,561)**	**($139,121)**

All of the above components will be discussed during Subcommittee hearings, as well as in joint hearings with the Senate Health Committee, during the course of the 2005-06 Legislative Session.

Today's hearing is focused on the hospital finance restructuring, managed care expansion and premium payment components of the Administration's Medi-Cal Redesign proposal.

II. Proposed Hospital Finance Restructuring *(Pages 3 to 10)*

A. California Needs Federal Funding Assistance for Hospitals: **Federal Medicaid financing**, presently provided through the state's Disproportionate Share Hospital Program (SB 855 funds), the Emergency Services and Supplemental Payments Program (SB 1255 funds), Graduate Medical Teaching Program, and the Capital Project Debt Reimbursement Program, **is an essential ingredient to California's overall health care system. Without these supplemental federal funds, California's hospital system would indeed collapse.**

California currently receives just over $2 billion for these supplemental federal funds as shown below:

(1) $1.033 billion Disproportionate Share Hospitals;

(2) $806 million for the Emergency Services and Supplemental Payments Program;

(3) $66.2 million for Graduate Medical Teaching Program; and

(4) $97.4 million for the Capital Project Debt Reimbursement Program.

Presently these supplemental federal fund programs operate through the use of "Intergovernmental Transfers" (IGT) and the state's existing Selective Provider Contract Waiver. Under the IGT process, governmental entities which operate hospitals—counties, the UC system, and hospital districts—transfer a specified amount of funds to the state by means of intergovernmental transfers. The state places these transfers into a special fund and then obtains federal matching funds. **No General Fund support is provided for this purpose.**

B. The President's Budget and Ongoing Discussions with the Federal CMS: The Schwarzenegger Administration **has been having ongoing discussions** with the federal Centers for Medicare and Medicaid (CMS) regarding California's supplemental federal funding programs and the state's Selective Provider Contract Waiver **since June 2004**. The federal CMS had intimated to the Schwarzenegger Administration that California's existing system of IGTs must be restructured due to continued concerns with the process.

To-date the only agreement that has been reached is that the state did receive a six-month federal extension for the Selective Provider Contract Waiver. This extension will continue the existing federal funding stream only until June 30, 2005.

The President's proposed budget, released on February 7, 2005, does not bode well for California. His budget proposes a reduction of $60 billion over ten years to Medicaid spending, including "inappropriate" IGTs. Among other reductions, it proposes **(1)** to curb the use of IGTs by $4.6 billion in five-years and $11.9 billion in ten-years, and **(2)** limit federal reimbursement for government providers to no more than the cost of providing services, which in effect, would reduce the Upper Payment Limit (UPL) for public hospitals ($1.2 billion in five-years and $3.3 billion in ten-years). **It should be noted that IGTs are legal and are in federal law.**

The outcomes from the negotiations with the federal CMS are truly the linchpin of the Medi-Cal Redesign.

C. Overview of Administration's REVISED Proposal: As a result of confidential discussions with the federal CMS, the Administration has **recently changed its January 2005 proposal.** However the DHS states that no agreements have as yet been made.

The Administration is seeking to obtain agreement with the federal government within the next few days or weeks. There are still many moving parts to the Administration's revised, draft proposal. In the end, any proposal would require (1) state statutory changes, **(2)** submittal of a five-year Waiver to the federal government, and **(3)** federal approval of the Waiver, along with any federal "conditions" that may be imposed.

Based on preliminary estimates, it appears that, besides making significant changes in order for California to maintain its baseline receipt of supplemental federal funds, the *potential* federal fund increases are: (1) $226 million (federal funds) that may be obtained through the "DSH swap", as discussed below, and **(2)** $193 million (federal funds) for certain indigent health care expenditures. **No new state General Fund support is proposed.**

Therefore a total of about $419 million in new federal funds *may be* available under this revised proposal. Clearly, this is less than the originally anticipated $700 million in new federal funds.

The core aspects of the revised proposal are as follows:

- **Retain the Selective Provider Contracting Program** to negotiate hospital inpatient rates as presently done.
- **Utilize a financing mechanism called "Certified Public Expenditures" (CPEs), instead of solely relying on IGTs, to draw the supplemental federal fund match. The CPE mechanism would be implemented at 21 public hospitals, including UC hospitals. These CPEs would include expenditures for indigent health care for 13 counties, as well as hospital outpatient expenditures.**
- **Establish a "Safety Net Care Pool"** which would be broadly defined to fund health care services to Medi-Cal enrollees and uninsured, indigent populations (13 counties ***and*** possibly some of the state's programs). **About $1.8 billion (federal funds) would be available for this purpose.**
- **Deposit *all* of the Disproportionate Share Hospital (DSH) funds and supplemental federal funds (SB 1255), along with some technical funding adjustments, into the "Safety Net Care Pool".**
- Eliminate the $85 million transfer from the public hospitals to the state (i.e., state administrative fee) which the state had used to backfill for General Fund support.
- Fund private hospitals (Private Essential Access Hospitals—PEACH) using "regular" Medi-Cal funding (state General Fund and federal funds), in lieu of using DSH funds. (**The Administration refers to this as the "DSH swap".)**
- **De-link Medi-Cal Managed Care Program inpatient hospital day payments from the receipt of supplemental federal funds.**

Each of the key components of the Administration's proposal are discussed in more detail below.

1. Selective Provider Contracting Program (SPCP) Waiver

A. Background—Existing Program Saves General Fund and Federal Dollars: Through this program, the state contracts on a competitive basis with **certain hospitals** (about **229 hospitals** mainly in urban areas) that want to provide inpatient services to Medi-Cal recipients at **a negotiated per diem rate for all hospital inpatient services**.

The CA Medical Assistance Commission (CMAC) negotiates rates with the hospitals through confidential discussions. A key requirement of the program is to ensure sufficient hospital beds to serve the Medi-Cal population. This program has been in existence since 1982 and has saved billions in state and federal funds.

The average statewide Medi-Cal *contract* rate was $1,029 per day using 2003-04 data. The average statewide Medi-Cal *non-contract* rate was $2,080 per day (2003-04 data). As such, for 2003-04 alone, the General Fund savings attributable to the SPCP are $703 million. In other words, these are funds that would have been spent had California not implemented the SPCP.

According to CMAC, the average rate a SPCP contract hospital receives has increased about 3.5 percent per year on a compounded basis, or by 100.4 percent from 1984 through 2003. In contrast, to the historical change in the average payment rate to *non-contracting* hospitals, the average payment from 1984 to 2003 has increased by 277.5 percent or about 6.9 percent per year on a compounded basis.

Below is a table that shows the average rates for SPCP contract hospitals.

Table: SPCP Contract Hospital Rates

Year	**1990**	**1993**	**1996**	**2000**	**2001**	**2002**	**2003**
Statewide	**$651**	**$780**	**$836**	**$905**	**$957**	**$991**	**$1,029**
Southern	$662	$789	$837	$891	$921	$952	$964
SF Bay Area	$682	$816	$873	$985	$1,104	$1,178	$1,218
Other	$620	$748	$815	$905	$962	$999	$1,060

Southern includes: Los Angeles, Orange, Riverside, San Bernardino and Ventura.
SF Bay Area includes: Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano and Sonoma.

With respect to Medi-Cal inpatient hospital days for 2003-04, almost 90 percent of the patient days were provided by SPCP contract hospitals. Hospitals in open areas and non-contract hospitals provided the remaining 10 percent of total inpatient acute care days in Medi-Cal.

B. SPCP under the Administration's Revised Proposal: **In essence, the SPCP would remain the same over the five-year proposed Waiver period.** Hospitals that choose to contract would negotiate with CMAC for an inpatient hospital rate and would likely be eligible to receive supplemental federal funds. Non-contract hospitals would receive a statewide rate.

2. Use of "Certified Public Expenditures" (CPE) for Public Hospitals:

A. Background—Existing Use of CPE: Several programs within Medi-Cal currently use certified public expenditures to draw down federal funds. Some of these include: (1) the Medicaid Administrative Activities (MAA), (2) Targeted Case Management (TCM), and (3) Mental Health Managed Care Program. **The specific requirements for each of these CPE programs vary, and are contingent on either a federally approved Waiver or a federally approved State Plan Amendment. In addition, the President's proposed budget seeks to limit some of these programs, such as MAA and TCM.**

B. Background—How Would the CPE Work?: Under the proposed CPE, **public hospitals and UC hospitals would "certify" they have expended public funds to provide services to indigent individuals and Medi-Cal individuals.** The CPE covered services would probably include inpatient and outpatient hospital services, clinic services, physician services provided in hospitals and clinics, and other ancillary services, such as durable medical equipment. **The CPE funds would be placed into the "Safety Net Care Pool" and be used to draw federal supplemental funds.**

The cost of serving indigent individuals and Medi-Cal individuals in these hospitals would be determined by using more restrictive federal Medicare cost reports, not existing state OSHPD reports as presently done. The Administration intends to seek additional reasonable cost categories from the federal CMS that more comprehensively reflect the costs of doing business in California hospitals; however this outcome is presently unknown.

Mechanically, the public entities would certify that expenditures being claimed meet federal government requirements and that any misrepresentation constitutes a violation of federal law. Each hospital must then sign and date a certification form that is submitted to the DHS along with a claim for federal funding. This new process may require data system and accounting changes at each of the impacted hospitals.

The state is responsible to the federal government for the accuracy and validity of the claims for federal funds. Generally, the state would be completing desk reviews and audits of hospitals in order to verify each of the hospitals CPE information. **However, a comprehensive CPE validation process has not yet been designed by the DHS.**

In the event that a hospital's actual cost report for a year, as finally accepted by the state, shows a higher or lower CPE, the difference would be accounted for by adjustments to subsequent payments to the hospital. This provision would be contained within the Waiver document.

C. Potential Concerns with CPE Approach: A key concern with this approach is how the federal CMS will define the cost methodology. **This definition could potentially limit the level of CPE that can be claimed for federal financial participation.** In order to achieve the level of federal funding needed, both the Administration and public hospitals believe we need to count expenditures for indigent health care. However it is unclear if the federal CMS will enable California to include these health care expenditures.

Another concern is that the CPE model may not work for all of the 21 hospitals. Some of the hospitals may have "higher" CPEs (meaning they currently draw down less supplemental federal funds than they have in matching indigent care expenditures) while others may have "lower" CPEs (currently receive more supplemental federal funds). Therefore in order to fully utilize available federal funds, some redistribution (from an accounting standpoint) may need to be done. This proposition could become quite complex and raise subsequent issues regarding differences between hospitals and regions.

3. "Safety Net Care Pool":

Description of Safety Net Care Pool: **This is a completely new concept** which just came forth from the Administration and is modeled after a Waiver completed by Massachusetts and approved by the federal CMS.

Under this concept, a "pool" would be established for use by California in providing health care services to Medi-Cal enrollees and uninsured, indigent populations (i.e., 13 counties *and* possibly some of the state's programs). The Administration wants to have a broad definition of how this pool can be used in order to maintain flexibility under the proposed Waiver.

Though no definitive federal dollar amount has been provided by the Administration since negotiations are ongoing with the federal CMS, the Administration contends that about $1.8 billion in federal funds would be potentially available in the Safety Net Pool.

Generally, the "pool" would consist of federal funds that are primarily accessed through the use of CPEs and through a limited level of IGTs (from public hospitals, or the UC system, *if available*). The primary intended use of the "pool" funds is to cover health care services to the uninsured and Medi-Cal populations provided in hospitals and through public programs.

This federal pool of funds would be capped based on an agreed to federal budget neutrality provision. (This is discussed further below.)

The federal revenue for the "pool" would consist of:

(1) California's entire Disproportionate Share Hospital (DSH) allocation from the federal government for that year (DSH would loose its identity);

(2) Other supplemental federal funds (SB 1255) along with some technical adjustments;

(3) A federal fund match for some indigent care expenditures (potentially);

(4) Up to $250 million (federal funds) if a limited IGT can be used to draw down the federal funds and public entities, such as the public hospitals or UC system, have funds available for this purpose. (The $250 million represents a portion of the amount that is available in the Upper Payment Limit for private hospitals); and,

(5) A growth trend factor to be calculated annually over the life of the Waiver, commencing from a defined base level amount and rolling forward. This growth factor would not apply to the DSH allocation.

In order to access this "pool", a non-federal share of payments needs to be made. The "non-federal share" payments (i.e., funds used to drawn down the federal revenues) **would consist of the following:**

(1) CPEs for indigent health care costs from the 21 hospitals;

(2) Intergovernmental transfers (IGTs) from public hospitals for payments to public and private hospitals for uncompensated care costs that are between 100 percent and 175 percent of costs (pertains to the Upper Payment Limit to enable private hospitals to draw down up to $250 million in federal funds); and

(3) ***Possibly*** state General Fund moneys or special fund moneys for certain health care services provided to indigents (i.e., non-Medi-Cal), such as California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), AIDS Drug Assistance Program (AIDS) or others. This aspect of the proposal is unknown at this time.

B. How Would the Safety Net Care Pool Work? The Administration **views the distribution of the Safety Net Care Pool as being a discussion that will occur *after*** the federal CMS conceptually approves the state's Waiver.

However, distribution of the Safety Net Care Pool is a significantly issue for the hospitals, particularly the public hospitals. The public hospitals are facing significant uncertainty, particularly with all DSH funds being transferred to the "pool" and with the proposed shift to CPEs.

In response to this concern, the Administration states that public hospitals would be "held harmless". However, there is no written reference to this in their proposal, nor has the Administration provided any fiscal detail on this topic. Therefore the risk to public hospitals is substantial.

4. De-Linking of Managed Care Inpatient Days: The federal revenues provided to the Safety Net Care Pool would be capped and the payments for inpatient hospital services to Medi-Cal eligibles would be subtracted out, including those payments to private hospitals.

Under this concept, the money would follow the Medi-Cal patient. The money being used for the Medi-Cal Managed Care patient would be included in the Managed Care Waiver (separate and apart from a Hospital Finance Restructuring Waiver). The supplemental federal funds (SB 1255 funds) now used for indigent care would go into the Safety Net Pool, as described above, and be available and unlinked to fee-for-service days or the movement to Medi-Cal Managed Care.

The Administration contends that this de-linking means that public hospitals would not be financially affected by any further movement to Medi-Cal Managed Care. The Administration notes that 70 percent of a hospital's expenditures are variable, not fixed because of labor funding and related items. As such, the Administration states that under the CPE concept, hospitals will be getting 50 percent of their costs funded by

federal funds. Under our current per diem rates to public hospitals, we pay only 50 percent (state and federal funds) of their Medi-Cal costs. Therefore according to the Administration, moving to the CPE model and paying 50 percent (federal funds) gets hospitals the same payment amount as they currently receive.

Public hospitals would likely maintain that Medi-Cal patients, and the reimbursement they bring, assist in stabilizing their funding stream. Otherwise the entire funding relationship becomes a county-federal partnership with limited or no state funding responsibility.

The federal CMS wants this de-linking because (1) they would want to share in any savings that result from the expansion of managed care, and (2) they don't want to pay twice for the service (i.e., fee-for-service and managed care payments).

5. Private Hospital Funding (DSH Swap). Under the Administration's proposal, **private hospitals would no longer be part of the DSH arrangement but would instead, receive "regular" Medi-Cal funding (state General Fund with a federal match).**

According to the Administration, this "DSH swap" enables the state to obtain about $226 million (federal funds) more from our existing DSH allotment. This is because in the past, some public hospitals had to receive higher DSH payments to recoup (net out) their IGT payment (remember that the IGT payment was needed in order to draw DSH for the private hospitals). Since DSH is losing its identity and IGTs would be used to a lesser degree, it makes the $226 million available.

The DSH "administrative fee" (i.e., the $85 million the state takes to backfill for General Fund) would be eliminated as part of this DSH swap. No General Fund increase would occur however because of the interactions with the DSH swap and SPCP Program contract per diem payments made to public hospitals.

6. Upper Payment Limits for Inpatient Services:

Federal law establishes maximum rates that can be paid for hospital inpatient and hospital outpatient services. The federal government defines these "Upper Payment Limits" (UPL) as the amount of money Medicare would pay for the same set of services provided by Medicaid (Medi-Cal). There are limits in the aggregate for the state, as well as limits for each group of services, such as hospital inpatient services, as well as others.

There is also an overall UPL limit for a group of hospitals. Each hospital is in one of three categories—(1) state owned and operated facilities, (2) non-state owned and operated facilities, or (3) private facilities. The federal government has classified the UC hospitals as "state owned and operated". County and district hospitals are in the "non-state" category. PEACH hospitals are in the private facilities category.

The Administration's Waiver proposal contains a UPL adjustment factor for the UC hospitals that is needed in order to fully recognize costs and to utilize the CPE model.

7. Federal Cap—Budget Neutrality Calculation: Generally, the federal revenue cap would be based on a calculation of what California's expenditures would have been for Medicaid (Medi-Cal eligible) inpatient hospital services in the absence of this Waiver.

This calculation is quite complex and hinges on obtaining federal CMS agreement on several components, including **(1)** maintaining the Upper Payment Limit (UPL) for public hospitals, **(2)** recognizing a technical adjustment in the Upper Payment Limit for state hospitals, **(3)** maintaining a specified level for California's DSH allotment, **(4)** obtaining an indigent health care funding amount, **(5)** maintaining certain payments for private hospitals, **(6)** maintaining certain payments for non-contract inpatient hospitals, **(7)** approval of increased payments to private hospitals through the use of a limited IGT, and **(8)** approval of a growth factor.

III. Proposed Managed Care Expansion *(Pages 11 to 15)*

A. Summary of Existing Medi-Cal Managed Care System: The DHS is the largest purchaser of managed health care services in California. Currently, some form of **Medi-Cal Managed Care serves about 3.2 million Medi-Cal enrollees**, primarily families and children and is **in 22 counties**. **Only 280,000 enrollees, or about 9 percent, are seniors and individuals with developmental disabilities.**

The state has federal approval to operate this *existing* system under State Medicaid Plan authority.

The Medi-Cal Managed Care system utilizes three types of contract models— (1) the Two Plan, **(2)** the County Organized Health Systems (COHS), and **(3)** Geographic Managed Care (GMC). About 74 percent of Medi-Cal managed care enrollees are in a Two Plan model which covers 12 counties. There are five COHS (federal law limit) that serve eight counties. The GMC model is used in two counties.

For people with disabilities, enrollment is *voluntary* in the Two Plan and GMC model, and *mandatory* in the COHS.

In addition, certain services are "carved-out" of the Two Plan and GMC models, as well as some of the COHS's. Most notably, Mental Health Managed Care, and the California Children's Services (CCS) Program are "carved-out", except for CCS in some selected counties which operate under the COHS model. Per existing state statute, CCS is carved-out until September 1, 2008.

Background--Two Plan Model (in 12 Counties): The Two Plan model was designed in the late 1990's. The basic premise of this model is that CalWORKS recipients (women and children) are automatically enrolled (mandatory enrollment) in either a public health plan (i.e., Local Initiative) or a commercial HMO. Other Medi-Cal members, such as aged, blind and disabled, other children and families, can voluntarily enroll if they so choose. About 74 percent of all Medi-Cal managed care enrollees in the state are enrolled in this model.

Plan Name	County	June 2003 Enrollment
Alameda Alliance for Health (LI)	Alameda	73,840
Blue Cross of California	Alameda, Contra Costa, Fresno, Kern, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare	360,760
Contra Costa Health Plan (LI)	Contra Costa	41,909
Health Net	Fresno, Los Angeles, Tulare	579,588
Kern Health Systems (LI)	Kern	69,432
La Care Health Plan (LI)	Los Angeles	824,271
Inland Empire Health Plan (LI)	Riverside, San Bernardino	232,318
Molina Healthcare of California	Riverside, San Bernardino	91,702
San Francisco Health Plan (LI)	San Francisco	28,796
Health Plan of San Joaquin (LI)	San Joaquin	56,046
Santa Clara Family Health Plan (LI)	Santa Clara	66,812
Two Plan Model Total		**2,425,474**

Background—Geographic Managed Care (GMC): The GMC model was first implemented in Sacramento in 1994 and then in San Diego County in 1998. In this model, enrollees can select from multiple HMOs. The commercial HMOs negotiate capitation rates directly with the state based on the geographic area they plan to cover. Only CalWORKS recipients are required to enroll in the plans. All other Medi-Cal recipients may enroll on a voluntary basis. **Sacramento and San Diego counties contract with nine health plans that serve about 10.6 percent of all Medi-Cal managed care enrollees in California.**

Plan Name	County	June 2003 Enrollment
Blue Cross of California	Sacramento and San Diego	92,173
Community Health Group	San Diego	66,086
Health Net	Sacramento and San Diego	39,558
Kaiser Foundation Health Plan	Sacramento and San Diego	29,049
Molina Healthcare of California	Sacramento	20,208
Sharp Health Plan	San Diego	50,238
Universal Care	San Diego	12,810
UC San Diego Healthcare	San Diego	13,344
Western Health Advantage	Sacramento	15,713
TOTAL		**339,179**

Background—County Organized Health Systems (Eight Counties): Under this model, a county arranges for the provision of medical services, utilization control, and claims administration for *all* Medi-Cal recipients. Since COHS serve all Medi-Cal recipients, including higher cost aged, blind and disabled individuals, COHS receive higher capitation rates on average than health plans under the other Medi-Cal managed care system models (i.e., Two Plan Model and the Geographic model).

It should be noted that the capitation rates for COHS are confidential since the California Medical Assistance Commission (CMAC) negotiates contracts with each county plan and there is only one plan for all Medi-Cal recipients in said county.

As noted in the chart below, **about 540,000 Medi-Cal recipients** receive care from these plans. This accounts for about 16 percent of Medi-Cal managed care enrollees and about nine percent of all Medi-Cal enrollees. **It should be noted that federal law mandates that only 10 percent of all Medi-Cal enrollees can participate in the COHS model. As such, the state is close to meeting this enrollment limit.**

Plan Name	County	June 2003 Enrollment
Cal Optima	Orange	281,839
Central Coast Alliance for Health	Monterey, Santa Cruz	84,363
Partnership Health Plan	Napa, Solano, Yolo	77,704
Health Plan of San Mateo	San Mateo	45,742
Santa Barbara Regional Health Authority	Santa Barbara	50,276
TOTAL		**539,924**

B. Overview of the Administration's Proposal: The Administration's Medi-Cal Managed Care expansion would be achieved through **a phased-in process over a twelve to eighteen month period commencing in January 2007.** The Administration's proposal would require **(1)** state statutory changes, **(2)** approval of a federal Waiver, and **(3)** adoption of state regulations.

It is anticipated that 816,000 additional Medi-Cal enrollees, including the *mandatory enrollment* of aged, blind and disabled individuals, would be added to managed care through this proposed expansion. These 816,000 new enrollees, of whom 554,000 would be aged, blind or disabled, would represent an increase of over 25 percent.

Dual eligibiles (i.e., Medi-Cal and Medicare) would be excluded from mandatory enrollment except in COHS and in certain newly proposed Long-Term Care Integration projects.

The table below displays the Administration's assumed fiscal impact. The DHS notes that time is needed to assure that appropriate delivery systems are in place before managed care is expanded. As such, initial costs will be incurred before out-year savings are realized.

In addition, particularly in 2007-08, the DHS states that as individuals transition from fee-for-service to managed care, the payment of costs for services already rendered under fee-for service are due at the same time as the monthly capitation arrangements to managed care plans (capitation payments are made for the month of enrollment without payment lags). Therefore, costs are incurred as the transition transpires.

Table—Administration's Fiscal Impact Summary from Managed Care Expansion

Fiscal Year	Assumed Increase In Enrollees (average mthly)	Local Assistance (General Fund)	State Support (General Fund)	Net Total (General Fund)
2005-06	0	$150,000	$3,262,000 (47.5 positions)	$3,412,000
2006-07	61,000	$36,836,000	$3,262,000	$40,098,000
2007-08	538,785	$51,390,000	$3,262,000	$54,652,000
2008-09	820,239	($88,749,000)	$3,262,000	($85,487,000)

If the Managed Care expansion is fully implemented as proposed, about 60 percent of all Medi-Cal recipients would be enrolled in an organized delivery system.

In addition to individuals who would not be enrolled in managed care, such as rural residents, the DHS states that about 17 percent of all applicants who qualify for Medi-Cal managed care are in "transition". These individuals in "transition" are either in the process of being determined eligible for Medi-Cal or are awaiting enrollment into managed care. During this transition period, health care services are being provided on a fee-for-service basis.

The proposed expansion assumes the following key components:

1. Expansion to 13 New Counties. The Administration would expand Medi-Cal Managed Care to 13 additional counties, **including El Dorado, Imperial, Kings, Lake, Madera, Marin, Mendocino, Merced, San Benito, San Luis Obispo, Sonoma, Placer and Ventura. Enrollment would include families, children and the mandatory enrollment of aged, blind and disabled individuals.**

The Administration assumes the following Managed Care model configurations for these new counties:

- Include El Dorado and Placer counties in the existing Sacramento GMC;
- Include Imperial County in the existing San Diego GMC;
- Convert Fresno County (now a Two Plan) to a GMC and include Madera, Merced, and potentially Kings counties;
- Expand existing COHS to include the counties of Marin, Mendocino, San Benito, San Luis Obispo, Sonoma, Ventura and possibly Lake. For example, San Luis Obispo County could merge with the existing Santa Barbara COHS.

The Administration assumes that all of these counties are up and operational (ready for enrollment) by no later than April 2008.

2. Aged, Blind and Disabled Individuals (Mandatory Enrollment). The DHS has identified **36 Medi-Cal aid codes** which they would require to enroll into a managed care plan. Dual eligibles (Medicare and Medi-Cal) would not be included in this mandated group but could be voluntarily enrolled at the individual's option. **It is assumed that about 554,000 or so aged, blind and disabled individuals would be enrolled in a managed care plan by the end of 2007-08 and beginning of 2008-09. The 554,000 new enrollees represents a 100 percent increase over the number of aged, blind and disabled individuals presently enrolled (i.e., 280,000 persons).**

The 13 new managed care counties as referenced above would immediately enroll these individuals as part of their implementation plan along with families and children enrollees. The existing Two-Plan and GMC plans would phase-in this new population over a period of 12 months.

3. Acute and Long-Term Care Integration. The Administration also proposes implementation of Acute and Long-Term Care Integration Projects (Projects) in Contra Costa, Orange, and San Diego counties. Dual eligibles (Medicare and Medi-Cal) living in these counties would be enrolled.

The DHS states that these Projects would offer a comprehensive scope of services that manages the full continuum of health care needs, including primary care, case management, acute care, long-term care, dental services, emergency services, and drugs.

C. Staff Comments--Key Considerations and Concerns: The Administration's proposed managed care expansion **is very ambitious, particularly given the state's history with past Medi-Cal managed care expansion efforts, including recent problems in Fresno County as well as in Stanislaus County.**

The expansion into new counties, coupled with a mandatory enrollment of aged, blind and disabled individuals, is too much to accomplish successfully within the 12 to 18 month period designated by the Administration. This is particularly true when it comes to transitioning very medically involved individuals from providers they know and who know them, to a new network of providers.

Aged, blind and disabled individuals require more extensive specialty medical care services, personalized durable medical equipment, and rehabilitation therapists who have experience with serving these medically involved individuals. As such, issues pertaining to physician networks, access to durable medical equipment and related needs will need to be comprehensively addressed prior to any transition for these individuals.

If this expansion is to occur, comprehensive planning with impacted constituency groups, particularly stakeholders in the mental health and developmental disabilities communities, needs to occur. Ongoing involvement from local communities, as presently done in San Diego County, should also be a component requirement.

In addition, considerable fiscal issues, including resolution of complex hospital financing concerns and the development of meaningful managed care rates, need to be further studied and resolved if aged, blind and disabled individuals are to be required to be enrolled. If rates are not appropriate, people will not receive necessary medical services.

It is well known that the COHS have been experiencing fiscal hardship in serving these very medically-involved individuals. In fact, the Budget Act of 2004 provided a three percent rate increase to the COHS due to low operating reserves and questions of fiscal solvency.

Key factors for the state to evaluate health plan readiness of any managed care arrangement includes: (1) analysis of available service utilization and cost data; (2) network adequacy; (3) care coordination and carve-outs; (4) quality monitoring and improvement; (5) linkages with non-Medi-Cal services; (6) accessibility and availability of new treatment modalities; (7) community, provider and consumer input into the planning process; and (8) health plan and provider compliance with the Americans with Disabilities Act of 1990.

The inclusion of aged, blind and disabled individuals (36 new aid codes) would require an expanded state evaluation to determine health plan readiness**.** In conjunction with the federal CMS, the DHS would conduct readiness reviews of all Medi-Cal Managed Care plans prior to health plans becoming operational to serve this population. Specifically the DHS states that they would use the readiness model established under the COHS process. However more analysis of this approach is needed in order to discern what factors are to be measured and what quality assurances will be put into action. Clearly, more detailed discussions with constituency groups and the Legislature are needed prior to any agreements for expansion.

IV. Proposed Implementation of a Premium *(Pages 16 to 21)*

A. Background—What is the Administration's Proposal? Under this proposal, effective January 1, 2007, Medi-Cal enrollees with **incomes above 100 percent of the federal poverty level would pay a monthly premium to maintain their Medi-Cal coverage.**

The 100 percent of poverty threshold represents **(1)** $1,306 per month for a family of three, **(2)** $812 a month for a senior, or disabled individual, and **(3)** $1,437 a month for a couple receiving SSI/SSP.

The proposed premium amounts are as follows:

- $4 per month for children under 21 years;
- $10 per month for adults; and
- $27 per month maximum for a family.

For example, a family of three with a monthly earned income of $1,306 per month would pay $24 per month for coverage or $288 annually. The required premium payment represents about 1.5 to 2 percent of the total annual income for the affected individuals.

Enrollees would be dropped from Medi-Cal if they do not pay premiums for two consecutive months. If re-enrollment is pursued, the individual would be required to pay back premiums owed from the previous six months in which they were enrolled. This can become confusing due to Medi-Cal eligibility retroactivity (which is 90-days) as allowed by federal law.

Counties would conduct a premium calculation to discern if the Medi-Cal eligible person needed to pay a monthly premium. The DHS would contract with a Vendor to conduct the actual collection of the premiums each month.

B. What are the Criteria for Determining a Premium? Premiums will be required of any family, child, or other individual who have incomes above 100 percent of the poverty level, **except for (1)** individuals with a share-of-cost (they spend down to become eligible for Medi-Cal), **(2)** 1931 (b) families enrolled in CalWORKS, **(3)** infants under one year of age, **(4)** American Indians, and **(5)** Alaskan Natives.

Therefore, the primary categories of Medi-Cal enrollees to be impacted by the proposal are:

- Children ages one to six with family incomes above 100 percent, and up to 133 percent, of poverty;
- Seniors and individuals with developmental disabilities with family incomes above 100 percent, and up to up to 133 percent, of poverty; and
- 1931 (b) families with incomes above 100 percent, up to 155 percent, of poverty ($2,024 per month for a family of three), and not enrolled in CalWORKS.

However, 1931 (b) families would be treated *differently* with respect to how the Administration makes the premium determination. The Administration proposes to change how the existing earned income deduction will be applied solely for the purpose of determining premiums. In effect, when determining whether premiums are to be paid, a different calculation will be used (i.e., allowing for only a $90 income disregard in lieu of the $240 and ½ disregards). **Therefore, the result under this revised calculation is that more families will need to pay premiums because they will be considered above the 100 percent of poverty level.**

Further, families enrolled in the 1931 (b) category will have difficulty re-enrolling into Medi-Cal if they are disenrolled due to failure to pay a premium. These "recipients" are usually individuals who have left CalWORKS and receive Medi-Cal-only services. The federal Welfare Reform Law of 1996 specifically authorized these individuals to receive Medi-Call services because Congress wanted to transition individuals from welfare to work. One of the barriers to this transition was receipt of health care services. As such, 1931 (b) families can have incomes up to 155 percent of poverty and be eligible for Medi-Cal. However if they loose their existing eligibility, they would be eligible for Medi-Cal-only if their income level was at 100 percent of poverty or below.

C. Who are Affected & How is Enrollment Impacted? This proposal would affect children, aged, blind and disabled individuals, and families. **A total of about 550,000 people would be required to pay a premium, including about 460,000 families with children, and 90,000 seniors and individuals with disabilities with incomes above the SSI/SSP level.**

In the first year alone, **the DHS assumes that almost 20 percent of these individuals or about 94,630 individuals will fail to pay and become disenrolled,** and thereby add to the increasing ranks of the uninsured living in California. **This is illustrated in the table below.**

It should be noted that the DHS assumes that *all dual eligibles* (Medicare and Medi-Cal eligible) will *not drop off* because Medi-Cal pays their Medicare premiums. However in practice this may not occur; therefore, even more individuals could fail to make the premium payment.

Table—DHS' Assumptions of Who Drops Off

Eligibility Category (Fee-for-Service & Managed Care)	Total Medi-Cal Enrollees Needing to Pay	Reduction in Enrollees (Drop-Off)
Aged, Blind & Disabled	90,601	2,817 (3%) (Assumes no duals are dropped)
Children	207,030	41,404 (20%)
Adults (ages 21-64)	252,045	50,409 (20%)
TOTALS	**549,676**	**94,630**

D. Medi-Cal Eligibility Processing— Likely Churning of Enrollees: **The proposal is almost certain to result in a churning of enrollees and increase administrative processing costs.**

First, under federal law, as well as SB 87 (Escutia), Statutes of 2000, individuals who loose Medi-Cal eligibility under one set of criteria may be eligible for Medi-Cal enrollment under another category. **As such Medi-Cal re-determinations must be made. Therefore, all of the Medi-Cal enrollees who are discontinued from Medi-Cal due to non-payment of premiums would conceivably need to be re-determined by the counties.**

Medi-Cal re-determination processing can require considerable work on the part of counties. Under re-determination processing, a county must first do an "ex parte" review. Under ex parte, the county must check certain public assistance data systems to see if there is appropriate information to make an eligibility determination. If not then additional information is obtained as needed from the individual through telephone contact and if needed, use of a special Medi-Cal form. **These administrative costs have *not* been addressed by the Administration's proposal.**

Second, as noted by the Administration's own analysis, individuals will drop-off due to the non-payment of premiums and then come back on when they need services (if eligible). **This churning of enrollees seems contrary to the Administration's own goal of expanding Medi-Cal Managed Care. Managed Care plans would not appreciate having Medi-Cal enrollees coming in and out of enrollment. This could also result in additional processing costs for the Medi-Cal Health Care Options contractor** since they will need to inform enrollees of their health plan choices and enroll them into a plan.

Third, it is unclear how the "Medi-Cal Eligibility Determination System" (MEDS) could maintain its data integrity. Counties maintain MEDS since they perform most Medi-Cal eligibility processing. In the event of Medi-Cal enrollees discontinuing due to non-payment of a premium, it is unclear how the Vendor will notify the county of this action. **If the two systems are not in synch with each other, the state could be making Managed Care plan payments for individuals no longer eligible for Medi-Cal, or Medi-Cal enrollees could be inadvertently disenrolled from Medi-Cal.**

Fourth, it is unclear how the continuous annual eligibility enrollment of children would be affected if premiums were not paid (such as in the 133 percent of poverty program). The original policy and fiscal concepts behind this annual enrollment was to ensure coverage for children and to reduce administrative costs. It appears that these would not be achieved under the proposal.

Fifth, a clear mechanism for re-enrollment would need to be established, or people's applications could be put on hold indefinitely while they are being asked to pay the premium. What if a parent or child requires medical attention while they are on hold? Should the family spend their money on the medical care, or on paying back their premiums? How will providers of health care know clearly what the status of an individual patient is at the moment of the health care delivery?

E. Proposed Administrative Costs Do Not Reflect All Necessary Expenditures: **The table below displays** the DHS' estimated expenditures for the administration of the premium. As noted below, they assume first year (i.e., 2005-06) implementation expenditures of $6.850 million General Fund, with on-going annual expenditures of **at least** $12.150 million General Fund.

However, not all of the expenditures are captured in the DHS' cost assumptions. First, no additional county administrative costs have been recognized for conducting Medi-Cal re-determinations as discussed above.

Second, the DHS fiscal summary assumes that counties would calculate a premium one time, and that would be it. However, in the reality of life, people may lose their job or have their hours reduced, get married, have a baby, or other related-life events that would result in them no longer having a premium requirement. **As such, additional administrative costs for calculating the premium would probably be needed.** In addition, would a family have to pay while their premiums are being re-determined? If they didn't pay, would they be inappropriately dropped off of Medi-Cal?

Third, expenditures for a contractor to *design* a premium collection system are not included, though expenditures for the actual collection of the premium are included. It is likely that development and design of an information system would be costly. **The DHS notes that it is unknown at this time what these costs would be.**

The DHS assumes that it will take at least 18 months for the "premium collection contractor" to develop a collection system and begin actual collection (assumes premiums begin to be paid as of January 1, 2007).

Table: Administrative Expenditures for Premium

Administrative Activity	**Proposed Expenditures (General Fund) 2005-06**	**Proposed Expenditures (General Fund) 2006-07** *(1/1/2007 start)*	**Proposed Expenditures (General Fund) 2007-08**
I. DHS Identified Costs			
County Determination of Premium	$6,200,000 (850,000 cases to review)	$7,200,000 (950,000 cases to review)	$7,200,000
Contract—Collection of Premiums	---	$2,150,000	$4,300,000
DHS State Staff (positions)	$650,000	$650,000	$650,000
Subtotal--DHS' total amount	**$6,850,000**	**$10,000,000**	**$12,150,000**
II. Unidentified Costs			
County Re-determination Costs		**Unknown**	**Unknown**
County Re-Enrollment Costs		**Unknown**	**Unknown**
County Premium Re-Calculation		**Unknown**	**Unknown**
County MEDS Linkage to Vendor		**Unknown**	**Unknown**
Vendor Design, Development and Maintenance of System		**Unknown**	**Unknown**
Health Plans Options Processing		**Unknown**	**Unknown**

F. Administration's Assumptions Regarding Savings: As shown in the table below, the Administration **assumes savings from the premium payments from two sources: (1)** the revenue received from the payment of the monthly premium, and **(2)** from health care costs not provided to individuals because they have dropped off of Medi-Cal due to the non-payment of the premium. These assumptions are open to interpretation since limited research data is available.

It is interesting to note that the Administration assumes no savings for in-patient care services from those individuals who are dropped off of Medi-Cal due to non-payment, and only from two to five percent savings from non-institutional care. This is because the Administration recognizes that individuals will come on and off Medi-Cal as they need services. As such, it decreases the likelihood of "managing" care.

As noted below, the Administration assumes savings of from about $15 million General Fund to about $23 million General Fund on an annual basis. However as previously discussed, it is unlikely that all costs associated with administration of this program have been captured.

Table: Administration's Assumed Savings from Premium Payments *(Annualized)*

2007-08 First full year (Annualized)	Aged, Blind & Disabled ($10 for 12 mths)	Children ($4 for 12 mths)	Adults (Ages 21-64) ($10 for 12 mths)	**Total Funds**
***Net* Premium** (After drop-off)	**$10,534,000** (87,783 people)	**$7,951,000** (165,627 children)	**$24,225,000** (201,636 people)	**$42,708,000** (455,046 people)
Dropped from Medi-Cal	2,817 People (3%)	41,404 Children (20%)	50,409 Adults (20%)	94,630 Total
2 % to 5 % Savings for Dropped People	$1,163,000 to $2,908,000	$3,697,000 to $9,244,000	$5,433,000 to $13,584,000	$10,295,000 to $25,735,000
SUBTOTAL	**$11,697,000 to $13,442,000**	**$11,648,000 to $17,195,000**	**$29,658,000 to $37,809**	**$53,003,000 to $68,443,000**
DHS' Assumed Administrative Costs				-$23,044,000
Administration's Net TOTAL (Rounded)				**$29,958,000 to $45,399,000**
Assumed General Fund Savings				**$14,979,000 to $22,700,000**

G. Administration's Proposed Implementation: The premium proposal **would require state statutory change as well as a federal Waiver.**

The Administration assumes approval by the Legislature during the 2005-06 Session and that a Waiver would be submitted to the federal CMS by December 2005. The DHS notes that the federal Waiver process might take from six to nine months from this date for approval. The Administration notes that the state contracting process typically takes 15-21 months once their Request for Proposal (RFP) is released. Therefore, the Administration assumes that premium payments and collections would begin January 2007.

Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda
Health & Human Services

Chair, Senator Denise Ducheny

Senator George Runner
Senator Tom Torlakson

February 23, 2005
9:30 AM
Room 112

Informational Hearing:
Enhancing Federal Funds through
Increased Accountability and Action

A. Department of Social Services (DSS)

1. Loss of $1 billion in Food Stamps from lack of DSS action

B. Department of Child Support (DCS)

1. Billions in arrearages, and over $200 million in penalties due to automation delays by DCS
2. Child Support Automation System Penalty

C. The President's Federal Budget and Implications for Medi-Cal

- Presentation by the Legislative Analyst's Office

D. Department of Health Services—Medi-Cal Discussion

1. Federal Denial of State Plan Amendment Costs Counties $14.1 million
2. Ongoing Federal audits of Medi-Cal
3. Potential to enhance federal funds for family planning in managed care
4. Changing how ICF/DD facilities are billed

E. Department of Developmental Services (DDS)

1. Loss of $30 million from continued lag in CA Developmental Disabilities Information System (CADDIS)
2. Potential to extend Targeted Case Management Services

A. Department of Social Services (DSS)

1. Food Stamp Participation Rate

Issue: According to various measures used by the U.S. Department of Agriculture (USDA), California's Food Stamp utilization rates are among the lowest in the nation. These low rates may result in a significant amount of lost federal funds for the state's economy, as well as reduced nutrition and increased hunger for low-income families.

- California's low participation rate may also contribute to obesity if low-income families choose quantity over quality when purchasing food. Access to Food Stamps benefits can help low-income persons afford healthier food, especially fresh fruits and vegetables.
- Furthermore, as the Legislative Analyst's Office reported in 2004, the income effect associated with additional Food Stamp benefits results in additional General Fund sales tax revenues that often exceed the state administrative costs for eligibility determination.
- Advocates indicate that California's low Food Stamp participation rate is due to the state's failure to take advantage of federal waiver options and implement administrative changes that would make it easier for working families to apply for and maintain benefits.
- According to the USDA, California's Food Stamp Participant Access Rate in 2003 was 39 percent, the lowest in the nation. The state's Food Stamp Participation Rate in 2001 was 54 percent, compared to the national average of 60 percent.
- The department indicates that the methodology used by the USDA and Mathematica Policy Research to measure participation does not reflect the full impact of California's SSI "cash out" policy, and the number of non-citizens that are ineligible for Food Stamps. They also indicate that the Administration seeks out all available federal waivers.
- The department also indicates that California's low food stamp participation rate is generally due to the following factors: lack of knowledge on who is eligible for the program; frustration with the application process; the negative stigma associated with food stamps including poor service in grocery stores and treatment by program staff; fears that permanent legal residence could be impacted and that benefits would have to be paid back from future earnings.
- The Governor's Budget includes eligibility simplification proposals that are estimated to increase benefits by $15.7 million in 2005-06 ($32 million annually).

Background: The Department of Social Services provides statewide oversight and administration for the Food Stamps program, and counties make eligibility determinations. Families eligible for CalWORKs are automatically eligible for Food Stamp benefits and low-income working families and individuals not enrolled in CalWORKs are also eligible for Food Stamp benefits. Average monthly Food Stamp caseload in 2005-06 is estimated to be 2.1 million persons (835,000 households), a 4.9 percent increase over 2004-05. Approximately 59 percent of these households are not receiving cash assistance.
Food Stamp benefits are funded entirely by federal funds. California received approximately $2 billion in Food Stamp benefits in 2004. The federal government also funds 50 percent of the program's administrative costs. The remaining 50 percent is split between the state and counties at a ratio of 70 percent to 30 percent, respectively.

Questions:

- **1. California Food Policy Advocates (CFPA),** please describe the state's Food Stamp participant access rate, and how it is determined.
- **2. CFPA**, how does the state's Food Stamp participation rate affect low-income families?
- **3. CFPA**, how can the state increase Food Stamp participation?
- **4. CFPA**, how much in additional federal Food Stamp benefits could California potentially receive?
- **5. LAO**, please describe the fiscal effect of Food Stamps on the state's overall economy and General Fund revenue.
- **6. DSS**, please briefly describe the Governor's Budget proposal to simplify eligibility.
- **7. DSS,** what additional steps can the state take to increase its participation rate without a net increase in administrative costs or error rate?
- **8. DSS,** how has the state's Food Stamp participation rate changed since 2000, and what accounts for those changes?
- **9. DSS**, would the President's proposed federal budget limit the state's ability to increase Food Stamp participation or benefits?

B. Department of Child Support Services (DCSS)

1. Child Support Collection System

Issue: Despite efforts in recent years to improve California's child support system, collections from non-custodial parents have not significantly increased, the amount of arrearages owed to families remains high, and the cost-effectiveness of the state's collection system is still far below the national average. As a result, annual federal incentive funding for the state has declined by $24 million since 2000, and many children in the state are living in poverty due to unpaid child support.

- **Cost-Effectiveness:** California's child support system collected $2.12 in revenue for every $1.00 spent on collection efforts in federal fiscal year 2004. This is significantly lower than the national average of $4.33 in revenue per dollar spent. Among 54 states and territories, California ranks 49th in cost-effectiveness.

- **Federal Performance Measures:** In Federal Fiscal Year 2004 California scored lower than the national average in three out of five federal performance measures (including cost-effectiveness), and ranked 41st in overall performance.

- **Federal Incentive Funding:** Federal incentive funding has declined from $69.4 million in FFY 2000 (16 percent of total federal incentive funding) to $45.2 million in FFY 2004 (10 percent of total federal incentive funding).

- **Significant Arrears:** Approximately $19 billion in child support arrears is currently owed to families in the state. An analysis conducted by the Urban Institute found that approximately $4.8 billion of the state's arrears, $2.3 billion of which is owed to the state, is collectable. The Compromise of Arrears Program (COAP) was established in 2003-04 to offer reduced lump sum settlements to parents in exchange for their commitment to make ongoing payments. This program is also intended to reconnect families estranged due to unresolved child support payments. The Governor's budget estimates $33.3 million in arrears will be collected in 2005-06 due to the COAP.

- **Children Living in Poverty:** According to the US Census Bureau, over 1.7 million California children (18.6%) were living in poverty in 2003, up from 18.2 percent in 2002. (The US Department of Health and Human Services' poverty guidelines set the poverty level at $15,260 for a family of three in 2003.) California ranks 38th out of 50 states and the District of Columbia in child poverty, despite having the 11th highest median family income ($50,220 in 2003). Thirty-two percent of female-headed households in the state were living in poverty in 2003.

Background: The Department of Child Support Services (DCSS) administers the child support enforcement program operated by local child support agencies. The budget anticipates collections of $2.4 billion in the budget year, an increase of 1.7 percent over the current year. The department's overall budget expenditures are proposed to increase by $279.2 million, or 25.5 percent, to $1.4 billion. Most of the additional funding request is due to the child support automation system penalty (see issue 2 below).

Questions:

- **1. LAO,** please describe the state's scores on federal child support performance measures, how those scores compare to the national average, and how those scores are linked to federal incentive funding.
- **2. LAO**, please describe the child support collections trends since 1999-2000.
- **3. LAO**, please describe the poverty rate for children in the state, and how the child support system can affect poverty among children.
- **4. DCSS**, please explain why the state's cost-effectiveness ratio is significantly lower than the national average, and why it has decreased since FFY 2000.
- **5. DCSS**, please describe how the Administration intends to address the state's low cost-effectiveness ratio.
- **6. DCSS**, please briefly describe why COAP implementation has been delayed, and how it will be implemented in the future.

2. Child Support Automation System Penalty

Issue: Since 1997, California has been subject to substantial federal penalties due to the state's failure to establish a single statewide system for the collection of child support. The cumulative federal penalty from 1998 through 2006 is expected to be over $1.2 billion General Fund. The automation system currently under development is scheduled to be completed by 2008.

- **$218 Million Federal Penalty in Governor's Budget:** The budget includes $218 million General Fund in 2005-06 for the federal fiscal year (FFY) 2005 penalty. The 2004 Budget Act did not include funding for this penalty, as the payment was entirely deferred to state fiscal year 2005-06.

- **2006 Penalty Deferral Denied:** The federal government recently denied the Administration's request to defer the FFY 2006 penalty to 2006-07. As the Governor's Budget assumed that this penalty would be deferred to 2006-07, the federal denial results in additional General Fund costs of $167 million in 2005-06 above the Governor's Budget.

- **2005 Certification Opportunity Denied:** In 2004 the Administration indicated that federal certification of automation system compliance might be possible as early as September 2005. If approved this would have reduced the 2005-06 penalty by 90 percent. In October 2004 the federal government clarified that certification and penalty

relief were dependent upon full operation of all components of the system. The Administration may still be pursuing a September 2006 early certification schedule, but it is unclear whether this October letter precludes any penalty relief before 2008.

- **Contract Amendments Not Performance-Based:** In November 2004 the Department of Finance submitted a request to the Legislature to increase project contract costs by $14 million in 2005-06 to implement the initial phase of the automation system more quickly. However, the November 2004 proposed contract amendments did not fully comply with current law, as they did not specify performance- or deliverable-based payment conditions. In response to concerns expressed by the Legislature in December 2004, the Administration has indicated it will amend the contract to include those payment conditions.

- **Cost Benefit Analysis Due March 1, 2005:** The Administration previously indicated that it would request early certification effective September 2006. However, in a June 2003 contract notification letter to the Legislature, the Department of Finance indicated that a condition of project approval would be "whether early federal project certification is a cost-beneficial strategy since it would cap federal financial participation." In light of the November 2004 Department of Finance request for additional contract funding, the Legislature has requested that the department submit a cost-benefit analysis of early certification by March 1, 2005.

Background: Since 1997, California has been subject to substantial federal penalties due to the state's failure to establish a single statewide system for the collection of child support. The penalties are a percentage of program administration costs, with an increasing percentage each year. California has reached the maximum percentage level at 30 percent of administrative costs.

Questions:

- **1. DCSS**, please describe how the Administration intends to address these penalties. Will the Administration request that further federal penalties be waived or deferred, and at what stage of project development?
- **2. DCSS,** when is the child support automation system expected to be completed?
- **3. DCSS,** when does the Administration expect that sufficient system development progress will have been made to avoid the federal penalty? In what year does the Administration expect to make the final federal penalty payment?
- **4. DCSS,** does the additional penalty payment in 2005-06 affect the state's cost-effectiveness and performance incentive payment?
- **5. LAO**, please briefly describe the department's progress on the child support automation system.

C. The President's Federal Budget and Implications for Medi-Cal

- **Presentation by Shawn Martin, Legislative Analyst's Office (LAO)**

D. Department of Health Services (DHS)

1. Federal Denial of California's State Plan Amendment for Public Guardian and Probation Expenditures Means a Loss of $14.1 million

Issue and Background: In a July 6, 2004 letter, the **federal CMS recently denied a request by California** to include reimbursement for certain health-related services provided by County probation officers and by County public guardians (i.e., **counties put up the *non-federal* match** to draw down the federal funds).

This denial has resulted in a loss of $6.7 million (federal funds) in 21 counties for County probation services and $7.4 million in 25 counties for public guardian services. As such, a total of $14.1 million is being lost for California counties at this time.

The DHS and Chief Probation Officers of California (CPOC) both disagree with the federal CMS denial and have submitted additional quantitative information to them. **However, no change from the original denial (in July 2004) has as yet been obtained. To date, the federal CMS has agreed to convene an administrative hearing for a re-consideration.**

Further, because these funds are so critical to the CPOC, they have retained the services of a law firm to work with the DHS Legal Office in presenting the appeal to the federal CMS.

The federal CMS has denied the state's request even though these services are eligible for Medicaid (Medi-Cal) reimbursement and were originally approved by the federal CMS back in 1995. Following the passage of enabling state legislation, the federal government approved California's request to authorize probation departments to claim for certain services, including case management, needs assessment, individual service planning, and periodic evaluation of clients.

As of 2002-03, **five probation departments were participating, including San Diego, Orange, Humboldt, Amador and Plumas. The July 2004 federal CMS letter stated that these five counties must be removed from participation beginning in 2005-06. (**The federal funds lost by these counties are included in the total figure provided above.)

The services in question are often referred to as "Targeted Case Management" (TCM) services because they provide assistance to "targeted" individuals who have the inability to handle personal, medical or other affairs. In the case of individuals coming into the adult probation setting, many fail to access the specialized treatment and counseling programs needed to deal with physical health, mental health and substance abuse related problems. As a result,

they do not know how to or are not motivated to seek assistance from conventional programs until they must obtain help in an emergency room.

The impacted counties include the following:

> ***Probation services ($6.7 million in 21 counties)***: Alameda, Amador, Del Norte, Fresno, Glenn, Humboldt, Lassen, Los Angeles, Orange, Plumas, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, Siskiyou, Sutter, Trinity, Tulare, and Ventura counties.
>
> ***Public Guardian services ($7.4 million in 25 counties)***: Amador, Butte, Contra Costa, El Dorado, Fresno, Glenn, Imperial, Inyo, Lassen, Los Angeles, Monterey, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Solano, Stanislaus, Yolo, and Yuba counties.

Questions:

- **1.** DHS, Please provide a brief overview of the issue from your perspective.
- **2.** DHS, Why did it take so long for the federal CMS to respond to our original request?
- **3.** DHS, When will the federal CMS administrative hearing be convened?
- **4.** DHS, What are the counties suppose to do at this point?

2. Significant Federal Audits being conducted on California

Background—Is the Federal Government Targeting California? The federal Centers for Medicare and Medicaid (CMS) has just added 100 additional field auditors to review state Medicaid payments nationwide. **At least six of these new auditors will be assigned to California on a permanent basis.**

According to information obtained from the DHS, there are numerous federal audits being conducted on California's Medi-Cal Program. **Any of the audits could result in "audit findings" that would require California to payback federal reimbursements either from the state General Fund or County General Fund (depending upon the type of program in question). In fact, one example is discussed below.**

Recent Federal Audit Finding—General Fund Loss of $5.4 Million. The federal government is in the process of issuing an audit finding regarding the Department of Health Services' method for claiming enhanced federal payments for certain medical personnel, such as nurses, physicians and other clinicians.

The Administration, through the Department of Finance, has already requested a General Fund deficiency of $5.4 million due to this *initial* audit finding. Further, the DOF notes that this dollar amount is subject to change "due to the fact that the federal CMS may deny

more claims when the department is officially notified of the disallowance (final audit finding). In fact, the federal CMS could ask for a disallowance of as much as $8.4 million, or $3 million more than what the DOF has presently identified (December 30, 2004 letter from the DOF to the Joint Legislative Budget Committee**).**

It should also be noted that a separate audit is being conducted on this same topic regarding local assistance funding. The results of this audit will not be known for a few months.

Questions:

- **1. DHS,** How many audits is the federal government conducting regarding the state's Medi-Cal Program?
- **2. DHS,** Has the level of federal audit activities increased? Why do you think this has occurred?
- **3. DHS,** What is the Administration doing to prepare for more audits?
- **4. DHS,** With respect to the audit referenced above regarding state positions and the receipt of federal funds for certain clinical positions, are more General Fund moneys at risk?

3. Receipt of Federal Funds for Family Planning Services in Managed Care

Issue and Background: **The federal government reimburses all states with an enhanced federal match of 90 percent for family planning services (such as contraceptive services). This has been a long standing federal policy for over 20 years.** In the Medi-Cal fee-for-service environment, California captures this "enhanced federal rate".

However, California is presently not capturing this level of federal reimbursement in the Medi-Cal Managed Care environment, such as in the Two-Plan model, Geographic Managed Care model, and County Organized Health Systems (COHS) model. Instead, the DHS is only capturing a 50 percent federal match (i.e., the existing "standard" rate for California) for these family planning services.

In a December 2004 report—Revenue Maximization Strategies—commissioned by The California Endowment, **it was noted that the DHS could use an audit module that identifies all costs eligible for enhanced federal funding in capitation payment environments.**

Specifically, the report estimated that $20 to $25 million in federal funds could be captured using this approach. (This is the difference between the 50 percent federal match and the 90 percent federal match.)

Therefore, a General Fund savings of $20 million to $25 million could be achieved.

Questions:

- **1.** DHS, could additional federal funds be achieved as noted?
- **2.** DHS, what specifically would need to be done (audit module or what) to effectuate this?

4. Potential to Modify Intermediate Care Facilities (ICF)/DD Billing

Issue and Background: The **Department of Health Services (DHS) is the "sole" Medicaid (Medi-Cal) state agency**. This means that all Medi-Cal-related issues, including services provided to individuals with developmental disabilities, must flow through the DHS first, and then to the federal government.

According to a January 2003 report (PNP associates), funded by the Department of Developmental Services, **tens of millions in General Fund savings could be achieved if the DHS re-structured how it reimburses ICF-DD facilities.**

Specifically, the report noted that federal regulations allow a state to create a broader definition of ICF-DD services than those presently used by the DHS. Specifically, additional services and supports for individuals with developmental disabilities could be included in the definition, **such as Day Programs and transportation services to Day Programs.**

All existing Day Program services, as well as ICF-DD facility services would remain the same. Only the funding mechanism would be changed.

Under the state's existing system, Day Program services for individuals with developmental disabilities are funded through the Department of Developmental Services and purchased by the non-profit Regional Centers. Presently, about 50 percent of expenditures for these Day Program services are funded using 100 percent General Fund support. **If Day Program services were reimbursed under a more inclusive ICF-DD rate, a federal match could be received for most of this General Fund expenditure.**

ICF-DD facilities are funded through the Medi-Cal Program managed by the DHS. **Rates for ICF-DD facilities are calculated by the DHS based upon cost reporting data received by the facilities and a DHS-established methodology.**

The existing DHS cost methodology for ICF-DD facilities is presently defined in California's state Medi-Cal Plan. Therefore, any change to this rate would require a "State Plan Amendment" (SPA) and federal CMS approval.

It should be noted that other states have been successful in covering additional services and supports (i.e., broader definition of ICF-DD services) as noted.

***Legislative Analyst's Office (LAO)* Option:** In their "options" summary, the LAO concurred with the DDS sponsored report (PNA Associates), and thought that a total of $51.1 million in General Fund savings could be achieved by restructuring the ICF-DD facility rate as noted above.

Additional Background--What Are Intermediate Care-DD Facilities? Generally, ICF-DD facilities are facilities that provide 24-hour assistance, including nursing care, habilitation services, active treatment, and supervision in a structured setting. This type of licensed facility includes the state Developmental Centers, as well as smaller six-bed facilities in various regions of the state.

Questions:

- **1. LAO, Please describe the proposal and your past year savings estimate.**
- **2. DHS, What concerns if any do you have? What would be required to do this?**
- **3. DDS, What technical guidance would you suggest for crafting this potential change?**

E. Department of Developmental Services (DDS)

1. CA Developmental Disabilities Information System--$30 million Loss

Issue: Due to continued delays in implementation of the "California Developmental Disabilities Information System (CADDIS), **California will lose $30.3 million in federal funds over the next two-years ($10.4 million in 2004-05 and $19.9 million in 2005-06). The receipt of these federal funds could have been used to off-set General Fund support.**

Transportation services were added to the state's Home and Community-Based Waiver last year. Through this Waiver, the state is able to claim federal matching funds (50 percent level) for certain services provided to individuals with developmental disabilities. The loss in federal funds is because CADDIS is not operational. **Specifically, CADDIS was supposed to be fully functional to capture this transportation billing information. However since it is unable to, the state continues to fund transportation services at 100 percent General Fund support.**

Background—What is CADDIS? The California Developmental Disabilities Information System (CADDIS) **is an integrated case management and fiscal accounting system that is being implemented by the Regional Centers (RCs) at the direction of the DDS.** CADDIS will replace the current Uniform Fiscal System (UFS) and the San Diego Information System (SANDIS) case management system, both developed and implemented over 20 years ago.

CADDIS is needed in order to obtain more accurate and necessary consumer data regarding needs and services, and in order to enhance the receipt of federal funds by meeting federal reporting requirements.

Initiated in July 2000, CADDIS has encountered several system delays. In the Budget Act of 2003, it was assumed that CADDIS would be operational by June 2004. This date was pushed back to December 2004 through the Budget Act of 2004. **Now the DDS contends that implementation will not occur until May 2006.**

As noted in the table below, system design and implementation costs are now at a total of $14.6 million (General Fund). Therefore the system is becoming more costly while delays in implementation continue.

Table: Summary of CADDIS Expenditures

Fiscal Year	General Fund
2000-01	$707,000
2001-02	$5,306,000
2002-03	$401,000
2003-04	NA
2004-05	$6,439,000
2005-06	$1,730,000
Total Funding	**$14,583,000**

Background—Steps DDS is Taking: In a recent discussion with the DDS, they note that the vendor—Deloitte—has replaced its project management team and is in the process of expediting its work. The DDS is also in negotiations with the DOF (information technology section) and Deloitte regarding what actions can be taken to remedy the delays and improve the overall project.

Questions:

- **1. DDS, Specifically, what is being done to expedite the project?**
- **2. DDS, Is the May 2006 still a realistic deadline? Could CADDIS be implemented sooner?**
- **3. DDS, Is it likely that additional project expenditures will need to be incurred for CADDIS? If so, why?**
- **4. DDS, Is there any other way that a federal match can be obtained for the transportation services, since these have been approved for reimbursement?**

2. Targeted Case Management Services

Issue: The state could amend its Medi-Cal Program to provide Targeted Case Management Services (TCM) to individuals with developmental disabilities **who are transitioning from ICF/DD facilities (such as a Developmental Center) for up to the last 180 consecutive days of a Medi-Cal person's institutional stay.**

Presently, the state is only capturing up to 30 days.

Background—What is TCM? Persons with developmental disabilities, along with certain other client groups, are identified in California's Medi-Cal State Plan as being a **"targeted" group" to receive assistance in their efforts to gain access to needed medical, social, educational and other services provided by Medi-Cal. This enables the state to draw a federal match for these services, versus solely using General Fund support.**

Targeted Case Management Services (TCM) are provided by Regional Centers (RC). Functions to be claimed under TCM include: (1) consumer assessment, (2) development of a specific care plan, (3) referral and related activities to assist the consumer to obtain needed services, and (4) monitoring and follow-up. **Therefore, most of an RC's case manager's time spent on a Medi-Cal eligible person in the RC system can be reimbursed under TCM.** According to the DDS, there are about 128,000 Medi-Cal eligible persons in the RC system (out of about 211,000 individuals).

Background—Current TCM Expenditures: For 2005-06, **the budget proposes expenditures of $247.8 million ($123.9 million General Fund) for RC "Operations**" to provide TCM services.

It should be noted that this funding reflects a current-year increase of $19.5 million (federal funds) obtained by the DDS, with assistance from the DHS, in working with the federal CMS. **Specifically, the DDS was able to obtain approval to revise their methodology for calculating TCM billing rates (i.e., brought them up-to-date).**

Proposal to Capture More TCM Federal Funds: In a December 2004 independent analysis conducted by Health Management Associates, as commissioned by the California Endowment, it was noted that the DDS could be capturing increased federal funds for TCM. No suggested federal dollar amount was specified.

As such, the DDS commenced with drafting a State Plan Amendment to allow for the provision of TCM services for up to 180 consecutive days prior to discharge from an institution (ICF/DD facility). On December 30, 2004, the DDS provided the draft State Plan Amendment to the Department of Health Services (as the sole Medicaid state agency) to review and begin discussions with the federal CMS.

It should be noted that the proposed change is very straightforward (i.e., 30 days to 180 days) and would not require any substantive changes on the part of the DDS.
It is estimated that **about $500,000 (General Fund)** could be saved from this action.

With the proposed closure of Agnews Developmental Center by June 30, 2007, implementation of this TCM change would make good policy sense to ensure pre-planning activities and to draw federal funds for them.

Questions:

- **1. DHS,** has the State Plane Amendment been submitted to the federal CMS? If not, when will it be submitted?
- **2. DDS,** what is required for implementation?

LAST PAGE OF AGENDA

Joint Informational Hearing of the

Senate Committee on Health and the Senate Committee on Budget and Fiscal Review, Subcommittee No. 3 Health and Human Services

Chairs
Senators Deborah Ortiz and Denise Moreno Ducheny

"Governor's Proposed Medi-Cal Redesign

Wednesday March 2, 2005
1:30-5:00 p.m.
State Capitol, John L. Burton Hearing Room (4203)

Agenda

I. Welcome and Opening Comments

- ***Senator Deborah Ortiz,*** Chair, Senate Health Committee
- ***Senator Denise Moreno Ducheny,*** Chair Senate Budget and Fiscal Review Subcommittee No. 3 on Health and Human Services
- ***Other Members Present***

II. Medi-Cal Managed Care in California

- ***Stan Rosenstein***, Deputy Director for Medical Care Services and Rene Mollow, Assistant Director for Health Policy, Department of Health Services
- ***Howard Kahn***, Chief Executive Officer, L.A. Care and Local Health Plans of California
- ***Michael Murray***, Executive Director, San Mateo Health Commission and California Association of Health Insuring Organizations.
- ***Joanne Bovee***, Legislative Advocate, California Association of Health Plans
- ***Steve Hon***, Program Manager, County of San Diego Health and Human Services Agency
- ***James Hunt***, Director, Sacramento County Department of Health and Human Services
- ***Lisa Folberg***, Legislative Advocate, California Medical Association

- ***Barbara Glaser***, Legislative Advocate, California Hospital Association

III. Premiums

- ***Stan Rosenstein***, Deputy Director for Medical Care Services and Rene Mollow, Assistant Director for Health Policy, Department of Health Services
- ***Angela Gilliard***, Legislative Advocate, Western Center on Law and Poverty, Inc.
- ***Deena Lahn***, Policy Director, Children's Defense Fund California
- ***Dr Richard Pan***, MD, California Medical Association

IV. Single Point of Entry

- ***Stan Rosenstein***, Deputy Director for Medical Care Services and Rene Mollow, Assistant Director for Health Policy, Department of Health Services
- ***Frank Mecca***, Executive Director, County Welfare Directors Association of California

V. Adult Dental Services

- ***Stan Rosenstein***, Deputy Director for Medical Care Services and Rene Mollow, Assistant Director for Health Policy, Department of Health Services
- ***Liz Snow***, Public Policy & Strategic Development, California Dental Association
  Dr. Irving Lebovics, DDS, Representative, California Dental Association

VI. Public Comment

Joint Informational Hearing of the

Senate Committee on Health and the Senate Committee on Budget and Fiscal Review, Subcommittee No. 3 Health and Human Services

Wednesday March 2, 2005
1:30-5:00 p.m.
State Capitol, John L. Burton Hearing Room (4203)

Governor's Proposed Medi-Cal Redesign

Staff Briefing Paper

Medi-Cal Overview

Medi-Cal is a publicly-funded program that provides health coverage to 6.6 million low-income children, their parents, senior citizens and disabled Californians or about one in five Californians. A versatile program, Medi-Cal covers about 25 percent of California's children, many living with AIDS and supplements Medicare for low-income elderly and persons with disabilities. The State Department of Health Services (DHS) administers the program with the federal government providing a matching Medicaid reimbursement rate of 50 percent.

According to DHS, California operates one of the most cost-effective Medicaid programs. Among states, California spends less per beneficiary. Nevertheless, the program is the second largest in the state budget, ranking only behind K-12 education.

Medi-Cal Redesign

According to DHS, Governor Schwarzenegger is proposing to redesign Medi-Cal in order to maintain health care coverage for eligible Californians while containing costs and achieving efficiencies.

The main elements of the redesign proposal are:

- **Managed Care Expansion:** This proposal expands managed care in several ways. First, managed care is increased from the current 22 counties to 13 additional counties. The second element of the expansion is the mandatory enrollment of certain seniors and persons with disabilities in those 35 managed care counties. (Mandatory enrollment for seniors and persons with disabilities is already required in the 8 counties that are services by County Organized Health

Systems.) In addition, there is a pilot project for acute and long-term care integration in three counties.

- **Stabilizing California's Safety Net Hospitals:** This is proposed to be achieved through a new five-year Medi-Cal financing waiver with the federal government. This proposal represents a comprehensive redesign of a significant portion of hospital funding. It will include replacing intergovernmental transfers with federally-acceptable sources of funding and replacing the current funding method with new methods that can optimize the amount of federal funds drawn down. A major objective is to preserve hospital financing for the uninsured irrespective of whether Medi-Cal beneficiaries are served through fee-for-service or managed care.

- **New Medi-Cal Premiums**: The Governor's proposal will institute monthly premiums for individuals with incomes above 100 percent of the federal poverty level. The federal poverty level is defined as monthly income of $1306 for a family of three. The premium amounts will be $4 per month for each child under 21 and $10 for adults. The premiums are capped at $27 per month per family.

- **Single Point of Entry Changes:** This proposal will alter the Medi-Cal eligibility determination process for children whose applications are submitted through the Health Families Program vendor, known as the Single Point of Entry. Medi-Cal applications received by the vendor will be processed by the vendor. The current practice is to forward to a county for processing.

- **Limit on Adult Dental Services:** The proposed limit will be $1,000 in a 12-month period. According to DHS this benefit will cover the majority of a beneficiary's dental needs. This limitation excludes the costs of federally mandated dental services, emergency services and hospital costs associated with dental treatment.

- **County Performance Standards Monitoring:** This aspect of the redesign proposal will secure a vendor to monitor county compliance with state and federal standards pertaining to eligibility determinations and annual redeterminations. Currently, the counties report about compliance, but the state does not verify these efforts. Under this proposal, if there is a lack of compliance, fiscal sanctions will be pursued.

Previous Hearings

This hearing builds and complements earlier hearings on this subject:

- On February 17, 2005 the Senate Budget and Fiscal Review, Subcommittee No. 3 on Health and Human Services held a hearing on the hospital financing, managed care and premium portions of the redesign plan.

- On August 11, 2004 the Senate Health and Human Services Committee held a hearing on the likely issues to be raised by Medi-Cal redesign, including waivers, enrollment caps, cost sharing and premiums.

The hearing today will address the single point of entry and the limit on adult dental services while focusing further on managed care expansion and premiums.

The following staff report contains these sections:

Proposed Managed Care Expansion	**Page 4**
Proposed Implementation of Premiums	**Page 9**
Single Point of Entry	**Page 14**
Limit on Adult Dental Services	**Page 17**

Proposed Managed Care Expansion

Summary of Existing Medi-Cal Managed Care System: DHS is the largest purchaser of managed health care services in California. Currently, some form of **Medi-Cal managed care serves about 3.2 million Medi-Cal enrollees**, primarily families and children and is **in 22 counties**. **Only 280,000 enrollees, or about 9 percent, are seniors and individuals with developmental disabilities.**

The Medi-Cal managed care system utilizes three types of contract models:

- Two Plan. About 74 percent of Medi-Cal managed care enrollees are in a Two Plan model which covers 12 counties.
- County Organized Health Systems (COHS). There are five COHS (federal law limit) that serve eight counties.
- Geographic Managed Care (GMC). The GMC model is used in two counties.

For people with disabilities, enrollment is *voluntary* in the Two Plan and GMC model, and *mandatory* in the COHS.

In addition, certain services are "carved-out" of the Two Plan and GMC models, as well as some of the COHS'. Most notably, Mental Health Managed Care, and the California Children's Services (CCS) Program are "carved-out", except for CCS in some selected counties which operate under the COHS model. Per existing state statute, CCS is carved-out until September 1, 2008.

Two Plan Model (in 12 Counties): The Two Plan model was designed in the late 1990's. The basic premise of this model is that CalWORKS recipients (women and children) are automatically enrolled (mandatory enrollment) in either a public health plan (i.e., Local Initiative) or a commercial HMO. Other Medi-Cal members, such as aged, blind and disabled, other children and families, can voluntarily enroll if they so choose. About 74 percent of all Medi-Cal managed care enrollees in the state are in this model.

Two Plan Model—Plans and Enrollment

Plan Name	**County**	**June 2003 Enrollment**
Alameda Alliance for Health (LI)	Alameda	73,840
Blue Cross of California	Alameda, Contra Costa, Fresno, Kern, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare	360,760
Contra Costa Health Plan (LI)	Contra Costa	41,909
Health Net	Fresno, Los Angeles, Tulare	579,588
Kern Health Systems (LI)	Kern	69,432
La Care Health Plan (LI)	Los Angeles	824,271
Inland Empire Health Plan (LI)	Riverside, San Bernardino	232,318
Molina Healthcare of California	Riverside, San Bernardino	91,702
San Francisco Health Plan (LI)	San Francisco	28,796
Health Plan of San Joaquin (LI)	San Joaquin	56,046
Santa Clara Family Health Plan (LI)	Santa Clara	66,812
Two Plan Model Total		**2,425,474**

Geographic Managed Care (GMC): The GMC model was first implemented in Sacramento in 1994 and then in San Diego County in 1998. In this model, enrollees can select from multiple HMOs. The commercial HMOs negotiate capitation rates directly with the state based on the geographic area they plan to cover. Only CalWORKS recipients are required to enroll in the plans. All other Medi-Cal recipients may enroll on a voluntary basis. In Sacramento and San Diego counties, DHS contracts with nine health plans that serve about 10.6 percent of all Medi-Cal managed care enrollees in California.

Geographic Managed Care—Plans and Enrollment

Plan Name	County	June 2003 Enrollment
Blue Cross of California	Sacramento and San Diego	92,173
Community Health Group	San Diego	66,086
Health Net	Sacramento and San Diego	39,558
Kaiser Foundation Health Plan	Sacramento and San Diego	29,049
Molina Healthcare of California	Sacramento	20,208
Sharp Health Plan	San Diego	50,238
Universal Care	San Diego	12,810
UC San Diego Healthcare	San Diego	13,344
Western Health Advantage	Sacramento	15,713
TOTAL		**339,179**

County Organized Health Systems (COHS) (Eight Counties): Under this model, a county arranges for the provision of medical services, utilization control, and claims administration for *all* Medi-Cal recipients. Since COHS serve all Medi-Cal recipients, including higher cost aged, blind and disabled individuals, COHS receive higher capitation rates on average than health plans under the other Medi-Cal managed care system models (i.e., Two Plan Model and the Geographic model). With the mandatory enrollment of all Medi-Cal beneficiaries there is no fee for services in these counties.

The capitation rates for COHS are confidential since the California Medical Assistance Commission (CMAC) negotiates contracts with each county plan and there is only one plan for all Medi-Cal recipients in each county.

As noted in the chart below, **about 540,000 Medi-Cal recipients** receive care from these plans. This accounts for about 16 percent of Medi-Cal managed care enrollees and about 9 percent of all Medi-Cal enrollees. **Federal law mandates that only 10 percent of all Medi-Cal enrollees can participate in the COHS model and the state is close to meeting this enrollment limit.**

County Organized Health Systems—Plans and Enrollment

Plan Name	County	June 2003 Enrollment
Cal Optima	Orange	281,839
Central Coast Alliance for Health	Monterey, Santa Cruz	84,363
Partnership Health Plan	Napa, Solano, Yolo	77,704
Health Plan of San Mateo	San Mateo	45,742
Santa Barbara Regional Health Authority	Santa Barbara	50,276
TOTAL		**539,924**

Overview of the Administration's Proposal: The Administration's Medi-Cal managed care expansion would be achieved through **a phased-in process over a twelve to eighteen month period commencing in January 2007.** The Administration's proposal would require **(1)** state statutory changes, **(2)** approval of a federal Waiver, and **(3)** adoption of state regulations.

It is anticipated that 816,000 additional Medi-Cal enrollees, including the *mandatory enrollment* of aged, blind and disabled individuals, would be added to managed care through this proposed expansion. These 816,000 new enrollees, of whom 554,000 would be aged, blind or disabled, would represent an increase of over 25 percent.

Dual eligibles (i.e., Medi-Cal and Medicare) would be excluded from mandatory enrollment except in COHS and in certain newly proposed Long-Term Care Integration projects.

The table below displays the Administration's assumed fiscal impact. DHS notes that time is needed to assure that appropriate delivery systems are in place before managed care is expanded. As such, initial costs will be incurred before out-year savings are realized.

In addition, particularly in 2007-08, DHS states that as individuals transition from fee-for-service to managed care, the payment of costs for services already rendered under fee-for-service are due at the same time as the monthly capitation arrangements to managed care plans (capitation payments are made for the month of enrollment without payment lags). Therefore, costs are incurred as the transition transpires.

Administration's Fiscal Impact Summary from Managed Care Expansion

Fiscal Year	Assumed Increase In Enrollees (average mthly)	Local Assistance (General Fund)	State Support (General Fund)	Net Total (General Fund)
2005-06	0	$150,000	$3,262,000 (47.5 positions)	$3,412,000
2006-07	61,000	$36,836,000	$3,262,000	$40,098,000
2007-08	538,785	$51,390,000	$3,262,000	$54,652,000
2008-09	820,239	($88,749,000)	$3,262,000	($85,487,000)

If the managed care expansion is fully implemented as proposed, about 60 percent of all Medi-Cal recipients would be enrolled in an organized delivery system.

In addition to individuals who would not be enrolled in managed care, such as rural residents, DHS states that about 17 percent of all applicants who qualify for Medi-Cal managed care are in "transition". These individuals in "transition" are either in the process of being determined eligible for Medi-Cal or are awaiting enrollment into managed care. During this transition period, health care services are being provided on a fee-for-service basis. Also outside of managed care are those who receive services in the months they pay a share of cost.

The proposed expansion assumes the following key components:

Expansion to 13 New Counties. The Administration would expand Medi-Cal managed care to 13 additional counties, **including El Dorado, Imperial, Kings, Lake, Madera, Marin, Mendocino, Merced, San Benito, San Luis Obispo, Sonoma, Placer and Ventura.** Enrollment would include families, children and the mandatory enrollment of aged, blind and disabled individuals.

The Administration assumes the following managed care model configurations for these new counties:

- Include El Dorado and Placer counties in the existing Sacramento GMC;
- Include Imperial County in the existing San Diego GMC;
- Convert Fresno County (now a Two Plan) to a GMC and include Madera, Merced, and potentially Kings counties;
- Expand existing COHS to include the counties of Marin, Mendocino, San Benito, San Luis Obispo, Sonoma, Ventura and possibly Lake. For example, San Luis Obispo County could merge with the existing Santa Barbara COHS.

The Administration assumes that all of these counties are ready for enrollment no later than April 2008.

Aged, Blind and Disabled Individuals (Mandatory Enrollment). DHS has identified **36 Medi-Cal aid codes** which they would require to enroll into a managed care plan. Dual eligibles (Medicare and Medi-Cal) would not be included in this mandated group but could be voluntarily enrolled at the individual's option. DHS assumes that **about 554,000 or so aged, blind and disabled individuals would be enrolled in a managed care plan by the end of 2007-08 and beginning of 2008-09. This increase represents a 100 percent increase over the number of aged, blind and disabled individuals presently enrolled (i.e., 280,000 persons).**

The 13 new managed care counties as referenced above would immediately enroll these individuals as part of their implementation plan along with families and children enrollees. The existing Two-Plan and GMC plans would phase-in this new population over a period of 12 months.

Acute and Long-Term Care Integration. The Administration also proposes implementation of Acute and Long-Term Care Integration Projects (Projects) in Contra Costa, Orange, and San Diego counties. Dual eligibles (Medicare and Medi-Cal) living in these counties would be enrolled. These counties were chosen because of existing managed care and their interest in participating in the pilot project.

DHS states that these Projects would offer a comprehensive scope of services that manages the full continuum of health care needs, including primary care, case management, acute care, long-term care, dental services, emergency services, and drugs.

Staff Comments--Key Considerations and Concerns: The Administration's proposed managed care expansion **is very ambitious, particularly given the state's history with past Medi-Cal managed care expansion efforts, including recent problems in Fresno County as well as in Stanislaus County.**

Aged, blind and disabled individuals require more extensive specialty medical care services, personalized durable medical equipment, and rehabilitation therapists who have experience with serving these medically-involved individuals. As such, issues pertaining to physician networks, access to durable medical equipment and related needs will need to be comprehensively addressed prior to any transition for these individuals.

The expansion into new counties, coupled with a mandatory enrollment of aged, blind and disabled individuals, may be too much to accomplish successfully within the 12 to 18 month period designated by the Administration. This is particularly true when it comes to transitioning very medically-involved individuals from providers they know and who know them and their condition to a new network of providers.

If this expansion is to occur, comprehensive planning with impacted constituency groups, particularly stakeholders in the mental health and developmental disabilities communities, needs to occur. Ongoing involvement from local communities, as presently done in San Diego County, should also be a requirement.

In addition, considerable fiscal issues, including resolution of complex hospital financing concerns and the development of meaningful managed care rates, need to be further studied and resolved if aged, blind and disabled individuals are to be required to be enrolled. If rates are not appropriate, people will not receive necessary medical services or the state will be unable to attract health plans.

It is well known that the COHS have been experiencing fiscal hardship in serving these very medically-involved individuals. In fact, the Budget Act of 2004 provided a 3 percent rate increase to the COHS due to low operating reserves and questions of fiscal solvency.

Key factors for the state to evaluate health plan readiness of any managed care arrangement includes: (1) analysis of available service utilization and cost data; (2) network adequacy; (3) care coordination and carve-outs; (4) quality monitoring and improvement; (5) linkages with non-Medi-Cal services; (6) accessibility and availability of new treatment modalities; (7) community, provider and consumer input into the planning process; and (8) health plan and provider compliance with the Americans with Disabilities Act of 1990.

The inclusion of aged, blind and disabled individuals (36 new aid codes) would require an expanded state evaluation to determine health plan readiness**.** In conjunction with the federal CMS, DHS would conduct readiness reviews of all Medi-Cal managed care plans prior to health plans becoming operational to serve this population. Specifically DHS states that they would use the readiness model established under the COHS process. However, more analysis of this approach is needed in order to discern what factors are to be measured and what quality assurances will be put into action. Clearly, more detailed

discussions with constituency groups and the Legislature are needed prior to any agreements for expansion.

Proposed Implementation of Premiums

What is the Administration's Proposal? Under this proposal, effective January 1, 2007, Medi-Cal enrollees with **incomes above 100 percent of the federal poverty level would pay a monthly premium to maintain their Medi-Cal coverage.**

The 100 percent of poverty threshold represents **(1)** $1,306 per month for a family of three, **(2)** $812 a month for a senior, or disabled individual, and **(3)** $1,437 a month for a couple receiving SSI/SSP.

The proposed premium amounts are as follows:

- $4 per month for children under 21 years;
- $10 per month for adults; and
- $27 per month maximum for a family.

For example, a family of three with a monthly earned income of $1,306 per month would pay $24 per month for coverage or $288 annually. The required premium payment represents about 1.5 to 2 percent of the total annual income for the affected individuals.

Enrollees would be dropped from Medi-Cal if they do not pay premiums for two consecutive months. If re-enrollment is pursued, the individual would be required to pay back premiums owed from the previous six months in which they were enrolled. This can become confusing due to Medi-Cal eligibility retroactivity (which is 90-days) as allowed by federal law.

Counties would conduct a premium calculation to discern if the Medi-Cal eligible person needed to pay a monthly premium. DHS would contract with a vendor to conduct the actual collection of the premiums each month.

What are the Criteria for Determining a Premium? Premiums will be required of any family, child, or other individual who have incomes above 100 percent of the poverty level, **except for (1)** individuals with a share-of-cost (they spend down to become eligible for Medi-Cal), **(2)** 1931 (b) families enrolled in CalWORKS, **(3)** infants under one year of age, **(4)** American Indians, and **(5)** Alaskan Natives.

Therefore, the primary categories of Medi-Cal enrollees to be impacted by the proposal are:

- Children ages one to six with family incomes above 100 percent, and up to 133 percent, of poverty;
- Seniors and individuals with developmental disabilities with family incomes above 100 percent, and up to up to 133 percent, of poverty; and

- 1931 (b) families with incomes above 100 percent, up to 155 percent, of poverty ($2,024 per month for a family of three), and not enrolled in CalWORKS.

However, 1931 (b) families would be treated *differently* with respect to how the Administration makes the premium determination. The Administration proposes to change how the existing earned income deduction will be applied solely for the purpose of determining premiums. In effect, when determining whether premiums are to be paid, a different calculation will be used (i.e., allowing for only a $90 income disregard in lieu of the $240 and ½ disregards). **Therefore, the result under this revised calculation is that more families will need to pay premiums because they will be considered above the 100 percent of poverty level.**

Further, families enrolled in the 1931 (b) category will have difficulty re-enrolling into Medi-Cal if they are disenrolled due to failure to pay a premium. These "recipients" are usually individuals who have left CalWORKS and receive Medi-Cal-only services. The federal Welfare Reform Law of 1996 specifically authorized these individuals to receive Medi-Cal services because Congress wanted to transition individuals from welfare to work. One of the barriers to this transition was receipt of health care services. As such, 1931 (b) families can have incomes up to 155 percent of poverty and be eligible for Medi-Cal. However if they loose their existing eligibility, they would be eligible for Medi-Cal-only if their income level was at 100 percent of poverty or below.

Who are Affected and How is Enrollment Impacted? This proposal would affect children, aged, blind and disabled individuals, and families. **A total of about 550,000 people would be required to pay a premium, including about 460,000 families with children, and 90,000 seniors and individuals with disabilities with incomes above the SSI/SSP level.**

In the first year alone, **DHS assumes that almost 20 percent of these individuals or about 94,630 individuals will fail to pay and become disenrolled,** and thereby add to the increasing ranks of the uninsured living in California. This is illustrated in the table below.

It should be noted that DHS assumes that *all dual eligibles* (Medicare and Medi-Cal eligible) will *not drop off* because Medi-Cal pays their Medicare premiums. However in practice this may not occur; therefore, even more individuals could fail to make the premium payment.

DHS' Assumptions of Who Loses Coverage

Eligibility Category (Fee-for-Service & Managed Care)	**Total Medi-Cal Enrollees Needing to Pay**	**Reduction in Enrollees (Drop-Off)**
Aged, Blind & Disabled	90,601	2,817 (3%) (Assumes no duals are dropped)
Children	207,030	41,404 (20%)
Adults (ages 21-64)	252,045	50,409 (20%)
TOTALS	**549,676**	**94,630**

Medi-Cal Eligibility Processing — Likely Churning of Enrollees: **The proposal is almost certain to result in a churning of enrollees and increase administrative processing costs.**

First, under federal law, as well as state law, (SB 87 (Escutia) Statutes of 2000), individuals who loose Medi-Cal eligibility under one set of criteria may be eligible for Medi-Cal enrollment under another category. **As such Medi-Cal re-determinations must be made. Therefore, all of the Medi-Cal enrollees who are discontinued from Medi-Cal due to non-payment of premiums would conceivably need to be re-determined by the counties.**

Medi-Cal re-determination processing can require considerable work on the part of counties. Under re-determination processing, a county must first do an "ex parte" review. Under ex parte, the county must check certain public assistance data systems to see if there is appropriate information to make an eligibility determination. If not then additional information is obtained as needed from the individual through telephone contact and if needed, use of a special Medi-Cal form. **These administrative costs have *not* been addressed by the Administration's proposal.**

Second, as noted by the Administration's own analysis, individuals will drop-off due to the non-payment of premiums and then come back on when they need services (if eligible). **This churning of enrollees seems contrary to the Administration's own goal of expanding Medi-Cal managed Care. Managed care plans would not appreciate having Medi-Cal enrollees coming in and out of enrollment. This could also result in additional processing costs for the Medi-Cal Health Care Options contractor** since they will need to inform enrollees of their health plan choices and enroll them into a plan.

Third, it is unclear how the "Medi-Cal Eligibility Determination System" (MEDS) could maintain its data integrity. Counties maintain MEDS since they perform most Medi-Cal eligibility processing. In the event of Medi-Cal enrollees discontinuing due to non-payment of a premium, it is unclear how the Vendor will notify the county of this action. **If the two systems are not in synch with each other, the state could be making managed care plan payments for individuals no longer eligible for Medi-Cal, or Medi-Cal enrollees could be inadvertently disenrolled from Medi-Cal.**

Fourth, it is unclear how the continuous annual eligibility enrollment of children would be affected if premiums were not paid (such as in the 133 percent of poverty program). The original policy and fiscal concepts behind this annual enrollment was to ensure coverage for children and to reduce administrative costs. It appears that these would not be achieved under the proposal.

Fifth, a clear mechanism for re-enrollment would need to be established, or people's applications could be put on hold indefinitely while they are being asked to pay the premium. What if a parent or child requires medical attention while they are on hold? Should the family spend their money on the medical care, or on paying back their premiums? How will providers of health care know clearly what the status of an individual patient is at the moment of the health care delivery?

Proposed Administrative Costs Do Not Reflect All Necessary Expenditures: **The table below displays** the DHS' estimated expenditures for the administration of the premium. As noted below, they assume first year (i.e., 2005-06) implementation expenditures of $6.850 million General Fund, with on-going annual expenditures of **at least** $12.150 million General Fund.

However, not all of the expenditures are captured in the DHS' cost assumptions. First, no additional county administrative costs have been recognized for conducting Medi-Cal re-determinations as discussed above.

Second, the DHS fiscal summary assumes that counties would calculate a premium one time, and that would be it. However, in the reality of life, people may lose their job or have their hours reduced, get married, have a baby, or other related life events that would result in them no longer having a premium requirement. **As such, additional administrative costs for calculating the premium would probably be needed.** In addition, would a family have to pay while their premiums are being re-determined? If they didn't pay, would they be inappropriately dropped off of Medi-Cal?

Third, expenditures for a contractor to *design* a premium collection system are not included, though expenditures for the actual collection of the premium are included. It is likely that development and design of an information system would be costly. **DHS notes that it is unknown at this time what these costs would be.**

DHS assumes that it will take at least 18 months for the "premium collection contractor" to develop a collection system and begin actual collection (assumes premiums begin to be paid as of January 1, 2007).

Administrative Expenditures for Premium

Administrative Activity	**Proposed Expenditures (General Fund) 2005-06**	**Proposed Expenditures (General Fund) 2006-07** *(1/1/2007 start)*	**Proposed Expenditures (General Fund) 2007-08**
I. DHS Identified Costs			
County Determination of Premium	$6,200,000 (850,000 cases to review)	$7,200,000 (950,000 cases to review)	$7,200,000
Contract—Collection of Premiums	---	$2,150,000	$4,300,000
DHS State Staff (positions)	$650,000	$650,000	$650,000
Subtotal--DHS' total amount	**$6,850,000**	**$10,000,000**	**$12,150,000**
II. Unidentified Costs			
County Re-determination Costs		**Unknown**	**Unknown**
County Re-Enrollment Costs		**Unknown**	**Unknown**
County Premium Re-Calculation		**Unknown**	**Unknown**
County MEDS Linkage to Vendor		**Unknown**	**Unknown**
Vendor Design, Development and Maintenance of System		**Unknown**	**Unknown**
Health Plans Options Processing		**Unknown**	**Unknown**

Administration's Assumptions Regarding Savings: As shown in the table below, the Administration **assumes savings from the premium payments from two sources: (1)** the revenue received from the payment of the monthly premium, and **(2)** from health care costs not provided to individuals because they have dropped off of Medi-Cal due to the non-payment of the premium. These assumptions are open to interpretation since limited research data is available.

It is interesting to note that the Administration assumes no savings for in-patient care services from those individuals who are dropped off of Medi-Cal due to non-payment, and only from two to five percent savings from non-institutional care. This is because the Administration recognizes that individuals will come on and off Medi-Cal as they need services. As such, it decreases the likelihood of "managing" care.

As noted below, the Administration assumes savings of from about $15 million General Fund to about $23 million General Fund on an annual basis. However, as previously discussed, it is unlikely that all costs associated with administration of this program have been captured.

Administration's Assumed Savings from Premium Payments *(Annualized)*

2007-08 First full year (Annualized)	Aged, Blind & Disabled ($10 for 12 mths)	Children ($4 for 12 mths)	Adults (Ages 21-64) ($10 for 12 mths)	**Total Funds**
***Net* Premium** (After drop-off)	**$10,534,000** (87,783 people)	**$7,951,000** (165,627 children)	**$24,225,000** (201,636 people)	**$42,708,000** (455,046 people)
Dropped from Medi-Cal	2,817 People (3%)	41,404 Children (20%)	50,409 Adults (20%)	94,630 Total
2 % to 5 % Savings for Dropped People	$1,163,000 to $2,908,000	$3,697,000 to $9,244,000	$5,433,000 to $13,584,000	$10,295,000 to $25,735,000
SUBTOTAL	**$11,697,000 to $13,442,000**	**$11,648,000 to $17,195,000**	**$29,658,000 to $37,809**	**$53,003,000 to $68,443,000**
DHS' Assumed Administrative Costs				-$23,044,000
Administration's Net TOTAL (Rounded)				**$29,958,000 to $45,399,000**
Assumed General Fund Savings				**$14,979,000 to $22,700,000**

Administration's Proposed Implementation: The premium proposal **would require state statutory change as well as a federal Waiver.**

The Administration assumes approval by the Legislature during the 2005-06 Session and that a Waiver would be submitted to the federal CMS by December 2005. DHS notes that the federal Waiver process might take from six to nine months from this date for approval. The Administration notes that the state contracting process typically takes 15-21 months once their Request for Proposal (RFP) is released. Therefore, the Administration assumes that premium payments and collections would begin January 2007.

Single Point of Entry
Proposed Processing Change for Children's Applications

Background—What is the Existing Single Point of Entry Process? Presently, **joint applications for children** (Medi-Cal and Healthy Families) are submitted to a "Single Point of Entry" where they are initially processed by the Healthy Families Program

(HFP) vendor. The HFP vendor processes the HFP eligibles and then makes an *initial* determination when an applicant appears to be eligible for Medi-Cal

The Medi-Cal applications are then sent by the HFP vendor to the individual's county of residence. The county then makes the final Medi-Cal eligibility determination. **As required by both federal and state law, county eligibility systems work through a progression of eligibility determinations in order to identify which category of eligibility is the most appropriate for the child.**

The 1931 (b) category of eligibility is the broadest category of eligibility for children. The key aspect of being enrolled in this program is that they receive at least six months of Transitional Medi-Cal if they become ineligible for Medi-Cal at any point during their 12-month eligibility period due to increased family income.

The next broadest category is "regular" Medi-Cal because children are given a larger income disregard than in the "percent" programs if anyone in the family is aged, blind or disabled. In addition, applicants are also allowed to deduct child care costs and eligibility extends to age 21 in this category.

The "percent" programs provide Medi-Cal coverage for (1) infants up to age 1 with family income up to 200 percent of poverty, (2) children aged 1 through 5 with family income up to 133 percent of poverty, and (3) children aged 6 through 18 up to 100 percent of poverty. Unlike the 1931 (b) program and regular Medi-Cal, these percent programs disregard the value of property owned by the family. Children aged 19 and over are not eligible for coverage under these percent programs.

Governor's Proposal to Change the Single Point of Entry: Under this proposal, Medi-Cal applications for children received through the "Single Point of Entry" would now be completely processed by the HFP vendor and then sent to the state for final certification. The state would then send the completed Medi-Cal application to the appropriate county for ongoing case management, including annual redeterminations. **DHS assumes that about 85,000 applications would be processed in this manner.**

The table below displays the *net* costs to the state for this proposal in 2005-06 which are $6.8 million ($2.1 million General Fund). This includes increased costs for 19.5 new state positions, as well as vendor contract expenditures and information system changes. It should be noted that the Healthy Families Program inadvertently did not capture the increased costs for the vendor processing in their budget. This is to be corrected in their May Revision.

Summary of Expenditures for Single Point of Entry Changes (2005-06)

Governor's Proposed Single Point of Entry (2005-06)	**DHS (Total Fund)**	**DHS (General Fund)**	**Healthy Families Program (General Fund)**
Local Assistance			
Program Savings	($210,000)	($105,000)	
County Administration	($2,182,000)	($1,091,000)	
Vendor Contract Costs	$1,150,000	$0	$1,150,000
Local Assistance	**($1,242,000)**	**($1,196,000)**	**$1,150,000**
Support Cost (19.5 new state positions)	**$6,909,000**	**$2,172,000**	
Additional Costs ($2.1 million General Fund)	**$5,667,000**	**$976,000**	**$1,150,000**

The Administration contends that savings of $9 million ($7 million General Fund) will be generated annually from this proposal once fully implemented. The savings generated from the proposal would primarily come from children being removed from Medi-Cal. Presently, when the HFP vendor does the initial Medi-Cal screen and the child seems initially eligible for Medi-Cal, the child is placed on "interim status" and is eligible to receive Medi-Cal services pending final determination being conducted by the county of origin. As such, there are some children who receive services who are later found to be ineligible for Medi-Cal and are subsequently disenrolled. The Governor's new proposal would change this practice.

Staff Comments: Additional information needs to be obtained as to how this restructuring of the Single Point of Entry is to actually work, including information systems processing changes, coordination between the HFP vendor, state, and counties, and related matters. For example, extensive changes to the Medi-Cal Eligibility Determination System (MEDS) and related systems needs to be completed before this can work.

On the surface, the proposal does not appear to actually streamline the process. Further, there may be other options available for improving the existing system that need to be explored.

Adult Dental Services

Governor's Proposal to limit Adult Dental Services at $1,000 per 12-month period

Summary Background—What is the Denti-Cal Program? Individuals enrolled in Medi-Cal are eligible to receive a range of dental health care services. Access to dental services for children under age 21 is required by federal law, whereas adult dental services are considered optional.

Generally, covered dental benefits for children and adults include:

- diagnostic and preventive services such as examinations and cleanings
- restorative services such as fillings
- oral surgery services.

Many services such as crowns, dentures and root canals require prior authorization.

State law requires most Medi-Cal enrollees to pay a co-payment for dental care. A $1 co-payment is required for services provided in a dental office and a $5 co-payment is required for non-emergency care provided in an emergency room. As directed by federal law, services cannot be denied to a recipient if a co-payment is not provided

Over 90 percent of Medi-Cal enrollees are eligible for fee-for-service care through the Denti-Cal Program. In addition, about 350,000 individuals receive dental services through managed care arrangements (including Sacramento, San Bernardino, Riverside and Los Angeles).

The reimbursement rates currently paid under Denti-Cal are very low—generally about 40 to 50 percent of the usual and customary fee charged by dentists in California.

Governor Schwarzenegger's Proposed $1,000 Cap on Denti-Cal: The Governor proposes savings of $48.2 million ($24.6 million General Fund) in 2005-06 in local assistance by restricting the amount of dental services provided to adults to $1,000 in any twelve-month period. An implementation date of August 1, 2005 is assumed. This proposal requires trailer legislation to enact.

DHS states that the $1,000 limit would not apply to:

> **(1)** Emergency dental services within the scope of covered dental benefits defined as a dental condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could result in serious impairment to bodily functions;
>
> **(2)** Medical and surgical services provided by a dentist which, if provided by a physician, would be considered physician services, including complex maxillofacial surgical procedures and comprehensive oral reconstruction; and

(3) Services that are federally mandated under 42 Code of Federal Regulations, Part 440, including pregnancy-related services and services for other conditions that might complicate the pregnancy.

As noted in the table below, about 95,000 Denti-Cal enrollees would be affected by the $1,000 limit. DHS has not been able to provide data regarding what procedures these individuals required and how they would be affected by the limit if one is implemented. For example, it is possible that all of the 95,000 would lose a similar, moderate number of services each year under the limit. However, another scenario could be that a small portion of the 95,000 would lose a significant number of services, while the rest would see a smaller reduction.

Average Monthly Adult Eligibles Impacted by Proposed Cap

Type of Adult Eligible	Total Adult Eligibles	Eligibles Impacted by Cap
Aged, Blind, Disabled	1,447,500	52,900
All Other Adults (21-64 years)	1,552,000	42,000
Total	2,998,500	94,900

Based on the data provided by DHS, it is unknown at this time how many of the potentially affected eligibles may be enrolled in California's Regional Center system which provides services to eligible individuals with developmental disabilities**. This is a key issue since it is likely that the Regional Center system would incur additional General Fund expenditures to provide dental services which fall above the $1,000 cap.**

It is also unclear at this time on how DHS will be tracking dental expenditures to discern when an enrollee is about to exceed the cap. The Administration assumes expenditures of $4 million ($1 million General Fund) for a tracking system; however it is not clear as to what this specifically includes. Any tracking system would need to track each adult Denti-Cal enrollee's annual expenditures. Participating Denti-Cal providers would need to have access to the tracking system in order to clearly know if their patient was near the expenditures limit.

Further, if the pending treatment is to exceed the $1,000 limit, does the Denti-Cal provider complete the procedure and collect on the difference or what exactly? The Administration's proposal is not clear on this aspect of providing or denying treatment.

With respect to state support, DHS is seeking an increase of $165,000 ($59,000 General Fund) to hire one Associate Information Systems Analyst and a half-time Staff Counsel to implement the proposal.

Finally, it should be noted that DHS intends to implement this proposal through all county letters, provider bulletins, or similar instructions. Thereafter, DHS *may* adopt regulations.

Staff Comment: The Administration seeks to implement a $1,000 cap in Denti-Cal in an effort to align benefits more closely to the commercial market place. However, Denti-Cal is quite dissimilar to the commercial market place in several ways. It serves more medically needy individuals than the commercial market, reimburses at rates which are generally 40 to 50 percent of the usual and customary fee charged by dentists in California, and has eliminated or restricted services to enrollees due to budgetary constraints over the years. For example, Denti-Cal enrollees may only receive one dental cleaning annually where as the commercial market provides for two cleanings annually.

If a cap is to be implemented, consideration of a sunset date, rate adjustment factors, and the need for more preventive dental services, need to be discussed. Medi-Cal dental reimbursement rates are extremely low and placing a cap in statute without consideration for out-year implications is not constructive policy. Adequate access to dental services needs to be a part of the discussion.

Clarification on the proposal is also needed in order to better discern what specific procedures are exempt from the cap, as well as what dental services would fall above a $1,000 cap. For example, dentures cost $900 but other related dental work associated with this procedure would likely fall above the cap, such as related gum work or necessary medications, or root canal work related to the denture. DHS has provided a list of 13 Medi-Cal dental services with fees that exceed $1000 and four services with an exact fee of $1000. In addition they have provided a number of other dental treatment sequences that would probably exceed $1000 annually.

Finally, DHS should not be granted broad authority for implementation. Regulations which require public discourse, versus solely using “all county” letters or provider bulletins, should be used if any aspect of this proposal is adopted by the Legislature.

Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda
Health & Human Services

Chair, Senator Denise Ducheny

Senator George Runner
Senator Tom Torlakson

March 7, 2005

Upon Adjournment of Session

Room 4203
(John L. Burton Room)

(Diane Van Maren)

Item	**Department**
4440	**Department of Mental Health—Selected Issues**

- **Community Mental Health issues**
- **State Hospital issues**

PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. Proposition 63 funding and other issues pertaining to the DMH will be discussed at subsequent hearings. *Please* see the Senate File for dates and times of subsequent hearings.

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

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

Department of Mental Health

A. OVERALL BACKGROUND

Purpose and Description of Department: The Department of Mental Health (DMH) administers state and federal statutes pertaining to mental health treatment programs. The department directly administers the operation of four State Hospitals—Atascadero, Metropolitan, Napa and Patton--, and acute psychiatric programs at the California Medical Facility in Vacaville and the Salinas Valley State Prison.

The department provides hospital services to civilly committed patients under contract with County Mental Health Plans (County MHPs) while judicially committed patients are treated solely using state funds.

Purpose and Description of County Mental Health Plans: Though the department sets overall policy for the delivery of mental health services, counties (i.e., County Mental Health Plans) have the primary funding and programmatic responsibility for the majority of local mental health programs as prescribed by State-Local Realignment statutes enacted in 1991 and 1992.

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

Overall Governor's Proposed Budget: The budget proposes expenditures of $2.747 billion ($1 billion General Fund) for mental health services, for an overall increase of $78.1 million, or 8.2 percent over the revised current year. This General Fund increase is the net result of significant adjustments in the State Hospital budget as well as the funding of local mandates after three years of suspended payments.

Summary of Expenditures (in thousands)	**2004-05**	**2005-06**	**$ Change**	**% Change**
Program Source:				
Community Services Program	$1,773,472	$1,860,792	$87,320	4.9
Long Term Care Services	$802,270	$875,193	$72,923	9.1
Unallocated Reduction to State Support		($949)	($949)	(100)
State Mandated Local Programs	$7	$12,509	$12,502	1,786
Total, Program Source	**$2,575,749**	**$2,747,545**	**$171,796**	**6.7**
Funding Source:				
General Fund	$956,640	$1,034,692	$78,052	8.2
General Fund, Proposition 98	$8,400	$8,400	--	--
Proposition 99 Funds (Hospital Acct)	$16,724	$20,491	$3,767	22.5
Federal Funds	$61,872	$61,936	$64	(0.1)
Reimbursements	$1,529,525	$1,619,810	$90,285	5.9
Other Special Funds	$2,588	$2,216	($372)	26.0
Total Department	**$2,575,749**	**$2,747,545**	**$171,796**	**6.7**

As noted in the table above, $1.861 billion is for local assistance, $875.2 million is for the State Hospitals, and $12.5 million (General Fund) is for state mandated local programs. In addition to the above expenditures, the DMH is also proposing capital outlay expenditures of $38.5 million ($5.4 million General Fund).

County Realignment Funds: In addition, it is estimated that almost $1.220 billion will be available in the Mental Health Subaccount (County Realignment Funds) which does not directly flow through the state budget. Counties use these revenues to provide necessary mental health care services to Medi-Cal recipients, as well as indigent individuals.

Realignment revenues are currently the largest revenue source for community mental health services in California. The second largest revenue source is federal Medicaid (Medi-Cal) dollars. Most of the state's General Fund support is expended on state-operated State Hospitals in order to serve Penal Code related patients.

Proposition 63: It should be noted that revenues generated from the passage of Proposition 63 are not yet reflected in the budget. An expenditure plan from the Administration, as required by the proposition, will be forthcoming at the May Revision. Projected revenues to be available for expenditure are $254 million in 2004-05 and $683 million for 2005-06. These funds are a continuous appropriation and are therefore, not subject to annual Budget Act appropriation.

B. ISSUES FOR VOTE ONLY (Items 1 and 2)

1. Healthy Families Program Adjustments—Supplemental Mental Health Services

Issue: The Governor's budget proposes an increase of $352,000 (federal reimbursements) to reflect technical adjustments to the supplemental mental health services provided by County Mental Health Plans under the Healthy Families Program.

Additional Background—What is the HFP and How are Supplemental Mental Health Services Provided:

The Healthy Families Program provides health insurance coverage, dental and vision services to children between the ages of birth to 19 years with family incomes at or below 250 percent of poverty (with income deductions) who are not eligible for no-cost Medi-Cal.

The enabling Healthy Families Program statute linked the insurance plan benefits with a supplemental program to refer children who have been diagnosed as being seriously emotionally disturbed (SED). The supplemental services provided to Healthy Families children who are SED can be billed by County Mental Health Plans to the state for a federal Title XXI match. Counties pay the non-federal share from their County Realignment funds (Mental Health Subaccount) to the extent resources are available. With respect to legal immigrant children, the state provides 65 percent General Fund financing and the counties provide a 35 percent match.

Under this arrangement, the Healthy Families Program health plans are required to sign Memoranda of Understanding (MOU) with each applicable county. These MOUs outline the procedures for referral. It should be noted that the health plans are compelled, as part of the required Healthy Families benefit package and capitation rate, to provide certain specified mental health treatment benefits prior to referral to the counties.

Subcommittee Staff Comments and Recommendation (Adopt): The proposed adjustment reflects two technical adjustments. First, a baseline adjustment is made to address changes in the percent of legal immigrants accessing these services. Based on the most recent data, two percent of the services are provided to legal immigrants enrolled in the program. Previously it was three percent. Second, the adjustment also reflects the impact of applying the forecast methodology to approved paid claims data.

The adjustments are reasonable and reflect existing cost methodology. No issues have been raised on this proposal. It is therefore recommended to approve as budgeted.

2. Adjustments for San Mateo Field Test Model

Issue: The Governor's budget proposes an increase of $1.136 million (reimbursements from the DHS to the DMH) to adjust the funding levels provided for pharmacy expenditures in the San Mateo Field Test Project.

Additional Background—What is the San Mateo Field Test Project? The San Mateo County Mental Health Department has been operating as the mental health plan under a federal Waiver agreement and state statute as a "field test" project since 1995. San Mateo is the only county that has responsibility for the management of some financial risk through a case rate system and the management of pharmacy and related laboratory services, in addition to being responsible for psychiatric inpatient hospital services and outpatient specialty mental health services.

The field test is intended to test managed care concepts which may be used as the state progresses towards the complete consolidation of specialty mental health services and eventually, a capitated or other full-risk model. As the San Mateo Field Test Project has matured and evolved, additional components have been added and adjusted.

Subcommittee Staff Comments and Recommendation (Adopt): The $1.136 million (reimbursements) is requested to reflect a forecasting methodology developed by the DMH for pharmacy expenditures specific to this field test project. Specifically, the forecasting methodology is based on a study conducted in 2003. The requested increase of $1.136 million reflects a 9.21 percent increase in pharmacy expenditures.

The budget proposes adjustments which reflect the existing agreement the state has with San Mateo. No issues have been raised on this proposal. It is therefore recommended to approve as budgeted.

C. DISCUSSION ITEMS--Community-Based Mental Health Services

1. Mental Health Managed Care Adjustments

Issues: *First*, the Governor's budget proposes a *net* increase of $11.4 million ($5.7 million General Fund) to reflect adjustments to Mental Health Managed Care. This net increase reflects the following adjustments:

- Increase of $11.5 million (total funds) to reflect an increase in caseload (both inpatient and outpatient); and
- Decrease of $450,000 (total funds) to reflect several minor technical adjustments.

The Governor's budget does not reflect a medical consumer-price index adjustment which was supposed to be part of the annual formula agreed to by the counties and the state. No medical consumer-price index adjustment has been provided since the Budget Act of 2000. For 2005-06, the cost of the medical consumer-price index would have been $8.5 million, if provided.

Second, the Waiver to continue California's Mental Health Managed Care Program is up for renewal. The current Waiver expires as of April 27, 2005. The DHS, DMH and federal CMS are in the process of discussing the renewal. The state anticipates receiving the federal CMS' comments and questions on the Waiver renewal within the next few weeks. A key discussion point will likely be how the state determines cost-effectiveness under the Waiver.

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

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

The Waiver promotes plan improvement in three significant areas—access, quality and cost-effectiveness/neutrality. The DMH is responsible for monitoring and oversight activities of the County MHPs to ensure quality of care and to comply with federal and state requirements.

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

An annual state General Fund allocation is also provided to the County MHP's. The state General Fund allocation is usually updated each fiscal year to reflect adjustments as contained in Chapter 633, Statutes of 1994 (AB 757, Polanco). These adjustments have typically included,

changes in the number of eligibles served, factors pertaining to changes to the consumer price index (CPI) for medical services, and other relevant cost items.

The state's allocation is contingent upon appropriation through the annual Budget Act.

Based on the most recent estimate of expenditure data for Mental Health Managed Care, County MHPs provided a 46 percent match while the state provided a 54 percent match. (Adding these two funding sources together equates to 100 percent of the state's match in order to draw down the federal Medicaid funds.)

Subcommittee Staff Comment and Recommendation: It is recommended to adopt the Governor's proposed budget at this time, pending receipt of the May Revision which is likely to make caseload adjustments. The proposal reflects the standard calculations, except for the medical CPI adjustment.

The renewal of the Waiver is clearly a critical issue. The Administration needs to keep the Legislature abreast of any issues that may arise during the renewal process.

Questions:

1. DMH, Please provide a brief summary of the budget proposal.
2. DMH, Please provide an update on the status of the renewal of the Waiver.
3. DMH, How will the Administration keep the Legislature informed as discussions continue with the federal CMS regarding renewal of this important Waiver?

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

Issue: The revised current-year reflects a decrease of $29.2 million (reimbursements) based on the most recent paid claims data. For the budget year, an increase of $47.5 million (reimbursements which reflect an increase of $23.7 million General Fund) is proposed. It should be noted that the Governor's May Revision will make caseload and cost adjustments based on revised data.

Summary Table of EPSDT Funds

Summary of Total EPSDT Expenditures (All Fund Sources)	Governor's Proposed 2005-06
Total Estimated Claims	$949.2 million
County Realignment Funds (Baseline)	($65.8 million)
County Realignment Funds (10 percent)	($16.4 million)
Subtotal for County Funds	$82.2 million
State General Fund	$392.5 million
Federal Funds (Medicaid match at 50%))	$474.5 million

It should also be noted that the DMH is commencing with audit reviews of EPSDT expenditures and estimate that General Fund recoupment from these audits will be about $4.2 million.

The budget reflects the existing funding methodology used by the Administration for this program. No issues have been raised by Subcommittee staff.

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

Further in January 2004, the U.S. District Court issued an Interim Order clarifying an earlier ruling regarding the provision of TBS that also required outreach, monitoring and related provisions to ensure that children receive EPSDT services as needed. The Court agreed that TBS utilization was too low statewide and ordered the parties to collaborate to develop a plan to increase TBS approvals.

EPSDT Funding Process—Both County and State Funds Used To Draw Federal Match: The DHS and DMH crafted an interagency agreement in 1995 to implement expanded services as required by the court.

Generally, this *original* agreement required County MHPs to provide a "baseline" amount using County Realignment Funds (essentially a county "maintenance-of-effort") and then the state was responsible for providing the nonfederal share of the growth in the program.

The baseline amount is established for each county based on a formula. For 2004-2005, the baseline is $65.8 million, plus an additional 10 percent county match ($16.4 million for the budget year) which was instituted in the Budget Act of 2002, for a total of $82.2 million (County Realignment Funds). The state will provide funding (via Medi-Cal) for costs above this amount (above the baseline and 10 percent match).

The General Fund dollars and accompanying federal matching funds are budgeted in the DHS and are transferred to the DMH as reimbursements. The DMH distributes EPSDT funds to the County MHPs responsible for the provision of specialty mental health in each county. Final payment is based on cost settled actual allowable costs, or rates.

Background—Overall: Most children receive Medi-Cal services through the EPSDT Program. Specifically, EPSDT is a federally mandated program that requires states to provide Medicaid (Medi-Cal) recipients under age 21 *any* health or mental health service that is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified by an assessment, including services not otherwise included in a state's Medicaid (Medi-Cal) Plan.

Though the DHS is the "single state agency" responsible for the Medi-Cal Program, mental health services including those provided under the EPSDT, have been delegated to be the

responsibility of the Department of Mental Health (DMH). Further, counties are responsible for providing, arranging and managing Medi-Cal mental health services under the supervision of the DMH and DHS. However, eligibility and the scope of services to which eligible children are entitled, are *not* established at the local level.

Types of Services: The state uses the term "EPSDT supplemental services" to refer to EPSDT services which are required by federal law but are not otherwise covered under the state Medi-Cal Plan for adults. Examples of services include family therapy, crisis intervention, medication monitoring, and behavioral management modeling.

Prevalence Rate for California: Based on a number of studies which estimate the prevalence of children exhibiting various levels of functional impairment, it is estimated that 20 percent of children suffer from diagnosable mental disorder, and up to 13 percent of these children are estimated to be seriously emotionally disturbed. Given these estimates it is likely that between 500,000 to 1.3 million children and adolescents in California have a severe emotional disturbance.

As a comparison, the actual statewide average EPSDT penetration rate was 5.36 percent as of 2002-03 (up slightly from 2001-02 when it was 5.29 percent).

It should be noted that the Little Hoover Commission's report (October 2001) on the existing inadequacies in the children's mental health system considered the potential savings if children's mental health utilization increased by 10 percent—the estimated prevalence rate. In one year, they estimated that California would save $44 million in juvenile justice, $27 million in CYA costs, $78 million in residential treatment and $1.4 million at Metropolitan State Hospital. A total of $110 million in savings!

Subcommittee Staff Comment and Recommendation: The Legislature has enacted several cost containment measures over the past several years, including the application of certain managed care principles to the program as well as directing the DMH to conduct regular audits of the program. The trend line of growth for this program has begun to diminish considerably. In past years the state experienced growth of well over $100million (plus).

The budget reflects existing methodologies and no issues have been raised. It is recommended to adopt the proposal pending receipt of the May Revision which will likely reflect caseload and cost adjustments (more recent cost reports will be available).

Questions:

1. DMH, Please provide a brief summary of the budget request, starting with the revised current-year adjustment.
2. DMH, Please provide a brief update on implementation of the EPSDT audit field work.

3. Mental Health Services Provided to Special Education Students ("AB 3632")

Issues: At this time, it is unclear as to what is actually proposed in the Governor's budget.

First, the Department of Education's budget appropriates $69 million in federal Individuals with Disabilities Education Act (IDEA) funds as reimbursement to County Mental Health Plans (County MHPs) for "AB 3632" services *and* continues $31 million in ongoing Proposition98/General Fund to local education agencies (LEAs) for mental health related services.

Second, the Department of Mental Health's budget *appears* to suspend the AB 3632 mandate by displaying a zero under the state mandate payment item (Item 4440-295-0001) of the Budget Bill as introduced. No written information, such as a "budget change proposal", was provided by the Administration for this item. The Legislative Analyst's Office (LAO) contends that suspending the mandate frees local government from the service requirement for 2005-06.

Prior to the Budget Act of 2002, County MHPs were primarily reimbursed for their AB 3632 mental health services provided to special education students through the Commission on State Mandates. However a moratorium was placed on mandate reimbursements for local government beginning in 2002. This moratorium was continued in the Budget Act of 2003. But $69 million in federal IDEA funds was appropriated to schools in the Budget Act of 2003. These funds were then to be allocated to County MHPs for their services. However, the County MHPs note that about $120 million was actually expended on AB 3632 services for this year. SB 1895 (Burton), as discussed below, clarified the funding stream interactions for the 2004-05 fiscal year.

Third, Proposition 1A, passed by voters last November, authorizes the state to pay over time all local agency mandate liabilities incurred before 2004-05. As noted by the Legislative Analyst's Office (LAO), Proposition 1A does not specifically mention mandate liabilities incurred during 2004-05, but it appears to require the Legislature to fund these costs in the 2005-06 budget unless (1) the Legislature suspends the mandate in 2005-06, or (2) the mandate pertains to employee rights. The LAO states that though it may be reasonable from a fiscal standpoint to pay the state's 2004-05 costs over time, this proposal does not appear consistent with the requirements of Proposition 1A. The Administration does have a proposal to lengthen the mandate payment term to 15 years (ACA 4x (Keene)).

Fourth, in a letter dated February 17, 2005, the Department of Finance provided notification and assurance to four litigant counties (San Diego, Sacramento, Orange and Contra Costa) that if a County MHP provides AB 3632 services on behalf of a County Office of Education and has unreimbursed allowable costs, then these counties are eligible for reimbursement under the state mandates claim process. This letter is consistent with SB 1895 (Burton), Statutes of 2004.

Fifth, among other things, SB 1895 (Burton) does the following:

- Requires LEAs, prior to the referral of a pupil to County MHPs, to follow procedures regarding an Individualized Education Plan (IEP), as defined in current law. It also directs the LEAs to request the participation of County MHPs in this process.

- Reconfirms that County MHPs are eligible for reimbursement from the state for all allowable costs for specified mental health services provided to special education students.
- Requires that $31 million (Proposition 98/General Fund) appropriated in the Budget Act of 2004 be distributed on the basis of provided services that are consistent with the federal IDEA. The intent is that the provision of upfront, more preventive services would over time lower the costs to counties for the mandate.
- Requires that the $69 million provided in the Budget Act of 2004 allocated to County Offices of Education be used to support mental health services by County MHPs for special education children. (This offsets General Fund mandate costs.)
- Specifies that a County MHP does not have fiscal or legal responsibility for any costs it incurs prior to the approval of an IEP, except for costs associated with conducting a mental health assessment.

Background—Mental Health Services to Special Education Pupils: Federal law (PL 94-142 of 1975-- the Education for All Handicapped Children Act—and the later Individuals with Disabilities Education Act (IDEA) mandates states to provide services to children enrolled in special education, including all related services as required to benefit from a free and appropriate education. Related services include mental health services, occupational and physical therapy and residential placement.

In California, County MHPs are responsible for providing mental health services to students when required in the pupil's Individualized Education Program (IEP). This is because AB 3632 (W. Brown), Statutes of 1984, shifted responsibility for providing these services from School Districts and transferred them to the counties. This was done because School Districts were not appropriately providing the services.

These services are an entitlement and children can receive services irrespective of their parent's income-level. In addition, County MHPs cannot charge families for these services because the children are entitled to a free and appropriate public education under federal law.

What Mental Health Services Are Mandated: Services to be provided, including initiation of service, duration and frequency of service, are included on the student's IEP and must be provided as indicated. Services can only be discontinued on the recommendation of the County MHP *and* the approval of the IEP team, or by parental decision. Among other things, mental health services include assessments, and all or a combination of individual therapy, family therapy, group therapy, day treatment, medication monitoring and prescribing, case management, and residential treatment.

Legislative Analyst's Office (Education Section): In her Analysis, the LAO recommends to (1) earmark the $100 million ($69 million in federal IDEA and $31 million in Proposition 98/General Fund) for mental health services into the base special education funding formula, and (2) redirect $42.8 million more in funding to the schools for these mental health services. As such, a total of $142.8 million would be provided. This dollar amount is based on past allowable claims made by County MHPs on what they have spent on an annual basis.

The LAO also recommends to eliminate the existing mental health mandate on counties since federal law requires School Districts to provide these services as directed by the IDEA. The LAO contends that by eliminating the state mandate on counties, the effect would be to return these responsibilities to the School Districts.

Subcommittee Staff Comment and Recommendation: At this time, considerable issues exist which need to be clarified, including certain legal issues pertaining to Proposition 98 funding, as well as service needs issues. For example, if School Districts receive these funds as part of their base special education funding, will they be used to provide needed mental health services?

Presently, discussions are ongoing regarding legal and administrative issues, as well as what constitutes an appropriate level of funding and how should it be allocated. As such, it is recommended to hold this issue open pending receipt of additional information, as well as discussions to be convened by Subcommittee #1, the Education Subcommittee of Senate Budget & Fiscal Review.

Questions:

1. DOF, Please clarify the Administration's budget proposal for AB 3632 services.
2. DOF, When will your legal analysis be available regarding the various aspects of funding, mandates and state constitutional issues?
3. DMH, Will the April 1, 2005 report on AB 3632 services as required by SB 1895 be provided to the Legislature at that time?

4. Federal Funds Report

Issue: In the Budget Act of 2004, the Legislature appropriated $472,000 (General Fund) and adopted Budget Act Language to direct the Department of Mental Health to identify and evaluate approaches for increasing federal funding and reducing state costs for both the community mental health system and the State Hospitals.

This report was to be provided to the Legislature by January 10, 2005. The report has not yet been provided.

Questions:

- **1.** DMH, When will the report be made available to the Legislature?
- **2.** DMH, Could you please share some ideas that may be constructive in obtaining additional federal funds for mental health services (community mental health and State Hospitals)?

D. DISCUSSION ITEMS—State Hospitals

Summary of State Hospital Patients and Funding Streams

Overall Background: The department directly administers the operation of five State Hospitals—Atascadero, Metropolitan, Napa, Patton, and Coalinga (to be activated). In addition, the DMH administers acute psychiatric programs at the California Medical Facility in Vacaville, and the Salinas Valley State Prison.

Patients admitted to the State Hospitals are generally either (1) civilly committed, or (2) judicially committed. As structured through the State-Local Realignment statutes of 1991/92, County Mental Health Plans (County MHPs) contract with the state to purchase beds. County MHPs reimburse the state for these beds using County Realignment Funds (Mental Health Subaccount).

Judicially committed patients are treated solely using state General Fund support. The majority of the General Fund support for these judicially committed patients is appropriated through the Department of Mental Health (DMH). However, a small amount of reimbursement is also provided to the DMH by the Department of Corrections and the Department of Youth Authority (18 years of age and younger) to support certain specified patient populations.

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

Of the total patient population, about 90 percent of the beds are designated for penal code-related patients and only about 10 percent are to be purchased by the counties, primarily Los Angeles County.

Summary of Overall Caseload: The DMH estimates a revised current-year population of 5,266 patients (as of June 30, 2005) and a budget-year population of 5,454 patients for 2005-06 (as of June 30, 2006). The DMH has a pending current-year deficiency of $21.6 million (total funds) due to the increase of 263 patients (all penal-code related patients).

Table: Summary of Population by Hospital

Hospital Summary	Budget Act of 2004 (6/30/2005)	*Revised* 2004-05 (6/30/2005)	Proposed Patient Growth for 2005-06	Proposed 2005-06 Population
Atascadero	1,484	1,470	(199)	1,271
Coalinga	0	0	583	583
Metropolitan	679	780	(35)	745
Napa	1,102	1,120	0	1,120
Patton	1,440	1,537	(161)	1,376
Vacaville	234	295	0	295
Salinas	64	64	0	64
TOTALS	**5,003**	**5,266** **263 increase**	**188**	**5,454**

Governor's Proposed Budget Overall: The budget proposes total expenditures of $840.8 million ($673.4 million General Fund, $145.7 million in reimbursements, mainly from the Department of Corrections, $20.5 million Proposition 99 Funds and $1.2 million Lottery Education Fund) for long-term care services (State Hospitals and the acute psychiatric facilities).

The budget proposes a *net* increase of $107.7 million ($86.3 million General Fund) compared to the Budget Act of 2004. Most of this increase is due to (1) increased penal code-related caseload, and (2) activation of Coalinga State Hospital.

It should be noted that the proposed budget reflects a shift of $20.5 million in General Fund support to Proposition 99 Funds (Hospital Services Account). This aspect of the proposal will be discussed at a later hearing when the *overall appropriations* of Proposition 99 Funds are discussed.

Table: Key Adjustments to State Hospitals and Acute Psychiatric Facilities

Type of Adjustment	Governor's Proposed 2005-06 (Total Funds)	Governor's Proposed 2005-06 (General Fund)
A. Key Baseline Adjustments:		
1. Employee compensation & related adjustments	$21.7 million	$17 million
2. Population adjustments due to patient caseload for current-year growth	$20.3 million	$7.5 million
3. Adjustments- full-year cost of prior year's caseload	$32.9 million	$34.9 million
4. Operating Expenses & Equipment	$8.7 million	$7 million
5. Price increase per DOF	$2.8 million	$2.2 million
6. Unallocated Reduction	($240,000)	($240,000)
B. Other Policy Adjustments		
1. Activation of Coalinga	$74.2 million	$65.7 million
2. Special staff adjustments for Metropolitan and Napa	$3.6 million	NA
3. Transfer of Pre-Commitment SVPs ***(rescinded as of March1)***	($9.2 million)	($9.2 million)
4. Restructure SVPs	($6 million)	($6 million)
5. Vacaville Psychiatric Program adjustments	$2.3 million	NA
6. Strategic Sourcing Savings	($2.4 million)	($2.4 million)

Specific issues regarding the State Hospitals and related items are discussed below.

1. State Hospital's and Acute Psychiatric Population Adjustments *(Baseline)*

Issue: The Governor's budget proposes a series of baseline adjustments for the State Hospital and acute psychiatric facilities related to patient population. As noted in the table below, (1) the current-year is being revised to accommodate an increase of 263 penal code patients, and (2) the budget year projects an increase of 188 penal code patients. The budget proposes the following key baseline adjustments:

- ***County MHP Beds:*** Reduces 45 beds from the County MHP contracts for a net reduction of $4 million (Reimbursements from County Realignment Funds).
- ***Overhead Adjustment:*** Increases by $842,000 (General Fund) to recognize a fixed cost adjustment factor due to the reduction in county-purchased beds. In essence, since the County MHPs are only purchasing about 10 percent of the beds, the state needs to increase its share of the fixed costs.
- ***Judicially Committed Patients:*** Provides an increase of $53.2 million (total funds) for the on-going costs of the current-year caseload increase, as well as for the increase in caseload for the budget year.
- ***Operating Expenses and Equipment:*** Increases by $8.7 million ($7 million General Fund) to provide for food, clothing, and related items due to the patient population increase.
- ***Employee Compensation:*** Provides a *net* increase of $32.9 million ($34.9 million General Fund) to reflect the ongoing baseline adjustments implemented in the current year for employee compensation, including wage, health, and worker's compensation.
- ***Price Increase per DOF:*** The DOF has proposed statewide increases for departments to make adjustments to certain operating expenditure and equipment items. The State Hospital budget includes $2.8 million ($2.2 million General Fund) for this purpose.
- ***Unallocated Reduction:*** The Administration is proposing an unallocated reduction of $240,000 (General Fund). It is unknown how this proposed action will be implemented.

Table: Summary of Caseload by Patient Type

Patient Type	Budget Act of 20004-05 Caseload	2004-05 Revised Caseload	2005-06 Proposed Caseload	Caseload Percent By Patient Type	Difference for 2005-06
Incompetent to Stand Trial	915	1,104	1,195	22%	91
Not Guilty—Insanity	1,288	1,288	1,329	24.4%	41
Mentally Disordered Offender	951	1,023	1,113	20.4%	90
Sexually Violent Predator ***(discussed below)***	632	573	534	9.8%	-39
Other Penal Code	118	118	118	2.2%	0
Penal Code 2684 and 2974	469	530	580	10.6%	50
CA Youth Authority	30	30	30	.5%	0
SUBTOTAL—Penal Code	**4,403**	**4,666** 263 over Budget Act	**4,899**	**89.8%**	**233**
County Purchased	**600**	**600**	**555**	**10.2%**	**-45**
TOTALS	**5,003**	**5,266**	**5,454**	**100%**	**188**

Subcommittee Staff Comment and Recommendation: The baseline adjustments proposed by the DMH for patient population as discussed above appear to be reasonable given the increase in the penal code patient population. In addition, no issues were raised by the LAO. However, it is recommended to leave the baseline adjustments "open" pending the receipt of the Governor's May Revision since caseload and fiscal adjustments will likely be needed.

In addition, it should be noted that the proposed budget reflects a shift of $20.5 million in General Fund support to Proposition 99 Funds (Hospital Services Account). This aspect of the proposal will be discussed at a later hearing when the overall appropriations of Proposition 99 Funds are discussed.

Questions:

1. DMH, Please provide a brief summary of the baseline adjustments.

2. DMH, Why are the penal-code related patient populations increasing so significantly?

3. DMH, Please explain the need for the "price" increase of $2.8 million ($2.2 million General Fund).

2. Activation of Coalinga State Hospital

Issue: The Governor proposes an increase of $74.2 million ($65.7 million General Fund and $8.5 million in reimbursements for the California Department of Corrections) for the continued activation of Coalinga State Hospital. The hospital is scheduled to open in September 2005 with an initial bed capacity of 250 beds. Ultimately, the hospital is designed to accommodate up to 1,500 beds for penal-code related patients.

Sexually Violent Predators (SVPs) currently at Atascadero State Hospital will be transferred to Coalinga. In addition, the California Department of Corrections will contract with the DMH for 50 beds (intermediate care level).

Of the amount proposed, $54.9 million is to support about 893 State Hospital positions (both level-of-care and non-level-of-care), and about $19 million is to support operating expenses, including $2.5 million for relocation costs for state employees choosing to transfer to Coalinga and $219,000 for workforce recruitment.

Background and Status of Project: Coalinga State Hospital, a 1,500 bed treatment facility is being constructed adjacent to Pleasant Valley State Prison near Coalinga in Fresno County. Construction began in October 2001 with planned patient occupancy scheduled to begin September 2005. At this juncture, a total of $382 million (total funds) has been committed to the construction phase of this hospital.

According to the Administration's plan for activation, CHS will open five treatment units and receive 250 patients beginning September 2005. The patient population will expand to a census of 683 patients at a rate of 100 patients per month, beginning November 2005 and extending through March 2006.

The DMH states that the activation operation represents a major undertaking in a relatively short time period. About 875 clinical, administrative and support staff must be recruited and hired by August 2005 to operate and license the facility to receive the first 250 patients. Another 449 staff will need to be hired between September 2005 and January 2006 in order for the hospital to ramp up and receive the remaining 433 patients by March 2006. All staff hires must be put through hospital orientation training before being assigned.

During this time, all key aspects of the hospital must be activated, including the following core components:

- All clinical treatment programs.
- Medical service support services, including pharmacy, clinical lab, x-ray, dental, emergency services, physical therapy, and central supply.
- Support services, such as laundry, library, canteen, kitchen, custodial, mail system and police services.
- Security services, including patient transport, perimeter security and sallyport access (all to be conducted by the Department of Corrections).

By the end of August 2005 all Department of Health Services (DHS) licensing and State Fire Marshall final approvals must be obtained for the facility to be issued an operating license by the DHS.

Subcommittee Staff Comment and Recommendation: The activation of Coalinga State Hospital by September 2005 reflects the revised activation date provided to the Legislature by the Administration during budget deliberations last year.

A key aspect of activating Coalinga is to relieve severe overcrowding at Atascadero State Hospital and Patton State Hospital. According to recent figures provided by the DMH, Atascadero is over its licensed bed limit by 96 patients and Patton is over its limit by 188 patients.

Both the LAO and Subcommittee staff have reviewed the fiscal request and have raised no issues regarding the data. It should be noted that payment of the debt service for the lease-payment bonds is included in the Governor's aggregate budget totals but not yet reflected in the DMH item. This technical issue is to be remedied at the May Revision. It is recommended to approve this proposal pending receipt of the May Revision.

Questions:

1. DMH, Please provide a brief update on the status of activation for the Coalinga, including an update on the construction completion, installation of key infrastructure and key staff activation functions. DMH, Will the project be completed on time?

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

3. Expansion of the Intermediate Care & Day Treatment at Vacaville

Issue: The Governor proposed an increase of $1.4 million for 2004-05 and $2.3 million for 2005-06 to support an increase of 61 intermediate care and day treatment program beds for the Vacaville Inpatient Psychiatric Program. The DMH is reimbursed for these beds by the California Department of Corrections using General Fund support.

With respect to the current-year request, the Joint Legislative Budget Committee (JLBC), chaired by Senator Chesbro, has approved the request though reluctantly. In a letter to DOF Director Tom Campbell, it was noted that the DMH proceeded with expending funds prior to obtaining JLBC approval. As such, the Legislature's appropriation authority was disregarded. The letter notes Section 32 of the annual Budget Act which expressly forbids officers of departments to make any unauthorized expenditures in excess of their appropriations. Further, the JLBC process allows for expedited review (i.e., waiver of the 30-day clause) in the event of urgency; however, this was not requested by the Administration in this instance.

The budget year request of $2.3 million would provide full-year funding for the 61 beds. This funding level includes the salaries and wages for 23.5 positions.

Additional Background: The California Department of Corrections (CDC) has been challenged in several class action lawsuits which allege that the CDC was not providing adequate mental health services. One such case is the Coleman decision (1996). With respect to the California Medical Facility at Vacaville, the CDC has been directed to increase the number of mental health treatment beds from its existing 83 intermediate care and day treatment beds to a total of 144 beds.

Subcommittee Staff Recommendation: It is recommended to approve the budget as proposed.

Questions:

1. LAO, Please provide brief comment regarding the concerns expressed by the JLBC.
2. DOF, Why wasn't appropriate notification provided to the Legislature?
3. DMH, Please provide a brief summary of the budget-year request.

4. Staff Increases for Youth and Skilled Nursing Facilities at MSH and NSH

Issue: The budget proposes an increase of $3.6 million (Reimbursements from County MHPs) to fund an additional 54 nursing staff. Specifically, 42 of the new staff would be for the youth treatment program at Metropolitan State Hospital and 12 positions would be for Napa State Hospital's skilled nursing programs.

The DMH notes that though the patient population for these two distinct programs has been gradually declining, due to patient acuity and medical needs, additional clinical resources are needed. The youth population at Metropolitan State Hospital has experienced multiple failed placements and numerous acute hospitalizations due to behavior that is dangerous to themselves or to others. The skilled nursing programs at Napa State Hospital have serious psychiatric behaviors coupled with serious physical problems that demand increased clinical care.

Legislative Analyst's Office Comment and Subcommittee Staff Recommendation: The LAO does not take issue with the need for increased clinical staff to serve these acute medical populations. However they observe that the DMH budget request assumes a patient level of 85 youths at Metropolitan when only about 50 youths presently reside there. It is therefore recommended for the Subcommittee to adopt the proposal pending receipt of the May Revision when the DMH can provide a more accurate patient estimate.

Questions:

1. DMH, Please provide a brief summary of the budget request.
2. DMH, Will you have a more accurate patient count at May Revision?

5. Strategic Sourcing Initiative's Affect on the State Hospitals

Issue: As part of the Administration's "strategic sourcing" initiative, as described further below, the DOF assigned savings of $2.4 million (General Fund) in *both* the current year and budget to the State Hospitals. Specifically, it was thought that the DMH State Hospitals could obtain savings through the DGS process of contracting more efficiently and effectively for medical supplies and medical services (i.e., those medical services needed to be provided outside of the State Hospitals).

However as noted by the LAO, savings for the current year are unlikely to be achieved and it is unclear whether the $2.4 million amount for the budget year will be obtained either.

Background—Strategic Sourcing Initiative: Budget Control Section 33.50 allows the DOF to reduce departmental appropriations due to savings achieved from the Department of General Services' "strategic sourcing" initiative. Strategic sourcing involves using past years' purchasing information and standard procurement methods to create new contracts for those same goods and services.. The newer contracts should result in lower costs.

This Control Section was first included in the Budget Act of 2004 and is presently proposed in the Governor's 2005-06 budget. The DOF assumes savings for the state overall to be $48 million (General Fund) in the current year, and $96 million (General Fund) for 2005-06. As noted by the LAO, the DOF needs to revise these overall state estimates to better reflect what is realistically achievable.

Subcommittee Staff Comment: It is recommended for the DMH to report back at the May Revision on how it intends to achieve both the current-year and budget-year savings levels.

Questions:

1. DMH, Please provide a brief summary of the department's involvement in the DGS strategic sourcing initiative.
2. DMH, it is likely that any savings will be achieved this year or in the budget year?
3. DMH, are there other options available for achieving savings? If so, please explain.

6. Sexually Violent Predator (SVP) Evaluation and Court Testimony Estimate

Issue: The budget proposes a reduction of $319,000 (General Fund) to reflect the revised estimate of the funding needed to support evaluation and court testimony costs for the SVP Program. This evaluation and court testimony estimate relates only to SVP evaluations performed by private contractors for initial, update, replacement and recommitment evaluations, as well as costs for evaluator court testimony.

The table below summarizes the proposed budget and component parts.

SVP Program Evaluation & Court Estimate	2004-05	2005-06	**Difference**
Initial Evaluations	$2,342,000	$1,264,000	($1,078,000)
Initial Court Testimony	615,0000	911,000	296,000
Initial Evaluation Updates	424,000	394,000	(30,000)
Recommitment Evaluations	804,000	1,369,000	565,000
Recommitment Testimony	626,000	436,000	(190,000)
Recommitment Updates	189,000	319,000	130,000
Airfare Costs	150,000	141,000	(9,000)
Consultation Costs	50,000	47,000	(3,000)
Totals	**$5,200,000**	**$4,881,000**	**($319,000)**

The DMH states that although case referral data is an indicator of program activity it fails to capture many cost drivers, such as additional reports resulting from court delays and lengthy court testimony. As such, the DMH used a one-year regression analysis on the most current 12-months of SVP billing data to project the number of services. *Key* factors used to build this estimate include the following:

- Two contract evaluators are assigned to each individual, who may reside at any one of 32 possible prison locations. Based on a review of records and an interview with the inmate, the

evaluators submit reports to the DMH. If two evaluators have a difference of opinion, two additional evaluators are assigned to the case.

- DMH pays a flat rate of $2,000 for initial evaluations. DMH allows evaluators to bill for extensive travel (over 5 hours) at an hourly rate of $100 per hour, and expenses at state rates. Initial evaluations average $2,450 ($2,000 plus travel and expenses). It is assumed that 516 initial evaluations will be done in 2005-06. Further, it is assumed that 498 testimony episodes will be needed as well.
- DMH pays a flat rate of $2,400 per recommitment evaluation. The average cost, including travel and expenses, is $2,536. All persons ending their two-year SVP commitment must be evaluated again by at least two clinicians. (State staff is also used for this purpose, not just contract staff.)
- Evaluators who perform recommitment evaluations are usually called to testify at SVP trials.

Background—Designation of SVP: In 1995, the Legislature established a civil commitment process for offenders deemed by a court or jury to be a Sexually Violent Predator (SVP). The SPV law is designed to ensure that specified offenders receive intensive inpatient treatment, as well as outpatient treatment and supervision upon their release from state prison.

To qualify as an SVP, an offender must have committed specified sexual acts (e.g., rape, sodomy and lewd or lascivious acts with a child) involving two or more victims and have a diagnosed mental disorder that makes the individual likely to engage in sexually violent predatory behavior in the future.

Background---Overview of the Process: All SVPs first serve their sentence in a CDC prison. Through an initial records review process, the CDC and Board of Prison Terms refer records of inmates suspected of meeting SVP criteria. The DMH orders evaluations to determine whether the offender potentially qualifies for a SVP commitment.

Any inmate meeting SVP criteria then receives a clinical evaluation to determine if a diagnosed mental disorder exists. Inmates meeting all the statutory SVP criteria are referred to District Attorneys for their action. For those cases which a DA decides to file a petition, a probable cause hearing is held before a judge to determine if the facts of the case warrant a full commitment trial.

If a jury or judge finds that it is likely an individual would re-offend, then the individual is committed to the DMH State Hospital system for treatment and supervision. The statutory length of commitment is presently two years. The DMH states that almost all SVPs are recommitted every two years.

According to statistics provided by the DMH as of January 2005 (from program inception):

- The CDC has referred to the DMH a total of 5,778 records of inmates suspected of committing qualifying SVP crimes.
- From these records, the DMH determined that 3,133 inmates had committed sexual acts that would be SVP-related.

- DMH clinicians concluded that 1,239 of these inmates have a diagnosed mental disorder making the individual likely to engage in sexually violent predatory behavior in the future and referred the cases to a District Attorney.
- The District Attorneys have filed 1,036 petitions and have rejected 183.
- The courts have found probable cause for 810 of these petitions, no probably cause for 153, and 73 were pending resolution (as of January 2005).
- About 500 individuals are committed at Atascadero State Hospital as SVPs, 192 trials are pending and 124 were not committed at trial.

Subcommittee Staff Comment and Recommendation: It is recommended to hold this issue "open" pending receipt of the May Revision due to questionable data. The DMH states that the initial evaluation costs are probably lower than they should be and the recommitment costs are probably too high.

The DMH states that they temporarily stopped assigning recommitment evaluations in mid-May 2004 pending resolution of policy changes to the program. However, these changes did not occur. Therefore, the past-year data are skewed and this is the data in which their budget is built. The DMH will be updating their information for the May Revision.

Questions:

1. DMH, Please provide a brief summary of the proposal, highlighting the key changes which are different from the current year, such as the cost of the initial evaluations.
2. DMH, Are substantial changes to this proposal anticipated for the May Revision?

7. Several Proposed Changes to the Sexually Violent Predator Program

Issues: The Administration is proposing to make several changes to the SVP Program. The budget assumes savings of $15.2 million (General Fund) from implementation of two of the measures. However, one of the savings proposals is now being rescinded by the Administration.

Three new changes are proposed to take the place of the rescinded proposal; however no budget year savings have as yet been identified for these proposed changes. Further, these proposals will need to proceed through legislation. Language for these new proposals has not yet been provided, though Senator Poochigian has a spot bill (SB 864) intended for this purpose.

- ***A. Eliminate Court-Ordered State Hospital Placement of "Pre-Trial" SVPs:*** As of March 1, this proposal by the Administration has been rescinded. The Governor's budget includes savings of $9.2 million (General Fund) by shifting "pre-trial" (or pre-commitment) SVPs to the counties, in lieu of having them reside at Atascadero State Hospital (ASH). There are about 174 such cases at ASH currently. This proposal was rejected by the Legislature last year for various reasons, including security concerns. The Administration will be making an adjustment at the May Revision to reflect this change.

In addition, the Administration is now proposing three other changes to the SVP Program in lieu of this proposal. These include (1) changing the term of commitment, (2) requiring a finding of good cause to extend SVP trial dates, and (3) suspending the period of parole during commitment as an SVP. These are all discussed directly below.

- ***B. Change SVP Commitment from a Two-Year Term to a Five Year Term (new):*** This proposal would change statute regarding the commitment and recommitment period for SVPs from its existing two-years to five-years. This proposed change would reduce the frequency of evaluations and recommitment proceedings, as well as other related court expenditures. The Administration notes that language is still being crafted. The Administration also notes that any savings from this proposal would not be forthcoming until future years (i.e., from new SVP commitments, not existing ones).

- ***C. Require Finding of Good Cause to Extend SVP Trial Dates (new):*** This proposal would change statute to require a Public Defender or District Attorney to obtain a finding of good cause from the court in order to obtain a continuance of any set SVP-related trial. The Administration contends that such a policy change would allow for more orderly processing of the cases and would help clarify and resolve reasons for delays. Again, the Administration notes that language is still being crafted. In addition, the Administration does not anticipate any savings from this proposal for the next several years. Any savings amount is contingent upon how the courts would respond to the proposed change.

- ***D. Suspend Parole During Commitment as an SVP (new):*** This proposal would change statute to suspend (or "toll") any period of parole for an SVP while that person is detained in a secure facility, including either the State Hospital or the County Jail *prior to* and during the individual's commitment as an SVP.

  The Administration states that this proposal would ensure that an SVP or "pre-trial" SVP who is unconditionally released has oversight upon re-entry into the community. Again, the Administration notes that language is still being crafted. It is likely that this proposal would slightly increase CDC parole expenditures.

- ***E. Restructure SVP Treatment in the State Hospitals:*** Effective January 1, 2006, the DMH would restructure the supervision and treatment services provided to SVP patients, including the establishment of a new secure SVP residential licensing category. The proposal assumes savings of $6 million (General Fund) in the budget year and $11 million in 2006-07. However, the Administration notes that language is still being crafted. The savings level is based on adjustments to staffing.

  Generally, the concept behind this restructuring is to use less nursing staff and more hospital police officers than done under the current model of treatment. Further, the design of the new Coalinga facility will allow for separation of the SVP patient population into different sub-categories as discussed below.

With the pending activation of Coalinga, the DMH states that it is now the time to modify treatment and to clinically categorize the SVP patient population into three distinct categories as follows:

- ***Passive Treatment Group:*** These are Phase 1 (treatment readiness) individuals who would be housed in a secure residential environment at Coalinga and would attend treatment on an outpatient basis.
- ***Active Treatment Group:*** Phases 2,3 and 4 SVPs would be referred to as the "active" treatment group. These individuals require 24-hour custody supervision in a secure residential facility . Their treatment would be provided in central locations in the facility on an outpatient basis.
- ***Licensed Health Facility Group:*** This group would include SVP patients who have mental or physical illnesses that require care in a licensed health facility. The patients in this third group would include: (1) those just being admitted to the facility and undergoing initial evaluation and screening, (2) those in need of psychiatric hospital care, and (3) those in need of medical care in a hospital setting.

The DMH contends that a new secure SVP residential facility license category is needed for them to achieve savings and to implement the proposed changes. Again, language has not been provided so it is unknown as to what exact changes will be requested at this time.

Background—SVP Treatment Program: The Sex Offender Commitment Program designed for SPV patients is organized into five phases. The first four phases are inpatient treatment and the fifth phase is outpatient.

SVP patients entering the SVP Treatment Program enter as Phase 1 patients. Based on their willingness to participate in the treatment programs and their performance, patients "graduate" to the next phase until reaching outpatient status. As of January 2005, there are a total of 135 patients from 32 counties in phases 2,3,4 and 5 of treatment. The balance of the SVP population (424 patients or 76 percent) remain in Phase I as noted below.

Phase 1: Treatment Readiness (474 patients)
Phase 2: Skills Acquisition (107 patients)
Phase 3: Skills Application (19 patients)
Phase 4: Skills Transition (7 patients)
Phase 5: Community Outpatient Treatment (2 patients)

The statute provides that the SVP patient or the DMH Director may petition the court for conditional release (Phase 5) after the initial two-year commitment. Unlike the initial commitment or re-commitment process (jury trial), the process for a petition for conditional release requires only a court hearing before a judge, no jury trial.

If warranted, the court may order a person into community outpatient treatment (Phase 5) if they think intensive supervision and treatment in the community will result in the likelihood of not re-offending. These individuals are placed in the DMH's Conditional Release Program (CONREP).

(This program is discussed separately in the next agenda item). According to the DMH, this has resulted in the following overall statistics:

- 3 SVPs have been placed into the community with one subsequently being unconditionally released by the court.
- 2 SVPs have been court-ordered into community placement, and are awaiting actual placement.
- 3 SVPs have filed petitions for community release.

Subcommittee Staff Comment: Clearly additional information from the Administration is needed for all four remaining proposals. Language from the DMH are still pending. It is unknown at this time when this information will be made available. These issues will need to be discussed at future hearings once language is available.

Questions:

1. DMH, Please briefly describe and discuss each of the issues, in the order of the agenda.
2. DMH, When will language and comprehensive fiscal estimates be provided for each of these proposals?
3. DMH, How may you adjust your budget to reflect the withdrawn proposal?
4. LAO, any comment on these proposals?

8. Forensic Conditional Release Program (CONREP) Funding Adjustments

Issue: The budget proposes total expenditures of $18.4 million (General Fund) for a net decrease of $144,000 (General Fund) for CONREP.

This request consists of **(1)** an increase of $165,000 in additional costs for State Hospital liaison visits, **(2)** a decrease of $485,000 for patient services, **(3)** an increase of $91,0000 to support an estimated nine Sexually Violent Predators (SVPs) for 12-months and five SVPs for 6 months, and **(4)** an increase of $85,000 for patients released from the State Hospitals into CONREP without resources and who are ineligible for SSI.

The budget consists of three key components, including (1) hospital liaison visits, (2) patient services, (3) funding for SVPs. Each of these is discussed below.

The hospital liaison visits are done to assess outpatient readiness of State Hospital patients who are either Not Guilty by Reason of Insanity (NGI) or are a Mentally Disordered Offender (MDO). The cost per visit is based on a $227 per visit cost. It is projected that about 4,650 visits will be conducted in 2005-06. The proposed budget for this purpose is $919,000 which reflects an increase of $165,000.

For patient services, including outpatient treatment and supervision services, the DMH contracts with 17 counties and three corporations. In addition, the DMH contracts for ancillary services, including toxicology services, pharmacy services for patients on Clozaril medication, an answering service to meet statutory requirements, the Bureau of Prison Terms for statutorily required Mentally Disorder Offenders (MDO) hearings, and for certain assessment services. The budget request is calculated on the number of outpatient cases and State Hospital inpatient population projections times an average statewide patient cost of $21,091. The budget requests a total of $15.5 million (General Fund) for this purpose which reflects a reduction of $400,000.

In August 2003, the first SVP was placed into CONREP. The program as developed by the DMH includes sex offender treatment, dynamic risk assessments, psychiatric medications, and various monitoring tools (such as polygraphs, substance abuse screenings, and GPS monitoring), as well as supervision. The DMH is responsible for program, medical and living costs for the patient.

The DMH contracts with Liberty Healthcare for SVP CONREP services in all 58 counties. The budget proposes expenditures of almost $1.9 million (General Fund) which reflects an increase of $91,000 (General Fund). The budget assumes that nine SVP patients will be court ordered into CONREP placement in 2004-05, and five additional SVP patients will be placed in 2005-06 (total of 14 patients overall)

Background—Description of CONREP: Existing statute provides for the Conditional Release Program (CONREP). Specifically, it mandates for the DMH to be responsible for the community treatment and supervision of judicially committed patients, including Not Guilty by Reason of Insanity (NGI), Mentally Disordered Sex Offenders (MDOs), and Sexually Violent Predators.

CONREP, in operation since 1986, provides outpatient services to patients in the community and hospital liaison visits to patients continuing their inpatient treatment at State Hospitals who may eventually be admitted into CONREP.

CONREP services are provided throughout the state and are either county-operated *or* private/non-profit operated under contract to the DMH. The goal of CONREP is to ensure greater public protection in California communities via a system of mental health assessment, treatment, and supervision to persons placed on outpatient status.

Subcommittee Staff Comment and Recommendation: The budget assumptions are based on existing methodology. No issues have been raised. It is recommended to adopt the proposal pending receipt of the May Revision which may make adjustments for caseload.

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

1. DMH, Please provide a brief description of the overall budget request.
2. DMH, Please provide an update on the SVP placements and current pending placements.

LAST PAGE OF AGENDA

Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda

Chair, Senator Denise Moreno Ducheny
Senator George C. Runner
Senator Tom Torlakson

Thursday, March 10, 2005
(Upon adjournment)
John L. Burton Hearing Room (4203)
(Consultant, Anastasia Dodson)

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Please Note: Only those items and issues contained in this agenda will be discussed at this hearing. Issues pertaining to these items may be reviewed again. Please see the Senate File for dates and times of subsequent hearings.

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4170 California Department of Aging (CDA)

The California Department of Aging (CDA) is the state agency designated to coordinate resources to meet the long term care needs of older individuals, to administer the federal Older Americans Act and the State Older Californians Act, and to work with Area Agencies on Aging (AAAs) to serve elderly and functionally impaired Californians.

Summary of Expenditures (dollars in thousands)	2004-05	2005-06	$ Change	% Change
General Fund	$35,155	$35,207	$52	0.1
State HICAP Fund	1,779	1,780	$1	0.1
Federal Trust Fund	143,322	142,796	-526	-0.4
Special Deposit Account	1,552	1,573	21	1.4
Reimbursements	6,384	6,439	55	0.9
Total	$188,192	$187,795	-$397	-0.2

CDA Issue 1: Medicare Modernization Act Part D Consumer Education

Description: The federal Centers for Medicare and Medicaid Services (CMS) and Social Security Administration (SSA) will soon launch a major media campaign to encourage Medicare beneficiaries to enroll in Medicare Part D prescription drug benefits. Beginning in November 2005, approximately 4.1 million California Medicare beneficiaries will make enrollment decisions for the Part D benefit. As a result, demand for local Health Insurance Counseling and Advocacy Program (HICAP) services is expected to dramatically increase.

The CDA received $765,000 in additional federal funds for HICAP in the current year. The Administration has requested additional funding for Part D consumer education, but the amount of addition federal funds that will be provided is unknown. The CDA and HICAP will face a tremendous need for individual consumer counseling on Part D in 2005-06.

Background:

- **Medicare Modernization Act (MMA) Enrollment in Late 2005:** The MMA created a new Part D prescription drug benefit for Medicare beneficiaries. The initial enrollment period will run from November 15, 2005 through May 15, 2006 for most beneficiaries, but only from November 15, 2005 through December 31, 2005 for beneficiaries eligible for both Medicare and Medi-Cal (dual eligibles). Over 4.1 million Californians, including 1.7 million dual eligibles, may enroll in Medicare Part D.

- **Health Insurance Counseling and Advocacy Program (HICAP):** HICAP is a volunteer-supported program that provides consumers with information about Medicare, related health care coverage, and long-term care insurance. In 2004, HICAP fielded

90,000 consumer phone calls, 40,000 of which resulted in insurance counseling appointments. This figure is expected to increase substantially in the last few months of 2005 when 4.1 million Californians receive MMA enrollment information.

- **Federal Funds for MMA Consumer Education:** Although a total of $900 million federal funds were provided by Congress for MMA advertising, outreach, education, and other implementation efforts, only $31.7 million was provided for local HICAP efforts across the nation in Federal Fiscal Year 2005. Of that amount, California received only $765,000, and this funding has already been spent in the current year. Much of the federal funding is used by the federal Centers for Medicare and Medicaid Services (CMS) to operate a toll-free telephone line to answer consumer questions. However, in many cases consumers calling this line are redirected to local HICAP offices for individual counseling.

- **2005-06 Governor's Budget Request:** The budget proposes to use $93,000 in existing federal funds to establish 1.0 permanent position to develop training and program standards for the HICAP, which will provide consumer information on the federal Medicare Modernization Act. Although the CDA previously contracted with consultants for these types of activities, it now indicates the need for ongoing specialized expertise and closer management oversight. Total funding for HICAP is $6.8 million in the current year and $6.0 million in the budget year. Funding in 2005-06 does not reflect any additional federal funds for MMA consumer education.

Questions:

1. CDA, please briefly describe Part D consumer education needs, and present the Administration's plan to address those needs, including:
    a. Timeline of CDA and HICAP activities.
    b. Details of how the supplemental federal funds for consumer education have been/will be expended.
    c. Description of activities performed by the position requested in the Governor's Budget.
    d. How last year's experience with the Medicare Drug Discount Card can inform Part D consumer information efforts.

2. CDA, has the Administration requested additional federal funds for consumer education? How quickly would these funds be available to local HICAP offices?

Recommendation: The Subcommittee may wish to hold this item open pending information on additional federal funding. The Subcommittee may also wish to ask the CDA to report back to the subcommittee in April with a summary of activities and outcomes related to the HICAP workload increase for the Medicare Drug Discount Card.

CDA Issue 2: Data Collection and Dissemination

Description: Due to the decentralized structure of most of its programs, the CDA does not regularly publish statewide figures on the number of clients served by its programs, funding by program type for each Area Agency on Aging (AAA), or the outcomes of those programs. However, the department is developing a common data set across AAAs, and plans to add statistical fact sheets to its website.

Background:

- **Statewide Data Not Published:** The CDA does not regularly publish statewide figures on the number of clients served by its programs, funding by program type for each Area Agency on Aging (AAA), or the outcomes of those programs. This is due to the decentralized structure of the program, which relies on local AAAs to perform needs assessments and allocate funding according to local priorities. While some outcome data may be available at the local level, and is reported to the federal government, statewide information is not regularly published.

  The CDA indicates it plans to add statistical fact sheets to their website this year. Information that may be contained in the fact sheets will include: expenditures, performance, and client demographics by program.

- **UC Berkeley Recommends Common Data Set:** A 2003 report by the California Policy Research Center at UC Berkeley recommended that CDA take steps to improve the consistency and reliability of data collected by local aging service providers and Area Agencies on Aging (AAA). This report was commissioned by the state in response to SB 910 (Vasconcellos, Statutes of 1999, Chapter 948), which promoted improved data collection for the formation of public policy and legislative action, as well as to allocate resources and provide services. Consistent, regularly reported data would help the Legislature determine if funding is being appropriately allocated and the extent of unmet need for services.

  The CDA indicates that they are in the process of developing a common dataset that will closely mirror the Minimum Data Set (MDS) recommended by the UC Berkeley report. The CDA's efforts include a standardization of descriptions and definitions and agreement that a standard unique identifier must be collected across programs. CDA is moving forward to collect client level data so that comprehensive data comparisons can be performed. The CDA indicates that the California Association of Area Agencies on Aging has endorsed CDA's plan for a common dataset.

Questions:

1. CDA, please explain the steps taken to improve data consistency in response to the UC Berkeley report.

2. CDA, please describe any regularly published information on statewide use and need for local aging services.

Recommendation: The Subcommittee may wish to adopt placeholder trailer bill language to require the CDA to report annually upon release of the Governor's Budget on the number of clients served and funding for each type of service included in the CDA budget, including services provided via AAA contracts.

CDA Issue 3: Multipurpose Senior Services Program – Information Only

Description: Annual funding for the Multipurpose Senior Services Program (MSSP) has remained relatively unchanged since 2002-03, at $46.9 million ($23.5 million General Fund). However, due to program changes included in a recently negotiated federal Medicaid waiver, overhead costs for these sites have increased. As with other home- and community-based waivers, MSSP must meet cost-neutrality provisions that require programs costs not exceed the costs of institutional care.

Background: Local MSSP sites provide social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community. The goal of the program is to arrange for and monitor the use of community services to prevent or delay premature institutional placement of these frail clients. The services must be provided at a cost lower than that for nursing facility care. California currently has 41 sites statewide, which serve up to 11,789 clients per month.

Funding for local MSSP sites of $44.5 million ($22.3 million General Fund) is included in the Department of Health Services budget, and administrative funding of $2.4 million ($1.2 million General Fund) is included in the CDA budget.

Questions:

1. CDA, please explain how funding for MSSP is distributed from the state to local centers, and the CDA's role in monitoring disbursement of these funds.

2. CDA, please describe MSSP program changes included in the renegotiated waiver. Do these changes affect the number of clients that can be served through MSSP?

4200 Department of Alcohol and Drug Programs (DADP)

The Department of Alcohol and Drug Programs (DADP) provides statewide leadership and oversight for local alcohol and drug intervention, prevention, detoxification, treatment and recovery services, including Drug Medi-Cal, Proposition 36 (the Substance Abuse and Crime Prevention Act of 2000), Drug Courts, Drug Dependency Courts, and the Office of Problem Gambling.

Summary of Expenditures (dollars in thousands)	2004-05	2005-06	$ Change	% Change
Program Funding				
Prevention	$71,322	$71,331	$9	0.0
Treatment and Recovery	489,678	497,475	$7,797	1.6
Perinatal	45,195	45,123	-$72	-0.2
Source of Funding				
General Fund	$238,778	$242,630	$3,852	1.6
Federal Funds	290,595	290,598	3	0.0
Reimbursements	72,753	76,007	3,254	4.5
Other Funds	4,069	4,442	373	9.2
Total	$606,195	$613,677	$7,482	1.2

DADP Issue 1: Office of Problem Gambling – Information Only

Description: Implementation of the Office of Problem Gambling (OPG) continues to be delayed. The OPG is funded by $3.0 million from the Indian Gaming Special Distribution Fund in each of the current and budget years. This funding supports three OPG positions, as well as a contract for a situational assessment available later this year, a resource website, and activities for **California Problem Gambling Awareness Week, March 6-12, 2005**.

Background: The Office of Problem Gambling (OPG) was established in August 2003 to reduce the prevalence of problem and pathological gambling. The first priority of the OPG is to develop a statewide plan for a problem gambling prevention program that includes:

- A toll-free telephone service for immediate crises management and containment.
- Public awareness campaigns.
- Empirically driven research programs.
- Training of health care professionals and educators, and training for law enforcement agencies and nonprofit organizations.
- Training of gambling industry personnel in identifying customers at risk for problem and pathological gambling and knowledge of referral and treatment services.

Questions:

1. DADP, please describe the completed and planned activities of the OPG.

DADP Issue 2: Drug Medi-Cal Reimbursement Rates – Information Only

Description: The Budget Act of 2004 reduced Drug Medi-Cal provider rates to 2002-03 levels during 2004-05. The budget proposes to maintain rates at the 2002-03 level in 2005-06, and provides $118.9 million ($62.8 million General Fund) for the Drug Medi-Cal program. This represents a 6.5 percent increase, due to a net caseload increase of 7.7 percent.

Drug Medi-Cal providers have requested a 5.0 percent rate increase for 2005-06 ($3 million General Fund), due to increased costs in recent years associated with the statewide nursing shortage and increased accreditation costs.

The department indicates that at an average cost of $11 to $13 per day, methadone maintenance treatment in particular is a cost-effective alternative to incarceration or hospitalization.

Background:

Approximately 70,000 Californians are anticipated to receive substance abuse treatment through Drug Medi-Cal in 2005-06. Treatment is provided through four modalities:

- **Narcotics Treatment Program** (NTP) provides narcotic replacement drugs (including methadone), treatment planning, body specimen screening, substance abuse related physician and nurse services, counseling, physical examinations, lab tests and medication services to person who are opiate addicted and have substance abuse diagnosis. The program does not provide detoxification treatment. NTP providers are the primary Drug Medi-Cal providers.

- **Day Care Rehabilitative** provides specific outpatient counseling and rehabilitation services to persons with substance abuse diagnosis who are pregnant, in the postpartum period, and/or are youth eligible for Early and Periodic Screening, Diagnosis and Treatment.

- **Outpatient Drug Free** provides admission physical examinations, medical direction, medication services, treatment and discharge planning, body specimen screening, limited counseling, and collateral services to stabilize and rehabilitate persons with a substance abuse diagnosis.

- **Perinatal Substance Abuse Services** is a non-institutional, non-medical residential program that provides certain rehabilitation services to pregnant and postpartum women with a substance abuse diagnosis.

Questions:

1. DADP, please present the Governor's Budget proposal to maintain Drug Medi-Cal rates at 2002-03 levels.

2. DADP, is this proposal consistent with federal Medicaid requirements that rates be based on a rate study, and that rates be set at a level to ensure a sufficient number of providers for adequate client access to services?

DADP Issue 3: Quality Improvement Assessment Fee Report

Description: The Budget Act of 2004 included budget bill language to require the DADP to report to the Legislature by January 10, 2005 on the feasibility of a Quality Improvement Assessment Fee (QIAF) for methadone clinics. If approved by the federal government, a QIAF would allow a fee to be assessed on clinics, and the fee revenue used to draw down additional federal funds.

Background: The Legislature previously approved the establishment of QIAFs for other Medi-Cal providers, including intermediate care facilities for the developmentally disabled (ICF-DDs), Medi-Cal managed care plans, and skilled nursing families (SNFs). The QIAF for ICF-DDs has been fully implemented, but the Department of Health Services is still in the process of implementing the fee for other types of facilities. The federal budget proposed by the President in February would reduce the amount of the fee that may be assessed on facilities, but the option would not be fully eliminated.

Questions:

1. DADP, please present the QIAF report.

Recommendation: Upon review of the report, the Subcommittee may wish to adopt a QIAF for Narcotic Treatment Providers, including placeholder trailer bill language, additional DADP expenditures, and additional General Fund revenue.

DADP Issue 4: Substance Abuse Services for Women and Children in Drug Medi-Cal and CalWORKs– Information Only

Description: The budget estimates that total funding for Drug Medi-Cal will increase by 6.5 percent, while funding for Perinatal Drug Medi-Cal is estimated to decrease by 3.0 percent, due to caseload changes. In 2004-05 the Legislative Analyst's Office (LAO) reviewed the Drug Medi-Cal program and found that a disproportionately small share of the Drug Medi-Cal budget is spent on women and children. Funding for substance abuse treatment under the California Work Opportunity and Responsibility to Kids (CalWORKs) program is also estimated to decline by 6.7 percent in 2005-06.

Drug Medi-Cal Program	Total Funding (dollars in thousands)		Percent Change
	2004-05	**2005-06**	
Narcotic Treatment Program (including Methadone Dosing)	$71,289	$73,986	3.8%
Day Care Rehabilitative	$6,606	$7,736	17.1%
Outpatient Drug Free	$30,991	$34,522	11.4%
Perinatal Services	$2,773	$2,691	-3.0%
Total	**$111,659**	**$118,935**	**6.5%**

Background:

- **Perinatal Treatment Programs:** The DADP Office of Perinatal Substance Abuse oversees a statewide network of approximately 288 publicly funded perinatal alcohol and drug treatment programs that annually serve over 37,600 pregnant and parenting women accompanied by approximately 56,400 children. These programs are intended to prevent the significant (and costly) health problems that can occur in babies born to substance-abusing women, strengthen families, and improve children's outcomes. Approximately 71 percent of babies born to women in perinatal treatment programs test negative for alcohol or other drug exposure. These programs are funded through a variety of sources, including Drug Medi-Cal, federal substance abuse grants, and the CalWORKs program, which is funded in the Department of Social Services (DSS) budget.

- **CalWORKs Substance Abuse Services:** The budget proposes $45.0 million for CalWORKs substance abuse services in 2005-06, a reduction of $3.0 million compared to 2004-05, due to a decline in caseload. County welfare agencies, which administer the CalWORKs program, provide for the treatment of substance abuse issues that may limit or impair a participant's ability to make the transition from welfare to work or retain employment over a long period of time. The budget includes $2.1 million for substance abuse and mental health services provided by Indian Health Clinics, the same amount included in 2004-05 for these services.

Questions:

1. LAO, please review your findings from 2004-05 regarding Drug Medi-Cal spending on women and children.

2. DADP, please explain why Drug Medi-Cal perinatal caseload has declined.

3. DSS/DADP, how do perinatal services funded by Drug Medi-Cal differ from CalWORKs funded substance abuse services?

4. DSS, please explain why CalWORKs substance abuse services caseload has declined.

5. DSS, how prevalent are substance abuse issues for CalWORKs families? How prevalent are substance abuse issues for CalWORKs families that have been sanctioned?

DADP Issue 5: Proposition 36 Status Update – Information Only

Description: Proposition 36, the Substance Abuse and Crime Prevention Act (SACPA), provides drug treatment instead of incarceration for certain first or second time non-violent adult drug offenders. The law also appropriates $120 million annually through 2005-06 for drug treatment. Although the state must continue spending this amount after 2005-06 to meet its maintenance of effort requirement for the federal Substance Abuse Prevention and Treatment Block Grant, the funding may be used for other drug and alcohol services beyond Proposition 36 clients. The sentencing guidelines established by Proposition 36 do not sunset. Researchers at the University of California at Los Angeles (UCLA) are currently evaluating SACPA results.

Background:

- **Voters Approved SACPA in 2000:** SACPA changed state sentencing laws, effective July 1, 2001, to require adult offenders convicted of nonviolent drug possession to be sentenced to probation and drug treatment instead of prison, jail or probation without treatment. The Act excludes offenders who refuse treatment or who are found by the courts to be "unamenable to treatment." The Act further requires that parolees with no history of violent convictions who commit a non-violent drug offense or violate a drug-related condition of parole be required to complete drug treatment in the community, rather than being returned to state prison.

- **Clients Served and Outcomes:** According to UCLA's November 2004 evaluation of SCAPA, in 2002-03 50,335 clients were referred to the system and 35,947 (71%) received treatment. This "show rate" compares favorably with show rates in other studies of drug users referred to treatment by criminal justice. The UCLA findings include:

    - Most SACPA clients (90%) were on probation. The remaining 10% were parolees.

    - SACPA clients had long histories of drug use and half were experiencing treatment for the first time. Methamphetamine was the primary drug used by 53% of SACPA clients.

    - Most SACPA clients (86%) were placed in outpatient drug-free programs, and 10% were placed in long-term residential programs. However, many clients had drug problems severe enough to suggest a need for residential treatment.

    - Of those clients who agreed to participate in the first year, 34% were tracked to completion. Of the total clients referred (clients entering treatment as well as those who dropped), the completion rate is 24%. SACPA treatment performance rates are typical for drug users referred to treatment.

- Success in treatment was particularly difficult for those with heroin addiction. Few heroin users (12.7%) were treated with methadone detoxification or maintenance programs, despite the proven effectiveness of those programs.

- **Program Funding and Expenditures:** SAPCA appropriated $60 million for 2000-01 and $120 million annually from 2001-02 through 2005-06. Of total expenditures in 2003-04, counties spent 76% on treatment and related services, and 24% on court, probation, and other criminal justice activities. In 2003-04, $8.6 million in federal funds were available for drug testing. Counties spent 62% of this funding on SACPA drug testing and the remaining funds on other allowable federal activities.

Total County Funds Available/County Expenditures FY 2000-01 - FY 2005-06

A	B	C	D	E	F*	G*
	Amount Allocated to Counties	Carryover Funds from Previous Year	Total Funds Available	Total Expenditures	Percentage Expended of Total Funds Available	Percentage Expended of Total Allocation
FY 2000/01	$58,800,000	Not applicable	$58,800,000	$7,177,107	12.2%	12.2%
FY 2001/02	$117,022,956	$54,241,609	$171,264,565	$92,783,434	54.2%	79.3%
FY 2002/03	$117,022,956	$85,971,954	$202,994,910	$136,392,288	67.2%	116.6%
FY 2003/04	$117,022,956	$66,893,352	$184,916,308	$143,211,902	77.4%	122.4%
FY 2004/05	$116,594,956	$52,936,422	$169,531,378	$150,372,498	88.7%	129.0%
FY 2005/06	$116,594,956	$42,446,151	$159,041,107	$157,891,122	99.3%	135.4%

*Columns F and G: Counties can expend more than their annual allocation by using carryover funds from previous fiscal years.

Notes:
(1) The data source for 2000-01 through 2002-03 is the SACPA Annual Financial Status Report/SACPA Reporting Information System.
(2) The figures for 2003-04 through 2005-06 are projections using five percent annual increase through 2005-06. The five percent is based on past history and then applied to future year projections.

- **Unspent Allocations:** Most counties have maintained reserves from previous fiscal years, especially the start-up period before July 1, 2001. Counties have used carryover funds to expend more than their annual allocations (see table above). The department indicates that statewide carryover will be virtually eliminated by the end of 2005-06. The department is drafting regulations to ensure that funds beyond those needed as a prudent reserve are moved to counties that need additional funding.

- **UCLA Program Evaluations:** The UCLA Integrated Substance Abuse Programs is conducting a five-year independent evaluation that will measure the fiscal impact and effectiveness of the program. The November 2004 report, summarized above, describes outcomes in 2002-03. An additional report will be provided to the Legislature by early 2006, and will address whether SACPA leads to overall cost savings, including treatment, criminal justice, and incarceration costs.

- **Farabee et al. Report on Early Program Recidivism:** In late 2004 David Farabee, a UCLA researcher, released a report on criminal recidivism during the first six months of

SACPA implementation. The report concluded, among other things, that SACPA participants admitted to drug treatment from July through December 2001 were more likely to be re-arrested than participants in other criminal justice programs. However, in this time period counties were still solving initial implementation problems, so it is unclear whether future recidivism rates will mirror these results.

- **2005 SACPA Improvement Study:** The department has contracted with the Avisa Group to investigate some of the UCLA findings in greater detail and make recommendations on best practices and program improvements. The Avisa Group report is scheduled to be available in April 2005.

Questions:

1. DADP, please briefly discuss who is being served by SACPA and how they compare to other treatment populations. Also discuss initial program outcome data, including the rate of client participation in treatment services and criminal recidivism.

DADP Issue 6: Drug Courts and Dependency Drug Courts

Description: The budget proposes trailer bill language to extend the Comprehensive Drug Court Implementation (CDCI) Act of 1999 sunset date from January 1, 2006 to January 1, 2007. A report on the CDCI outcomes was due to the Legislature on March 1, 2005.

Also, the Budget Act of 2004 also provided $1.8 million in federal funding to expand dependency drug courts, and required the DADP, with input from DSS, to measure program outcomes and cost-effectiveness of dependency drug courts, including the amount of Foster Care savings realized. The Governor's Budget proposes a 2.6 percent increase for Foster Care, for a total of $1.6 billion to care for 74,000 children.

Background:

- **Drug Court History:** The first drug court in California began in Oakland in 1993. As a result of the significant increase in drug-related crime, Drug Courts expanded in the 1990's. The Drug Court Partnership Act of 1998 appropriated $4 million for competitive grants to counties to expand drug courts, and required periodic reporting to demonstrate the cost-effectiveness of the grants. The Comprehensive Drug Court Implementation (CDCI) Act of 1999 expanded drug courts to include juvenile drug courts, dependency drug courts, family drug courts, and increased capacity in existing adult drug courts. The CDCI was originally due to sunset on January 1, 2005, but was amended in 2003 to sunset on January 1, 2006.

- **Drug Court Program:** Drug Courts use a team approach that emphasizes sobriety and accountability. They integrate drug treatment with other rehabilitation services, conduct frequent drug testing, and provide intensive judicial supervision that deals promptly with relapses of drug use and its consequences. Judges may modify program services and

exercise enforcement options, including jail sentences and other sanctions, to assure client compliance. Drug courts are diverse and serve different populations. There are over 150 drug courts for adult and juvenile offenders in 50 counties in California.

- **Adult Drug Court Results:** In the March 2004 Interim report on the CDCI, the DADP reported that adult drug court participants who completed the CDCI program averted a total of $34.2 million in prison costs, compared to $22.3 million in drug court expenditures. The ratio of prison costs avoided to drug court costs is 1.53 to 1.

- **Dependency Drug Courts:** These drug courts work to reduce foster care costs and increase permanency for children by providing substance abuse treatment to parents who are involved in dependency court cases. Failure to comply with a court-ordered plan could result in termination or limitation of parental rights and placing the child or children in foster care.

- **Dependency Drug Court Results:** San Diego, Santa Clara, and Sacramento Counties have well-established dependency drug courts that have demonstrated significant positive results, including: reduced time to reunification, greater reunification rates, shorter stays in out of home care (including Foster Care), and greater participation in substance abuse treatment. Many studies have found that for one-third to two-thirds of children involved with the child welfare system, parental substance abuse is a contributing problem.

- **Dependency Drug Court Expanded in 2004 with Additional Reporting Language:** The Budget Act of 2004 included $1.8 million federal funds to expand dependency drug courts, as well as trailer bill language as follows: "The department [DADP], in collaboration with the Judicial Council and with input from the State Department of Social Services, shall adopt appropriate data collection and reporting requirements to measure program outcomes and cost-effectiveness, including the amount of foster care savings realized." (Health and Safety Code Section 11970.2 (b) (4))

- **2005-06 Governor's Budget:** The budget proposes trailer bill language to extend the sunset of CDCI from January 1, 2006 to January 1, 2007. Current statute requires the DADP to present a report on the effectiveness of the CDCI by March 1, 2005.

Questions:

1. DADP, why does the Governor's Budget propose to extend the CDCI Act by one year?

2. DADP, please present the CDCI report due March 1, 2005.

3. DADP, please describe the status of the $1.8 million appropriated in 2004-05 for dependency drug court expansion.

4. DADP and DSS, please describe the status of measurements to determine how Child Welfare Services and Foster Care caseload and costs are affected by dependency drug courts. Have

counties with dependency drug courts been provided with specific reporting requirements to measure program outcomes and cost-effectiveness?

5. LAO, please comment on the effect of dependency drug courts on Foster Care and Child Welfare Services caseload.

Recommendation: The Subcommittee may wish to hold this issue open pending further information from DADP and DSS on the cost-effectiveness of dependency drug courts. The Subcommittee may wish to review this issue again at the April Subcommittee hearing on the DSS budget for Child Welfare Services and Foster Care.

5180 Department of Social Services (DSS)

The California Work Opportunity and Responsibility to Kids (CalWORKs) program provides cash benefits and welfare-to-work services to low-income families. CalWORKs is funded through an annual federal Temporary Assistance for Needy Families (TANF) block grant of $3.7 billion, plus $2.7 billion in state funds to meet a federal Maintenance of Effort (MOE) requirement. The state's MOE is based on welfare spending in 1994, adjusted downward for achievement of certain work participation goals. Federal law requires states to spend TANF funds on current and former welfare recipients, with limited exceptions. Accordingly, California spends most federal TANF funds on CalWORKs, and directs some TANF and state MOE funding to activities in other departments.

The budget proposes total TANF/MOE funding of $5.9 billion ($4.7 billion of which will be spent on the CalWORKs program and $1.2 billion to support non-CalWORKs federally allowable activities). This constitutes a $528 million, or 10 percent decrease in CalWORKs expenditures from the current year.

DSS Issue 1: CalWORKs Caseload Estimate – Vote Only

Description: Upon review of the recently available CalWORKs caseload and grant cost data, the Legislative Analyst's Office (LAO) indicates that CalWORKs cost estimates are overbudgeted by a combined total of $135.9 million in the current year and budget year.

Background: The DSS estimates current year and budget year CalWORKs caseload and costs in November and May of each year. The LAO reviews the DSS estimates and compares them to the most recent available data.

Recommendation: The Subcommittee may wish to recognize the identified savings and shift this savings into the TANF reserve for further consideration.

4130 Health and Human Services Agency Data Center (HHSDC)

The HHSDC provides consolidated electronic data processing and project management. The Operations component provides computer services, telecommunications support, information systems, and training support. The Systems Management component manages nine major projects for the DSS and one project for the Employment Development Department (EDD).

HHSDC Issue 1: Transfer of Automation Projects to Health and Human Services Agency

Description: The budget proposes to transfer the HHSDC Systems Management component (including all ten automation projects) to the Health and Human Services Agency (HHSA). The Unemployment Insurance (UI) Modernization project is sponsored by EDD, and the remaining nine projects are sponsored by DSS.

Background: Effective July 1, 2005, the Governor's Budget proposes to eliminate the HHSDC and consolidate the Operations component and the Teale Data Center into the newly proposed Department of Technology Services (DTS). This consolidation proposal is in response to Legislative direction in the Budget Act 2003 to consolidate data center activities. Senate Budget Subcommittee number 4 is considering this proposal.

Due to concerns about the high level of oversight needed to successfully implement and maintain large automation projects, the Administration proposes to transfer the management of the DSS and EDD-sponsored automation projects to the HHSA.

However, the LAO recommends that all DSS-sponsored projects be placed in DSS, as DSS should be held accountable for the projects' success and agencies are designed to provide policy direction and oversight rather than carry out day-to-day operational responsibilities. The LAO also recommends that the EDD-sponsored project be placed at DTS, along with remaining operations component of the HHSDC. To address transition risks, the LAO recommends additional reporting to the Legislature and oversight by the Department of Finance in 2005-06.

Questions:

1. HHSA, please describe the proposal to shift the automation projects to HHSA from HHSDC. Is trailer bill language necessary to implement this proposal?

2. LAO, please present your recommendation.

Recommendation: The Subcommittee may wish to adopt the LAO proposal to: 1) shift all positions and funding for DSS-sponsored projects to the DSS; 2) shift all positions and funding for the EDD-sponsored project to the DTS; 3) adopt placeholder budget bill language to require DSS to provide project status reports and independent oversight reports to the Legislature on a quarterly basis; 4) direct the Department of Finance Technology, Oversight, and Security Unit (TOSU) to review the projects of the next year to ensure that DSS is providing adequate guidance and direction to the projects consistent with state policies and procedures; and 5) adopt

placeholder budget bill language to require TOSU to report to the Legislature by March 1, 2006 on its review of the projects.

Department of Social Services Projects Managed by Health and Human Services Agency Data Center *(Chart prepared by LAO)*

(In Millions)

Project Name	Current Activities	2005-06 Costs
Child Welfare Services/Case Management System (CWS/CMS) Provides a statewide data base, case management tools, and a reporting system for the state's CWS program.	Status: project undergoing major modifications. • Transferring CWS/CMS equipment to Department of Technology Services. • Conducting procurement for new software maintenance contract. • Maintaining and operating current CWS/CMS.	$121.1
Electronic Benefit Transfer Uses debit card technology and retailer terminals to automate benefit authorizations, delivery, redemption, and financial settlement for food stamp program.	Status: implementation. • Completing implementation within counties.	20.8
In-Home Supportive Services (IHSS)/ Case Management Payrolling System Provides case management and payroll services for the IHSS program.	Status: development. • Conducting procurement for the development, maintenance, and operation of replacement system.	13.7
Statewide Automated Welfare System Consists of four separate projects. Provides uniform information technology capability to county welfare offices. Counties belong to one of four consortia.	Status: implementation, and maintenance and operations. • Implementing new system in certain counties. • Maintaining and operating remaining consortium systems.	237.0[a]
Statewide Fingerprint Imaging System Automates the collection, interpretation, and storage of fingerprints for persons applying for public benefits.	Status: maintenance and operation.	8.0
Welfare Data Tracking Implementation Project Determines time-on-aid for CalWORKS program.	Status: maintenance and operation.	3.9

a Some of these costs are included in the Department of Social Services' budget.

Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda

Chair, Senator Denise Moreno Ducheny
Senator George C. Runner
Senator Tom Torlakson

Thursday, March 10, 2005
Upon Adjournment of Session
John L. Burton Hearing Room (4203)
(Consultant, Anastasia Dodson)

Materials for Hearing

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 11970.4 of the Health and Safety Code is amended to read:

11970.4. This article shall remain operative only until January 1, ~~2006~~ 2007, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, ~~2006~~ 2007, deletes or extends that date.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make the necessary statutory changes to implement the Budget Act of 2005 at the earliest possible time, it is necessary that this act take effect immediately.

SUBCOMMITTEE NO. 3 Agenda
Health & Human Services

Chair, Senator Denise Ducheny

Senator George Runner
Senator Tom Torlakson

March 14, 2005

2:00 PM or Upon Adjournment of Appropriations

Room 4203
(John L. Burton Hearing Room)

(Diane Van Maren)

Item	Department
4260	**Department of Health Services—*Selected Public Health Issues as noted***

PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. Both the Department of Health Services and the Managed Risk Medical Insurance Board will be discussed at several additional hearings. *Please* see the Senate File for dates and times of subsequent hearings.

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

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

I. 4260 Department of Health Services

***Overall Purpose of the Department*:** The goals of the Department of Health Services (DHS) are to: (1) promote an environment that contributes to human health and well-being; (2) ensure the availability of equal access to comprehensive health services using public and private resources; (3) emphasize prevention-oriented health care programs; (4) promote the development of knowledge concerning the causes and cures of illness; and (5) ensure economic expenditure of public funds to serve those persons with the greatest health care needs. These goals are carried out through three key programmatic areas, including the Medi-Cal Program, Children's Medical Services, and Public and Environmental Health.

Summary of Department's Proposed Budget: The budget proposes expenditures of $37.6 billion ($13.6 billion General Fund), or a *net* increase of $280.1 million ($1.019 billion General Fund) over the revised 2004-05 budget. Of the total budget amount, $36.6 billion ($13.387 billion General Fund) is for local assistance.

The Governor proposes state support expenditures of $987.3 million ($264.2 million General Fund) which would support 6,069 authorized positions for an increase of 327 new positions over the revised current-year. Even though the Governor has imposed an unallocated reduction of $11.5 million (General Fund) on the department for 2005-06, expenditures for state support are proposed to grow by $10.5 million over the revised current-year

Summary of Expenditures (dollars in thousands)	2004-05	2005-06	$ Change	% Change
Program Source				
Public & Environmental Health	$862,717	$887,587	$24,870	2.9
Medical Care Services	$33,848,236	$34,067,010	$218,774	0.6
County Health Services	$52,867	$52,867	--	--
Primary Care & Family Health	$1,533,989	$1,556,728	$22,739	1.5
State Mandates	$4	$3,761	$3,757	939
State Administration & Operations	$976,806	$987,341	$10,535	1.0
Totals, by Program Source	$37,274,619	$37,555,294	$280,675	0.8
Funding Source				
General Fund	$12,631,405	$13,651,257	$1,019,852	8.1
Federal Funds	$21,417,896	$20,980,414	($437,482)	-2.0
Special Funds & Reimbursements	$3,225,318	$2,923,623	($301,695)	-9.4
Totals, by Fund	$37,274,619	$37,555,294	$280,675	0.8

A. ISSUES FOR VOTE ONLY (Items 1 through 4)

1. Cannery Inspection

Issue: Pursuant to AB 3027, Statutes of 2004, the budget requests to transfer $1.6 million (reimbursements) to a newly created special fund—the Cannery Inspection Program Fund. Licensing fees presently deposited into the General Fund will now be captured in this special fund for expenditure on DHS licensing activities as noted below. No changes in the program or in the level of service are anticipated. Presently nine positions are funded for these activities.

Existing statute requires the food industry to fully fund the DHS for the inspection of low acid canned foods. The foods inspected under the program are shelf-stable soups, vegetables, meet, fish, salsas, sauces and beverages packed in cans, jars and aseptic packages. The program has been in existence for over 75-years.

Subcommittee Staff Comment and Recommendation: The proposal conforms to recently chaptered legislation. No issues have been raised. It is recommended to approve as budgeted.

2. State Administration of the Women's, Infants and Children (WIC) Supplemental Food Program

Issue: The budget proposes to redirect $527,000 (federal funds) from operating expenses to fund 7 positions (two permanent, three for six-months, and two for 18 months). The positions include (1) 1.5 Public Health Nutrition Consultant II positions, (2) two Associate Governmental Program Analysts, and (3) two information systems analysts-related positions. All of the positions are limited-term.

The DHS states that the positions would be used as follows:

- *Local Agency Support (1):* A Public Health Nutrition Consultant position would be used to monitor and support local WIC programs to meet federal requirements. The position would perform on-site monitoring evaluations, conduct on-site technical assistance in nutrition areas, review the training and competency of local agency staff, and monitor contracts.

- *Staff for Food Cost Containment (4)*: Four of the positions would be used to implement new requirements of the Child Nutrition and WIC Reauthorization Act of 2004. This Act requires states to achieve food cost containment through the management of high cost grocers and imposes an 18-month implementation deadline on states for meeting the requirements. Specifically, this Act mandates implementation of a grocer peer group and reimbursement system that distinguishes between high price grocers and competitive grocers. These staff will develop and implement cost containment policies in accordance with the Act, monitor grocer

redemption, develop and implement state regulations, hire and oversee a contractor to perform specialized item processing services and ensure that the necessary infrastructure is in place.

- *Staff for Breastfeeding Peer Counseling (2):* The DHS states that California is still far below the needed rates for women who breastfeed for six months to a year as recommended. The DHS wants to use staff to support local WIC programs in hiring and training breastfeeding peer counselors. Thirty-six other states have implemented this approach and numerous studies document its effectiveness.

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

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

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

Subcommittee Staff Comment and Recommendation: The request for the staff is reasonable and no issues have been raised. According to the DHS, the funds being redirected to fund the staff positions are from contract services that are not needed at this time. It is therefore recommended to approve as budgeted.

3. Electronic Death Registration System

Issue: The budget requests an increase of $225,000 (Health Statistics Fund) to fund efforts at the local level and to train system users to ensure the successful integration of the Electronic Death Registration System. Specifically, these funds will be used to contract for services to enroll users (Local Registrars) and provide training on the new system. A total of $1.463 million (Health Statistics Fund) is appropriated for the Electronic Death Registration System.

Chapter 857, Statutes of 2002 (AB 2550, Nation), mandates the DHS to, among other things, develop and maintain an Electronic Death Registration System. AB 2550 provided for increased revenues for this purpose.

Subcommittee Staff Comment and Recommendation: The proposal is reasonable and no issues have been raised. No fees are being increased. It is recommended to approve as budgeted.

4. County Medical Services Program (CMSP)

Issue: The Governor proposes to suspend for another year the $20.2 million (General Fund) appropriation for the County Medical Services Program (CMSP). This $20.2 million has been suspended for the past several years.

The County Medical Services Program (CMSP) provides medical and dental care to low-income "medically indigent" adults who reside in small counties (total of 34 counties) (populations of 300,000 or less, with a few exceptions) and are not eligible for Medi-Cal. The responsibility for providing these services was transferred from the state to the counties as of January 1, 1983.

The CMSP Governing Board is responsible for the administration of pooled funds from the participating counties to provide services to over 65,000 CMSP participants.

Revenues to support the CMSP come from several sources, including County Realignment Funds (i.e., sales tax, vehicle license fees, and growth account), Proposition 99 Funds (selected accounts), Member County Participation Fees, and the General Fund (on deferral for the past 4 years). In 1993 as part of an overall agreement with the counties, the state capped its participation in the local assistance portion of the CMSP at $20.2 million General Fund. The last time the state actually provided the General Fund support was in 1999.

Subcommittee Staff Comment and Recommendation: This proposal is consistent with prior years when the state has chosen not to provide any General Fund support to the program. It is recommended to approve as budgeted, including technical trailer bill legislation. The trailer bill legislation is the same language as has been used in past years and just includes one more year of deferral.

B. ISSUES FOR DISCUSSION

1. Governor's Proposed Elimination of the CA Office of Binational Border Health

Issue: The Governor proposes to eliminate all General Fund support—i.e., $694,000—from the California Office of Binational Border Health (COBBH) which would eliminate all contract positions at the University of San Diego for the COBBH and in effect, eliminate the entire function of the office. The Governor's action would only retain some federal bioterrorism funds which are specifically earmarked for the state's Early Warning Infectious Disease Surveillance Program. The only rational for the proposed action to eliminate the COBBH is to reduce General Fund expenditures.

The existing $694,000 (General Fund) is used to fund contracts with (1) the University of California, San Diego ($569,000), and (2) the County of Los Angeles ($40,000). The DHS states that the balance of the funds (i.e., $90,000) were not encumbered under contracts as it was part of a DHS General Fund cut drill.

When quarried about whether additional federal bioterrorism funds could be used for the COBBH, **the DHS** stated the following:

- The scope of the existing bioterrorism preparedness activities are addressed by the Early Warning Infectious Disease Surveillance (EWIDS) Program. The DHS said that the CDC provided a similar set aside for all other states sharing a border with Mexico or Canada. Specifically, the DHS has a $1.182 million (federal funds) contract with UC San Diego to conduct the EWIDS Program through the COBBH, and the DHS supports two state positions for $246,000 (federal bioterrorism funds).
- With respect to continuation of the EWIDS Program total funds of $1.4 million (federal bioterrorism funds), the DHS was non-committal as to whether even these funds would be continued into 2005-06 since the CDC grant process is not at all clear at this time (This is discussed in Agenda Item 2, below).
- The CDC strictly reviewed the state's use of federal bioterrorism funds in this area and noted to the DHS that California could not supplant existing OBBH efforts with federal funds.

Background—CA Office of Binational Border Health It has long been recognized that the health and well-being of communities on both sides of the U.S.-Mexico international boundary are intertwined and inextricably linked. The California-Mexico border region is a tremendous area of human contact where two cultures meet, flow back and for the across political borders, share common experiences, economic and environmental conditions, as well as, health and disease. San Diego has the busiest border in the world with over 60 million crossing in 2001.

Disease knows no boundaries and because it is a porous border, the regional can be considered an epidemiological area for approaching disease prevention and control, for reducing disease and injury risk factors, and for promoting health.

There has been a State Office of Border Health since 1993. However, AB 63 (Ducheny), Statutes of 1999, formally established the California Office of Binational Border Health in January 2000. The mission of the Office is to protect and improve the health of California communities affected by border or binational conditions and activities through facilitating cooperation between California and Mexico health officials and health professionals. As noted by the DHS, the COBBH serves as the single point of coordination on border health activities.

These efforts included (1) assessing public health status of border and binational communities, (2) coordinating environmental health issues such as air quality, water quality, food safety and lead exposure, (3) mitigating the spread of infectious disease, and (4) promoting health policy and program development for binational cooperation.

The COBBH is strategically located near the California and Mexico border and it has developed expertise and contacts critical to rapid and effective binational infectious disease monitoring and response. These issues include Tuberculosis, West Nile Virus, HIV/AIDS, contaminated food products and environmental health concerns.

Among many other things, the COOBH has participated in (1) investigations of disease outbreaks and food-borne illness concerns, (2) the tracking and monitoring of various health issues, and (3) educational campaigns for immunization programs, access to health care and TB treatment.

Linkage with Bioterrorism Preparedness: Every month millions of people traverse the 140-mile long border between California and Mexico. Improved surveillance for disease on both sides of the border will ensure greater likelihood of diction of an intentional outbreak caused by a chemical or biological agent. Infectious agents released on either side of the border could spread rapidly throughout California and Baja California.

Report—The Border that Divides and Unites: Addressing Border Health in CA: In a recently completed report (October 2004) commissioned by The California Endowment (TCE), the following key aspects were noted:

- Due to distinctive demographic, ecological, social and cultural factors in the border region, a set of special health indicators has emerged that require a binational approach.
- Among the most pressing health issues in the region were public health emergencies, access to health care, environmental health, infectious diseases, HIV and AIDS, substance abuse, mental health, and migrant and agricultural worker health.
- The six-months of research and analysis of this region that was under taken by the contractors pointed to a set of recommendations made in the report, including:
    - Fund and support the creation of a comprehensive border health vision and mission;
    - Support the development of "best practices" in border health and binational health;
    - Support capacity building and training for agencies on establishing partnerships, setting goals, strategic planning and creating a sustainability plan;

- Agencies need to incorporate policies and practices to better integrate a border binational approach to health issues; and
- Increase data collection for research and policy purposes.

Subcommittee Staff Comment: With thousands of individuals crossing the border every day, coupled with the extensive exchange of commerce and goods between California and Mexico, it only makes sense to maintain the COBBH to help ensure public health safety. The importance of the COBBH was highlighted in an independent analysis commissioned by the California Endowment in October 2004 (prior to any budget proposal).

The DHS contends that existing Sacramento-based staff would absorb the responsibilities of the COBBH and thereby, perform the functions now being conducted by COBBH. This is a complete fallacy. First, the DHS has difficulties operating existing public programs with existing staff, let alone absorbing additional responsibilities which pertain to a large, diverse region of California that is over 700 miles away from Sacramento. This region has unique public health challenges that cannot be addressed effectively or efficiently from Sacramento.

Second, the complexity and importance of this region dictates that a comprehensive, single point of coordination is needed. Diffused efforts result in inefficiencies and it derogates from the concept of having a "rapid" response to emerging health concerns.

It is a reasonable investment for California and actually is quite cost-beneficial. The various preventive focused functions performed by the COBBH assist substantially in mitigating the spread of disease in Californians.

Questions:

1. DHS, Please describe the functions of the COBBH and its effectiveness.
2. DHS, Please explain why the budget is proposing to, in effect, eliminate the COBBH?

2. Expenditure of Federal Bioterrorism Funds—State Support & Local Funds

Issues: *First*, the Governor is requesting to extend 94.8 positions for two-years (to June 30, 2007) to continue existing efforts relating to bioterrorism preparedness and response as directed under federal grant agreements with the federal Centers for Disease Control and Prevention (CDC) and the federal Health Resources and Services Administration (HRSA). The DHS is requesting an appropriation of $8.2 million (federal funds) to continue these 94.8 positions in 2005-06.

Presently the DHS has a total of 104.8 positions of which 10 are permanent and 94.8 are limited-term and expire as of June 30, 2005. Of the 94.8 limited-term positions, 76 positions are associated with functions related to the CDC grant and 18.8 positions pertain to the HRSA grant. The remaining 10 permanent positions all pertain to the CDC grant.

The tables below summarize the request to extend (two-years) the 94.8 positions. As noted in the background discussion below, the existing CDC grant has seven "focus" areas and the HRSA grant has four "benchmark" measurements. The requested positions are therefore listed by these areas.

I. CDC Grant and Focus (76 positions)	Positions		Positions
A. Preparedness Planning & Readiness		**D. Laboratory Capacity--Chemical**	
Health Prog Mgr II/III	2	Research Scientist Supervisor IV	1
Environmental Sci IV	1	Research Scientist II/III	2
Medical Officer III	1	Staff Services Analyst	1
Pharmaceutical Consultant	1		7 total
Health Prog Specialst	1	**E. Health Alert Network**	
Staff Services Manager	1	Sr Information System Supvsr	1
Sr Accounting Officer	1	Information System Analysts	1
Associate Gov Analyst	4	Associate Info System Analysts	2
Office Technician	1		4 total
	15 total		
B. Surveillance & Epidemiology		**F. Health Risks & Health Info**	
Medical Officers II/III	3	Health Education Consultant III	1
Research Scientists II/III/ IV	12	Research Analyst II	1
Sr Information Systems Analysts	3	Staff Services Analyst	1
Associate Gov Analyst	2		3 total
Sr Sanitary Engineer	2		
Office Technician	1		
	23 total		
C. Laboratory Capacity--Biologic		**G. Education & Training**	
Microbiologist Specialists	3	Medical Officer III	2
Microbiologist I/II	11	Nurse Consultant III	1
Research Scientist IV	2	Associate Systems Analyst	1
Associate Gov Analyst	1	Associate Gov Analyst	1
Office Technician	1	Office Technician	1
	18 total		6 total

HRSA Grant Positions (18.8 total)	Positions		Positions
Priority Area 1—Program Direction		**Priority Area 3—Laboratory Connectivity**	
Staff Services Manager I	1	Health Program Specialist I	1
Health Program Specialist I	1.5		1 total
Research Analyst II	0.5	**Priority Area 4—Laboratory Data Standard**	
Associate Governmental Prog Analyst	2	Medical Officer III	2
Office Technician	1	Research Scientist III/IV	3
	6 total	Associate Governmental Prog	1
Priority Area 2—Regional Surge Capacity			6 total
Nurse Consultant II	1		
Associate Info Systems Analyst	1		
Health Program Specialist II	1.7		
Word Processing Technician	1		
Office Technician	1		
	5.7 total		

Second, the five-year bioterrorism grant provided by the Centers for Disease Control (CDC) used to fund 86 of the positions (i.e., 76 limited-term and 10 permanent) will expire on August 30, 2005 and a new multi-year grant will begin. The CDC has yet to finalize specifics on the requirements for the new federal grant funding cycle and it is unclear at this time when this guidance will be forthcoming to the states. As such, it is unclear as to whether all of the requested positions can be funded under the new cycle or whether the CDC will be changing its focus for states.

The table below summarizes the total funds received by the DHS to-date for both the CDC and HRSA grants.

Summary of DHS Funding (as of 12/30/04)	CDC Grant	HRSA Grant	TOTALS
1. Total Federal Funds Received (From 8/31/99 to 8/30/05)	**$195,152,000**	**$87,511,000**	**$282,663,000**
2. State Operations Total Amount	**$60,894,000**	**$35,017,000**	**$95,911,000**
Expenditures	$34,012,000	$12,550,000	$46,562,000
Encumbrances	$12,590,000	$8,403,000	$20,993,000
Remaining Balance	($14,292,000) 23.5 %	($14,064,000) 40.2%	($28,356,000) 29.6%
3. Local Assistance Total Amount	**$134,258,000**	**$52,494,000**	**$186,752,000**
Expenditures	$83,451,000	$3,272,000	$86,723,000
Encumbrances	$47,405,000	$42,532,000	$89,937,000
Remaining Balance	($3,402,000) 2.5%	($6,690,000) 12.7%	($10,092,000) 5.4%
4. Total Summary for the Grants	**$195,152,000**	**$87,511,000**	**$282,663,000**
Expenditures	$117,463,000	$15,822,000	$133,285,000
Encumbrances	$59,995,000	$50,935,000	$110,930,000
Remaining Balance (Not obligated)	($17,694,000) 9.1%	($20,754,000) 23.7%	($38,448,000) 13.6%

Third, the Legislative Analyst's Office (LAO) contends that the Administration overall, including the DHS, Office of Homeland Security (OHS), and others, lacks a unified strategic approach to homeland security, and that only 31 percent of the state's overall homeland security funds have been spent to date.

Specifically regarding the DHS, the LAO notes the following key aspects:

- The OHS, in collaboration with the DHS, should develop a comprehensive homeland security strategic plan and annual expenditure report.
- The DHS needs to expand its monitoring efforts regarding the expenditure of funds for the Local Health Jurisdictions. Though the DHS was provided with new positions in the Budget Act of 2004 to conduct financial and contract management activities for these grants, as well as to monitor Local Health Jurisdiction's expenditures, the LAO recommends for the DHS to include fiscal audits of Local Health Jurisdiction's grant expenditures. (The DHS states that more staff would be needed to do fiscal audits.)
- Since specifics regarding the CDC grant are still pending, the LAO withholds any comment on the DHS request for continuing the 94.8 positions which are expiring as of June 30, 2005.

Additional Information from the Administration Regarding a "Strategic Plan": The Administration has recently informed the Subcommittee that the Office of Homeland Security is drafting a "high level" statewide Strategic Plan for emergency preparedness that is to cover all sectors, including health care, emergency medical services and public health. The DHS will then provide input into this plan which is intended to serve as the overall Strategic Plan for the state.

Further, the DHS is to be undertaking a strategic planning process for public health emergency planning. According to the Administration, this DHS plan will be more detailed than the OHS plan as it pertains to public health. A group of stakeholders are working with the DHS to provide assistance in crafting the plan. According to the DHS, this workgroup includes local health departments and health officers, emergency physicians, hospitals, managed care organizations, clinics, and several state agencies.

Background—Overall Summary: The Emergency Supplemental Appropriations for Recovery & Response to Terrorist Attacks on the US Act (Public Law 107-117 of 2002), and subsequent federal legislation, provided states with additional federal funds to support and address both local and state concerns regarding the threat of bioterrorism.

Under this federal law there are two *key* funding streams made available to California—one from the federal Centers for Disease Control (CDC), and one from the federal Health Resources and Services Administration (HRSA). The CDC grant is in support of state and local public health measures to strengthen the state against bioterrorism via a "Cooperative Agreement" to the DHS. The HRSA grant is for the development and

implementation of regional plans to improve the capacity of hospitals, their emergency departments, outpatient centers, emergency medical systems and related matters.

The DHS notes that they are responsible for detecting and responding to bioterrorism acts. Regardless of source, surveillance of infectious diseases, detection, and investigation of outbreaks, identification of etiologic agents and their modes of transmission, and the development of prevention and control strategies are the responsibility of state and local public health agencies.

Existing State Statute: Existing statute provides a framework for the DHS to contract with, and allocate to, Local Health Jurisdictions for expenditure of bioterrorism funds (local assistance). Among other things, existing statute (1) requires the DHS to develop a plan with representatives of local governments for submittal to the federal government for receipt of the grant funds, (2) requires the DHS to develop a streamlined process for continuation of bioterrorism preparedness funding that will address any new federal requirements and will assure continuity of local plan activities, (3) enables the DHS to contract with public or private entities to meet the federally-approved bioterrorism plan and these contracts shall be exempt from the State Contract Act, and (4) enables the DHS to allocate these funds to Local Health Jurisdictions generally on a per capita basis.

Subcommittee Staff Comment and Recommendation: The federal bioterrorism funds clearly have been difficult for the DHS to administer. Some of this difficulty has been due to a lack of timely guidance by the federal CDC and to the way in which the funds have been provided to the state. However as noted by the LAO, as well as analyses conducted by other independent entities, the DHS needs to engage in a more comprehensive planning and expenditure process where clear outcomes are achieved. It does appears that this is beginning to occur.

Since grant application guidance, as well as the grant award, are still pending from the CDC, it is recommended to keep open the DHS' request to extend the 94.8 positions until the May Revision when hopefully more information is available.

With respect to the LAO recommendations, in lieu of requiring the DHS to perform fiscal audits of each Local Health Jurisdiction, it is recommended to request the Bureau of State Audits to conduct an audit of the state's entire bioterrorism program. Having an independent entity conduct an audit would be helpful and would not require additional DHS resources. Further, the DHS can always utilize its own Audits and Investigations Branch on an as needed basis if they believe a particular Local Health Jurisdiction warrants a fiscal audit or more detailed fiscal review.

It is also recommended to adopt the LAO recommendation to require the DHS to provide the Legislature and the public with an accounting of their expenditures. It is recommended to adopt "placeholder" trailer bill language for this purpose and to direct Subcommittee staff to craft compromise language (i.e., Administration, LAO, and both Subcommittee fiscal staff) for this purpose.

Questions:

1. DHS, Please provide a brief summary of the budget request regarding the need for the requested positions.
2. DHS, Please describe how the local assistance portion of both the CDC and HRSA grant funds are used by the Local Health Jurisdictions.
3. DHS, Please provide a brief status update of the pending CDC grant process. When is California supposed to hear from the CDC regarding application guidance *and* potential funding level?
4. DHS, What outcomes, accomplishments, or goals have resulted from these funds at both the state level, as well as the local level? (Please be specific.)
5. DHS, Specifically, how do you coordinate and monitor expenditures at the local level?
6. LAO, Please present your concerns.
7. DHS, What specifically is the Administration contemplating to address the concerns raised by the LAO?
8. DHS, How will you keep the Legislature informed as to when the CDC provides the state its new guidelines and allocation?

3. AIDS Drug Assistance Program (ADAP)

Issues: *First*, the budget proposes total expenditures of $263.6 million ($91.2 million General Fund, $100.8 million federal funds—Ryan White CARE Act grant, and $71.6 million in drug rebates) which reflects an increase of $18.8 million (total funds) over the current year.

However, due to one-time only adjustments to the ADAP Rebate Fund, a total of $56.2 million ($24.6 million General Fund and $31.6 million drug rebates) is requested as noted in the table (below). The proposed increase is based on actual ADAP expenditures through June 2004 and reflects ongoing cost trends for the program. It is estimated that ADAP will serve 30,446 clients in 2005-06.

Most HIV/AIDS drugs are still under patent protection, so manufacturers can set high prices for antiretroviral drugs which account for 84 percent of ADAP expenditures. Medications to combat opportunistic infections account for an additional 6 percent of ADAP.

Other principle cost factors for ADAP are steadily increasing drug prices and an increasing client caseload. Individuals enrolled in the ADAP often continue in the program for long periods since HIV/AIDS is a chronic illness, and other public and private healthcare are limiting prescription drug coverage.

Summary Table: AIDS Drug Assistance Program (Local Assistance)

Fiscal Year	General Fund	Federal Funds	ADAP Rebates	TOTALS
Budget Act 2004	$66.5 million	$100.8 million	$66.8 million	$234.1 million
• One Time Only			-$26.8 million	-$26.8 million
Revised Baseline	$66.5 million	$100.8 million	$40 million	$207.5 million
Proposed Increase	**$24.6 million**		**$31.5 million**	**$56.2 million**
Proposed 2005-06	**$91.2 million**	**$100.8 million**	**$71.5 million**	**$263.6 million**

Second, the Administration acknowledges that due to the traditional timing of the federal award for the Ryan White CARE Act funds (i.e., April) , as well as the collection of rebate funds, it is likely that the ADAP will be updated at the time of the Governor's May Revision. As such, the General Fund appropriation may need to be adjusted to reflect adjustments to the federal funds as well as the rebates. However the Administration states that ADAP has successfully collected mandatory drug manufacturer rebates over the last seven fiscal years, and in fact, has exceeded the anticipated level in more recent years. Further, it is anticipated that about the same level of federal funds will be awarded to California for ADAP expenditures (i.e., no increase per say is expected).

Third, the DHS is also seeking a state support increase of $230,000 (AIDS Drug Assistance Program Rebate Fund) to fund two state positions for the negotiation of price discounts and manufacturer rebates for ADAP drugs. As such, the total DHS state support budget for ADAP would be $1.430 million ($600,000 General Fund and $830,000 ADAP Rebate Fund).

Fourth, the DHS requested an analysis of the state's ADAP regarding several key areas including: (1) drug purchase model, (2) utilization management, and (3) formulary changes. The University-wide AIDS Research Program (UARP) conducted the state's analysis. Key findings from this analysis include the following:

- *Drug Purchase Models:* The average cost paid by state ADAPs nationally for key anti-retroviral medications does not relate in a statistically significant way to the manner in which the state ADAP Program is organized. Therefore, there is no evidence that California could reduce its drug acquisition costs by changing the purchasing model of its ADAP Program. However, California should explore means of obtaining additional discounts from pharmacies, in addition to rebates from manufacturers.
- *Utilization Management:* Among other things, the analysis noted that the DHS was going to implement a process to enroll prescribers. It is thought that this registration process may provide an opportunity for the ADAP Program to communicate to primary care providers about the cost of different regimens and drugs, and about ways to maintain clinical quality while at the same time reducing costs.
- *Formulary Changes:* Among other things, the analysis noted that 82 percent of ADAP expenditures are spent on anti-retrovirals and 7 percent are spent on opportunistic infections. As such, the potential for cost savings by dropping certain drugs is nominal. Further, dropping some of the drugs may result in substitution of other, possibly higher cost drugs that are retained on the formulary.

Background—ADAP Uses a Pharmacy Benefit Manager: Beginning in 1997, the DHS contracted with a pharmacy benefit manager (PBM) to centralize the purchase and distribution of drugs under ADAP**.** A new contract for this purpose is expected to be tentatively awarded at the end of March. Presently there are about 238 ADAP enrollment sites and about 3,309 pharmacies available to clients located throughout the state.

Background—ADAP Drug Rebates (Federal and State Supplemental): Both federal and state law require ADAP drug manufacturer rebates to be paid in accordance with the same formula by which state Medicaid (Medi-Cal) programs are paid rebates. This formula is established by the federal Center for Medicare and Medicaid (CMS). Due to federal restrictions regarding the rebate calculation formula, the actual calculation (i.e., the specific multiplier) is not available to the state or the public. *Therefore, the actual rebates that California actual receives varies by the amount invoiced to the drug manufacturer.*

In addition, California also negotiates additional "supplemental" rebates under ADAP via a special national taskforce, along with eight other states (representing the largest ADAP's in the country). The mission of this taskforce is to secure additional rebates from eight manufacturers of antiretroviral drugs (i.e., most expensive and essential treatment therapies). The rebate arrangements vary by manufacturer and may change annually or upon renewal of manufacturer agreements. These efforts have been very successful in the past. The DHS also notes that they have also begun to negotiate supplemental rebates on non-antiretroviral drugs.

The Omnibus health trailer legislation to the Budget Act of 2004 established a special account in which all ADAP drug rebates are now deposited. This was done in order to better track and account for the rebates, as well as to define the parameters for their expenditure.

Background—How Does AIDS Drug Assistance Program Serve Clients? ADAP is a subsidy program for low and moderate income persons (individual income cannot exceed $50,000) with HIV/AIDS who have no health care coverage for prescription drugs and are *not* eligible for the Medi-Cal Program. On average, ADAP clients access the program an average of 7.4 months per year.

ADAP is cost-beneficial to the state. Without ADAP assistance to obtain HIV/AIDS drugs, infected individuals would be forced to (1) postpone treatment until disabled and Medi-Cal eligible or (2) spend down their assets to qualify for Medi-Cal. About 50 percent of Medi-Cal costs are borne by the state, as compared to only 28 percent of ADAP costs.

Under the program eligible individuals receive drug therapies through participating local pharmacies under subcontract with the statewide contractor**.** The state provides reimbursement for drug therapies listed on the ADAP formulary (about 153 drugs currently). The formulary includes anti-retrovirals, opportunistic infection drugs, hypolipidemics, anti-depressants, vaccines, analgesics, and oral generic antibiotics.

Since the AIDS virus can quickly mutate in response to a single drug, medical protocol now calls for Highly Active Antiretroviral Treatment (HAART) which minimally includes three different anti-viral drugs. Studies consistently demonstrate that early intervention, minimizes more serious illness, reduces more costly treatments and maximizes an individual's productivity and health.

Subcommittee Staff Comment and Recommendation: Based on current information, it is likely that the DHS will obtain increased rebates under ADAP and that the federal Ryan White CARE Act funds will be about what California is presently receiving.

However, since ADAP is a caseload-driven program, the pharmacy benefit manager contract is still pending award, and the receipt of both federal funds and drug rebate funds will be clearer in a few weeks, it is recommended to hold this item open pending any additional May Revision adjustments. The awarding of the contract will likely provide additional detail regarding anticipated expenditures.

Questions:

1. DHS, Please provide a brief summary of the budget request.
2. DHS, Please describe key cost containment measures that have been recently implemented.
3. DHS, Please provide brief comments regarding the key aspects of the UARP report. Are there any additional cost-containment options which would not hinder ADAP client compliance with the drug regimen that the Administration is considering for implementation?

4. DHS, Please provide an update as to the pending status of the federal Ryan White CARE Act funds. Is it likely that California will receive about the same amount as presently noted in the Governor's proposed budget?

5. DHS, Please provide an update on the status of California's participation in the national taskforce's efforts to capture drug manufacture rebates. Is it likely that California will obtain about the same amount as presently noted in the Governor's proposed budget or more?

6. DHS, Please provide an update on the status of the ADAP pharmacy benefit manager contract.

4. Domestic Violence Shelter Program—Unserved and Underserved (U/U)

Issues: *First*, the Administration proposes an increase of $1.1 million ($515,000 General Fund, $235,000 Domestic Violence Training Fund and $350,000 in Nine West Settlement Funds) to restore funds used to assist shelters to serve communities of color, teens, disabled women and others that traditionally do not seek shelter services but are at high risk for domestic/intimate partner relationship violence. It should be noted that this is a direct service program and not an outreach program.

According to the DHS, they define "unserved and undeserved" populations with descriptors such as ethnicity, age, culture, sexual preference, language, literacy level, geography, physically challenged, and other criteria that inhibit access to services.

Second, it is not yet clear on how the DHS intends to allocate these unserved and underserved funds if approved for appropriation. Historically, a Request for Application was used to allocate these funds. Yet in more recent times, the funds have been allocated directly to the shelters for their use as they determine. As such, accountability on whether these funds were actually used to address needs has not always been monitored effectively.

The DHS has noted that they are presently conducting a survey to better determine and identify the needs in this area, and to vastly improve the monitoring and accountability of the expenditure of these funds for the purpose of better serving unserved and underserved communities.

Background on the Need for Unserved and Underserved Funds: Anecdotal information supports that some populations who are experiencing domestic violence do not generally access shelters as often as other populations. For some communities, the use of shelter programs and the identification with domestic violence are not culturally relevant or appropriate. Although one's sexual preference, culture, poverty and age are not causes of domestic violence, some communities have unique cultural differences, differing traditions and beliefs, and speak different languages that need to be taken into account when working with these communities.

It is well recognized that societal problems related to domestic violence must be addressed in a comprehensive and multi-faceted manner to gain a full appreciation of the complex role that culture plays in program development and service delivery.

Subcommittee Staff Comment: Since the DHS is still awaiting the results of their survey, the Subcommittee may want to hold this item open pending the results of the survey and clearer direction on how the funds are to be allocated.

Background—Domestic Violence Shelter Program: A total of $22.9 million ($22.3 million General Fund) is proposed for the DHS program. Of this amount, (1) $21.3 million is allocated to 97 shelters for services, (2) $262,00 is for data management and a women's health survey, (3) $85,000 is for technical assistance and training as required by statute, and (4) $1.1 million is for unserved/underserved individuals. The existing program was established in statute in 1994 (AB 167, Freidman).

It should be noted that as a condition of receiving funds, shelters must, among other things, provide matching funds or in-kind contributions equivalent to not less than 20 percent of the grant they would receive.

Questions:

1. DHS, Please describe how these funds can provide a vital linkage to communities.
2. DHS, Please briefly describe how the department conducts over sight for this program.
3. DHS, Please provide an update on the status of the survey and its intended use.
4. DHS, When will you have a more definitive idea as to how the funds will be allocated and what type of monitoring and accountabilities will there be with these funds?

5. New Born Screening Program Adjustments

Issue: SB 142 (Alpert), Statutes of 2004, expanded the existing Newborn Screening Program from 39 conditions to 76 conditions through the use of Tandem Mass Spectrometry. This expansion is the product which resulted from a Pilot Project (AB 2427, Kuehl, Statutes of 2000) which operated from January 2002 through June 2003. The pilot ended when one-time funding from the Genetic Disease Testing Fund was expended.

To fund this expansion effort, the DHS is requesting an increase of $15 million (Genetic Disease Testing Fund) to (1) support three new positions, and (2) purchase $14.8 million in equipment and related services, including Tandem Mass Spectrometry equipment and software, laboratory services, and information processing system modifications.

The three requested positions include one Public Health Chemist, one Research Scientist IV, and one Staff Services Analyst.

The enabling statute provided the DHS with authority to increase fees for this program, if required for the expansion effort. As such, the DHS is proceeding with emergency regulation authority to increase the fee from $60 to a total of $78, effective January 1, 2005.

According to statute as contained in SB 142 (Alpert), Statutes of 2004, the expanded program is to be up and operational by August 1, 2005.

Background—Newborn Screening Program: The Newborn Screening Program screens about 525,000 infants, or 99 percent of the annual births, in about 325 maternity hospitals. Newborns are screened for a series of heritable preventable metabolic disorders. At the time of birth, the heel of the infant is pricked and a drop of blood tested for different disorders. Birth defects often have no immediate visible effects on a baby but unless detected and treated early, can cause physical problems, mental retardation, and death.

When test results are abnormal, early diagnosis and proper treatment can make the difference between lifelong impairment and healthy development. Further, significant cost savings can be achieved through early detection and in some cases, simple dietary treatment of some disorder. Cost benefit analyses have found that expanded newborn screening produces significant net benefits. The DHS estimates that for every dollar spent on expanded screening, two dollars and fifty-nine cents ($2.59) is saved in average lifetime medical costs alone.

All screening is fee supported and is voluntary. Fees are collected from individuals, their health insurance, hospitals, birthing centers and the Medi-Cal Program. All fee collections are deposited in the Genetic Disease Testing Fund.

Subcommittee Staff Comment and Recommendation: The proposal is consistent with the enacted legislation. It is recommended to approve as budgeted.

Questions:

1. DHS, Please describe the budget request to fund the three positions and to purchase equipment and related services (including all of the contracts).
2. DHS, Please provide a comprehensive update on the status of the different implementation aspects for expanding the program as required.
3. DHS, What is the status of the emergency regulations to increase the fees?
4. DHS, Please provide comment regarding the fund condition statement for the Genetic Disease Testing Fund. What level of revenues and expenditures is the DHS projecting?

6. Richmond Laboratory—Phase III

Issue: The budget reflects a *net* savings of $1.640 million ($820,000 General Fund) for implementation of the "Phase III Office Building" of the Richmond Laboratory which is scheduled for completion by March 2005. This net savings reflects the interaction of savings from rent related to a building move and potential expenditures related to operating the new building.

The DHS states that occupancy of the new building will begin in late 2004-05 with the relocation of 170 staff from the DHS' old facility. This initial relocation is to be accomplished with existing funds. In 2005-06, the majority of the 625 staff will be moved from various leased space into the new building during the Summer of 2005.

Specifically, this budget-year proposal consists of a request to establish 6 new state positions and to fund certain operating equipment.

The proposed *net savings* result from the following adjustments:

- *Savings of $3.629 million* ($1.8 million General Fund, and $1.8 million in various special funds) from reduced rent due to the vacated lease from the old building.
- *An increase of $2 million* ($996,000 General Fund, and $979,000 special funds) for the following adjustments:
    - $457,000 ($229,000 General Fund, and $228,000 special funds) to support 6 new state positions. This includes the following personnel: (1) an Office Building Manager I, (2) a Staff Services Analyst, (3) three Stationary Engineers, and (4) an Office Technician. This also includes their operating expenses.
    - $77,000 one-time only for the purchase of equipment, including (1) electric carts (2 carts at $8,000 each), (2) various ladders, tools and tool carts ($5,000), (3) parking lot lighting repair service unit (1 at $50,000), and (4) electronic security cameras (3 at $2,000).
    - $188,000 for a moving contract.
    - $350,000 for utilities.
    - $917,000 for other contracts including landscaping, janitorial and security.

The DHS states that of the $2 million increase, $1.7 million will be on-going and $265,000 will be one-time only.

Additional Background Information: According to the DHS, the construction of the 200,000 square foot building is to be completed as of June 2005.

Presently there are 46.6 DHS maintenance staff that manage the Richmond Laboratory complex. The 6 new positions being requested would be an addition to this staff.

Questions:

1. DHS, Please describe the proposal and the need for the expenditures.

Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda

Chair, Senator Denise Moreno Ducheny
Senator George C. Runner
Senator Tom Torlakson

Thursday, March 17, 2005
(Upon Adjournment)
John L. Burton Hearing Room (4203)
Consultant, Anastasia Dodson

Item	Department	Page
5160	Department of Rehabilitation	1
7100	Employment Development Department	1
5180	Department of Social Services	
	Supplemental Security Income/State Supplementary Payment (SSI/SSP)	5
	In-Home Supportive Services (IHSS)	8

Due to the volume of issues testimony will be limited. Please be direct and brief in your comments so that others may have the opportunity to testify. Written testimony is also welcome and appreciated. Thank you for your consideration.

Please Note: Only those items and issues contained in this agenda will be discussed at this hearing. Issues pertaining to these items may be reviewed again. Please see the Senate File for dates and times of subsequent hearings.

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

5160 Department of Rehabilitation (DOR)
7100 Employment Development Department (EDD)

DOR Issue 1: Economic Engagement: Employment Services for Persons with Disabilities – Information Only

Description: People with disabilities are more likely to be unemployed and low-income than people without disabilities. According to the Governor's Committee on Employment of People with Disabilities, "The employment profile of Californians with disabilities … is one of a minority population in need of the right opportunities and supports to obtain employment and enjoy what most people take for granted---a life of self-sufficiency and independence."

While significant efforts have been made to improve state employment programs for persons with disabilities, further efforts for youths may be needed. In addition, the federal Ticket to Work program, which funds employment services for people with disabilities, has been significantly underused due to structural problems at the federal level.

Background:

- **Number of Persons with Disabilities, Unemployment Rates and Poverty:** Although exact figures vary due to differences in how disability is defined, current research consistently indicates that:

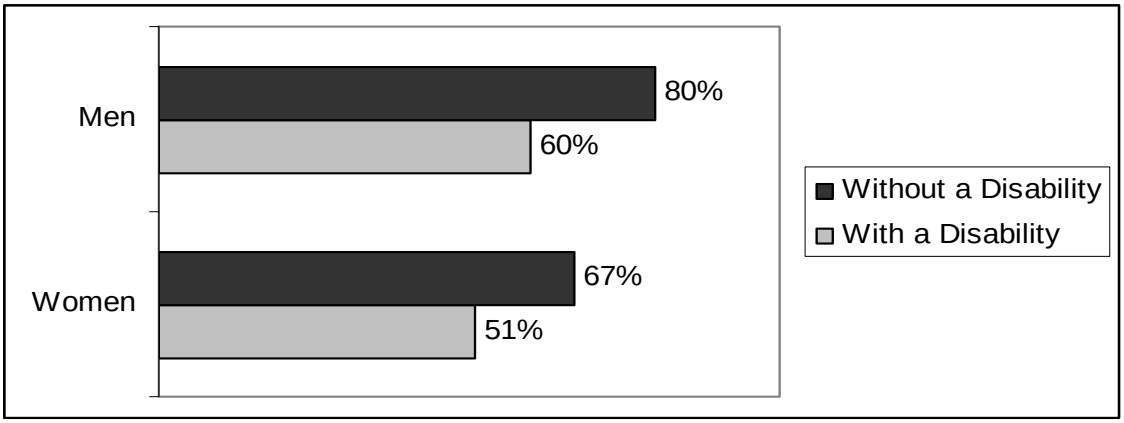
    - Persons with disabilities are much less likely to be employed than those without disabilities. Employment rates are lowest among those with a self-care disability or with both physical and mental disabilities.

    - Even if employed, persons with disabilities have lower earnings than those without disabilities. Overall, persons with disabilities have a much higher likelihood of poverty than those without disabilities.

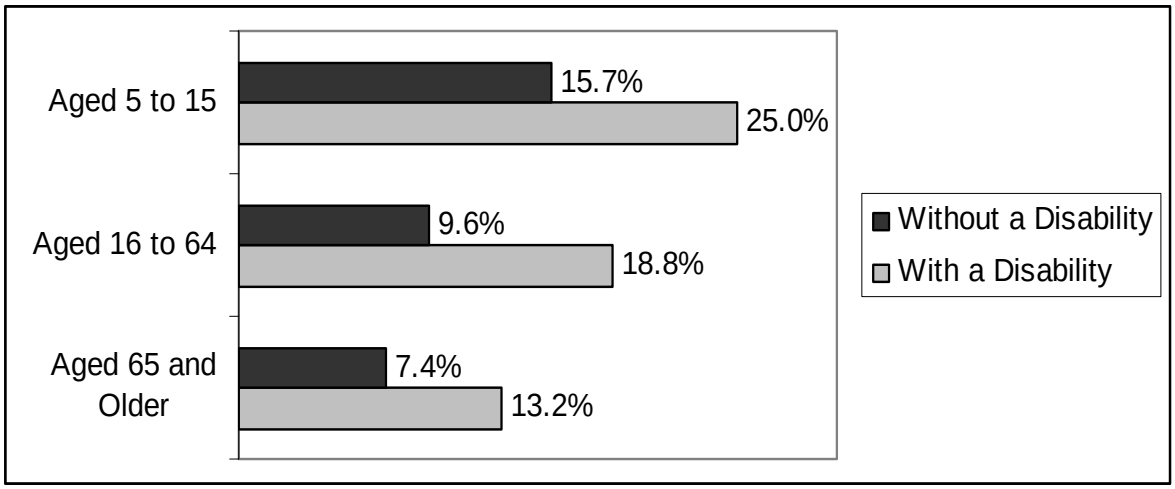
- **According to US Census Bureau figures for 2000**, 19.2 percent of Californians report some type of disability, including 2.5 percent with a self-care disability. Among Californians aged 16 to 64, 12.8 percent report an employment disability.

  The charts below show national employment and poverty statistics for persons with and without disabilities.

Employment Among Persons in the US Aged 16 to 64 (US Census 2000)



Poverty Rates Among Persons in the US Aged 5 and Older (US Census 2000)



- **Employment Barriers for Persons with Disabilities:** Several factors tend to limit employment, and affect both employees and employers:

  - **Competitive Job Market:** Limited opportunities in an increasingly competitive job market.
  - **Skills:** Limited access to programs that teach the necessary skills to meet industry standards required by a competitive job market.
  - **Health Insurance:** Concerns about securing or retaining health coverage to provide the comprehensive healthcare necessary to live independently and participate fully in the workforce.
  - **Personal Care Assistance:** The need for personal care assistance in the workplace.
  - **Supportive Services:** The need for services such as transportation, child care, and housing.
  - **Workplace Liability**: Concerns regarding potential liability or increased workers' compensation costs.

- **Workplace Accommodation:** Concerns that the possible cost of accommodation would be prohibitive.

- **Employment and Public Benefits Are Not Incompatible:** The two primary federal grant programs for persons with disabilities, Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI), require that applicants initially prove they cannot work. However, if recipients later want to work, they can continue receiving reduced grant benefits during a nine-month trial work period, and continue receiving health benefits through Medi-Cal in many cases even after the trial work period ends.

- **Ticket to Work Program:** Under the federal Ticket to Work program, qualified SSDI and SSI beneficiaries receive a "Ticket" in the mail. They may use their Ticket to obtain vocational rehabilitation, employment or other support services from an approved provider of their choice to help them go to work and achieve their employment goals. In the initial roll-out, Californians received their Tickets between November 2003 and September 2004. Tickets continue to be issued to new beneficiaries.

  Of the 985,601 job training "Tickets" mailed to Californians with disabilities, only 5,564 have been brought to an employment services provider and assigned. This low utilization rate is comparable to other states. Approximately 80 percent of the assigned Tickets in the state have been served through the Department of Rehabilitation (DOR) Vocational Rehabilitation program.

- **Vocational Rehabilitation (VR):** The DOR operates the VR program, funded primarily with federal funds, to provide vocational services to persons with disabilities. Due to limited funding, the VR program operates under an Order of Selection, which means that persons with the most severe disabilities are served first.

  The Governor's Budget includes $325.5 million to serve 123,000 consumers in 2005-06. This funding includes $12.5 million in anticipated federal Social Security Administration reimbursement for VR services provided to approximately 1,000 consumers that are expected to achieve earnings above the SSI or SSDI level for at least nine months.

- **One-Stop Career Centers:** The Employment Development Department (EDD) operates over 250 One-Stop Career Centers throughout the state that provide employment and training services to persons with and without disabilities. At least one One-Stop Center in each of the 50 Local Workforce Investment Area must be fully accessible for persons with disabilities.

  The department indicates that about 1.4 percent of the 758,000 participants in the Job Service program in 2003-04 self-identified as having a disability. Approximately 9.5 percent of the 76,200 participants in Workforce Investment Act training programs in 2003-04 had disabilities. Participants with disabilities were less likely to be

employed when exiting the program than participants without disabilities. This was particularly true for older youth with disabilities.

- **AB 925 and Governor's Committee on Employment of People with Disabilities:** AB 925 (Aroner, Chapter 1088, Statutes of 2002) established a number of changes to increase employment among persons with disabilities. Overall, this bill required the Health and Human Services Agency and the Labor and Workforce Development Agency to create a sustainable, comprehensive strategy to accomplish various goals toward increasing employment among persons with disabilities. AB 925 designated the Governor's Committee on Employment of People with Disabilities to lead the state in implementing AB 925.

- **Ongoing Challenges for Employment Services Programs**

    - **Ticket to Work Program Improvements Needed:** The US Government Accountability Office (GAO) recently reported on implementation problems and improvements needed to increase the use of this program. The GAO found that inadequate incentives for service providers and beneficiaries to participate, limited marketing, and other factors have hindered the program's success. Less than 1 percent of Ticket holders nationwide have used their Tickets, and only about 160 Ticket holders have had sufficient earnings to result in discontinuance of their disability benefits.

    - **Youth with Severe Disabilities:** Youth with severe disabilities who receive cash assistance through SSI face a difficult choice when they move to adulthood. When they turn 18, young people on SSI will be reevaluated to see if they still quality for cash benefits. Those who decide to try to prove that they can't work may be making a choice of a lifetime of cash assistance at a very young age. The either/or nature of the SSI program makes the transition very challenging for young people with disabilities and their families. (From "Five Questions" interview on Urban Institute website with Pamela Loprest, Senior Research Associate in the Urban Institute's Income and Benefits Policy Center).

Questions:

1. Berkeley Center for Independent Living: Please briefly comment on unemployment and poverty rates for persons with disabilities.

2. DOR: Please briefly describe the latest utilization figures for the Ticket to Work program, the state's efforts to increase Californians' use of the program.

3. EDD: Please briefly describe the department's efforts to enhance One-Stop Center staff training to assist persons with disabilities.

5180 Department of Social Services (DSS)

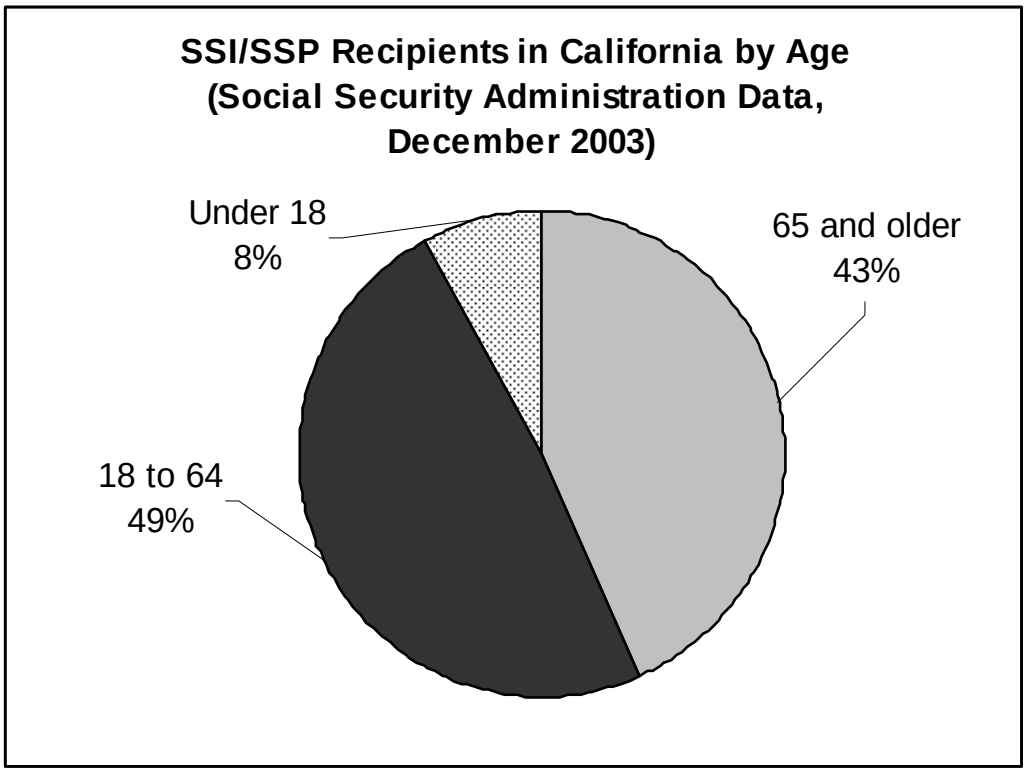
DSS Issue 1: Suspend State and Federal COLAs for Supplemental Security Income/State Supplemental Payment (SSI/SSP) – Information Only

Description: The Governor's Budget proposes to withhold the January 2006 state and federal Cost of Living Adjustments (COLAs), for savings of $229 million General Fund in 2005-06, and $458 million General Fund annually.

Background:

- **SSI/SSP Program Description:** The SSI/SSP program provides cash grants to persons who are elderly, blind and/or too disabled to work and who meet the program's federal income and resource requirements. Beneficiary grants generally reflect the maximum grant less any offsetting income from Social Security or other sources. The SSI/SSP program is primarily administered by the federal Social Security Administration.

- **Maximum and Average Grant Amounts:** As of April 2005, the maximum grant will be $812 per month for an aged or disabled individual living independently, and $1,437 per month for an aged or disabled couple living independently. The Governor's Budget projects the average grant for a disabled individual will be $618 per month in 2005-06.



- **SSI/SSP Funding and Caseload:** The SSI portion of the grant is federally-funded, and the SSP portion of the grant is state-funded. The budget estimates total funding for SSI/SSP will be $8.6 billion ($3.44 billion General Fund) in 2005-06. The budget projects SSI/SSP average monthly enrollment will grow by 2.4 percent, from 1,189,000 in 2004-05 to 1,216,000 in 2005-06.

- **Annual COLA Adjustments**: Under current law, both the federal and state grant payments for SSI/SSP recipients are adjusted for inflation each January through Cost of Living Adjustments (COLAs). Federal law provides an annual SSI COLA based on the Consumer Price Index, and state law provides an annual SSP COLA based on the California Necessities Index.

- **Governor's Budget Proposals:** The Governor's Budget proposes to withhold the January 2006 2.3 percent federal SSI COLA, for savings of $84.7 million General Fund in 2005-06, and $169.4 million annually. This is achieved by reducing the state SSP component of the grant by the same amount as the January 2006 SSI COLA. The budget also proposes to suspend the January 2006 4.07 percent state SSP COLA, for savings of $144 million General Fund in 2005-06, and $288 million General Fund annually.

  The Administration indicates that even with these actions, California continues to provide the highest level of cash grants to SSI/SSP recipients among the ten most populous states.

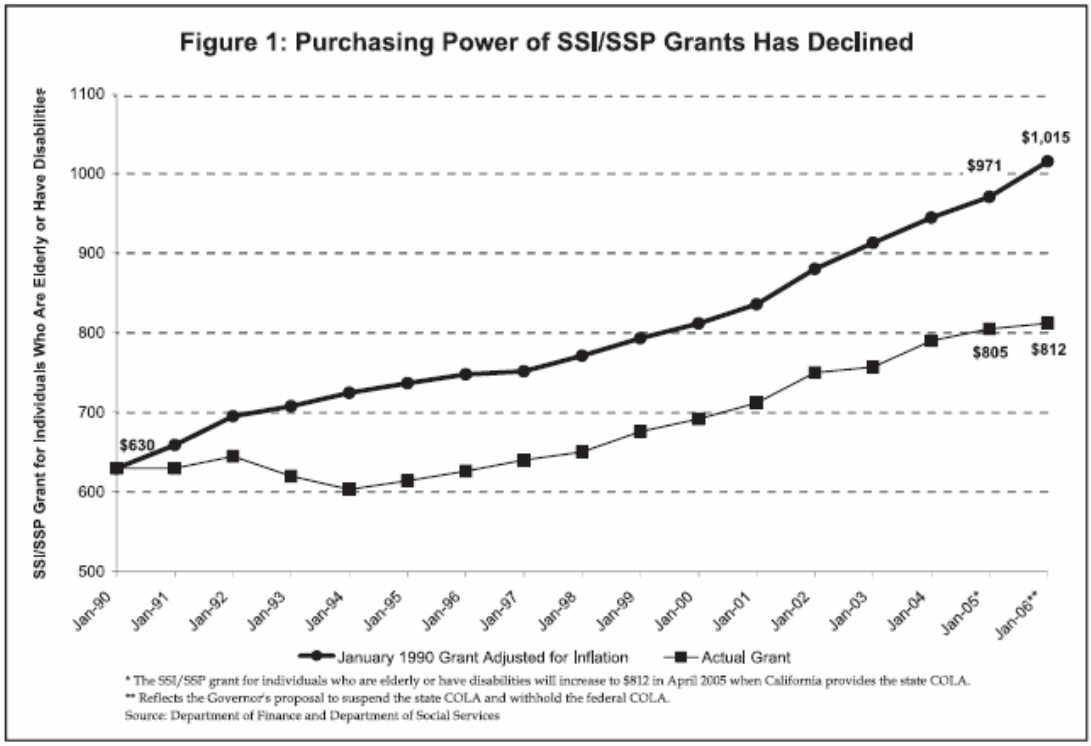
  The January 2006 COLAs proposed for suspension would have increased the maximum grant for an individual by approximately $33, to $845 per month, and would have increased the maximum grant for a couple by approximately $58 to $1,495 per month. The LAO estimates that approximately 1,200 SSP-only recipients would become ineligible for SSP under this proposal. Becoming ineligible for SSI/SSP may result in a Medi-Cal share of cost for affected individuals.

- **Eroding Value of SSI/SSP Grant:** Grant levels have not kept pace with inflation in recent years due to the suspension of the January 2004 SSP COLA and the deferral of the January 2005 COLA until April 2005. Suspension of the January 2006 COLAs would further erode the ability of grant payments to keep pace with cost of living increases, such as rising food, housing, and transportation costs.

  Since 1990, rent prices have increased by 36 percent and the SSI/SSP purchasing power has declined by 18 percent. Without the COLA, beneficiaries will face additional pressure to reduce spending on food or utilities as housing costs increase.

  In addition, California's SSI/SSP beneficiaries are ineligible for Food Stamps benefits, due to the state's "cash-out" policy. California is the only state in which SSI/SSP recipients are ineligible for Food Stamps under this policy.

  The chart below, prepared by the California Budget Project, shows the decline in the purchasing power of SSI/SSP grants since 1990.



Although the SSI/SSP grant level is higher in California than other states, housing costs in California are also higher than in other states. The fair market rent for a studio apartment exceeds the SSI/SSP grant in 10 counties in California, and exceeds 50 percent of the grant in all but two counties. According to the U.S Department of Housing and Urban Development, fair market rents for a studio apartment in California average $772 per month, and range from $376 in Siskiyou County to $1,000 in San Mateo and San Francisco Counties.

State	Studio	1 Bedroom	2 Bedroom
California	**$772**	**$902**	**$1,104**
Ohio	$440	$505	$628
Pennsylvania	$522	$596	$719
Michigan	$532	$587	$706
Texas	$531	$590	$720
Illinois	$602	$696	$803
Georgia	$601	$651	$734
Florida	$601	$674	$799
New York	$767	$832	$945
New Jersey	$810	$905	$1,058

As a result, when California's grants are compared to housing costs, California's grants are comparable to other large States.

State	Studio	SSI/SSP Grant for Individual	Grant/Rent
California	**$772**	**$812**	**105%**
Ohio	$440	$579	132%
Pennsylvania	$522	$606	116%
Michigan	$532	$593	111%
Texas	$531	$579	109%
Illinois	$602	$579	96%
Georgia	$601	$579	96%
Florida	$601	$579	96%
New York	$767	$666	87%
New Jersey	$810	$610	75%

Questions:

1. DSS, please present the proposal.

2. DSS, how would this proposal affect recipients? How would recipients pay for cost increases in rent, food, and utilities?

DSS Issue 2: Reduce State Participation to Minimum Wage for In-Home Supportive Services (IHSS) – Information Only

Description: The Governor's Budget proposes to reduce the level of state participation in IHSS provider wages and benefits from $10.10 per hour to the state minimum wage ($6.75), to achieve General Fund savings of $195 million in 2005-06, and $260 million annually. Although the extent to which counties would reduce wages is unknown, a reduction in wages could potentially result in additional General Fund costs for the Medi-Cal, Healthy Families, and CalWORKS programs. Reduced wages would also likely result in increased provider turnover, which may reduce the quality of care for IHSS consumers and lead to increased institutionalization. Further, to the extent that wages are reduced and fewer IHSS providers are available, this proposal may result in legal action against the state under federal Medicaid statute that requires sufficient provider access.

Background:

IHSS Program Description: The IHSS program funds personal care services for low-income aged, blind or disabled individuals that are at risk for institutionalization. IHSS services include domestic services (such as meal preparation and laundry), nonmedical personal care services,

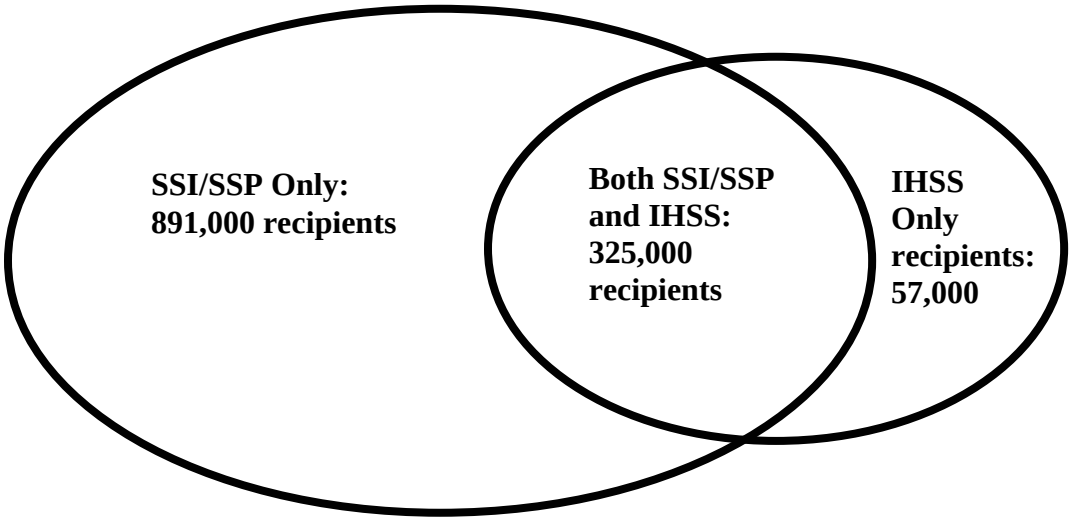
paramedical services, assistance while traveling to medical appointments, teaching and demonstration directed at reducing the need for support, and other assistance. Services are provided through individual providers hired by the consumer, county contracts with service providers, or through welfare staff. County welfare department staff visit consumers in their homes to determine the number of authorized hours of service per day.

Enrollment Summary: The budget estimates that IHSS enrollment will increase to 382,000 in 2005-06, an increase of 7.7 percent over 2004-05 caseload. Approximately half of IHSS consumers are age 65 and older. Persons with developmental disabilities constitute more than 12 percent of the IHSS caseload.

IHSS Consumer Age	Percent of Total Caseload (as of December 2001)
1-17	5.2%
18-44	17.0%
45-64	27.9%
65-74	25.8%
75-84	18.6%
85+	5.5%

IHSS and SSI/SSP Caseload Overlap: In a January 2003 report, based on February 2002 data, the DSS reported that 85 percent of IHSS recipients were also SSI/SSP recipients. In that report the department also noted that about 90 percent of recipients who receive both SSI/SSP and IHSS are living independently. This is different from the overall SSI/SSP population, in which about three-quarters of all recipients are living independently.

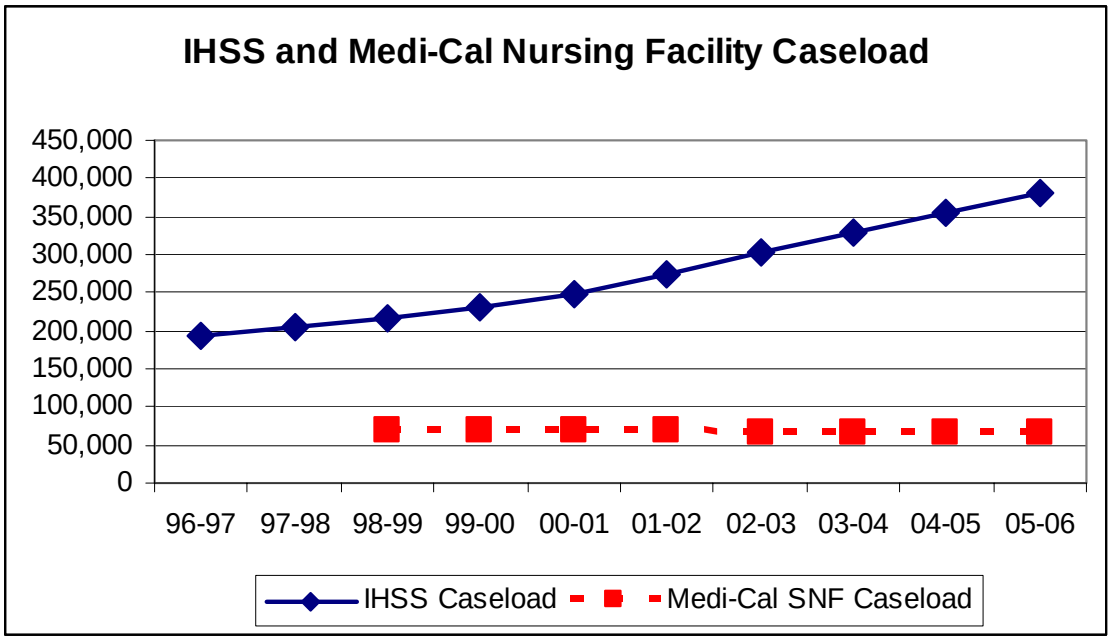
The Venn diagram below shows the overlap between IHSS and SSI/SSP caseload, using the February 2002 ratios, updated for 2005-06 estimated caseload. Note: Diagram is not drawn to scale.



Funding Summary: IHSS program costs are currently shared as follows: 50 percent federal funds, 32.5 percent state General Fund, and 17.5 percent county funds. The budget proposes $3.2 billion ($1.02 billion General Fund) for the IHSS program in 2005-06. This represents a decline of $513 million ($160 General Fund) below the current year funding level. The decline is due to proposed provider wage participation reductions of $195 million General Fund, offset by an increase in funding to reflect caseload growth.

IHSS General Fund costs have more than doubled from $527 million in 1998-99 to $1.2 billion in 2004-05, despite $231 million in additional federal funds from a recent federal Medicaid waiver for part of the program. Nonetheless, the average annual cost per individual (approximately $10,300 total funds in the current year) is still less than one-fifth the cost of nursing home placement in total funds.

The program's growth rate has been fueled by multiple factors, including the establishment of a state entitlement for personal care services, population increases, an increase in the proportion of IHSS consumers who are severely disabled, greater utilization of service hours by case, and higher provider rates. In addition, a programmatic shift to support the elderly and persons with disabilities in community settings have increased the number of beneficiaries. In 1998, 92 percent of long-term care recipients lived in their own homes or in a community setting, while the remaining 8 percent were in institutions such as nursing homes or developmental centers. As the table below shows, Medi-Cal nursing home caseload has remained flat in recent years while IHSS caseload has increased.



Current Wage Rates: The state has participated in IHSS provider wages above the minimum wage since 1999-2000. In the current year the state participates in wages up to $10.10 per hour, although each county's wage rates are determined by the board of supervisors and public authority that negotiates a contract with providers. Ninety-three percent of IHSS providers are currently paid more than minimum wage.

Provider Summary: As of February 2005, there were approximately 290,000 IHSS providers in California, according to the Making Homecare a Better Job Report. According to a DSS report from October 2000, about 43 percent of IHSS providers are immediate family members. According to an October 2001 DSS report, approximately 7 percent of IHSS providers receive assistance through the California Work Opportunity and Responsibility to Kids (CalWORKs) program. Approximately 145,000 providers were eligible for and approximately 53,000 were enrolled in health insurance offered by their county or public authority.

Governor's Proposed Reduction: The Governor's Budget proposes to reduce the level of state participation in IHSS provider wages and benefits. Effective July 1, 2005 state participation in 11 counties (comprising 57 percent of IHSS providers) would be reduced to the wage and benefit levels in effect on June 30, 2004. The budget reflects savings of $43 million General Fund for this proposal. Effective October 1, 2005, state participation in IHSS wages and benefits would be limited to minimum wage ($6.75 per hour). The budget reflects savings of $152 million General Fund for this proposal. These two proposals would result in General Fund savings of $195 million in 2005-06, and $260 million annually.

The Administration points out that counties have the option of reinvesting local savings ($112 million from 2004-05 and $93 million from 2005-06) obtained under the recent IHSS federal waiver, to maintain existing wage and benefit levels. The Administration also indicates that this reduction would avoid more severe reductions in services.

The Governor's Budget does not include any changes to IHSS caseload, or caseload or costs for any other program, as a result of the proposed reduction in state participation for IHSS provider wages. The DSS indicates that information is not available to determine how the counties or the providers would respond to this change.

Affected Counties:

- **Above Minimum Wage:** 93% of all IHSS providers statewide are currently paid more than the state's minimum wage level of $6.75 per hour. That 93% statistic covers providers in the following 38 counties: Alameda, Alpine, Amador, Butte, Contra Costa, El Dorado, Fresno, Glenn, Los Angeles, Marin, Mendocino, Merced, Mono, Monterey, Napa, Nevada, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Sierra, Solano, Sonoma, Stanislaus, Ventura, Yolo, and Yuba.

- **At Minimum Wage:** 7% of all IHSS providers statewide are currently paid $6.75 per hour. These IHSS providers are in the following 20 counties: Calaveras, Colusa, Del Norte, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Mariposa, Modoc, Shasta, Siskiyou, Sutter, Tehama, Trinity, Tulare, and Tuolumne.

- **2004-05 Wage Increases:** 11 counties, comprising 57.3% of statewide IHSS providers, have increased wages and/or benefits since June 30, 2004 and would, therefore, be

affected by the July 1, 2005 rollback of state sharing: El Dorado, Fresno, Los Angeles, Mendocino, Placer, Riverside, San Benito, San Diego, San Luis Obispo, Ventura, and Yuba.

- **Collective Bargaining Agreements:** 28 Public Authority counties, representing 89.62% of statewide IHSS providers, have a binding collective bargaining agreement with the exclusive union that represents IHSS providers. San Diego County has the latest expiration date on their collective bargaining agreement (January 31, 2008).

    - **County Protection:** 22 of those Public Authority counties have adopted some form of county protection within the local ordinance or collective bargaining agreement that addresses potential changes in state or federal sharing levels in IHSS wages and/or benefits. Those local protection provisions fall into two categories:

        - re-opener language that requires a meet and confer process without specifying outcomes
        - or specific language that would modify wages and/or benefits if state or federal funding is diminished.

    - **No County Protection**: 6 of those Public Authority counties have not adopted or established any county protection provisions within their ordinances or collective bargaining agreements if state or federal funding levels are changed. Those counties are Alameda, Contra Costa, Mendocino, San Francisco, Santa Clara, and Santa Cruz.

- **No Collective Bargaining Agreement:** 30 counties have not adopted any collective bargaining agreement over IHSS wages or benefits. 10 of these counties have adopted an IHSS wage that is higher than $6.75 (7 counties pay $7.11 per hour and 3 counties pay $6.95 per hour). Most are currently involved with the collective bargaining process. Four counties (Glenn, Lassen, Modoc and Mono) have not completed the election to establish an exclusive (union) representative for IHSS providers and, therefore, cannot yet engage in the collective bargaining process.

Issues Raised Regarding Governor's Budget Proposal:

- **County Cost Pressures:** If all counties were to maintain wages at current levels, the Governor's Budget proposal would result in annual costs to the counties of $260 million, over $100 million more than the annual anticipated savings to counties from the IHSS federal Independence Plus waiver that was approved in July 2004. Moreover, counties have expressed concern that this savings is based on a five-year limited-term waiver, which is subject to federal renewal.

  Furthermore, the county share of IHSS is funded through state-local realignment monies, which have not kept pace with caseload costs. Realignment revenue growth is over one year behind caseload growth: the 2003-04 revenue growth of $134 million was used to

fund the remaining portion of 2001-02 caseload growth and a portion of the 2002-03 growth. A total of $276 million in unfunded caseload growth remains ($128 million in 2002-03 and $148 million in 2003-04).

In addition, Proposition 1A reduced local government funding in 2005-06 by $1.3 billion. Although this shift is temporary, the combined effect of the Governor's Budget IHSS proposal, the $1.3 billion temporary reduction, and the lagging realignment funding puts pressure on counties to reduce IHSS wages in 2005-06.

- **Federal Medicaid Provider Rate Implications:** Federal law sets certain requirements for Medicaid provider rates that may apply to the IHSS program, as the IHSS program is funded with 50 percent federal Medicaid funds. The central provision of federal law that may affect IHSS provider rates is 42 U.S.C. Section 1396a(a) (30) (A) ("Section 30(A)," which requires a Medicaid State Plan to:

> Provide such methods and procedures related to the utilization of, and the payment for, care and services available under the plan… as may be necessary… to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

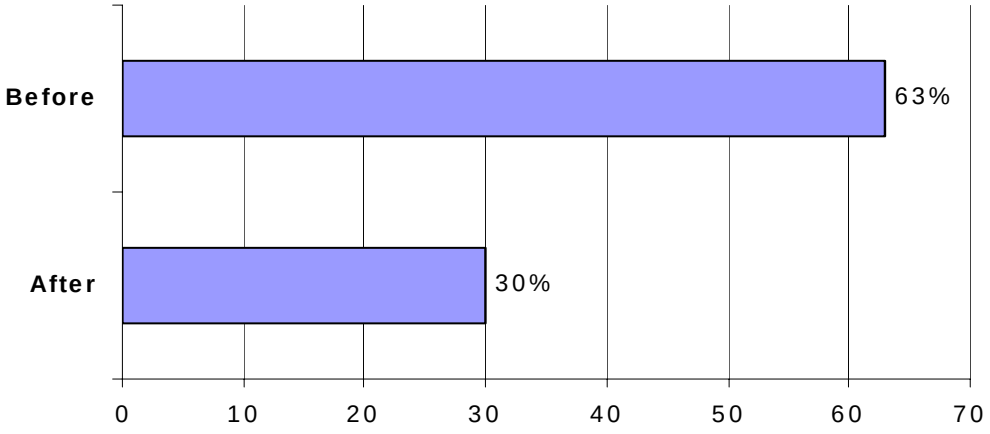
In *Clayworth v. Bonta*, the state has thus far been prevented from implementing a 5 percent Medi-Cal fee-for-service provider rate reduction, due a finding related to Section 30(A). In a December 2003 ruling, the U.S. District Court found that, "Because the State failed to consider the effect of a rate reduction on beneficiaries' equal access to quality medical services, in view of provider costs, the pending rate reduction is arbitrary and cannot stand."

- **Provider Turnover and Supply, Quality of Care, and Olmstead Compliance:**

Note: A number of research studies have looked at various aspects of the IHSS program and other long-term care issues. The findings of many of these studies, and their applicability to potential budget reductions, are summarized in a May 2004 briefing paper prepared by the California Policy Research Center. Findings relevant to the 2005-06 Governor's Budget proposal are discussed below. The briefing paper and specific source for the research outcomes discussed below may be found at: http://www.ucop.edu/cprc/boris.pdf

Research indicates that provider turnover has been reduced where wages have risen. For example, when IHSS wages rose from the minimum wage to $10.10 per hour in San Francisco, turnover decreased by 24 percent, and the supply of homecare workers doubled for both family and nonfamily providers.

San Francisco Turnover of New Providers
Before and After Wage and Benefit Increases



Currently 27 percent of all IHSS providers leave their jobs every year, including 35 percent of non-family providers and 22 percent of family providers. Based on a recent 5-county survey[1], nearly half of the providers surveyed believed it would be possible to find another job with wages and benefits comparable to their current pay. This survey also found that nearly half of all providers surveyed believed it would be possible to find another job with wages and benefits comparable to their current pay, and if wages fell below current levels at least 12,000 providers would look for other jobs.

Furthermore, other research has linked consumer satisfaction and positive outcomes with lower turnover. To the extent that reducing wages has the opposite effect, and increases provider turnover, quality of care may be reduced.

Research also indicates that if family providers shift to outside employment and nonfamily providers are hired instead, nursing home admissions and homecare nurse visits may increase. To the extent that wages are reduced and nonfamily providers are hired instead, additional Medi-Cal costs may result from the Governor's proposal.

In a 2001 report, the DSS projected a widening gap between IHSS providers and consumers. In 2000 the ratio of consumers to providers was roughly 1.2:1. This could increase to 1.4:1 by 2020 and to 1.8:1 by 2040. If counties reduce wages, this gap may widen.

Finally, an IHSS wage reduction may affect California's compliance with the July 1999 Supreme Court *Olmstead v. L. C.* decision. This decision interpreted Title II of the Americans with Disabilities Act and its implementing regulation, requiring States to

[1] Survey of 4,800 IHSS providers in 5 counties (Los Angeles, San Francisco, Sutter, Yolo, and Yuba) during July-September 2004 under the "Making Homecare a Better Job" project, part of the Better Jobs, Better Care Program, funded by the Robert Wood Johnson Foundation and Atlantic Philanthropies.

administer their services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." California's Health and Human Services Agency is currently coordinating efforts to implement the state's Olmstead plan, including efforts to shift nursing home and other institution residents back to home- and community-based settings. Reduced IHSS wages may affect the availability of IHSS providers to support these transitions out of institutions.

- **Offsetting Costs in Other Programs:** Research indicates that the cost effectiveness of home- and community-based services relative to nursing homes is complex and depends on such factors as the level of care consumers need, which makes it difficult to give an overall assessment of relative costs. However, based on the assumptions in the table below, the Governor's Budget proposed savings would be fully offset if 4.4 percent of IHSS consumers shifted from IHSS to skilled nursing facilities (SNFs) due to provider turnover. Since the state has a lower share of cost for IHSS (32.5%) than for SNFs (50%), maintaining consumers in IHSS rather than SNFs may be more cost-effective for the state in many circumstances.

Medi-Cal Skilled Nursing Facility (SNF) Resident (average annual General Fund cost)	$26,600
IHSS Consumer (maximum annual General Fund cost for 283 hour/month at $10.10/hour)	$11,150
Difference between IHSS max cost and SNF average cost	$15,450
IHSS Wage Roll-Back Annualized General Fund Savings	$260,000,000
Number of IHSS Consumers Shifted to SNF that would entirely offset Governor's Budget Savings	16,828
Percent of IHSS 2005-06 Caseload represented by 16,828	4.4%

Furthermore, wage reductions for IHSS providers may result additional costs for community care facilities for persons with developmental disabilities. Reduced wage may result in the loss of providers and the ability to attract new providers with the necessary skills to serve this population. Services most likely affected by wage reductions include independent and supported living options.

In addition, if all counties discontinued health insurance in response to the Governor's proposal, 53,000 IHSS providers would lose insurance coverage, according to research under the Making Homecare a Better Job project. That research indicates that if all counties reduced wages to $6.75 per hour, an estimated 22,500 new people would enroll in Medi-Cal, and the additional Medi-Cal costs could offset at least 55 percent of the proposed IHSS savings. Based on this survey, an estimated 2,280 consumers may shift to SNF care

If all counties were to reduce wages to the minimum wage, the DSS indicates that CalWORKs grant costs would increase by up to $10 million in 2005-06, due to the reduction in recipient earned income. The impact to the CalWORKs caseload is unknown. It is possible that there may be some additional families that become eligible

for CalWORKS if wages were reduced. However, it is not possible to determine the number given the lack of characteristic data available for IHSS providers.

Questions:

1. DSS, please present the Governor's proposal.

2. DOF, is this proposal consistent with the letter and intent of Proposition 1A? What other cost pressures are counties facing in 2005-06, under existing law and as a result of the Governor's Budget? What is the status of Realignment revenue growth and caseload growth for IHSS?

3. DSS/DOF, how many counties do you expect may reduce provider rates under this proposal?

4. LAO, what factors will affect county funding decisions for IHSS under this proposal? How likely is it that some counties would reduce provider wages?

5. DHS, what are the key federal requirements for Medicaid provider rates with regard to quality of care and equal access? Is the Governor's Budget proposal consistent with the access and quality of care provisions of Section 30(A) of federal Medicaid statute? Has a rate study been performed for the IHSS program?

6. DSS, if IHSS wages are reduced, how would that affect provider turnover and quality of care? Is the Governor's Budget proposal consistent with the state's Olmstead plan?

7. DSS, what offsetting costs may result from this proposal, including nursing home costs, other Medi-Cal costs, CalWORKs costs, and Regional Center costs?

8. DSS, a 2001 DSS report projects a widening gap between the number of providers and consumers, assuming current law. How is the Governor's Budget proposal consistent with the need to address that widening gap?

Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda

Chair, Senator Denise Moreno Ducheny
Senator George C. Runner
Senator Tom Torlakson

Thursday, March 17, 2005
Upon Adjournment of Session
John L. Burton Hearing Room (4203)
(Consultant, Anastasia Dodson)

Materials for Hearing

SEC. 29. Section 12201 of the Welfare and Institutions Code is amended to read:

12201. (a) Except as provided in subdivision (d), the payment schedules set forth in Section 12200 shall be adjusted annually to reflect any increases or decreases in the cost of living. Except as provided in subdivision (e), these adjustments shall become effective January 1 of each year. The cost-of-living adjustment shall be based on the changes in the California Necessities Index, which as used in this section shall be the weighted average of changes for food, clothing, fuel, utilities, rent, and transportation for low-income consumers. The computation of annual adjustments in the California Necessities Index shall be made in accordance with the following steps:

(1) The base period expenditure amounts for each expenditure category within the California Necessities Index used to compute the annual grant adjustment are:

Food	$ 3,027
Clothing (apparel and upkeep)	406
Fuel and other utilities	529
Rent, residential	4,883
Transportation	1,757
Total	$10,602

(2) Based on the appropriate components of the Consumer Price Index for All Urban Consumers, as published by the United States Department of Labor, Bureau of

Labor Statistics, the percentage change shall be determined for the 12-month period which ends 12 months prior to the January in which the cost-of-living adjustment will take effect, for each expenditure category specified in paragraph (1) within the following geographical areas: Los Angeles-Long Beach-Anaheim, San Francisco-Oakland, San Diego, and, to the extent statistically valid information is available from the Bureau of Labor Statistics, additional geographical areas within the state which include not less than 80 percent of recipients of aid under this chapter.

(3) Calculate a weighted percentage change for each of the expenditure categories specified in subdivision (a) using the applicable weighting factors for each area used by the State Department of Industrial Relations to calculate the California Consumer Price Index (CCPI).

(4) Calculate a category adjustment factor for each expenditure category in paragraph (1) by (1) adding 100 to the applicable weighted percentage change as determined in paragraph (2) and (2) dividing the sum by 100.

(5) Determine the expenditure amounts for the current year by multiplying each expenditure amount determined for the prior year by the applicable category adjustment factor determined in paragraph (4).

(6) Determine the overall adjustment factor by dividing (1) the sum of the expenditure amounts as determined in paragraph (4) for the current year by (2) the sum of the expenditure amounts as determined in paragraph (4) for the prior year.

(b) The overall adjustment factor determined by the preceding computational steps shall be multiplied by the payment schedules established pursuant to Section 12200 as are in effect during the month of December preceding the calendar year in

which the adjustments are to occur, and the product rounded to the nearest dollar. The resultant amounts shall constitute the new schedules for the categories given under subdivisions (a), (b), (c), (d), (e), (f), and (g) of Section 12200, and shall be filed with the Secretary of State. The amount as set forth in subdivision (h) of Section 12200 shall be adjusted annually pursuant to this section in the event that the secretary agrees to administer payment under that subdivision. The payment schedule for subdivision (i) of Section 12200 shall be computed as specified, based on the new payment schedules for subdivisions (a), (b), (c), and (d) of Section 12200.

(c) The department shall adjust any amounts of aid under this chapter to insure that the minimum level required by the Social Security Act in order to maintain eligibility for funds under Title XIX of that act is met.

(d) (1) No adjustment shall be made under this section for the 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998, ~~and~~ 2004, and 2006 calendar years to reflect any change in the cost of living. Elimination of the cost-of-living adjustment pursuant to this paragraph shall satisfy the requirements of Section 12201.05, and no further reduction shall be made pursuant to that section.

(2) Any cost-of-living adjustment granted under this section for any calendar year shall not include adjustments for any calendar year in which the cost of living was suspended pursuant to paragraph (1).

(e) For the 2003 calendar year, the adjustment required by this section shall become effective June 1, 2003.

(f) For the 2005 calendar year, the adjustment required by this section shall become effective April 1, 2005.

SEC. 30. Section 12201.03 of the Welfare and Institutions Code is amended to read:

12201.03. (a) For the 1992, 1993, 1994, 1995, 1996, 1997, and 1998 calendar years, or for the period of January 1, 2003, to May 31, 2003, inclusive, if no cost-of-living adjustment is made pursuant to Section 12201, the payment schedules set forth in Sections 12200, 13920, and 13921, as adjusted pursuant to Section 12201, shall include the pass along of any cost-of-living increases in federal benefits under Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code.

(b) Notwithstanding paragraph (2) of subdivision (d) of Section 12201, any adjustments made pursuant to this section to reflect the pass along of federal cost-of-living adjustments shall be included in the base amounts for purposes of determining cost-of-living adjustments made pursuant to Section 12201.

(c) Notwithstanding subdivision (a), no pass along of any cost-of-living increase in federal benefits under Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code shall be made in 1994 and 2006. This provision shall not apply to those persons receiving payments pursuant to subdivisions (e), (g), and (h) of Section 12200.

(d) Notwithstanding subdivision (a), in no event shall the payment schedules be reduced below the level required by the federal Social Security Act in order to maintain eligibility for federal funding under Title XIX of the federal Social Security Act, contained in Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

SEC. 31. Section 12201.05 of the Welfare and Institutions Code is amended to read:

12201.05. (a) Commencing with the 2004 calendar year, and thereafter, except for the 2006 calendar year, in any calendar year in which no cost-of-living adjustment is made pursuant to Section 12201, the payment schedules set forth in Sections 12200, 13920, and 13921, as adjusted pursuant to Section 12201, shall include the pass-along of any cost-of-living increases in federal benefits under Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code.

(b) Notwithstanding paragraph (2) of subdivision (d) of Section 12201, any adjustments made pursuant to this section to reflect the pass-along of federal cost-of-living adjustments shall be included in the base amounts for purposes of determining cost-of-living adjustments made pursuant to Section 12201.

SEC. 32. Section 12306.1 of the Welfare and Institutions Code is amended to read:

12306.1. (a) When any increase in provider wages or benefits is negotiated or agreed to by a public authority or nonprofit consortium under Section 12301.6, then the county shall use county-only funds to fund both the county share and the state share, including employment taxes, of any increase in the cost of the program, unless otherwise provided for in the annual Budget Act or appropriated by statute. No increase in wages or benefits negotiated or agreed to pursuant to this section shall take effect unless and until, prior to its implementation, the department has obtained the approval of the State Department of Health Services for the increase pursuant to a

determination that it is consistent with federal law and to ensure federal financial participation for the services under Title XIX of the federal Social Security Act, and unless and until all of the following conditions have been met:

(1) Each county has provided the department with documentation of the approval of the county board of supervisors of the proposed public authority of nonprofit consortium rate, including wages and related expenditures. The documentation shall be received by the department before the department and the State Department of Health Services may approve the increase.

(2) Each county has met department guidelines and regulatory requirements as a condition of receiving state participation in the rate.

(b) Any rate approved pursuant to subdivision (a) shall take effect commencing on the first day of the month subsequent to the month in which final approval is received from the department. The department may grant approval on a conditional basis, subject to the availability of funding.

(c) The state shall pay 65 percent~~, and each county shall pay 35 percent,~~ of the nonfederal share of ~~wage~~ wages and ~~benefit increases~~ benefits negotiated by a public authority or nonprofit consortium pursuant to Section 12301.6 and associated employment taxes, only in accordance with subdivisions (d) ~~to (f), inclusive~~ and (e).

~~(d) (1) The state shall participate as provided in subdivision (c) in wages up to seven dollars and fifty cents ($7.50) per hour and individual health benefits up to sixty cents ($0.60) per hour for all public authority or nonprofit consortium providers. This paragraph shall be operative for the 2000–01 fiscal year and each year thereafter~~

~~unless otherwise provided in paragraphs (2), (3), (4), and (5), and without regard to when the wage and benefit increase becomes effective.~~

~~(2) The state shall participate as provided in subdivision (c) in a total of wages and individual health benefits up to nine dollars and ten cents ($9.10) per hour, if wages have reached at least seven dollars and fifty cents ($7.50) per hour. Counties shall determine, pursuant to the collective bargaining process provided for in subdivision (c) of Section 12301.6, what portion of the nine dollars and ten cents ($9.10) per hour shall be used to fund wage increases above seven dollars and fifty cents ($7.50) per hour or individual health benefit increases, or both. This paragraph shall be operative for the 2001–02 fiscal year and each fiscal year thereafter, unless otherwise provided in paragraphs (3), (4), and (5).~~

~~(3) The state shall participate as provided in subdivision (c) in a total of wages and individual health benefits up to ten dollars and ten cents ($10.10) per hour, if wages have reached at least seven dollars and fifty cents ($7.50) per hour. Counties shall determine, pursuant to the collective bargaining process provided for in subdivision (c) of Section 12301.6, what portion of the ten dollars and ten cents ($10.10) per hour shall be used to fund wage increases above seven dollars and fifty cents ($7.50) per hour or individual health benefit increases, or both. This paragraph shall be operative commencing with the next state fiscal year for which the May Revision forecast of General Fund revenue, excluding transfers, exceeds by at least 5 percent, the most current estimate of revenue, excluding transfers, for the year in which paragraph (2) became operative.~~

~~(4) The state shall participate as provided in subdivision (c) in a total of wages and individual health benefits up to eleven dollars and ten cents ($11.10) per hour, if wages have reached at least seven dollars and fifty cents ($7.50) per hour. Counties shall determine, pursuant to the collective bargaining process provided for in subdivision (c) of Section 12301.6, what portion of the eleven dollars and ten cents ($11.10) per hour shall be used to fund wage increases or individual health benefits, or both. This paragraph shall be operative commencing with the next state fiscal year for which the May Revision forecast of General Fund revenue, excluding transfers, exceeds by at least 5 percent, the most current estimate of revenues, excluding transfers, for the year in which paragraph (3) became operative.~~

~~(5) The state shall participate as provided in subdivision (c) in a total cost of wages and individual health benefits up to twelve dollars and ten cents ($12.10) per hour, if wages have reached at least seven dollars and fifty cents ($7.50) per hour. Counties shall determine, pursuant to the collective bargaining process provided for in subdivision (c) of Section 12301.6, what portion of the twelve dollars and ten cents ($12.10) per hour shall be used to fund wage increases above seven dollars and fifty cents ($7.50) per hour or individual health benefit increases, or both. This paragraph shall be operative commencing with the next state fiscal year for which the May Revision forecast of General Fund revenue, excluding transfers, exceeds by at least 5 percent, the most current estimate of revenues, excluding transfers, for the year in which paragraph (4) became operative.~~

~~(c) (1) On or before May 14 immediately prior to the fiscal year for which state participation is provided under paragraphs (2) to (5), inclusive, of subdivision (d), the~~

~~Director of Finance shall certify to the Governor, the appropriate committees of the Legislature, and the department that the condition for each subdivision to become operative has been met.~~

~~(2) For purposes of certifications under paragraph (1), the General Fund revenue forecast, excluding transfers, that is used for the relevant fiscal year shall be calculated in a manner that is consistent with the definition of General Fund revenues, excluding transfers, that was used by the Department of Finance in the 2000-01 Governor's Budget revenue forecast as reflected on Schedule 8 of the Governor's Budget.~~

~~(f) Any increase in overall state participation in wage and benefit increases under paragraphs (2) to (5), inclusive, of subdivision (d), shall be limited to a wage and benefit increase of one dollar ($1) per hour with respect to any fiscal year. With respect to actual changes in specific wages and health benefits negotiated through the collective bargaining process, the state shall participate in the costs, as approved in subdivision (c), up to the maximum levels as provided under paragraphs (2) to (5), inclusive, of subdivision (d).~~

(d) Through September 30, 2005, the state shall participate as provided in subdivision (c) in a total of wages and individual health benefits in each county, up to the level at which it participated in that county on June 30, 2004. Each county shall pay 100 percent of the remaining nonfederal share through September 30, 2005.

(e) Effective October 1, 2005, the state shall participate as provided in subdivision (c) in a total of wages and individual health benefits only up to the state minimum wage. Each county shall pay the remaining 35 percent up to the state

minimum wage and 100 percent of the nonfederal share above the state minimum wage.

Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda
Health & Human Services

Chair, Senator Denise Ducheny

Senator George Runner
Senator Tom Torlakson

April 4, 2005

1:30 PM

Room 4203

(Diane Van Maren)

Item	Department
4270	California Medical Assistance Commission—Selected Issues
4260	Department of Health Services—Selected Medi-Cal Program Issues
4280	Managed Risk Medical Insurance Board—Selected Issues

PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. Additional issues regarding these departments will also be discussed at future hearings. *Please* see the Senate File for dates and times of subsequent hearings.

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

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

I. Item 4270—California Medical Assistance Commission (CMAC)

A. Background and Summary of Budget

The California Medical Assistance Commission (CMAC) was established in 1983 to negotiate contracts with specific services under the Medi-Cal Program on behalf of the Department of Health Services. State law and regulations govern the Commission's activities. The Commission is composed of seven voting members appointed to four-year terms.

Major CMAC Commission activities include the following:

- Negotiating contracts under the state's Selective Provider Contracting Program for Medi-Cal fee-for-service hospital inpatient services statewide;
- Negotiating contracts with hospitals for supplemental payments under the (1) Emergency Services and Supplemental Payment Program (SB 1255 funds), (2) Medi-Cal Medical Education Supplemental Payment Program, (3) Construction and Renovation Reimbursement Program (SB 1732), and (4) Small and Rural Supplemental Payment Program; and
- Developing and negotiating per capita, at-risk managed care contracts for health care services to Medi-Cal enrollees with County Organized Health Care Systems and participating Geographic Managed Care Plans.

Summary of Expenditures (dollars in thousands)	2004-05	2005-06	$ Change	% Change
CA Medical Assistance Commission	$2,604	$2,622	$18	0.6%
General Fund	$1,195	$1,207	$12	1.0%
Emergency Services & Supplemental Payments Fund	$111	$108	($3)	(2.7%)
Reimbursements	$1,298	$1,307	$9	0.7%

B. DISCUSSION ITEMS--CMAC

1. CMAC Commission Salaries

Issue: Section 14165.8 of Welfare and Institutions Code provides for the reimbursement of the seven CMAC Commissioners at the annual salary of members of the Legislature, or $99,000 annually. This equates to annual expenditures of $693,000 (General Fund) for their salaries. Generally, the CMAC meets about 23 times per year, or almost twice per month (December being the exception).

Subcommittee Staff Recommendation: Due to ongoing fiscal concerns, it is recommended to reduce the annual salary of the Commission from $99,000 to $50,000, effective as of July 1, 2005, and provide for a cost-of-living adjustment (COLA) as applicable. This recommendation would save $343,000 (General Fund) and requires adoption of trailer bill legislation as shown below.

> Amend Section 14165.8 of Welfare & Institutions Code as follows:
>
> The Commission shall be reimbursed at the annual salary of ~~members of the Legislature.~~ $50,000. The Commission shall set the salary of the executive director and other staff consistent with funds appropriated. The annual compensation provided by this section shall be increased in any fiscal year in which a general salary increase is provided for state employees. The amount of the increase provided by this section shall be comparable to, but shall not exceed, the percentage of the general salary increases provided for state employees during that fiscal year.

The recommended $50,000 annual salary is a higher salary level than contained in SB 1083 (Ackerman), as introduced. This legislation proposes for the Commission to be reimbursed at the annual salary of members of the State Personnel Board, or at about $36,251 annually, plus a COLA adjustment if applicable.

The $50,000 annual salary level is recommended in lieu of the $36,251 amount in recognition of the analysis and review functions which the CMAC Commission performs outside of their convened meeting process and the complexities of the hospital financing arena.

Does the Subcommittee want to (1) adopt the proposed trailer bill language, and (2) reduce the CMAC budget by $343,000 General Fund to reflect this salary adjustment?

II. Item 4260--Department of Health Services, Medi-Cal Program *(Selected Issues)*

A. Background Summary of the Medi-Cal Program

Purpose: The federal Medicaid Program (called Medi-Cal in California) provides medical benefits to low-income individuals who have no medical insurance or inadequate medical insurance. It is at least three programs in one: (1) a source of traditional health insurance coverage for poor children and some of their parents, (2) a payer for a complex set of acute and long-term care services for the frail elderly and people with developmental disabilities and mental illness, and (3) a wrap-around coverage for low-income Medicare recipients.

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

Men and women who are not elderly and do not have children or a disability *cannot* qualify for Medi-Cal no matter how low-income they are.

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.

Medi-Cal provides health insurance coverage to about 18 percent of Californians. Average monthly caseload is anticipated to increase in 2005-06 by about 170,500 enrollees, or about 2.6 percent, for a total of 6.8 million eligibles.

Of the total Medi-Cal eligibles about 38.7 percent or 2.6 million people are categorically-linked to Medi-Cal through enrollment in public cash grant assistance programs (i.e., SSI/SSP or CalWORKs). The majority of the projected Medi-Cal caseload increase is occurring in the working families and children eligibility categories as noted in the Table below.

Medi-Cal Eligibles	2004-05	2005-06	Caseload Change	Percent Change
	(thousands)	(thousands)	(thousands)	2.3%
Families/Children	**4,873**	**4,983**	**111**	**-3.4**
CalWORKS	1,356	1,310	-47	5.3
Working Families	2,853	3,004	151	1.4
Pregnant Women	187	190	3	0.7
Children	477	481	4	3.2%
Aged/Disabled	**1,648**	**1,701**	**53**	**4.1**
Aged	630	655	26	2.7
Disabled	1,18	1,046	28	5.6
Undocumented Persons	**119**	**126**	**7**	
TOTALS	**6,639 people**	**6,810 people**	**171**	**2.6%**

Summary of Budget: The Governor proposes total expenditures of $34.1 billion ($12.9 billion General Fund) which reflects a General Fund increase of $981.7 million, or 8.2 percent above the revised current-year budget.

The General Fund increase primarily reflects (1) increases in caseload and utilization for aged, blind and disabled individuals; (2) increases in federal Medicare premiums for which the state pays; (3) implementation of quality improvement fees and cost-of-living adjustments for nursing homes; (4) elimination of 2004-05 one-time savings; (5) changes in assumptions used for estimating anti-fraud savings; and (6) slower implementation of prior year cost containment activities.

Table: Medi-Cal General Fund Summary

(Dollars in thousands)	**2004-05 Estimated**	**2005-06 Proposed**	**Difference**	**Percent**
Local Assistance				
Benefits	$11,250	$12,193	$940	8.4%
County Admin (eligibility)	621	654	33	5.3%
Fiscal Intermediaries (claims processing)	93	101	8	8.9%
Total Local Assistance	**$11,965**	**$12,948**	**$984**	**8.2%**
DHS Operations	**$112**	**$121**	**$9**	**7.9%**
TOTALS	**$12,077**	**$13,069**	**$993**	**2.6%**

B. DISCUSSION ITEMS-- THE MEDI-CAL PROGRAM

1. Fiscal Appropriations for Funding of Nurse-to-Patient Ratio *(Joint CMAC & DHS)* *(See Hand Outs)*

Issue: The Governor's revised 2004-05 budget and proposed 2005-06 budget both reflect expenditures to *fully* implement the Nurse-to-Patients Ratio Regulations within the Medi-Cal Program as proposed in the enabling DHS regulation package to implement the Nurse-to-Patient Ratios (i.e., October 12, 2002).

Generally, these October 12, 2002 regulations require general acute care hospitals to provide nurse staffing for each hospital unit (e.g., critical care, burn, labor and delivery, medical, surgical, medical/surgical and mixed units) at a specified minimum ratio of nurses-to-patients. These various ratios were required to be implemented as of January 1, 2004, with an enrichment of the ratio to occur as of January 1, 2005.

In a Notice of Emergency Rulemaking issued as of November 4, 2004 (as signed by the DHS Director), the Governor moved to postpone until January 1, 2008 the enrichment of the ratio for medical, surgical, medical/surgical, and mixed units that was set to change from 1:6 to 1:5 on January 1, 2005. Under this timeframe, the Administration had ample time to adjust their proposed budgets (current-year and budget-year) prior to their submittal to the Legislature for consideration (i.e., due as of January 10, 2005). However, no fiscal adjustment was proposed.

Through discussion with Subcommittee staff it became evident that funds appropriated for the Nurse-to-Patients Ratio Regulations had been used by the Administration—both the DHS and the California Medical Assistance Commission (CMAC) for rate adjustments that are not specifically related to the regulations, as directed by the Legislature through the Budget Act of 2004.

In the Budget Act of 2004, $144.4 million (total funds) was approved for 2004-05 (full-year costs) for implementation of the ratios as represented by the October 12, 2002 regulations. This figure was developed by the DHS, and approved by the DOF at the May Revision for submittal to the Legislature. The Legislature adopted the Administration's fiscal proposal as presented because it reflected the amount needed to implement the regulations for this stated fiscal year.

The Administration's fiscal estimate included expenditures for hospitals, as well as for Medi-Cal Managed Care expenditures. In addition, it assumed that the enrichment of the nurse-to-patient for medical, surgical, medical/surgical, and mixed units that was set to change from 1:6 to 1:5 on January 1, 2005 would be implemented.

In addition, as discussed further below, the Administration's fiscal estimate is based on the "Hospital Nurse Staffing and Quality of Care, Hospital Nurse Staffing Survey Analysis" by the University of California, Davis, with adjustments done by the DHS based on the Office of Statewide Health Planning's hospital data system.

At the request of the Subcommittee, the DHS provided fiscal information as to how the Administration expended the current-year (2004-05) funds. The budget year appropriation as contained in the Governor's proposed 2005-06 budget reflects a continuation of that funding.

As shown in the table below, a total of $323.6 million ($161.8 million General Fund) is appropriated in the Governor's proposed budgets across the two-years (i.e., *revised* current-year and the proposed budget year.) for the Nurse-to-Patient Ratios.

Further as noted below, a total of $72.7 million ($36.4 million General Fund) is contained in the Governor's budgets across the two-year period for **implementation of the January 1, 2005 enhanced ratio** (i.e., 1:5 nurse-to-patients). Yet the Governor has proposed to defer the enhanced ratio.

Table—Administration's Calculations for 2004-05 and 2005-06

Medi-Cal Program Budget: **Nurse-to-Patient Ratio Funding for Hospitals & Managed Care Plans**	**Governor's Revised 2004-05 Budget (Total Funds)**	**Governor's 2005-06 Budget (Total Funds)**	**Difference If January 1, 2005 Ratio is Deferred (Total/General Funds)**
I. Fee-for Service (Total)	$80.5 million	$106.8 million	
A. Jan 1, 2004 Ratio (Total)	($71.9 million)	($77.9 million)	
Contract Hospital	$60.4 million	$65.4 million	
Non-Contract Hospital	$11.5 million	$12.5 million	
B. Jan 1, 2005 Ratio (Total)	($8.5 million)	($28.9 million)	$37.4 million ($18.7 million GF)
Contract Hospital	$8.5 million	$28.9 million	
Non-Contract Hospital	0	0	
II. Managed Care (Total)	$67.6 million	$68.8 million	
A. Jan 1, 2004 Ratio (Total)	($45.9 million)	($45.9 million)	
Other retroactive payments	$9.2 million	n/a	
B. Jan 1, 2005 Ratio (Total)	($12.4 million)	($22.9 million)	$35.3 million ($17.7 million GF)
III. TOTALS ($323.6 million)	$148 million	$175.6 million	**$72.7 million** **($36.4 million GF)**
A. Total Jan 1, 2004 Ratio/Retro	($127.1 million)	($123.8 million)	n/a
B. Total Jan 1, 2005 Ratio	($20.9 million)	($51.8 million)	$72.7 million ($36.4 million GF)

Joint Letter from the President Pro Tempore of the Senate and the Speaker of the Assembly: In a letter addressed to Secretary Belshe, dated March 7, 2005, President pro Tempore Don Perata and the Speaker of the Assembly Fabian Nunez questioned the expenditure of funds by the Administration for a purpose other than as directed in the Budget Act of 2004. Specifically, the funds were provided to hospitals and managed care plans as a rate increase without a direct linkage to the Nurse-to-Patients regulations, as directed by existing state statute, and as directed by the Budget Act of 2004.

The letter noted that implementation of the ratios has been a legislative priority for the past six years and that they are troubled by the Administration's unilateral action regarding the transfer of the funds. The President pro Tempore and Speaker of the Assembly further note that the transaction should have been communicated to the Legislature before any action was taken.

Background—Original Fiscal Statement in Regulation Package (October 12, 2002) and Updating of Costs: AB 394 (Kuehl), Statutes of 1999, as modified by AB 1760, Statutes of 2000, added Section 1276.4 to the Health and Safety Code. This section requires the DHS to develop minimum, specific numerical licensed nurse-to-patient ratios for specified units of general acute care hospitals. In a regulation package dated October 12, 2002, the DHS made a determination that set forth minimum staffing ratios necessary to protect public health and safety.

The regulations specify the number of patients that may be assigned per licensed nurse in the following hospital units: critical care, burn, labor and delivery, post anesthesia, emergency, surgery, pediatric, intermediate care, specialty care, telemetry, general medical care, subacute care, and transitional inpatient care.

The "Fiscal Impact Statement" in this October 12, 2002 regulation package, which was crafted by the DHS and approved by the DOF, estimated the following expenditures for the Medi-Cal Program for implementation of the ratios:

- $43.3 million ($21.6 million General Fund) for 2003-04;
- $106 million ($53 million General Fund) for 2004-05; and
- $125.4 million ($62.7 million General Fund) for 2005-06.

According to the DHS, the fiscal assumptions they developed were based on the "Hospital Nurse Staffing and Quality of Care Hospital Nurse Staffing Survey Analysis" by the University of California, Davis, as well as data the DHS obtained from the Office of Statewide Health Planning's hospital data reporting system.

The Budget Act of 2003 provided an appropriation of $42.7 million ($21.3 million General Fund) for the Nurse-to-Patients Ratio which corresponds to the amount identified in the "Fiscal Impact Statement" for the first six months of implementation (i.e., January 1, 2004 to June 30, 2004). The fact of the matter is that the "Fiscal Impact Statement" is supposed to reflect an accurate estimate of what the regulations are to cost the state and the Budget Act of 2003 reflected that amount.

The Budget Act of 2004 appropriation reflects a technical updating of the Fiscal Impact Statement, which is expected since overall data and fiscal estimates were updated since the release of the October 2002 regulations.

Background—Legal Status of Governor's Proposed Emergency Regulations (November 2004):

On March 14, 2005, the California Superior Court enjoined enforcement of the Governor's emergency regulations to postpone until January 1, 2008 the enrichment of the ratio for medical, surgical, medical/surgical, and mixed units that was set to change from 1:6 to 1:5 on January 1, 2005. The court order voids the emergency regulation. The Administration is appealing this decision and is requesting the Court of Appeal to stay the Superior Court order.

Due to the court ruling, in a March 17, 2005 letter from Brenda Klutz, Deputy Director, the DHS notified general acute care hospitals that the original Nurse-to-Patients Regulations (October 12, 2002) are in effect.

Background—California Medical Assistance Commission Hospital Contracting: The California Medical Assistance Commission (CMAC), established in 1983, negotiates contracts for specific services—primarily hospital inpatient services—provided under the Medi-Cal Program on behalf of the Department of Health Services. The Commission is composed of seven voting members appointed to four-year terms. In addition, both the Department of Health Services and the Department of Finance serve as ex-officio members on the CMAC Commission. Major Commission activities include the following:

- Negotiating contracts under the state's Selective Provider Contracting Program for Medi-Cal fee-for-service hospital inpatient services statewide;
- Negotiating contracts with hospitals for supplemental payments under the (1) Emergency Services and Supplemental Payment Program (SB 1255 funds), (2) Medi-Cal Medical Education Supplemental Payment Program, (3) Construction and Renovation Reimbursement Program (SB 1732), and (4) Small and Rural Supplemental Payment Program; and
- Developing and negotiating per capita, at-risk managed care contracts for health care services to Medi-Cal enrollees with County Organized Health Care Systems and participating Geographic Managed Care Plans.

In discussions with Subcommittee staff regarding the expenditure of the funds appropriated for the Nurse-to-Patients Ratios in the Budget Act of 2004, the CMAC staff noted the following key aspects:

- All hospital contracts are done on a negotiated basis, and as such, take into account a range of competitive factors unique to each negotiation situation, including the need for funding the Nurse-to-Patient Ratios.
- Most of the rate negotiations affecting the 2004-05 (current-year) took place before the current year budget was passed. Therefore, the 2004-05 affect of the negotiated rate increases includes the impact of rate increases approved in 2003-04 and even earlier when dealing with multi-year rate agreements.
- 90 percent of the estimated 2004-05 (current-year) budget cost of the rate increases was approved prior to November 2004. (When the Governor had the DHS issue emergency regulations to postpone the enriched ratios from January 1, 2005 to January 2008.)
- CMAC continues to negotiate rate increases on an ongoing basis as required by competitive situations as they arise.

Background—Department of Health Services and Managed Care Rate Adjustment:
Generally, the Department of Health Services uses a three-step process for making rate determinations for Medi-Cal Managed Care plans. First, they use a calculation of the cost of providing care for Medi-Cal enrollees which is based on historic data obtained from four County Organized Health Systems (COHS). Second, the DHS adjusts this data based on a number of factors, including audit information, age/sex of the enrollees, enrollee aid code, plan coverage and others. Third, the DHS adjusts the rate based on the state's budget appropriation for the Medi-Cal Program.

According to the DHS, when Managed Care rates were developed for 2004-05, the DHS actuaries who perform the rate calculations adjusted the rates based on the level of funding available in the budget. The rates were developed in the fall for implementation by October 1, 2004 (new rates are usually identified by October 1). The DHS included the funding available for both components of the Nurse-to-Patients ratios. They note that these rates are set and are prospective. The DHS does not allow the rates to be re-opened mid-year unless there is a change that affects the rate by more than one-percent.

Subcommittee Staff Comment: Clearly, the Legislature has appropriated funds through the budget process to fully support the Nurse-to-Patients Ratio. These funds were appropriated in good faith, based on data that was researched and adjusted for the California marketplace and the Medi-Cal Program by the DHS. The Medi-Cal Estimate contains a "policy change"—number 64--which reflects the assumptions used to calculate the amount for the Nurse-to-Patients Ratio (as the policy change is entitled—"Nurse-to-Patient Ratios for Hospitals").

The Medi-Cal Estimate is a complex document which contains dozens and dozens of policy changes which are subject to adjustment when new, updated data becomes available. After all, a budget is an estimate which is adjusted based on many factors. The Medi-Cal Estimate for the Nurse-to-Patient Ratios was indeed adjusted as new data was added to the DHS' assumptions. The dollars were appropriated with the clear intent to fund existing state law for the Medi-Cal Program to fully implementation the Nurse-to-Patient Ratios.

Questions:

1. DHS, Please briefly explain the assumptions used for policy change #64 and the amount of funds provided for 2004-05 and 2005-06.

2. CMAC, Please briefly explain how the contract and non-contract hospital rates are determined. How does the CMAC know if General Fund moneys are available for this purpose?

3. DHS, Are the Nurse-to-Patient Ratios fully funded according to your own Medi-Cal Estimate for 2004-05 and 2005-06?

2. Quality Improvement Fees--$294 million in Revenues Not Captured

Issue: The Administration inadvertently failed to capture $294 million (General Fund) in revenues made available to the state through the implementation of two quality improvement fees as adopted in past budgets. The DOF has acknowledged the error as identified by the Legislative Analyst's Office.

Specifically, the Administration proposed to implement two quality improvement fees in the Medi-Cal Program over the past two fiscal years. Both of these proposals were adopted by the Legislature and included in the Budget Acts (2003 and 2004). One quality improvement fee was implemented for Intermediate Care Facilities for the Developmentally Disabled (ICF-DD facilities) and another was implemented for Medi-Cal Managed Care Plans.

Both of these fees have now been approved by the federal CMS for implementation. (A March 2, 2005 letter approved the Managed Care Plan quality improvement fee which had been pending.)

Generally through this mechanism, certain health care service providers pay a fee to the state. The state places this fee revenue into the state General Fund and then uses a portion of the paid fees to obtain a federal match (at 50 percent). The combined state and federal funds are then used to increase the reimbursement rates paid to the providers paying the fee. The remaining amount of the fee paid by the provider that remains in the state General Fund is reflected as revenue to the state.

The DOF inadvertently did not capture the revenues generated by the fees as being part of the General Fund revenue baseline for 2005-06.

Legislative Analyst's Office Recommendation: In their review of the Governor's proposed General Fund revenues for 2005-06, the LAO recognized that a total of $294 million generated from the above referenced fees was not recognized by the DOF in their General Fund revenue stream.

According to the LAO, the $294 million consists of (1) $58 million from the ICF-DD fees for the current-year, (2) $29 million from the ICF-DD fees for the budget year and (3) $207 million for Managed Care Plans, assuming a July 1, 2005 implementation date.

Subcommittee staff concurs with the recommendation. It should also be noted that the Managed Care Plan quality assurance fee cannot be implemented sooner than the July 1, 2005 date due to the need for some managed care plans to make technical modifications as required by the federal CMS for approval.

Questions:

1. LAO, Please briefly describe the recommendation.
2. DOF, Do you concur with the LAO recommendation and the dollar amount identified?
3. DHS, Please provide an update on the status of including County Organized Health Systems (COHS) in the quality improvement fee program.

3. Quality Improvement Fee—Medi-Cal Managed Care Plans

Issue: The Administration proposes to implement a quality improvement fee on Medi-Cal Managed Care plans as of July 1, 2005 for an overall net savings of $37.7 million (General Fund).

Under the proposal the DHS would assess a quality improvement fee of 6 percent on Medi-Cal Managed Care plans (Two Plan model, Geographic Managed Care, and the AIDS Healthcare Foundation). The amount actually paid by each plan would vary, depending on their gross Medi-Cal revenue.

The quality improvement fee would be deposited into the General Fund and used to (1) obtain increased federal funds to provide a rate adjustment for Medical Managed Care plans, and (2) obtain increased funds to offset $37.7 million in General Fund support in the overall Medi-Cal Program.

Based upon information provided by the DHS, the fiscal arrangement would be as follows:

- 6 percent fee paid by Managed Care plans =$207.2 million to General Fund (11 months)
- State provides plans with rate adjustment =$339 million ($169.5 million GF)
    - Net Increase to Managed Care plans =$131.8 million
    - Net savings to the General Fund =$37.7 million (General Fund)

Implementation of this fee, and rate increase, has been proposed since the Budget Act of 2003. However various implementation issues arose in discussions with the federal Center for Medicare and Medicaid (CMS) as well as with some of the plans. Through trailer bill legislation—SB 1103—enacted as part of the Budget Act of 2004, language was crafted for implementation. However it has taken the federal CMS since last year to finally approve California's request. CMS approval was finally granted as of March 10, 2005.

Medi-Cal Managed Care plans are presently in the process of doing "material modifications" to their lines of business in order to meet certain federal CMS and state requirements. These modifications, which require working with the Department of Managed Care Health (DMHC), are presently in process.

The DHS states that the July 1, 2005 effective date is generally on target. They further note that even if this date slips somewhat, the fee collection and rate adjustment can be done retroactively to July 1, 2005.

It should be noted that the proposal does *not* include the participation of County Organized Health Systems (COHS). According to the DHS, inclusion of the COHS in the Quality Improvement Fee would require a federal law change. Specifically, federal law excludes "health insuring organizations" such as COHS from this financing mechanism. As such, the COHS' are seeking a federal law change.

Background—Federal Law and Quality Improvement Fees: Under the authority of the federal Social Security Act, Title 19, Section 1903(w)(7)(A), any state may impose a "quality improvement fee" on managed care contracts providing services under the Medicaid Program (Medi-Cal in California). According to this federal law and regulations, these state taxes must:

- Be imposed on a permissible class of health care services;
- Be broad-based or apply to all providers within the class;
- Be uniform such that all providers within a class must be taxed at the same rate; and
- Avoid hold harmless arrangements in which collected taxes are returned to the taxpayers either directly or indirectly.

This mechanism can be used to then draw down additional federal funds.

Subcommittee Staff Comment and Recommendation: This is the same proposal as adopted by the Legislature through the Budget Act of 2004 which was not implemented in the current year due to the need for federal CMS approval. Since this approval has now been obtained, Managed Care plans can now proceed with their necessary administrative changes that need to be filed with the DMHC.

The Governor's May Revision will probably contain some minor adjustments to the calculation, but no other aspects are anticipated to change. No issues have been raised regarding the policy. As such, it is recommended to adopt the proposal pending the receipt of the May Revision.

Subcommittee Request and Questions: The Subcommittee has requested the DHS to briefly respond to the following questions:

1. DHS, Please briefly describe the proposal to implement a quality assessment fee for Medi-Cal Managed Care plans.

4. Cost-of-Living Adjustment & Quality Improvement Fees for Skilled Nursing Facilities

Issue: The budget assumes implementation of AB 1629, Statutes of 2004, which **(1)** requires the DHS to provide a cost-of-living-adjustment (COLA) to nursing homes, effective August 1, 2004; **(2)** provides for the establishment of a facility specific rate methodology by August 1, 2005; and **(3)** institutes a Quality Improvement Fee to be effective by August 1, 2004.

In order to proceed with implementation on these three aspects, the DHS needed to do the following:

(1) Obtain federal approval for a State Plan Amendment for the August 1, 2004 COLA (filed with the federal CMS as of September 30, 2004);

(2) Obtain federal approval for a State Plan Amendment for establishing a facility specific rate methodology in lieu of the peer group process presently used for rate setting (filed with the federal CMS as of February 2, 2005); and

(3) Obtain federal approval to waive the federal requirement regarding "uniformity" of the Quality Improvement Fee, as discussed in more detail below (filed with the federal CMS as of March 25, 2005).

The Quality Improvement Fee is 3 percent for the current-year (due to the timing of implementation), and 6 percent for the budget year and thereafter. Revenues from the fee are deposited into the General Fund. It is assumed that General Fund savings of $120 million for 2004-05 and $257 million for 2005-06 will be achieved from the fee.

Costs to the Medi-Cal Program for the cost-of-living-adjustment (COLA) and new rate methodology are expected to be $99 million (General Fund) in 2004-05 and $259.5 million (General Fund) in 2005-06. For the current year these dollars reflect about a 5.7 percent COLA, and for the budget year it is 8 percent (which is the capped level as contained in the enabling legislation.)

Subcommittee Staff Comment: The DHS has filed with the federal CMS all three components necessary to proceed with implementation of AB 1629, Statutes of 2004. However, no federal CMS approvals have been obtained and it is unclear at this time when approvals may be forthcoming.

No policy issues have been raised since the budget reflects implementation of existing statute. However, the enabling state legislation requires federal CMS approval of both State Plan Amendments and the Quality Improvement Fee for the new facility specific rate methodology to go into effect. In addition, the enabling legislation contains a "poison pill" that says if the Quality Improvement Fee ends, then the new facility specific rate methodology ceases.

Therefore, federal CMS approval is paramount for implementation of the enabling legislation and the funding level (need for federal 50 percent match).

Questions:

1. DHS, Please provide a brief description of the fiscal affects of the proposal.
2. DHS, What is the status of each of the submittals to the federal CMS (i.e., the two State Plan Amendments and the rule waiver request)?
3. DHS, Are there any potential fiscal issues that may arise if we do not receive federal CMS approval in a timely manner? Is the COLA for August 1, 2004 at risk?
4. DHS, Is this Quality Improvement Fee at risk due to the President's proposed Medicaid budget which would limit fees?

5. Joint Discussion (MRMIB and DHS) on Prenatal Care Federal Fund Shift

Issue: The Governor's budget for 2004-05 and 2005-06 assumes recognition of recent federal regulations under the State's Children Health Insurance Program (S-CHIP) (Healthy Families in California) that declare an unborn child (from conception) may be considered an eligible child under the program. Under these federal regulations a state may elect to extend eligibility to unborn children using federal S-CHIP funds (a 65 percent federal match rate) for health benefits coverage, including prenatal care and delivery.

California would need to submit an S-CHIP State Plan Amendment (SPA) to the federal CMS for approval in order to obtain the 65 percent federal match. In order to capture the proposed current-year General Fund savings, the SPA must be submitted to the federal CMS by no later than June 30, 2005.

The Governor's proposal would capture state savings—both General Fund and Proposition 99 Funds—through the use of the 65 percent federal match. Specifically the federal match would be used for both the Medi-Cal Prenatal Care Program for Undocumented Women (100 percent General Fund supported now), and the Access for Infants and Mothers (AIM) Program (Proposition 99 Fund supported).

The Governor also proposes new General Fund support for AIM in order to draw down the 65 percent federal S-CHIP match. This increased General Fund amount is shown in the table below. Under Proposition 99 requirements, a four-fifths vote is required to use Proposition 99 Funds to draw a federal match. As such, the Governor's proposal avoids this requirement by using General Fund support in lieu of Proposition 99 Funds.

As illustrated in the table below, the overall fiscal affect of this fund shift is as follows:

- Saves $191 million (General Fund) in Medi-Cal for the two-year period;
- Saves $149.8 million (Proposition 99 Funds) in AIM for the two-year period; and
- Increases by $52.4 million (General Fund) for AIM for the two-year period.

Table: Fund Shifts Resulting from Use of S-CHIP Funds

	2004-05 Fund Shifts			2005-06 Fund Shifts		
Governor's Proposed Funding Shifts	**Prop 99 Funds**	**General Fund**	**Federal Funds**	**Prop 99 Funds**	**General Fund**	**Federal Funds**
Shift Access for Infants & Mothers Program to GF and federal funds.	-$71,354	$24,974	$46,380	-$78,440	$27,454	$50,986
Use S-CHIP federal funds for Prenatal Care to Undocumented Women in Medi-Cal.		-$95,500	$95,500		-$95,500	$95,500
Net Adjustments Overall by Year	-$71,354	-$70,526	$141,880	-78,440	-$68,046	$146,486

The Governor's proposal also uses a portion of the unencumbered Proposition 99 Funds—about $120.5 million across the two years-- to backfill for General Fund support across several different programs, including the State Hospitals that serve individuals with mentally illness, the Expanded Access to Primary Care Clinic Program, Medi-Cal services provided to legal immigrants, as well as other programs. These Proposition 99 Funds-related issues will be discussed at a later Subcommittee hearing as a group.

Overall, the Governor's proposal would save a *net* total of about $259 million (General Fund) across the two fiscal years. This savings level assumes (1) approval by the federal CMS of the S-CHIP State Plan Amendment and therefore receipt of federal funds for AIM and the Medi-Cal Prenatal Care services for Undocumented Women Program, (2) using $120.5 million in unencumbered Proposition 99 Funds available from AIM to backfill for General Fund support in various programs, and (3) providing General Fund support to AIM to draw the new federal match of 65 percent.

Subcommittee Staff Comment and Recommendation: The Governor's proposal clearly has fiscal merit in its use of S-CHIP funds to save General Fund moneys. However, concerns have been raised regarding the need to articulate that receipt of these federal funds for unborn children does not erode or jeopardize existing California law regarding the provision of prenatal care services to women, or existing Supreme Court rulings regarding a woman's right to privacy.

Both the Prenatal Care Program for Undocumented Women and the AIM Program provide comprehensive prenatal care services, including post-partum care, to eligible pregnant women. Though the Administration has not proposed to change existing state statute regarding these comprehensive prenatal care services, the language contained in the federal guidelines is narrower in its interpretation of services. For example, the federal regulations address pregnancy-related services provided to unborn children and does not reference post-partum care.

The Administration contends that since California uses a "bundled" rate of global fee method for our prenatal care programs including post-partum care, in lieu of individual services, the federal CMS will not likely raise concerns. However the federal CMS could raise concerns once they review the S-CHIP State Plan Amendment.

With respect to a woman's right to privacy, concerns have been raised that accepting the S-CHIP funds under the federal regulation's definition of eligible child may place into question Supreme Court rulings regarding a woman's reproductive rights.

The California Health & Human Services Agency (CHHS Agency) is in the process of working with constituency groups to potentially craft language regarding these two concerns. At this time, consensus has not been fully attained.

Therefore, in an effort to facilitate resolution of the issue it is recommended to (1) adopt trailer bill language, as shown below, (2) assume receipt of the federal S-CHIP funds for the Prenatal Care Services to Undocumented Women Program and AIM Program, and (3) require the DHS and MRMIB to provide the Subcommittee with a draft of the proposed State Plan Amendment prior to its submittal to the federal CMS (mid-April). If desired by the Subcommittee, this issue can be revisited at the time of the May Revision and adjustments can be made.

> Proposed placeholder trailer bill language (Add Section xxx to Welfare and Institutions Code):
>
> (a) Through its courts, statutes, and under its Constitution, California protects a woman's right to reproductive privacy. California reaffirms these protections and specifically its Supreme Court decision in *People v. Belous* (1969) 71 Cal.2d 954, 966-68.
>
> (b) The state Department of Health Services and the Managed Risk Medical Insurance Board may accept or use moneys under Title XXI of the federal Social Security Act

(known as the State Children's Health Insurance Program, or S-CHIP), as interpreted in Title 42, Code of Federal Regulations, Section 457.10, to fund services for pregnant women pursuant to Welfare and Institutions Code Section 14007.7 (Medi-Cal) and Insurance Code Sections 12695 et seq (Access for Infants and Mothers (AIM)) only when during the period of coverage the pregnant woman is the beneficiary, the scope of services covered under Medi-Cal and AIM, as defined in statutes, regulations and state plan amendments is no more restrictive than the scope of such services on January 1, 2005, and California's S-CHIP plan and any amendments thereto are consistent with this section.

(c) This section is a declaration of existing law.

6. Administrations Proposal to Implement a Premium *(See Hand Out)*

Issue and Description of the Overall Proposal: The Governor is proposing to require certain Medi-Cal enrollees to pay premiums effective as of January 1, 2007. This proposal requires trailer bill legislation as well as a federal Waiver.

The Administration is seeking an increase of $6.2 million (General Fund) in the budget to begin preparation for collection of the premiums. These proposed expenditures are shown in Table 3, below.

Under the proposal, most Medi-Cal enrollees with incomes above 100 percent of the federal poverty level would pay a monthly premium to maintain their Medi-Cal coverage. The 100 percent of poverty threshold represents **(1)** $1,306 per month for a family of three, **(2)** $812 a month for a senior, or disabled individual, and **(3)** $1,437 a month for a couple receiving SSI/SSP.

Premiums would be required of any family, child, or other individual who have incomes above 100 percent of the poverty level, except for **(1)** individuals with a share-of-cost (they spend down to become eligible for Medi-Cal), **(2)** 1931 (b) families enrolled in CalWORKS, **(3)** infants under one year of age, **(4)** American Indians, and **(5)** Alaskan Natives. Therefore, the primary categories of Medi-Cal enrollees to be impacted by the proposal are:

- Children ages one to six with family incomes above 100 percent, and up to 133 percent, of poverty;
- Seniors and individuals with developmental disabilities with family incomes above 100 percent, and up to up to 133 percent, of poverty; and
- 1931 (b) families with incomes above 100 percent, up to 155 percent, of poverty ($2,024 per month for a family of three), and not enrolled in CalWORKS.

The proposed premium amounts are: (1) $4 per month for children under 21 years; (2) $10 per month for adults; and (3) $27 per month maximum for a family. The table below shows how this would be applied.

Table 1: Administration's Proposed Premium Amounts

Family Size (children, adults, seniors, disabled & pregnant women)	Premium Amount	Annual Payment	Yearly Income>100 percent of poverty
1 child + 1 adult	$4 child x 12 mths $10 adult x 12 mths	$168	$12,504 (1.3%)
2 children + 1 adult	$8 children x 12 mths $10 Adult x 12 mths	$216	$15,684 (1.4%)
1 child + 2 adults	$4 child x 12 mths $10 adult x 12 mths	$288	$15,684 (2%)
Adult (seniors+disabled)	$10 adult x 12 mths	$120	$9,480 (1.3%)
Couple (seniors+disabled)	$20 adult x 12 mths	$240	$16,788 (1.5%)

It should be noted that 1931 (b) families would be treated *differently* with respect to how the Administration makes the premium determination. The Administration proposes to change how the existing earned income deduction will be applied solely for the purpose of determining premiums. In effect, when determining whether premiums are to be paid, a different calculation will be used (i.e., allowing for only a $90 income disregard in lieu of the $240 and ½ disregards). Therefore, the result under this revised calculation is that more families will need to pay premiums because they will be considered above the 100 percent of poverty level.

Further, families enrolled in the 1931 (b) category will have difficulty re-enrolling into Medi-Cal if they are disenrolled due to failure to pay a premium**.** These "recipients" are usually individuals who have left CalWORKS and receive Medi-Cal-only services. The federal Welfare Reform Law of 1996 specifically authorized these individuals to receive Medi-Call services because Congress wanted to transition individuals from welfare to work. One of the barriers to this transition was receipt of health care services. As such, 1931 (b) families can have incomes up to 155 percent of poverty and be eligible for Medi-Cal. However if they loose their existing eligibility, they would be eligible for Medi-Cal-only if their income level was at 100 percent of poverty or below.

Enrollees would be dropped from Medi-Cal if they do not pay premiums for two consecutive months. If re-enrollment is pursued, the individual would be required to pay back premiums owed from the previous six months in which they were enrolled. This can become confusing due to Medi-Cal eligibility retroactivity (which is 90-days) as allowed by federal law.

This proposal would affect children, aged, blind and disabled individuals, and families. A total of about 550,000 people would be required to pay a premium, including about 460,000 families with children, and 90,000 seniors and individuals with disabilities with incomes above the SSI/SSP level.

In the first year alone, the DHS assumes that almost 20 percent of these individuals or about 94,630 individuals will fail to pay and become disenrolled, and thereby add to the increasing ranks of the uninsured living in California. This is shown in Table 2 below.

It should be noted that the DHS assumes that *all dual eligibles* (Medicare and Medi-Cal eligible) will *not drop off* because Medi-Cal pays their Medicare premiums. However in practice this may not occur; therefore, even more individuals could fail to make the premium payment.

Table 2 DHS' Assumptions of Who Drops Off

Eligibility Category (Fee-for-Service & Managed Care) (See Hand Outs for aid code reference)	**Total Medi-Cal Enrollees Needing to Pay**	**Reduction in Enrollees (Drop-Off)**
Aged, Blind & Disabled	90,601	2,817 (3%) (Assumes no duals are dropped)
Children	207,030	41,404 (20%)
Adults (ages 21-64)	252,045	50,409 (20%)
TOTALS	**549,676**	**94,630 uninsured**

The Administration is seeking an increase of $6.2 million (General Fund) in the budget to begin preparation for collection of the premiums. These proposed expenditures are shown in Table 3, below. Counties would conduct a premium calculation to discern if the Medi-Cal eligible person needed to pay a monthly premium. The DHS would contract with a Vendor to conduct the actual collection of the premiums each month.

Table 3 DHS' Identified Administrative Expenditures

Administrative Activity	**Proposed Expenditures (General Fund) 2005-06**	**Proposed Expenditures (General Fund) 2006-07** ***(1/1/2007 start)***	**Proposed Expenditures (General Fund) 2007-08**
County Determination of Premium	$6,200,000 (850,000 cases to review)	$7,200,000 (950,000 cases to review)	$7,200,000
Contract—Collection of Premiums	---	$2,150,000	$4,300,000
DHS State Staff (3.5 positions initially, and more later)	$650,000	$650,000	$650,000
DHS' Total Identified Amount	**$6,850,000**	**$10,000,000**	**$12,150,000**

As noted by the DHS, implementing premium requirements would require a significant new investment in systems and resources. Extensive changes to the Medi-Cal Eligibility Determination System (MEDS) and related systems would be required due to the complexities associated with adding the premium payment collection vendor (contractor) to the eligibility system. In addition by allowing various payment options, along with including numerous exceptions, the premium proposal creates various complexities within MEDS processing.

The DHS notes that, besides hiring 3.5 new staff, the following key administrative activities would be required to implement this proposal:

- Develop and submit a federal 1115 Waiver, and enact state statutory changes;
- Design and implement a new system to handle premium payments and reconciliation, as well as Medi-Cal enrollee notices. Such a system would need to interact with the Medi-Cal Eligibility Determination System (MEDS) to reflect premium related updates. This system could be maintained and operated using either DHS staff or contracted staff;
- If operated through a contract, the DHS would need to do a procurement. It is assumed that a procurement would require from 15 to 21 months to implement from the initial Request for Proposal (RFP) development.
- Develop *several* regulation packages to (1) define terms such as gross and net income, and countable income; (2) specify what sources of expenditures (such as child care costs) will be excluded from family income calculations; (3) specify what sources of income are excluded from the calculation of family income under federal law; (4) specify processes and criteria for appealing financial participation requirements; (5) specify any exceptions for aged and disabled enrollees; and (6) adopt uniform standards for assigning cost sharing requirements for enrollees, including premiums, deductibles and co-pays.

Background-- Administration's Assumptions Regarding Savings: As shown in the table below, the Administration assumes savings from the premium payments from two sources: **(1)** the revenue received from the payment of the monthly premium, and **(2)** from health care costs not provided to individuals because they have dropped off of Medi-Cal due to the non-payment of the premium. These assumptions are open to interpretation since limited research data is available.

It is interesting to note that the Administration assumes no savings for in-patient care services from those individuals who are dropped off of Medi-Cal due to non-payment, and only from two to five percent savings from non-institutional care. This is because the Administration recognizes that individuals will come on and off Medi-Cal as they need services. As such, it decreases the likelihood of "managing" care.

As noted below, the Administration assumes savings of from about $15 million General Fund to about $23 million General Fund on an annual basis.

Table: Administration's Assumed Savings from Premium Payments *(Annualized)*

2007-08 First full year (Annualized)	Aged, Blind & Disabled ($10 for 12 mths)	Children ($4 for 12 mths)	Adults (Ages 21-64) ($10 for 12 mths)	**Total Funds**
***Net* Premium** (After drop-off)	**$10,534,000** (87,783 people)	**$7,951,000** (165,627 children)	**$24,225,000** (201,636 people)	**$42,708,000** (455,046 people)
Dropped from Medi-Cal	2,817 People (3%)	41,404 Children (20%)	50,409 Adults (20%)	94,630 Total
2 % to 5 % Savings for Dropped People	$1,163,000 to $2,908,000	$3,697,000 to $9,244,000	$5,433,000 to $13,584,000	$10,295,000 to $25,735,000
SUBTOTAL	**$11,697,000 to $13,442,000**	**$11,648,000 to $17,195,000**	**$29,658,000 to $37,809**	**$53,003,000 to $68,443,000**
DHS' Assumed Administrative Costs				-$23,044,000
Administration's Net TOTAL (Rounded)				**$29,958,000 to $45,399,000**
Assumed General Fund Savings				**$14,979,000 to $22,700,000**

Subcommittee Staff Comment: The proposal is almost certain to result in a churning of enrollees and increase administrative processing costs. First, under federal law, as well as SB 87 (Escutia), Statutes of 2000, individuals who loose Medi-Cal eligibility under one set of criteria may be eligible for Medi-Cal enrollment under another category. As such Medi-Cal re-determinations must be made. Therefore, all of the Medi-Cal enrollees who are discontinued from Medi-Cal due to non-payment of premiums would conceivably need to be re-determined by the counties.

Medi-Cal re-determination processing can require considerable work on the part of counties**.** Under re-determination processing, a county must first do an "ex parte" review. Under ex parte, the county must check certain public assistance data systems to see if there is appropriate information to make an eligibility determination. If not then additional information is obtained as needed from the individual through telephone contact and if needed, use of a special Medi-Cal form. These administrative costs have *not* been addressed by the Administration's proposal.

Second, as noted by the Administration's own analysis, individuals will drop-off due to the non-payment of premiums and then come back on when they need services (if eligible). This churning of enrollees seems contrary to the Administration's own goal of expanding Medi-Cal Managed Care. Managed Care plans would not appreciate having Medi-Cal enrollees coming in and out of enrollment. This could also result in additional processing costs for the Medi-Cal Health Care Options contractor since they will need to inform enrollees of their health plan choices and enroll them into a plan.

Third, it is unclear how the "Medi-Cal Eligibility Determination System" (MEDS) could maintain its data integrity. Counties maintain MEDS since they perform most Medi-Cal eligibility processing. In the event of Medi-Cal enrollees discontinuing due to non-payment of a premium, it is unclear how the Vendor will notify the county of this action. If the two systems are not in synch with each other, the state could be making Managed Care plan payments for individuals no longer eligible for Medi-Cal, or Medi-Cal enrollees could be inadvertently disenrolled from Medi-Cal.

Fourth, it is unclear how the continuous annual eligibility enrollment of children would be affected if premiums were not paid (such as in the 133 percent of poverty program). The original policy and fiscal concepts behind this annual enrollment was to ensure coverage for children and to reduce administrative costs. It appears that these would not be achieved under the proposal.

Fifth, a clear mechanism for re-enrollment would need to be established, or people's applications could be put on hold indefinitely while they are being asked to pay the premium. What if a parent or child requires medical attention while they are on hold? Should the family spend their money on the medical care, or on paying back their premiums? How will providers of health care know clearly what the status of an individual patient is at the moment of the health care delivery?

Prior Subcommittee Hearings: The Subcommittee has discussed this issue twice previously. In the February 17th Subcommittee hearing as well as in the March 2nd hearing convened jointly with the Senate Health Committee.

Questions:

1. DHS, Are there any additional comments that the Administration would like to convey regarding the Premium proposal that has not been discussed in the prior two hearings?

7. County Performance Standards--Medi-Cal to Healthy Families Bridge *(See Hand Outs)*

Issue: The Administration proposes to expand Medi-Cal performance standards for County Welfare Departments, enacted through the Budget Act of 2003, to now include the Medi-Cal to Healthy Families one-month bridge eligibility processing component. It is assumed that the new standard would be implemented by October 1, 2005.

This proposal contains several components, including: **(1)** trailer bill legislation; **(2)** an increase of $995,000 ($312,000 General Fund) to fund 2.5 new DHS positions and to contract for performance monitoring functions with a vendor; **(3)** an increase of $1.5 million ($500,000 General Fund) in Medi-Cal local assistance for the anticipated *additional* 22,500 children who will receive the Medi-Cal bridge; and **(4)** an increase of $3.1 million ($1.1 million General Fund) in the Managed Risk Medical Insurance Board's budget for the Healthy Families Program for the anticipated 9,907 children who are anticipated to shift from Medi-Cal to the HFP due to the application of the performance standards.

First, the Administration is proposing trailer bill legislation to require County Welfare Departments, who conduct the Medi-Cal to HFP bridge eligibility processing, to meet specified performance criterion regarding the enrollment of these children. This performance criterion is similar to legislation enacted for other aspects of the Medi-Cal Program as part of the Budget Act of 2003.

The trailer bill legislation would require that when a child is determined to change from *no share-of-cost* Medi-Cal to a share-of-cost Medi-Cal, the child shall be placed into the Medi-Cal to HFP bridge benefit program. This is consistent with existing practice as presently done under the bridge.

The trailer bill legislation then would require the counties to meet the following performance criterion for processing the bridge benefit program:

- 90 percent of the families with children placed into the Medi-Cal to HFP bridge shall be sent a notice informing them of the HFP within 5-days from the determination of a share-of-cost.
- 90 percent of the families submitting applications for children placed into the Medi-Cal to HFP bridge shall be sent a notice informing them of the HFP Program within 5-days from the determination of a share-of-cost if the parent has given consent to send the case to the HFP.
- 90 percent of the families with children placed into the Medi-Cal to Healthy Families bridge benefits program who have not consented to sending the application to the Healthy Families Program shall be sent a request, within 5-days from the determination of a share-of-cost, to consent to send the case to the Healthy Families Program.

Further, the trailer bill language provides for a contractor, in addition to the DHS, to obtain performance information from counties and to perform other various monitoring aspects.

Second, the budget proposes the following fiscal adjustments as shown in the table below. Specifically, a total of $6.3 million ($2.3 million General Fund) is being requested across the two programs—Medi-Cal and Healthy Families--, including DHS administrative costs.

The DHS is seeking an increase of $995,000 ($312,000 General Fund) to hire 2.5 positions (two analysts and a half-time Staff Counsel) and to fund a contractor to monitor the counties performance. It should be noted that in the Budget Act of 2003, when overall county performance standards were crafted, the DHS received funds for 9 positions and the contractor concept was rejected by the Legislature. As noted by the LAO, the DHS never filled the positions and instead, eliminated them and used the funding as part of their mandated statewide reductions in state operations for that year.

Table—Total Proposed Increase for Medi-Cal to HFP Bridge Performance

Description of Bridge Components	Governor's Proposed 2005-06 (Total Funds)	Governor's Proposed 2005-06 (General Fund)
I. DHS Requested State Support Total (Assumes a July 1, 2005 start date)	**$995,000**	**$312,000**
• 2.5 new state positions	($252,000)	($126,000)
• Contract for monitoring of counties	($753,000)	($186,000)
II. Medi-Cal Local Assistance Total (To serve 22,500 more children beginning Oct 2005)	**$2,165,600**	**$860,480**
• County Administration Processing	($685,000)	($342,500)
• Medi-Cal Services (one-month bridge)	($1,480,600)	($517,980)
III. Healthy Families Local Assistance Total (To serve 9,907 more children beginning Oct 2005)	**$3,122,454**	**$1,092,859**
• HFP Administrative Vendor	($142,166)	($49,758)
• HFP Services (full on-going enrollment)	($2,980,288)	(1,043,101)
Total DHS State Support	**$995,000**	**$312,000**
Total Local Assistance	**$5,288,054**	**$1,953,339**
Total Proposal for 2005-06	**$6,283,054**	**$2,265,339**

The local assistance funding increase assumes that more children are enrolled in both Medi-Cal and the HFP as a result of the proposal. This is because some children who would otherwise be eligible to receive the bridge benefit program are presently not getting enrolled. As discussed further below, counties contend that enrollment into the bridge is problematic and needs to be revised, including most of the forms and some existing procedures.

According to the DHS, there are *presently* 50,000 children enrolled in the one-month bridge. The fiscal estimate of $2.2 million (total funds) assumes that an additional 22,500 children, or about 45 percent more, will be enrolled in the budget year. Of these additional children, it is

assumed that 9,907, or about 44 percent of the children, will be enrolled into the HFP during the budget year.

Background—The Existing "Bridge": Existing law provides that children who are discontinued from enrollment in Medi-Cal due to increased family income are eligible to apply for enrollment into the Healthy Families Program (HFP). During the application period for the HFP, the child receives one additional month (i.e., bridge) of Medi-Cal eligibility to mitigate any potential break in health care coverage.

Under the existing Medi-Cal to HFP bridge, if a parent has not already consented to their child's information being shared with the HFP, DHS rules require County Welfare Departments to contact the parents of the child who is no longer eligible for no-cost Medi-Cal and request consent from the parent to forward the child's information on to the HFP.

In addition, children moving from the HFP to Medi-Cal are provided a two-month bridge of eligibility while the County Welfare Department completes the final Medi-Cal eligibility determination. This bridge takes effect when the HFP determines at annual eligibility review that the family's income qualifies the child for no-cost Medi-Cal coverage. Therefore, as a families income rises or falls, children can continue to receive health care coverage as they transition to the other program, pending eligibility determination and plan transfer, when applicable. (The Healthy Families Program to Medi-Cal bridge will be discussed along with other Healthy Families Program issues on April 25th.)

Background—The County Performance Standards for Medi-Cal Processing: California currently delegates most administration for Medi-Cal eligibility determinations and redeterminations to the County Welfare Departments and reimburses them with state and federal funds for this work. Federal and state laws require the counties to complete initial eligibility determinations within 45 days of application and to annually redetermine enrollee's eligibility.

Through the Budget Act of 2003, county performance standards for most aspects of eligibility processing in the Medi-Cal Program were adopted. These included standards regarding both enrollment and disenrollment processes, semi-annual reporting, and annual redeterminations. This action has resulted in hundreds of millions in General Fund savings.

On January 1 of each fiscal year, each county is required to report to the DHS on the county's performance of eligibility and redetermination standards, which are subject to verification by the DHS. If a county does not initially meet the performance criterion, then they must submit a corrective action plan to the DHS for approval. Failure to comply with the performance standards can result in a two percent reduction in county administrative funding for Medi-Cal.

Barriers with Existing Bridge Process: In a letter to the Subcommittee, the County Welfare Directors Association identified several "tools" that would enable the counties to better assist families in bridging from Medi-Cal to the HFP. These included the following key aspects:

- *Update all relevant forms and provide instructions to counties:* The application forms as well as the annual redetermination forms which are presently used do not ask parents for consent to share information between programs. As such, the overwhelming majority of parents whose children are not eligible for no cost Medi-Cal must be contacted. In turn, the counties contend that no standard instructions have been provided to counties for how this parental consent is to be obtained and documented (i.e., to show the state "performance").

- *Streamline County Packaging of Materials:* Once parental consent is given to share information across programs, counties must copy the annual redetermination form and "notice of action" form, complete a transmittal form, package the documents together, and mail them to the HFP administrative vendor. The HFP vendor then mails an application to the individual because the HFP vendor will not accept the annual redetermination form as an application for the HFP. As such, the counties are seeking to have the state re-examine these existing procedures to streamline the process.

The DHS and MRMIB have been working with constituency groups to modify various forms but progress has been quite slow.

Legislative Analyst's Office Comments: In her Analysis, the LAO discusses county eligibility processing and monitoring in a broader context than the Medi-Cal to HFP bridge program. As required in trailer bill legislation from the Budget Act of 2003, the DHS is working with counties to develop overall guidelines covering staffing levels, overhead, and expenditure adjustments to control costs while also enabling timely Medi-Cal eligibility processing (i.e., the County Administrative Cost Control Plan). The LAO recommends to have the DHS report back on this plan.

The LAO also recognizes that the DHS was provided 9 positions and funding in the Budget Act of 2003 but used this funding as part of their mandated statewide reductions in state operations for that year. However, the LAO recommends to provide the DHS with four two-year limited-term positions to monitor selected counties' performance overall on an *exploratory* basis.

Subcommittee Staff Comment and Recommendation: Implementation of county performance measures for the Medi-Cal to HFP bridge program makes sense and would be consist with direction provided by the Legislature through the Budget Act of 2003. However, the existing forms should contain a provision for parents to provide consent to share information across programs, particularly the annual redetermination form. Additional administrative costs are being incurred due to the need to mail notices to parents, and worse yet, children are not receiving timely health care coverage or are experiencing gaps in health care coverage.

Therefore with respect to the trailer bill legislation, it is recommended to (1) adopt the Administration's three proposed performance standards for the bridge as proposed, *except* clarify that the performance standards will not commence until 60-days after the revised applicable forms are available, (2) add language to require the state to develop procedures in collaboration with the counties and stakeholder groups for developing implementing instructions for the bridge by no later than September 1, 2005, (3) add language to require the state to issue by no later than September 1, 2005 a revised annual redetermination form that includes a section for parental

consent to be provided, (4) add language to require the state to streamline methods of providing the necessary information for Healthy Families to make an eligibility determination, and (5) delete language that enables a contractor to perform county monitoring activities in lieu of state staff.

With respect to the Administration's request for $995,000 ($312,000 General Fund) in increased DHS state support, it is recommended to (1) approve two Associate Governmental Program Analyst positions for expenditures of $200,000 ($100,000 General Fund), including benefits and operating expenditures, and (2) delete the remaining $795,000(total funds) intended to fund a half-time Staff Counsel III position and vendor contract for monitoring. These two positions can be used to address both the revised forms and streamlining needs identified above, as well as for overall county performance monitoring purposes.

DHS staff should be used to monitor the counties, not contractors. County oversight is a core function of state government and should be performed by the DHS. It should be noted that the DHS operates a Program Review Section which conducts ongoing reviews of county performance as well as ad hoc reviews as needed. Therefore, providing the DHS with two more staff is adequate.

Questions:

1. DHS, Please provide a brief update on the County Administrative Cost Control Plan, and the existing county performance measures.
2. DHS, Please briefly describe the proposed changes to the Medi-Cal Program's county performance process for the bridge benefit program and how more children would be enrolled into Medi-Cal and the HFP under this proposal.
3. DHS, Why is a contractor proposed to do monitoring in lieu of the DHS?
4. DHS, When will revised forms, that contain a request for parental consent for information to be shared, be available?

8. Proposed Changes to the Existing Single Point of Entry Process for Children (See Hand Outs) (Joint DHS and MRMIB Discussion)

Issue: The Administration is proposing to change the existing "Single Point of Entry" process which is used to process the Joint Medi-Cal/Healthy Families applications (designed for children, pregnant women and adult family members).

Under this proposal, the Medi-Cal applications for children received through the Single Point of Entry would now be completely processed by the HFP vendor (presently Maximus) and then sent to the state for final "certification". The state would then send the completed Medi-Cal application to the appropriate county for ongoing case management, including annual redeterminations. The DHS assumes that about 85,000 applications would be processed in this manner.

The table below displays the *net costs* to the state for this proposal in 2005-06 which are $6.8 million ($2.1 million General Fund). This includes increased costs for 19.5 new state positions, as well as vendor contract expenditures and information system changes. It should be noted that the Healthy Families Program inadvertently did not capture the increased costs for the vendor processing in their budget. This is to be corrected in their May Revision budget.

Table: Summary of Expenditures for Single Point of Entry Changes (2005-06)

Governor's Proposed Single Point of Entry (2005-06)	DHS (Total Fund)	DHS (General Fund)	Healthy Families Program (General Fund)
Local Assistance			
Program Savings	($210,000)	($105,000)	
County Administration	($2,182,000)	($1,091,000)	
Vendor Contract Costs	$1,150,000	$0	$1,150,000
Local Assistance	**($1,242,000)**	**($1,196,000)**	**$1,150,000**
Support Cost (19.5 new state positions)	**$6,909,000**	**$2,172,000**	
Additional General Fund Costs of Proposal = $2.1 million	**$5,667,000**	**$976,000**	**$1,150,000**

The Administration contends that savings of $9 million ($7 million General Fund) will be generated annually from this proposal once fully implemented. The savings generated from the proposal would primarily come from children being removed from Medi-Cal. Presently, when the HFP vendor does the initial Medi-Cal screen and the child seems initially eligible for Medi-Cal, the child is placed on "interim status" and is eligible to receive Medi-Cal services pending final determination being conducted by the county of origin. As such, there are some children who receive services who are later found to be ineligible for Medi-Cal and are subsequently disenrolled. The Governor's new proposal would change this practice.

Background—What is the Existing Single Point of Entry Process? Presently, joint applications for children (Medi-Cal and Healthy Families) are submitted to a "Single Point of

Entry" where they are initially processed by the Healthy Families Program (HFP) vendor. The HFP vendor processes the HFP eligibles and then makes an *initial* determination when an applicant appears to be eligible for Medi-Cal

The Medi-Cal applications are then sent by the HFP vendor to the individual's county of residence. The county then makes the final Medi-Cal eligibility determination. As required by both federal and state law, county eligibility systems work through a progression of eligibility determinations in order to identify which category of eligibility is the most appropriate for the child.

For example, the 1931 (b) category of eligibility is the broadest category of eligibility for children. The key aspect of being enrolled in this program is that they receive at least six months of Transitional Medi-Cal if they become ineligible for Medi-Cal at any point during their 12-month eligibility period due to increased family income.

The next broadest category is "regular" Medi-Cal because children are given a larger income disregard than in the "percent" programs if anyone in the family is aged, blind or disabled. In addition, applicants are also allowed to deduct child care costs and eligibility extends to age 21 in this category.

The "percent" programs provide Medi-Cal coverage for (1) infants up to age 1 with family income up to 200 percent of poverty, (2) children aged 1 through 5 with family income up to 133 percent of poverty, and (3) children aged 6 through 18 up to 100 percent of poverty. Unlike the 1931 (b) program and regular Medi-Cal, these percent programs disregard the value of property owned by the family. Children aged 19 and over are not eligible for coverage under these percent programs.

Subcommittee Staff Comments and Recommendation: First, the proposal does not streamline the process. In fact, it adds more administrative bureaucracy by requiring additional shuffling of applications and adding an *initial* 19 new state positions for "certification" purposes. The clients whom the state is trying to serve are not better off. The proposal actually inserts the state into the process when state "certification" is presently not required because counties can certify now.

The proposed change does not even contain enough detail to know how this restructuring of the Single Point of Entry would be implemented. For example, the following questions still remain:

- What information systems processing changes are needed?
- How would coordination between the HFP vendor, state, and counties, be conducted?
- What changes to the Medi-Cal Eligibility Determination System (MEDS) and related systems need to be completed and what is the cost of this?

It is recommended to delete this proposal and save $5.7 million ($2.1 million General Fund).

Questions:

1. DHS, Please explain your proposal, including the cost per case assumptions.
2. DHS, Are all of the anticipated expenditures associated with the proposal reflected in the Governor's proposed budget?

9. Governor Proposes to Capitate Adult Dental in Denti-Cal at $1,000 *(See Hand Outs)*

Issue: The Governor is proposing to restrict the amount of dental services provided to adults to $1,000 in any twelve-month "rolling" period for proposed *net* savings of $48 million ($24.5 million General Fund) in 2005-06. An implementation date of August 1, 2005 is assumed. This proposal requires trailer legislation to enact.

The proposed net savings assumes **(1)** a reduction of $50.2 million ($25.1 million General Fund) in Medi-Cal dental services, **(2)** an increase of $4 million ($1 million General Fund) for a tracking system, and **(3)** an increase of $165,000 ($59,000 General Fund) to fund 1.5 new DHS positions (Information Systems Specialist and a half-time Staff Counsel).

The DHS states that the $1,000 limit would not apply to:

(1) Emergency dental services within the scope of covered dental benefits defined as a dental condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could result in serious impairment to bodily functions (such as a very severe infection, hemorrhage, or trauma related to a dental origin);

(2) Medical and surgical services provided by a dentist which, if provided by a physician, would be considered physician services, including complex maxillofacial surgical procedures and comprehensive oral reconstruction; and

(3) Services that are federally mandated under 42 Code of Federal Regulations, Part 440, including pregnancy-related services and services for other conditions that might complicate the pregnancy.

According to the DHS, about 900,000 adults enrolled in Medi-Cal actually access dental services annually. Of these individuals, about 95,000 Denti-Cal enrollees would be affected by the $1,000 limit. As noted in the table below, over 55 percent of these individuals, or 52,900 people, are aged, blind and/or disabled.

Table: Average Monthly Adult Eligibles Impacted by Proposed Cap

Type of Adult Eligible	Total Adult Eligibles	Eligibles Impacted by Cap
Aged, Blind, Disabled	1,447,500	52,900
All Other Adults (21-64 years)	1,552,000	42,000
Total	2,998,500 (about 900,000 access dental services annually)	**94,900**

The DHS has not been able to provide data regarding what procedures these individuals required and how they would be affected by the limit if one is implemented. For example, it is possible that all of the 95,000 would lose a similar, moderate number of services each year under the limit. However, another scenario could be that a small portion of the 95,000 would lose a significant number of services, while the rest would see a smaller reduction.

The Subcommittee Hand Out package provides four lists of dental procedure information, including; **(1)** dental treatment sequences that would likely exceed a $1,000 cap; **(2)** procedures with an exact fee of $1,000; **(3)** procedures with fees that exceed $1,000; and **(4)** emergency dental procedures.

It should be noted that the Administration will still continue to use their existing "treatment authorization request" (TAR) process for the dental program. As such, TAR's will continue to be reviewed and adjudicated regardless of the 12-month rolling period.

Further, though claims for emergency services do not require a TAR, dental service claims (done by a dentist) must be accompanied by an emergency certification and medical claims (hospital or physician) claims for emergency dental services must have the appropriate diagnosis code to be paid by Medi-Cal.

The Administration assumes expenditures of $4 million ($1 million General Fund) in 2005-06 for the Denti-Cal fiscal intermediary to track each adult enrollee's dental usage. According to the DHS, system modifications are necessary to accumulate the total dollars spent by enrollee, to then edit the incoming claims for exclusions to the cap, and add a capability for providers to call in and "look-up" the balance available for each enrollee.

Participating Denti-Cal providers would need to access this tracking system to check on the usage status of each and every Denti-Cal patient. The DHS maintains that upon implementation of the proposed cap, dental providers would be able to check the enrollee's level of expenditures through a telephone voice response system. Within six-months, the DHS would include a web-based retrieval system.

According to the DHS, the proposed tracking system would operate as follows:

1. Claim is received by Medi-Cal fiscal intermediary (presently Delta Dental).
2. System checks to see if the billed service is excluded from the $1,000 cap.
3. If the service billed is excluded, the claim moves forward to adjudication.
4. If the service is not on the exclusion list, the system checks the prior 12-month paid claim history (back 12 months from the billed date of service).
5. If claim payment history shows that the dental cap will not be exceeded, the claim will move forward to adjudication.
6. If the cap is met, the claim will be denied.

Dental providers would be encouraged to check the tracking system prior to scheduling or providing any dental services to the enrollee. This is because providers will not be able to directly bill Medi-Cal enrollees that are above the $1,000 cap without a written agreement with the enrollee prior to rendering the service.

With respect to state support, the DHS is seeking an increase of $165,000 ($59,000 General Fund) to hire one Associate Information Systems Analyst and a half-time Staff Counsel to implement the proposal.

Finally, it should be noted that the Administration's proposed trailer bill language provides extremely broad authority to the DHS by enabling them to implement this proposal through all county letters, provider bulletins, or similar instructions. Thereafter, the DHS *may* adopt regulations.

Background—Overview of Existing Denti-Cal Program: Individuals enrolled in Medi-Cal are eligible to receive a range of dental health care services. Access to dental services for children under age 21 is required by federal law, whereas adult dental services are considered "optional".

Generally, covered dental benefits for children and adults include: (1) diagnostic and preventive services such as examinations and cleanings, (2) restorative services such as fillings and (3) oral surgery services. Many services such as crowns, dentures and root canals require prior authorization.

State law requires most Medi-Cal enrollees to pay a co-payment for dental care. A $1 co-payment is required for services provided in a dental office and a $5 co-payment is required for non-emergency care provided in an emergency room. As directed by federal law, services cannot be denied to a recipient if a co-payment is not provided

Over 90 percent of Medi-Cal enrollees are eligible for fee-for-service care through the Denti-Cal Program. In addition, about 350,000 individuals receive dental services through managed care arrangements (including Sacramento, San Bernardino, Riverside and Los Angeles).

It is well recognized that the reimbursement rates currently paid under Denti-Cal are very low—generally about 40 to 50 percent of the usual and customary fee charged by dentists in California.

Prior Subcommittee Hearings--Subcommittee Request for Information and Potential Options: In the Subcommittee's March 2nd hearing, numerous issues were raised regarding the Administration's dental capitation proposal, and the Subcommittee chair requested additional information regarding a range of potential options.

First, in response to concerns raised about the potential affect on individuals with developmental disabilities being served through the Regional Center system, the Department of Developmental Services (DDS) was contacted. The DDS noted they had not calculated a fiscal impact for this DHS proposal as part of their January budget estimate for the Regional Centers.

However based on subsequent information provided by the DHS, the DDS estimates that 1,680 Regional Center consumers would be affected at a cost of $1.160 million General Fund for 2005-06 (11 months). If services are not available through Medi-Cal, then the Regional Centers must purchase them using 100 percent General Fund support. The DDS notes that this estimate will be refined at the time of the May Revision.

Second, existing statute provides for one dental cleaning annually. Any subsequent cleanings require a Treatment Authorization Request (TAR) and must be approved by the DHS. Based on data obtained from the DHS, if a TAR was not required for the second cleaning, there would be a 60 percent increase in the number of cleanings (i.e., second cleaning) which would require an increase of $12 million ($6 million General Fund) annually.

Third, there are numerous options that can be crafted for a dental cap. The three key factors are (1) dollar amount of the cap, (2) dental services to be excluded under the cap (not counted towards the cap amount), and (3) the period of time for the cap (one-year or two years, and "rolling" versus calendar year). At the request of the Subcommittee, the DHS has provided fiscal information based on several options as requested. The key options and their estimated fiscal affect are in the Hand Out package. (In reading the options list, the grey shaded area is the area to focus on. This shows the fiscal affect assuming exclusion of emergency services and services provided to individuals residing in a nursing home.)

Subcommittee Staff Comment: The Administration seeks to implement a $1,000 cap in Denti-Cal in an effort to align benefits more closely to the commercial market place. However, Denti-Cal is quite dissimilar to the commercial market place in several ways. It serves more medically needy individuals than the commercial market, reimburses at rates which are generally 40 to 50 percent of the usual and customary fee charged by dentists in California, and has eliminated or restricted services to enrollees due to budgetary constraints over the years.

If a cap is to be implemented, it is suggested to narrow down the potential options for further discussion to the following:

Option Description (***All*** **assume exclusions for emergency services & long-term care)**	**Impacted Enrollees**	**Estimated Savings (total funds)**
1. Administration's proposal: $1,000 annual cap (rolling) (figures are revised from budget due to emergency & LCT)	93,117	$41,680,000 *(revised)*
2. $1,500 annual cap (calendar year) and no additional exclusions.	37,285	$18,244,000
2. $1,500 annual cap (calendar year) *and* excludes dentures & complex oral surgeries	27,074	$14,020,000
4. $2,000 aggregate cap over two-years and no additional exclusions	34,899	$18,913,850
5. $2,000 aggregate cap over two-years and excludes dentures & complex oral surgeries	34,899	$14,502,000
6. $1,800 aggregate cap over two-years and no additional exclusions	48,159	$25,327,000
7. $1,800 aggregate cap over two-years and excludes dentures & complex oral surgeries	33,388	$19,000,000

If a cap is to be implemented, a sunset date should be placed in the statute to provide for an opportunity to revisit the cap and if needed, adjust rates or other factors to ensure adequate access to dental services. In addition, a "calendar" year (as done in the commercial market) year should be used in lieu of a "rolling" year cap.

Finally, the DHS should not be granted broad authority for implementation. Regulations which require public discourse, versus solely using "all county" letters or provider bulletins, should be used if any aspect of this proposal is adopted by the Legislature.

Questions:

1. DHS, Please provide your technical assistance perspective of the options outlined above.

10. Program of All-Inclusive Care for the Elderly (PACE)

Issue: Constituency groups have raised concerns with the current status of the Program of All-Inclusive Care for the Elderly (PACE) in California. Specifically, nonprofit organizations who have invested resources to develop a PACE program are delayed and have no assurance that their applications will be processed and approved by the DHS in a timely manner. They contend that current PACE providers are unable to expand service areas because of DHS' lack of staff and commitment to the program.

Through the Budget Act of 2001, the Legislature provided $200,000 ($100,000 General Fund) for additional DHS staff to process PACE applications but this was vetoed by the Governor. Through the Budget Act of 2002, the Legislature again provided $200,000 ($100,000 General Fund) for additional DHS staff but the DHS was unable to fill the positions in a timely manner and the funds were swept as part of a reduction to state administration.

According to the National PACE Association, over 65 organizations in California have inquired about developing a PACE. At a minimum, all of the existing PACE providers, as noted below, want to expand their number of sites, and the following organizations are in varying stages of the application process: (1) St Paul's Senior Homes and Services/Community Eldercare of San Diego; (2) LifeSteps Foundation of San Luis Obispo; (3) Santa Teresita Hospital of Durate; (4) Well and Fit ADHC of Diamond Bar; (5) Masonic Homes of Union City, (6) Daylight Adult Day Health Center of San Gabriel, and (7) Downey, Regional Medical Center of Downey.

It should be noted that On Lok, with funding from The California Endowment (TCE), is presently working with federal and state regulators, providers and consumer groups on a project to streamline the regulatory oversight for PACE and other integrated (Medicare and Medicaid) providers. As part of this effort, a task force is exploring what quality indicators are important for seniors and persons with disabilities.

According to the DHS, there are 3.5 positions within the DHS Office of Long-Term Care that are dedicated to processing PACE applications. According to the DHS, it can take up to three DHS staff to bring up one PACE provider, and it can take several years to do so.

Background—What is PACE: PACE providers integrate all Medicaid (Medi-Cal) and Medicare funding and services so that older individuals in need of long-term care can continue living in the community. PACE coordinates the care of each participant enrolled in the program based on individual needs.

PACE provides comprehensive medical and long-term care services, with the program's interdisciplinary team (physicians, nurse practitioners, nurses, social workers, therapists, van drivers and others) fully coordinating these services. PACE programs receive monthly capitated payments from Medicare, Medi-Cal and private individuals depending on the individual's eligibility for public programs.

To be eligible for PACE, an individual must:

- Be 55 years of age or older;
- Be certified by the state to need nursing home care;

- Reside in the service area of the PACE organization; and
- Be able to live in a community setting without jeopardizing his/her health or safety.

PACE providers and the National PACE Association have successfully worked with the federal CMS and State Medicaid agencies to implement PACE nationally. In 1986, Congress authorized a federal demonstration program—PACE—to replicate the successful model of care developed by On Lok in San Francisco. Through the Balanced Budget Act of 1997, Congress set up PACE as a permanent provider type under Medicare and Medicaid (Medi-Cal). In 2002, state legislation was enacted to make PACE a permanent benefit under the Medi-Cal Program.

California presently has four approved PACE providers that have 13 PACE centers in different low-income communities, serving over 1, 700 seniors. The PACE programs include: (1) On Lok in San Francisco, (2) Center for Elders Independence in Oakland, (3) Sutter SeniorCare in Sacramento, and (4) AltaMEd Health Services Corporation in Los Angeles.

Background—PACE is Cost-Effective: PACE receives a capitated Medi-Cal rate, as well as Medicare rate. The Medi-Cal capitated rates provide the state with a 5 percent to 15 percent savings relative to its expenditures for a Medi-Cal nursing home population. PACE programs have full financial risk for services including nursing home placement if participants need this service.

Subcommittee Staff Comment: PACE continues to be a cost-effective model and providers are interested in joining PACE. The Legislature has provided additional staff resources to the DHS in the past, only to have them left unfilled and eliminated. However, continued expansion of the PACE model appears to be warranted. As such, the Subcommittee may want to consider a redirection of two DHS staff for this purpose.

Questions:

1. DHS, Please describe the benefits of the existing PACE model.
2. DHS, Please explain how PACE applications could be processed in a more timely manner.
3. DHS, Is the Administration interested in the continued expansion of the PACE model?

11. Administration's Proposed Acute Long-Term Care Program *(See DHS Hand Out)*

Issue: The Administration proposes to implement a new program—the Acute and Long-Term Care Integration Program through trailer bill legislation (See page 24 of Administration's language). As proposed in the trailer bill legislation, the program would be an expansion of the Medi-Cal Managed Care Program, and *not* simply a pilot project for three county areas (Contra Costa, Orange and San Diego) as originally perceived by many prior to the release of the Administration's language (provided on March 25th).

The language provides the DHS with complete discretion as to how the ALTCI would operate including any federal waivers they choose to seek or any state plan amendment they choose to make, and it provides that they can implement, interpret, or make specific any aspect of the program by means of all county letters, all plan letters, or provider bulletins, or similar instructions. No public discourse through Legislative hearings or regulatory rulemaking would be necessary.

Under the proposal, "Acute and Long Term Care Integration" (ALTCI) health plans would provide comprehensive Medi-Cal services to enrolled seniors and adults with disabilities (i.e., Medi-Cal and Medicare eligibles) and would incorporate primary, acute and long-term care services, and home and community-based services and providers in their networks (such as mental health services, social services, personal care services provided under IHSS, nursing facility services, and others). The chart below displays the differences between Medi-Cal Managed Care coverage and the newly proposed ALTCI.

Traditional Managed Care Coverage	ACTCI Coverage
Primary Care	Primary Care
Hospital Care, Emergency Room Services, Surgeries	Hospital Care, Emergency Room Services, Surgeries
Case Management of Medical Services	Case Management of Medical Services
Medi-Cal Scope of Benefits (all offered)	Medi-Cal Scope of Benefits
	Expanded Case Management across medical, social and supportive services with consumer participation as a priority and with interdisciplinary team support. Case Management would have a priority to avoid institutional placements.
	Nursing Facility Services
	Adult Day Health Care
	Personal Care Services (IHSS)
	Mental Health Services
	Home and Community-Based Services (home modifications, personal emergency response systems, nutrition, and others necessary to avoid or delay inpatient nursing facility care.

The integration of Medi-Cal and Medicare funding and services would occur at the health plan level. As such, the participating health plans must also be federally approved as Medicare Plans ("Medicare Advantage plans), and must include Medicare prescription drug coverage.

ALTCI plans would be reimbursed through a capitated payment from the state for Medi-Cal services and a capitated payment from the federal CMS for the Medicare services for eligible members. The plans would assume full risk for a comprehensive array of services including acute hospital care, nursing facility care and home and community based services and supports under this funding mechanism. The DHS states that capitated rates across the entire health and social support continuum creates fiscal incentives for the plans to provide proactive and preventive services to avoid higher costs in institutional settings.

The DHS states that the policy, standards and measures, and safeguards for the ALTCI plans would be developed through a stakeholder process which is going to be convened to discuss the Administration's overall plan to expand managed care. The DHS states that the stakeholder process would be a nine to ten month process with the goal of developing recommendations in early 2006. The DHS contends that identified program changes can then be adopted, implemented, and included in health plan contracts as appropriate. No state statutory changes would be required.

The ALTCI plans would be phased into Contra Costa, San Diego and Orange counties first. These three geographic areas were selected for several reasons. First, these areas have been actively engaged in the state's long-term care integration planning grants process intended to develop integrated local services systems for seniors and the disabled. Second, each represent a different Medi-Cal Managed Care model—Contra Costa has a Two Plan Model, San Diego has a Geographic Managed Care Model, and Orange County operates a County Organized Health System (COHS). Third, each area has an array of home and community-based support services. Fourth, each area has an active stakeholder process.

The Administration wants to implement the model in these counties to facilitate modifications on a smaller scale should they become necessary and to validate the model before it is implemented statewide.

Summary Table of ALTCI Enrollment and Start Dates

ALTCI Areas (Phase I)	DHS Estimated Enrollment (Seniors and adults with disabilities)	DHS Proposed Start Dates
Contra Costa	27,092 adults	January 1, 2007
San Diego	89,417 adults	March 1, 2007
Orange County	74,139 adults	September 1, 2006

Enrollment options for individuals would vary contingent upon eligibility for Medicare and the geographic area. For "Medi-Cal-only" individuals (about 40 percent of seniors and adults with disabilities) living in San Diego or Contra Costa, these individuals will have a choice to either (1) enroll or stay in a "traditional" Medi-Cal Managed Care Plan, (2) enroll in an ALTCI plan, or (3) be "defaulted" into an ALTCI plan if no choice is made.

For the dually eligible living in these two areas (60 percent are dually eligible), the individual can (1) enroll in an ALTCI plan and maintain Medicare coverage separately, (2) enroll in an ALTCI plan and enroll in the same plan for Medicare coverage and Medicare Drug coverage

through a "Prepaid Drug Plan", (3) enroll in a PACE plan if eligible and one is available, or (4) be "defaulted" into an ALTCI plan if no choice is made.

Since Orange County operates CalOPTIMA, all individuals would enroll into its ALTCI plan but could also maintain Medicare coverage separately if desired.

The DHS will use different approaches in selecting the ALTCI plans for the three areas since each area operates a different Medi-Cal Managed Care Model. In Orange County, CalOPTIMA will develop a service delivery system.

Contra Costa as a Two Plan Model will have Contra Costa Health Plan (local initiative) as well as a competitive procurement to select the second ALTCI plan (commercial plan). If the Contra Costa Health Plan does not want to participate as an ALTCI then a second competitive procurement would be done.

San Diego as a Geographic Managed Care Model would use a Request for Application process. The state would release specifications and requirements for ALTCI plans through the RFA process and would review and select participating ALTCI plans based on meeting both state and county requirements. The number or participating plans would be determined by the number of successful applicants.

Core major milestones that the ALTCI plans will need to meet (as presently identified) include the following:

- Apply to the federal CMS to become a Medicare Advantage Plan (subject to federal CMS timelines for Medicare applications);
- Access current home and community-based services provider capacity and utilization in the county. From this data, develop recommendations to the state regarding provide networks.
- Expand and draft ALTCI care management protocols and submit to DHS.
- Establish cultural competency standards including age and disability issues for enrolled populations.
- Participate with the state on Quality Assurance measures for enrolled populations.
- Establish policies to "operationalize" Quality Assurance measures that ALTCI plans must meet to serve the enrolled population.
- Identify assessment tool/protocol and ALTCI service authorization guidelines.
- Assess and build information technology support for comprehensive care management across medical and social services providers/functions.
- Enroll members.

The DHS Office of Long-Term Care presently has 7.5 positions (3.5 positions used for PACE and 4 positions used for the Long-Term Care Integration Projects—see below). Of these positions, two are scheduled to expire as of June 30, 2005.

The DHS is requesting funds for 8 positions (permanent) to perform a number of implementation functions regarding this proposal, and is also seeking an increase of $500,000 to contract for the development and implementation of a Long-Term Care Diversion Assessment Protocol.

It is the intent of the state to have the ALTCI plans work with a contractor on the development and implementation of a uniform Long-Term Care Diversion and Assessment Protocol for seniors and adults with disabilities. This protocol would be used to determine functional needs and preferences and to ensure that seniors and adults with disabilities receive care that supports maximum community integration and self-direction.

The DHS notes that the development of this protocol will involve stakeholders, including consumers, advocates and representatives from home and community-based programs, and is consistent with the United States Supreme Court's Olmstead decision for community integration.

Background—Long Term Care Integration Projects: The Legislature authorized planning grants commencing in 1998 as a result of state and local interest in creating a more efficient delivery system for seniors. The first grants were allocated by the DHS in 1999. A total of $2.6 million (General Fund) has been awarded to 16 counties between 1999 and 2004.

Both San Diego and Contra Costa counties have sustained ongoing planning efforts and were the first entities to receive "implementation" grant awards (total of $897,500) in 2004-05 to precede with various integration activities. These funds are continuing into 2005-06.

Subcommittee Staff Comment: The Administration's proposal to craft a new ALTCI Program for seniors and adults with disabilities has merit. Consumers with chronic care needs and long term care needs often must seek services and supports from several distinct health care programs and home and community-based service entities, each with its own separate assessment process and care plan. Discussions regarding the integration of programs that serve this community has been ongoing for several years.

However, such a comprehensive effort should not be enacted through the budget process particularly when significantly more work needs to be completed prior to any implementation, even one that is "phased-in". Policy legislation which provides a framework for the program and enables the three areas to proceed as a pilot could be crafted by the Administration in lieu of trailer bill legislation.

The Administration is seeking broad authority in their language to proceed with federal waivers and state plan amendments prior to working with stakeholder groups to more definitively frame the proposed ALTCI Program. Many issues abound as to even what kind of waivers the Administration will be seeking or how cost-effectiveness would be calculated. Considerable discussion with the federal CMS still needs to occur regarding issues pertaining to both the Medicaid (Medi-Cal) and Medicare programs (100 percent federally funded), as well as many of California's social services programs and mental health programs.

No fiscal analysis of the proposal has been provided and only last week was a paper even describing the proposal provided to the Legislature. In addition, the LAO has submitted numerous questions to the Administration regarding the proposal and responses are still pending.

If desired, the Subcommittee could (1) approve the $500,000 for the Long-Term Care Diversion Assessment Protocol to be developed, and (2) provide two to three staff to continue work with the three counties and to commence with stakeholder discussions. However is it recommended to reject the proposed trailer bill legislation. There is ample time for a new program such as this to proceed through the Policy Committee process.

Questions:

1. DHS, Please describe the key aspects of the proposed ALTCI Program.
2. DHS, Please describe what federal waivers would be needed for implementation and what specifically would be waived?
3. DHS, Please describe the proposed trailer bill legislation (reference Hand Out if needed).
4. DHS, Please describe your proposed schedule for implementation.

12. Administration's Medi-Cal Managed Care Proposal—*Informational Only*

Issue: The Subcommittee has convened two public hearings in which the Administration's proposal to expand Medi-Cal Managed Care has been discussed. Through these discussions several concerns have been raised, including issues related to: (1) access to health care, particularly for seniors and persons with disabilities, but also for certain rural populations in some counties proposed for expansion of the program;(2) the lack of quality indicators specific to the senior and persons with disabilities population, and (3) setting Medi-Cal Managed Care rates.

A. Access to Care and Care Coordination: According to data recently analyzed by the Lewin Group through a project under the management of the California Healthcare Foundation (CHF), Medi-Cal enrollees who are in fee-for-service and are categorically aged, blind or disabled are much more likely to have chronic conditions than all other Medi-Cal aid codes. For example, they note the following:

- At least 45 percent have Pulmonary disease (compared to 20 % of other enrollees)
- 40 percent have musculo-skeletal concerns (compared to less than 10% of others)
- Almost 30 percent have significant mental health concerns (others less than 5 percent)
- 25 percent have hypertension (others less than 5 percent)
- 20 percent have cardiovascular disease (others less than 8 percent)

Since these individuals are proposed to be enrolled on a mandatory basis under the Managed Care expansion, how is access to care for specialty physicians and services going to be achieved and how is care coordination to be managed?

"Access to care" encompasses many activities and features that guarantee, enhance, or promote access to care. These may include network access standards (e.g., provider to member ratios, time and distance standards to health care services), requirements for physical accessibility (e.g., ADA compliance) and translation/interpreter services, and requirements for access to particular provider types, second opinions, and other services.

The federal Balanced Budget Act of 1997 requires states to apply certain federal regulations that govern state Medicaid (Medi-Cal) contracts. As noted by the CHF analysis, in many cases states have developed additional or specific requirements to address local concerns or market conditions.

Care coordination may include definitions and requirements for case management, disease management and care coordination. Coordination of care may include coordination with other managed care organizations, other state programs, non-capitated services and/or family members. Care coordination may also include requirements for developing individual care plans, authorization of services and the credentials of care coordination staff.

Again, the federal Balanced Budget Act of 1997 requires states to apply certain federal regulations that govern state Medicaid (Medi-Cal) contracts. As noted by the CHF analysis, in many cases states have developed additional or specific requirements to address local concerns or market conditions.

Questions:

1. DHS, Could you please describe whether the state presently has any additional or state-specific requirements to address local concerns or market conditions now for these areas and if so, what are they?
2. DHS, How may the existing practice change with the proposed expansion? Please be specific.

B. Quality Indicators Specific To Seniors and Persons with Disabilities Population: As noted by the CHF materials, state Medicaid programs often rely on national performance measures and too few of these measures focus on people with disabilities. They note that this may be attributed to limited information about evidence-based practices, prevalence relative to other conditions, and commercial purchaser priorities (which tend to drive national measurement sets). The development of performance measures for this population is needed and is necessary in order to ensure quality. Considerable work will need to be done in this area. The table below displays what California presently uses in the Medi-Cal Managed Care Program.

Medi-Cal Plan	**Reporting/Monitoring**	**Frequency**
County Organized Health System	• Health Plan Employer Data (HEDIS)—7 measures • Standards & Performance Requirements for linguistic services	Annually
Local Initiative	• External Accountability Set (by county) • Under/Over-Utilization monitoring • Consumer Satisfaction Survey • Group Assessment for Cultural Linguistic Needs	Annually Annually DHS decides 5 years
Commercial	• External Accountability Set (by county) • Under/Over-Utilization monitoring • Consumer Satisfaction Survey • Group Assessment for Cultural Linguistic Needs	Annually Annually Annually 5 years

Questions:

1. DHS, Please briefly discuss the existing quality indicators. What does the DHS do with the information?
2. DHS, What additional quality indicators are being contemplated? How will stakeholders be involved in this process?

C. Medi-Cal Managed Care Rate Structure: Questions regarding the existing Medi-Cal Managed Care rate structure have been evolving for several years. As noted by the LAO in past Analyses, the existing methodology is outdated.

Though the DHS did change its methodology in 2003 in order to meet federal law requirements to be actuarially based, amongst other things, the DHS does not use encounter data to make rate determinations.

The "base cost" is the part of the rate that relates to experience from the past. Generally, to calculate the base cost, an attempt is made to find a group of individuals that will be similar to the group for which the rates are being set. Claims tapes for four COHS's is used for determining the Two Plan Model rates. Various adjustment factors are applied to the base costs, such as for age/sex population mix, enrollee's duration of Medi-Cal enrollment, trend factors for hospital inpatient and outpatient services, trend factors for pharmacy, and other factors. In addition, changes made through the state budget process are also to be factored in as part of the process.

Currently there are contract provisions that provide for an administrative remedy and an appeals process when disputes are raised by the plans regarding contract issues. These provisions are included in the Two Plan Model, Geographic Managed Care and the COHS contracts. Specifically, there is (1) an initial "notice of dispute" process, (2) an administrative appeals process, and (3) a Writ of Mandate process which is filed with the Superior Court to protest the Administrative Appeal decision. Within the last two-years, 15 plans have filed some form of Administrative Appeal regarding rates. Four cases have been taken to Superior Court.

The DHS notes that they have recently awarded a contract to Mercer which begins May 1, 2005. Expenditures in the current year for this contract are expected to be $300,000 (total funds) and $1 million for 2005-06.

Questions:

1. DHS, Please provide an overview of the existing rate determination process for Medi-Cal Managed Care.
2. DHS, Please provide an overview of the work products to be produced by Mercer.
3. DHS, How may this new information be used to develop a revised rate methodology?

Background for Reference—Summary of the Administration's Proposed Managed Care Expansion: The Administration's Medi-Cal Managed Care expansion would be achieved through a phased-in process over a twelve to eighteen month period commencing in January 2007. The Administration's proposal would require (1) state statutory changes, (2) approval of a federal Waiver, and (3) adoption of state regulations.

It is anticipated that 816,000 additional Medi-Cal enrollees, including the *mandatory enrollment* of aged, blind and disabled individuals, would be added to managed care through this proposed expansion. These 816,000 new enrollees, of whom 554,000 would be aged, blind or disabled, would represent an increase of over 25 percent

The proposed expansion assumes the following key components:

1. Expansion to 13 New Counties: The Administration would expand Medi-Cal Managed Care to 13 additional counties, including El Dorado, Imperial, Kings, Lake, Madera, Marin, Mendocino, Merced, San Benito, San Luis Obispo, Sonoma, Placer and Ventura. Enrollment would include families, children and the mandatory enrollment of aged, blind and disabled individuals.

The Administration assumes the following Managed Care model configurations for these new counties:

- Include El Dorado and Placer counties in the existing Sacramento GMC;
- Include Imperial County in the existing San Diego GMC;
- Convert Fresno County (now a Two Plan) to a GMC and include Madera, Merced, and potentially Kings counties;
- Expand existing COHS to include the counties of Marin, Mendocino, San Benito, San Luis Obispo, Sonoma, Ventura and possibly Lake. For example, San Luis Obispo County could merge with the existing Santa Barbara COHS.

The Administration assumes that all of these counties are up and operational (ready for enrollment) by no later than April 2008.

2. Aged, Blind and Disabled Individuals (Mandatory Enrollment): The DHS has identified 36 Medi-Cal aid codes which they would require to enroll into a managed care plan. Dual eligibles (Medicare and Medi-Cal) would not be included in this mandated group but could be voluntarily enrolled at the individual's option. It is assumed that about 554,000 or so aged, blind and disabled individuals would be enrolled in a managed care plan by the end of 2007-08 and beginning of 2008-09. The 554,000 new enrollees represents a 100 percent increase over the number of aged, blind and disabled individuals presently enrolled (i.e., 280,000 persons).

The 13 new managed care counties as referenced above would immediately enroll these individuals as part of their implementation plan along with families and children enrollees. The existing Two-Plan and GMC plans would phase-in this new population over a period of 12 months.

13. Disease Management Pilots: Status Update and Funding Level Discussion

Issue: The budget proposes expenditures of $4 million ($2 million General Fund) in Medi-Cal local assistance to contract with at least two disease management organizations in 2005-06. This funding level assumes a July 1, 2005 implementation date.

Through the Budget Act of 2003 and accompanying trailer legislation, the Legislature authorized the DHS to apply for a federal Waiver to test the efficacy of providing a Disease Management benefit to Medi-Cal enrollees. The DHS received three state positions for this purpose.

According to the DHS, implementation of the Disease Management Pilots is behind schedule. Based on the most recent schedule, at the *earliest*, the awards for the contracts will not be made until mid-December, 2005. Specifically, the following activities need to be completed:

Activity	Estimated Completion
• Submit State Plan Amendment (SPA)	May 31, 2005
• Federal CMS approves SPA	August 1, 2005
• Submit Request for Application (RFP) to Medi-Cal Procurement	August 1, 2005
• RFP released to bidders	November 1, 2005
• Bid/Evaluation process completed	December 15, 2005
• Contract awarded	December 15, 2005

This schedule is contingent upon (1) a timely federal CMS approval of the SPA, (2) a timely release of the RFP to bidders, and (3) no protests from bidders.

Background—Disease Management and Its Use: Existing state statute defines "disease management programs and services" as services administered to patients in order to improve their overall health and to prevent clinical exacerbations and complications utilizing cost-effective, evidence-based, or consensus-based practice guidelines and patient self-management strategies.

Existing statute defines a "disease management organization" as an entity that provides disease management programs and services, which contracts with any of the following: a health care service plan; a contractor of a health care service plan; an employer; a publicly financed health care program, or a government agency.

Disease management can improve the quality of life of patients by catching health-related problems early, enabling patients to subsequently avoid high cost medical treatments and procedures—especially those associated with hospitalizations. Evidence of the efficacy of these programs has been shown for a variety of chronic conditions including diabetes, coronary artery disease, chronic obstructive pulmonary disease, asthma, renal disease and other chronic illnesses.

The expansion of disease management programs is a nationwide trend. At least seven or so states have implemented Disease Management pilots for Medicaid (Medi-Cal) enrollees through a federal Waiver, and 30 states have implemented various types of Disease Management Programs since at least 1995.

Legislative Analyst's Office Comment: The LAO notes that Disease Management Programs, particularly for asthma, diabetes, renal function failures, chronic obstructive pulmonary disease and depression, can be effective. For example they note that a one percent reduction in costs for these five chronic conditions could result in annual savings of $15 million ($7 million General Fund)

Subcommittee Staff Comment and Recommendation: Implementation of Disease Management Projects within Medi-Cal is over due and the schedule has slipped to be a January 1, 2006 implementation date, at the earliest. As such from a strictly fiscal perspective, it is recommended to reduce the Disease Management Projects by $2 million ($1 million General Fund) to reflect a six month implementation amount for 2005-06.

Questions:

1. DHS, Please describe the projects and the updated schedule.

14. Medi-Cal Assistance Claiming—Request for DHS Staff

Issue: The DHS requests an increase of $938,000 ($469,000 reimbursements from Local Government Agencies and $469,000 in federal funds) to support ten new positions due to increased workload associated with Medi-Cal Administrative Activities (MAA) and the Targeted Case Management Program (TCM). Specifically, eight of the positions would be for MAA and two would be for TCM. No General Fund support is necessary.

The DHS states that positions are required to manage the continuous growth in MAA claiming and need for TCM oversight. More local entities are interested in MAA claiming because these federal matching funds are not capped and are an under utilized source of revenue. The DHS estimates that MAA claiming will be $430 million (federal funds) for the current-year. The TCM positions would be used in the Audits and Investigations unit to conduct financial and compliance audits of local entities accessing these funds and periodic site reviews.

Background—MAA and TCM Programs: The MAA and TCM programs enable county departments of public health and local education consortia to receive federal reimbursement from Medi-Cal for the cost of providing services for certain activities. Public health departments and local education consortia contract with the DHS to manage their MAA and TCM programs (i.e., process invoices, contracts and claims for federal matching funds). These contracts finance, among other things, (1) local outreach for Medi-Cal, (2) facilitation of Medi-Cal application/enrollment, (3) case management to specific target populations, and (4) claims administration.

Subcommittee Staff Comment and Recommendation: No issues have been raised. The requested DHS positions require no General Fund investment and the workload is justified. Therefore it is recommended to approve as budgeted.

Questions:

1. DHS, Please explain your need for the eight positions.

LAST PAGE OF AGENDA.

Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda

Chair, Senator Denise Moreno Ducheny
Senator George C. Runner
Senator Tom Torlakson

Thursday, April 7, 2005
(Upon Adjournment)
John L. Burton Hearing Room (4203)
Consultant, Anastasia Dodson

Item	Department	Page
5175	Department of Child Support Services	1
5180	Department of Social Services	
	California Work Opportunity and Responsibility to Kids (CalWORKs)	9

Please Note: Only those items and issues contained in this agenda will be discussed at this hearing. Issues pertaining to these items may be reviewed again. Please see the Senate File for dates and times of subsequent hearings.

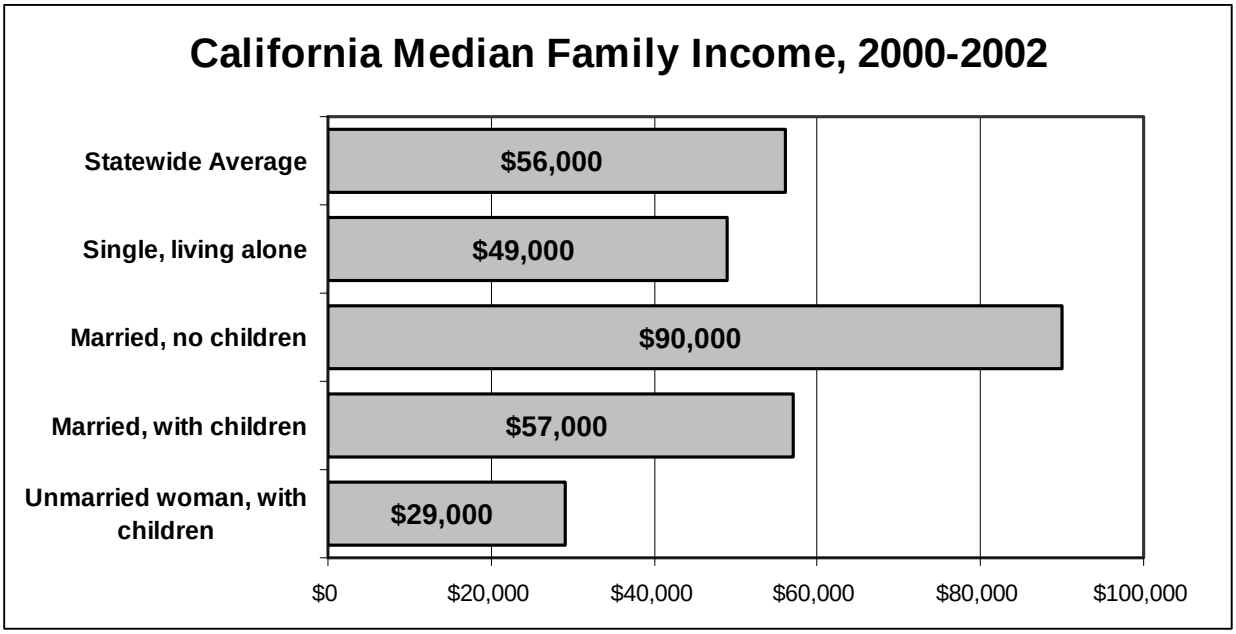
Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by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

5175 Department of Child Support Services (DCSS)

Budget Summary: The Department of Child Support Services (DCSS) administers the child support enforcement program operated by local child support agencies (LCSAs). The budget anticipates collections of $2.4 billion in the budget year, an increase of 1.7 percent over the current year. The department's overall budget expenditures are proposed to increase by $279.2 million to $1.4 billion. Most of the additional funding request is due to the child support automation system penalty (see issue 1 below).

Mission: The mission of the Department of Child Support Services is to promote the well-being of children and the self-sufficiency of families by providing child support establishment, collection, and distribution services to help both parents meet the needs of their children.

Figure 1



Source: Public Policy Institute of California, *Recent Trends in Income and Poverty*, February 2004

Children and Families in Poverty: Child support can help mitigate the low income and high poverty rates for children and families headed by single women. As shown in Figure 1 above, median family income for unmarried women with children is $29,000 per year, slightly more than half of the married with children family income level. Over 1.7 million California children (18.6%) live in poverty. California ranks 38th out of 50 states and the District of Columbia in child poverty, despite having the 11th highest median family income. Thirty-two percent of female-headed households in the state were living in poverty in 2003. (The federal poverty level was $15,260 for a family of three in 2003.)

DCSS Issue 1: California Child Support Automation System (CCSAS) Federal Penalty

Description: Since 1997, California has been subject to substantial federal penalties due to the state's failure to establish a single statewide system for the collection of child support. The cumulative federal penalty from 1998 through 2006 is expected to be over $1.2 billion General Fund. The automation system is scheduled to be completed and implemented statewide by 2008.

Background:

- **$218 Million Federal Penalty in Governor's Budget:** The budget includes $218 million General Fund in 2005-06 for the federal fiscal year (FFY) 2005 penalty. The 2004 Budget Act did not include funding for this penalty, as the payment was entirely deferred to state fiscal year 2005-06. The federal government recently informed the department that payment of the FFY 2006 penalty will be deferred to 2006-07. The penalty amount is a percentage of program administration costs, with an increasing percentage each year. California has reached the maximum percentage level at 30 percent of administrative costs.

- **2005 Penalty Reduction Denied:** During 2004 budget hearings, the department indicated that federal certification of automation system compliance might be possible as early as September 2005. If approved this would have reduced the 2005-06 penalty by 90 percent. Based on an October 2004 letter from the federal government, the department now indicates certification and penalty relief are not expected until September 2006.

Questions:

1. DCSS, when does the Administration expect that the federal penalty will be reduced? In what year does the Administration expect to make the final federal penalty payment?

2. DCSS, has the Administration requested from the federal government that the state be allowed to reinvest the penalty in child support program activities?

DCSS Issue 2: CCSAS Governor's Budget Augmentations

Description: The Governor's Budget proposes $267 million ($92 million General Fund) for the continued development of CCSAS, including an augmentation of $90 million ($25 million General Fund) above the current year. This includes funding for both the CCSAS Child Support Enforcement (CSE) component and the State Disbursement Unit (SDU) component. The Franchise Tax Board (FTB) acts as DCSS' agent for the procurement, development and maintenance of the CCSAS project. Due to Legislative concerns, recent CSE contract amendments have been renegotiated to include deliverable-based payment conditions.

Background:

- **CCSAS Child Support Enforcement (CSE) Component:** The CSE component of CCSAS will provide a statewide central database for case management, financial management, and interstate communication. The budget proposes to redirect 1.5 existing DCSS positions and reestablish 1.5 expiring limited-term positions to implement the CSE component. Total costs for the CSE are projected to be $1.3 billion ($466 million General Fund) from 2003-04 through 2012-13. This component is scheduled to be completed by September 2008.

- **CCSAS State Disbursement Unit (SDU) Component:** The SDU component of CCSAS will provide statewide collections and electronic disbursement. The budget proposes 37.0 additional positions (10.5 new and 26.5 redirected) for SDU project development and operations. Total costs for the SDU are projected to be $217 million ($76 million General Fund) from December 2004 through December 2011. This component is scheduled to be completed by September 2006.

- **Redirected Positions:** The Administration's proposal to redirect 29.5 positions includes 13.0 expiring limited-term positions that were originally established for the Compromise of Arrears program. The department indicates that the remaining 16.5 positions were redirected from non-CCSAS project positions, and from non-critical mission areas that would allow the department to still meet state and federal requirements at a reduced level. The areas of redirection include Forms and Outreach, Quality Assurance, Data and Performance Analysis, California Parent Locator Services, Accounting and Fiscal Services, and Business Services. The department indicates that it is committed to the CCSAS SDU project and plans to do what is necessary to ensure the successful development and implementation is completed in a timely manner.

- **Trailer Bill Language for SDU General Fund Loan Authority:** The budget also includes trailer bill language that would authorize DCSS to borrow up to $150 million from the General Fund to ensure timely disbursement of child support payments.

  The department indicates this loan authority is necessary to rule out potential delays in moving collections through the State Treasury system. It will take a minimum of two days to move collections through the State Treasury system to the Service Provider (Bank of America). This process can take longer depending on the timing of when remittances are received and processed by the State Treasurer. Additionally, the loan authority would cover fund liabilities such as non-sufficient fund (NSF) checks and IRS negative adjustments.

  The department also indicates that failing to process collections within two days would result in non-compliance with the federally mandated child support payment deadline of two days, which could lead to federal penalties and the loss of federal incentive funds. Also, delayed payments could create financial hardships for families that depend upon these payments for basic living expenses and could result in significant dissatisfaction among child support clients, especially the non-IV-D population who will be receiving child support payments from the State for the first time once the CCSAS is implemented.

- **Contract Amendments Renegotiated Due to Legislative Concerns:** In November 2004 the Department of Finance submitted a request to the Legislature to increase project contract costs by $14 million in 2005-06 to implement the initial phase of the automation system more quickly. However, the November 2004 proposed contract amendments were not consistent with prior Legislative intent, as they did not specify performance- or deliverable-based payment conditions. In response to concerns expressed by the Legislature in December 2004, the Administration indicates it has amended the contract to include those payment conditions.

Questions:

1. LAO, please describe the $14 million contract amendments proposed by the Administration in November 2004, and why the structure of these amendments was not consistent with Legislative intent.

2. FTB, please briefly describe the performance-based contract amendments that were recently negotiated in response to Legislative concerns.

3. DCSS, please describe the impact of the proposed redirection of 29.5 positions, including 13.0 positions redirected from the Compromise of Arrears Program. Will redirecting these positions reduce child support revenue collection efforts?

DCSS Issue 3: Federal Performance Measures

Description: The state receives federal financial incentives and penalties based on five child support performance measures. In FFY 2002 California's average score ranked 41st among 54 states and territories, and scored lower than the national average on three out of five measures. The budget estimates only a 1.7 percent increase in collections in 2005-06.

In addition, approximately $19 billion in child support arrears is currently owed to families in the state. An analysis conducted by the Urban Institute found that approximately $4.8 billion of the state's arrears is collectable, including $2.3 billion of which is owed to the state for CalWORKs reimbursements.

Background:

Figure 2

Federal Performance Measure	National FFY 2003	California FFY 2004	Federal Minimum Standard
IV-D Paternity Establishment	77%	**88%**	50%
Support Orders Established	72%	**78%**	50%
Collections on Current Support	58%	**48%**	40%
Collections on Arrears	60%	**55%**	40%
Cost-Effectiveness Ratio	$4.33	**$2.12**	$2.00

Cost-Effectiveness: California's child support system collected $2.12 in revenue for every $1.00 spent on collection efforts in federal fiscal year 2004. This is significantly lower than the national average of $4.33 in revenue per dollar spent. Among 54 states and territories, California ranks 49th in cost-effectiveness.

The California Child Support Directors Association indicates that the following factors contribute to the state's relatively poor cost-effectiveness ratio:

- **Automation Projects Still in Development:** California is still spending significant resources on CCSAS development and legacy automation costs. All but two other states no longer have major automation development costs.

- **Judicial Child Support Model:** California has a court-based child support system that that Association indicates is more expensive than the administratively based systems used in many other states.

- **Uncollectable Arrears:** Much of the child support arrears is owed by low-income non-custodial parents. According to a March 2003 report prepared for the department, 25 percent of debtors have no recent income, 36 percent have net annual income of $10,000 or less, and only 1 percent have net annual income over $50,000. In addition, California has a disproportionate share of the nation's child support arrears – 12 percent of the nation's child support caseload, vs. 20 percent of the nation's arrears.

- **Caseload Composition (CalWORKs vs. non-CalWORKs cases):** Child support collections are generally lower for families that have or are currently receiving CalWORKs, as the non-custodial parent is more likely to be low-income. California has a higher proportion of child support families that are current or former CalWORKs recipients than other states. However, an analysis of individual county cost-effectiveness conducted by the department last year found that a high proportion CalWORKs families in a county did not necessarily result in proportionately higher county costs.

- **Lack of Universal Caseload Model:** Three states require all parents to make child support payments through the state's child support system. The Association indicates that states with universal caseloads are more cost-effective because they have more cases with higher orders that are more likely to pay voluntarily or via wage assignment.

Child Support for CalWORKs Leavers: A recent MDRC report [1] concludes that when families receive child support, it is an important contributor to their overall income, and it generally takes on more importance in the family budget after women leave welfare. However, the report also indicates that too few families receive child support, and it can be a fairly

[1] MDRC. *The Interaction of Child Support and TANF: Evidence from Samples of Current and Former Welfare Recipients*, January 2005.

unreliable source of income, at least on a monthly basis. Receipt rates and award rates are lower in general for current and former recipients than for all eligible women.

The department indicates that all CalWORKs recipients are automatically eligible to continue receiving child support services at no cost after leaving CalWORKs. Local Child Support Agencies (LCSAs) notify custodial parents continuing child support services are available at no cost, and the custodial parent is advised to contact the LCSA. The existing case remains open, and parents are not required to reapply for child support services.

The department indicates that child support services are discontinued **only** when the custodial parent fails to respond to the LCSA notice or declines continuing support services. The LCSA verifies, in writing, the custodial parent's intentions to decline child support services. However, if welfare arrears, owed to the state, have accrued and the parent has declined continuing services, the LCSA is required to continue to enforce and collect the arrears. Custodial parents declining continuing services receive information concerning future child support needs, including the option at any time to have their child support case re-opened.

Collections on Arrears: Approximately $19 billion in child support arrears is currently owed to families in the state. An analysis conducted by the Urban Institute found that approximately $4.8 billion of the state's arrears is collectable, including $2.3 billion of which is owed to the state for CalWORKs reimbursements.

The Compromise of Arrears Program (COAP) was established in 2003-04 to offer reduced lump sum settlements to parents in exchange for their commitment to make ongoing payments. This program is also intended to reconnect families estranged due to unresolved child support payments. The DCSS indicates that due to automation system constraints, this program cannot be implemented as initially designed. The budget proposes to retool the program and extend 9.0 of the 22.0 positions initially provided for this program. The remaining positions are proposed to be redirected to CCSAS in the Governor's Budget, including 8.0 currently vacant positions.

$2.3 Billion in Uncollected Arrears: The amount of arrears collected under COAP has been significantly less than originally estimated. The Governor's budget estimates that of the $2.3 billion in collectable child support arrears owed to the state for CalWORKs families, approximately $6 million will be collected in the current year and $12 million will be collected in the budget year as a result of COAP. The original estimate of COAP collections was $50 million annually.

Questions:

1. DCSS, please explain why the state's cost-effectiveness ratio is significantly lower than the national average. How does the Administration propose to improve the state's low cost-effectiveness ratio?

2. DCSS, please describe the status of the COAP, and why original revenue estimates were not achieved.

DCSS Issue 4: Local Child Support Funding

Description: The Governor's Budget proposes to continue holding local child support funding flat at $710 million ($194 million General Fund) in 2005-06. The relationship between local funding and collections was discussed in last year's budget hearings, but is still not entirely clear. The Legislative Analyst's Office recommends that the department lead a workgroup to develop a consistent local administrative cost reporting methodology. The Child Support Directors Association suggests that an administrative cost methodology be developed by January 2006.

Background:

Local Child Support Agency (LCSA) Functions: Local child support agencies are responsible for the administration of child support programs at the county level and perform functions necessary to establish and collect child support. Program activities include establishing child support cases, establishing child support orders, collecting current and past-due child support, enforcing medical support orders, and implementing customer service initiatives.

LCSA Funding Structure: California provides baseline compensation to counties, on a statewide basis, at a level comparable to 13.6% of the estimated level of collections adjusted to reflect county expenditures and available General Fund resources. The DCSS allocates resources for administration of local child support programs in a lump sum and does not control county expenditures for program activities and for child support initiatives.

Baseline county funding for the implementation of local child support programs is established according to a statutory formula based on child support collections. Individual county allocations are generally based on historic county expenditures and vary across the state.

Allocation Relationship to Performance: In recent years, the Legislature has considered the effect on program performance of child support administrative funding reductions, and the relationship of existing allocations to program performance and actual costs. No statewide consensus has been reached, although some data suggests that California can improve its performance without investing new resources in the child support program if under-performing local agencies improve their performance.

LCSA Staffing Reductions: The Child Support Directors Association reports that state and local staffing has declined from 11,070 in 2001-02 to 9,319 in 2003-04, due to the lack of funding increases. Additional local positions may be eliminated or held vacant in 2005-06 as a result of flat funding. Some counties indicate that flat funding may prevent revenue collections from increasing in 2005-06.

LAO Proposal: The Legislative Analyst's Office (LAO) reviewed local cost reports and initially recommended that local funding for administrative activities be limited to 25 percent of each county's total allocation in 2005-06. However, further review found that counties did not receive sufficient information to ensure consistent reporting of administrative costs. The LAO

now notes an alternate proposal, that the department may instead lead a workgroup to develop a consistent local administrative cost reporting methodology.

Questions:

1 DCSS, please present the Governor's Budget proposal to hold local child support funding flat in 2005-06. How would this proposal affect LCSA staffing levels and collections levels?

2 LAO, please present your recommendation for administrative cost reporting.

3 DCSS, how does the department propose to ensure that local administrative costs are consistently reported? Do you concur with the LAO's recommendation?

Recommendation: Reduce the DCSS state operations appropriation by $50,000 General Fund, and adopt placeholder budget bill language to restore this appropriation if the department submits a report to the Legislature by November 1, 2005 with recommendations for a consistent statewide LCSA cost reporting methodology.

5180 Department of Social Services (DSS)

CalWORKs Program Description. The California Work Opportunity and Responsibility to Kids (CalWORKs) program provides cash benefits and welfare-to-work services to low-income children and their parents or caretaker relatives. The average family of three must have an annual net income below $12,389, or 77 percent of the federal poverty level (FPL), in a low-cost county to be eligible for CalWORKs. A family of three in a high cost county must have income below 81 percent of the FPL to be eligible for CalWORKs. Parents are required to work or participate in work-related activities for at least 32 hours per week, and income above $225 per month offsets a portion of the grant. Adults have a lifetime limit of five years (60 months) in CalWORKs.

Enrollment Summary. After peaking in March of 1995, CalWORKs enrollment dropped by 48 percent through 2004. Enrollment decreased by 33 percent since CalWORKs replaced the former Aid to Families with Dependent Children (AFDC) program in 1998. The caseload decline is due to a combination of demographic trends (such as decreasing birth rates for young women), California's economic expansion, and full implementation of welfare reform. After years of declines, enrollment bottomed out in 2003-04, and is projected to increase by 1.9 percent in 2004-05.

The budget proposes significant reductions in the CalWORKs program, resulting in a caseload decrease of 0.8 percent below the current year. The department estimates CalWORKs average monthly caseload will be 472,786 families in 2005-06, which includes almost 961,000 children (see Figure 3 below). Without the proposed reductions, average monthly enrollment would have been 486,425 families in 2005-06.

Figure 3

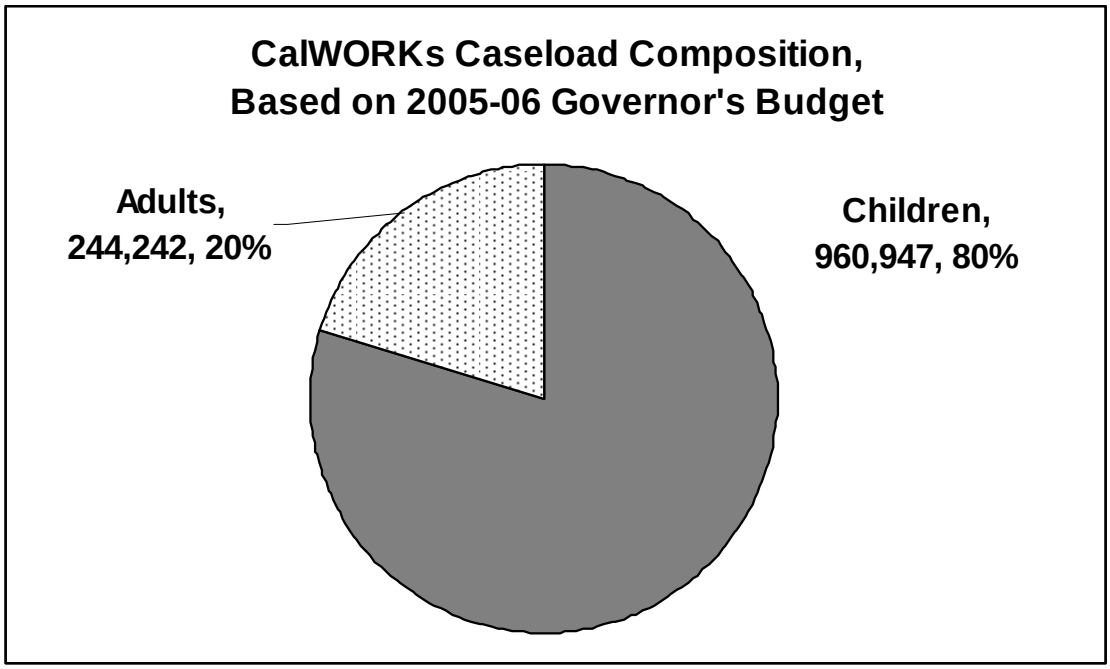
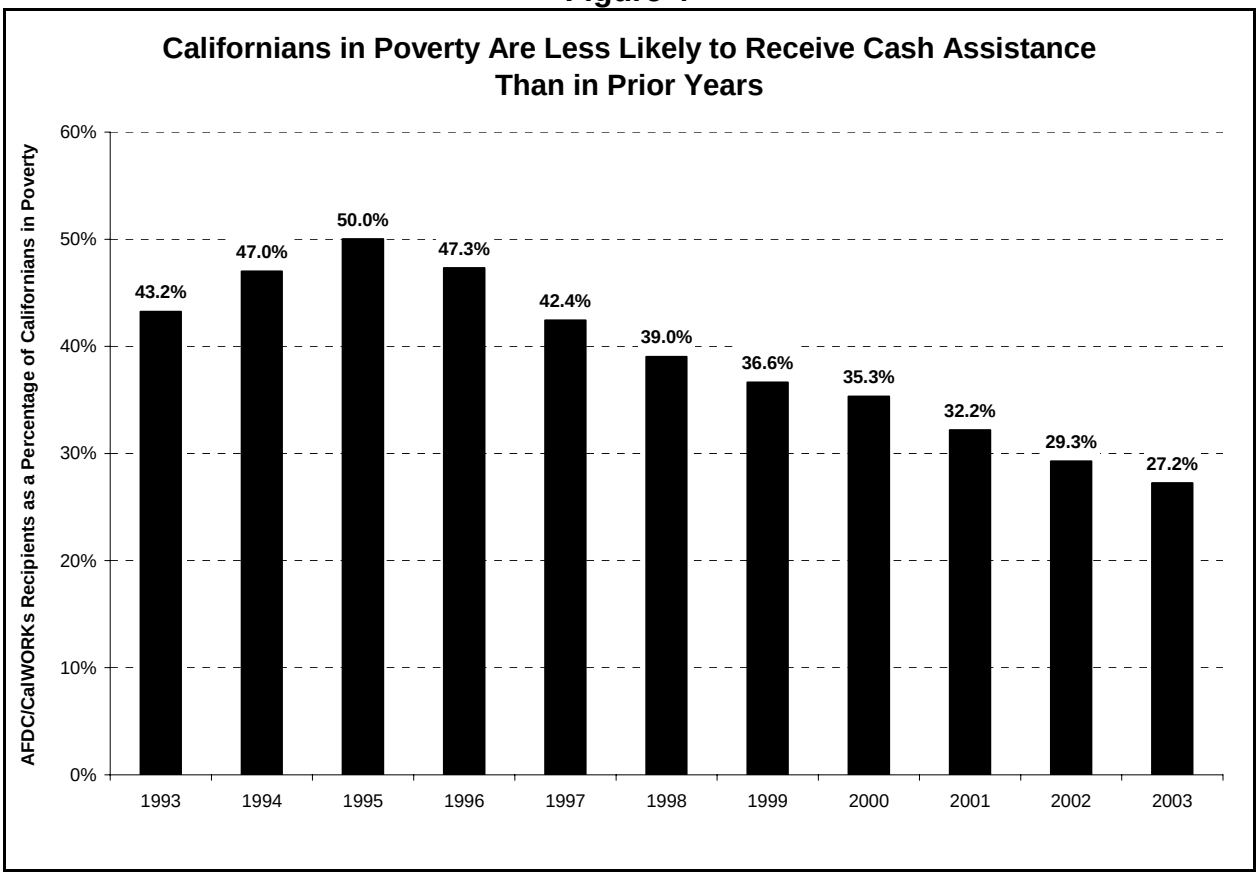


Figure 4



Source: **California Budget Project**

While welfare enrollment has decreased since 1995, Figure 4 above shows that during that same period low-income Californians have become less likely to receive cash assistance. This is partly the result of many families leaving CalWORKs and remaining in low-wage employment.

Proposed Reductions: The Governor's Budget includes a total of $582 million in reductions to the CalWORKs program in 2005-06:

- **Reduce CalWORKs Grants by 6.5 percent.** The budget proposes to reduce CalWORKs grants by approximately 6.5 percent, resulting in savings of $212 million. For a typical family of three, the maximum grant would be reduced from $723 to $676 per month.

- **Eliminate CalWORKs Cost of Living Adjustment (COLA).** The budget proposes to suspend the July 2005 COLA, and permanently suspend all future CalWORKs COLAs, resulting in savings of $143 million.

- **Reduce Earned Income Disregard.** The budget proposes to reduce the Earned Income Disregard for CalWORKs families, resulting in $82 million savings.

- **Increase Sanctions and Work Requirements.** The budget proposes to expand the CalWORKs work participation reforms based a pending evaluation of CalWORKs sanction policies, for estimated savings of $12 million.

- **Reduce Employment Services Funding.** The budget proposes to eliminate $50 million in 2005-06 that was included in the 2004 Budget Act for CalWORKs employment services.

- **Child Care Reform.** The budget proposes to reduce license-exempt child care reimbursement levels, and establish a tiered reimbursement structure for all child care providers, resulting in savings of $61 million in the DSS, and $53 million Prop 98 savings in the California Department of Education (CDE).

- **County Pay for Performance Proposal.** The budget proposes to tie county administration funding to CalWORKs client work participation rates, for projected savings of $22 million.

DSS Issue 1: CalWORKs Funding Structure

Description: The Governor's Budget proposes to transfer $316 million in federal Temporary Assistance for Needy Families (TANF) funds from the CalWORKs program to other areas of the budget. The budget also proposes to count an additional $201 million General Fund in existing expenditures in the California Department of Education's budget toward the state's TANF Maintenance of Effort (MOE) requirement, instead of funding the CalWORKs program.

Background:

CalWORKs Funding Summary. CalWORKs is funded through an annual federal Temporary Assistance for Needy Families (TANF) block grant of $3.7 billion, plus $2.7 billion in state funds to meet a federal Maintenance of Effort (MOE) requirement. The state's MOE is based on welfare spending in 1994, adjusted downward for achievement of certain work participation goals. As a matter of policy, California has chosen to treat the MOE level as a ceiling for General Fund CalWORKs spending. Federal law requires states to spend TANF funds on current and former welfare recipients, with limited exceptions. Accordingly, California spends most federal TANF funds on CalWORKs, and directs some TANF and state MOE funding to activities in other departments.

TANF Funding for Non-CalWORKs Programs. Over time, California has broadened its definition of expenditures that can be considered to meet the state's MOE. Additionally, the state has transferred a growing amount of TANF funds to non-CalWORKs programs. As a result, available TANF and MOE funding for the CalWORKs program had been substantially declining.

The 2004 Budget Act addressed this issue through the elimination of TANF funds for juvenile probation services, reduction of most TANF transfers to Title XX, and changing the definition of

child care expenditures counted toward the MOE. The Governor's Budget proposes to reverse the decisions made in 2004-05.

The budget proposes total TANF/MOE funding of $5.9 billion ($4.7 billion of which will be spent on the CalWORKs program and $1.2 billion to support non-CalWORKs federally allowable activities). This constitutes a $528 million, or 10 percent decrease in CalWORKs expenditures from the current year. As shown in Figure 5 below, total funding for the CalWORKs program has decreased by $707 million since 1998-99.

Figure 5: Federal TANF and State MOE Funding for CalWORKs and Other Programs

	FY 1998-99	2004-05 Governor's Budget	2005-06 Governor's Budget	98-99 to 05-06	
Total TANF Grant/Required MOE	**6,640,971,000**	**6,401,487,000**	**6,393,328,000**	**-247,643,000**	**-3.73%**
				0	
CalWORKs Program (*Actuals*)	**5,452,464,887**	**5,273,999,000**	**4,745,760,000**	**-706,704,887**	**-12.96%**
Grants	3,728,895,597	3,350,291,000	2,904,332,000	**-824,563,597**	-22.11%
Administration	518,317,463	500,519,855	477,958,234	**-40,359,229**	-7.79%
Services	450,275,279	767,713,739	733,107,986	**282,832,707**	62.81%
Child Care	360,733,329	549,370,406	524,606,779	**163,873,450**	45.43%
Substance Abuse/Mental Health Svcs	21,212,219	106,104,000	105,755,000	**84,542,781**	398.56%
*County Share of Admin/Svcs**	80,807,136	61,692,000	62,638,000	**-18,169,136**	
Performance Incentives(budgeted)	373,031,000			**-373,031,000**	-100.00%
				0	
Probation	**201,413,000**	**67,138,000**	**201,413,000**	**0**	**0.00%**
KinGAP	**0**	**95,557,000**	**102,930,000**	**102,930,000**	
				0	
Non-CalWORKs MOE in CDSS	**(11,269,000)**	**(10,322,000)**	**(10,129,000)**	**1,140,000**	**-10.12%**
Other MOE in CDSS	**305,663,000**	**324,819,000**	**307,290,000**	**1,627,000**	**0.53%**
MOE In Other Department Budgets	**402,839,000**	**293,218,000**	**495,938,000**	**93,099,000**	**23.11%**
State Support	**29,016,000**	**26,262,000**	**26,206,000**	**-2,810,000**	**-9.68%**
				0	
Total Expenditures	**6,380,126,887**	**6,070,671,000**	**5,869,408,000**	**-510,718,887**	**-8.00%**
Federal TANF	3,472,973,887	3,403,002,000	3,209,898,000	**-263,075,887**	-7.57%
General Fund	2,733,123,474	2,467,210,000	2,464,886,000	**-268,237,474**	-9.81%
Other State Funds *(ETF, Prop 10)*	0	40,084,000	40,119,000	**40,119,000**	
County Funds	174,029,526	160,375,000	154,505,000	**-19,524,526**	-11.22%
				0	
Total TANF transfers	**284,965,000**	**544,555,000**	**839,471,000**	**554,506,000**	**194.59%**
Non-CalWORKs Transfers	0	63,099,000	179,892,000	**179,892,000**	
Transfers to Stage 2, Tribal TANF and Reserve	284,965,000	481,456,000	659,579,000	**374,614,000**	131.46%
TANF Grant/Required MOE	6,640,971,000	**6,401,487,000**	**6,393,328,000**	**-247,643,000**	-3.73%
Prior Year TANF Carryforward	617,020,000	522,246,000	315,551,000	**-301,469,000**	-48.86%
Unspent Performance Incentives				**0**	
High Performance Bonus		7,044,000		**0**	
Total Available Funding	**7,257,991,000**	**6,930,777,000**	**6,708,879,000**	**-549,112,000**	**-7.57%**
Total TANF/MOE Expends	**6,665,091,887**	**6,615,226,000**	**6,708,879,000**	**43,787,113**	**0.66%**
NET TANF Carry-over Funds	592,899,113	315,551,000	0	**-592,899,113**	-100.00%
				0	
CalWORKs contribution to the General Fund	708,502,000	956,757,000	1,265,948,000	**557,446,000**	78.68%

New TANF or MOE Transfers: The Governor's Budget proposes to increase TANF fund transfers to non-CalWORKs activities and count additional funding in non-CalWORKs programs toward the MOE. Reducing the TANF or MOE funding from these programs would require a corresponding General Fund backfill to maintain total funding for these programs at the level proposed in the budget.

- **$55 million TANF to the Foster Care program.** Administration indicates trailer bill language is necessary, and is proposed. Denied by the Legislature last year.

- **$60 million TANF to the Department of Developmental Services.** Administration indicates trailer bill language is not necessary. Denied by the Legislature last year.

- **$201 million TANF to Juvenile Probation Facilities.** Administration indicates trailer bill language is not necessary. However, last year the Administration indicated that TANF funding for juvenile probation would not be continued due to the November 1, 2004 sunset of the Comprehensive Youth Services Act. The Administration now contends that this TANF transfer may be achieved under a Memorandum of Understanding between DSS and the Board of Corrections. Continuation of this TANF transfer past November 1, 2004 was denied by the Legislature last year.

- **$201 million General Fund in existing California Department of Education child care funding counted toward the MOE.** Administration indicates trailer bill language not necessary. Although a portion of the $201 million in additional MOE is due to caseload changes, the majority of this funding is shifted MOE from the CalWORKs program.

Questions:

1. LAO, please briefly describe the federal TANF MOE requirement and CalWORKs program funding structure. What has happened to CalWORKs funding as share of TANF/MOE over time, and how has that affected the program?

2. DSS, how much TANF and MOE funding is proposed to be shifted to other programs from CalWORKs in 2005-06, compared to 2004-05?

3. DSS, how does this amount compare to the funding reductions proposed for the CalWORKs grant reduction, suspension of the CalWORKs COLA, and reduction of the earned income disregard?

DSS Issue 2: CalWORKs Grant Reduction and Cost of Living Adjustment (COLA) Suspensions

Description: The budget proposes to reduce CalWORKs grants by 6.5 percent, suspend the July 2005 CalWORKs COLA, and permanently suspend all future COLAs, for combined savings of $355 million in 2005-06. The budget also proposes trailer bill language so that should the state lose its appeal of the *Guillen* v. *Schwarzenegger* case (which addresses the October 2003 CalWORKs COLAs and the vehicle license fee changes made by the Governor), a COLA would only be provided retroactively from October 2003 through the effective date of the trailer bill, and not provided in the future. By eliminating CalWORKs eligibility for some working families, this proposal may reduce the state's federal work participation rate.

Background:

Maximum Aid Payment (MAP) would be Reduced: The proposed CalWORKs grant changes would have a combined effect of reducing the maximum monthly grant for a family of three with no earnings from $723 to $676, a reduction of $47 per month. The reduction would be partially offset by an increase in Food Stamp benefits. In general, Food Stamp increases offset about 45 percent of the proposed grant reductions.

The proposed maximum grant level of $676 per month is $18 lower than the amount provided to AFDC recipients in 1989. At the same time, the purchasing power of the grant in 2005-06 would be 60.5 percent of the 1989 level. Absent the 6.5 percent reduction, the July 2005 COLA would have increased the maximum CalWORKs grant to $752 per month for a family of three.

Average Aid Payment for Working Families would be Reduced: Actual grants for families vary depending on family size and household income. Families that work or have other income receive grants lower than the MAP. The projected average grant for all families for 2004-05 is $555 and for 2005-06 is $501.

The average CalWORKs grant for a working family of three without any proposed reductions is approximately $395 (not including the July 2005 COLA). The proposed grant reduction would reduce that average grant by $47, and the proposed decrease in the earned income disregard (see Issue 3 below) would further reduce the average grant for working families by $80 per month. Therefore, the combined average grant reduction for working CalWORKS families is about $127 (this reduction would be partially offset by an increase of about $58 in Food Stamp benefits).

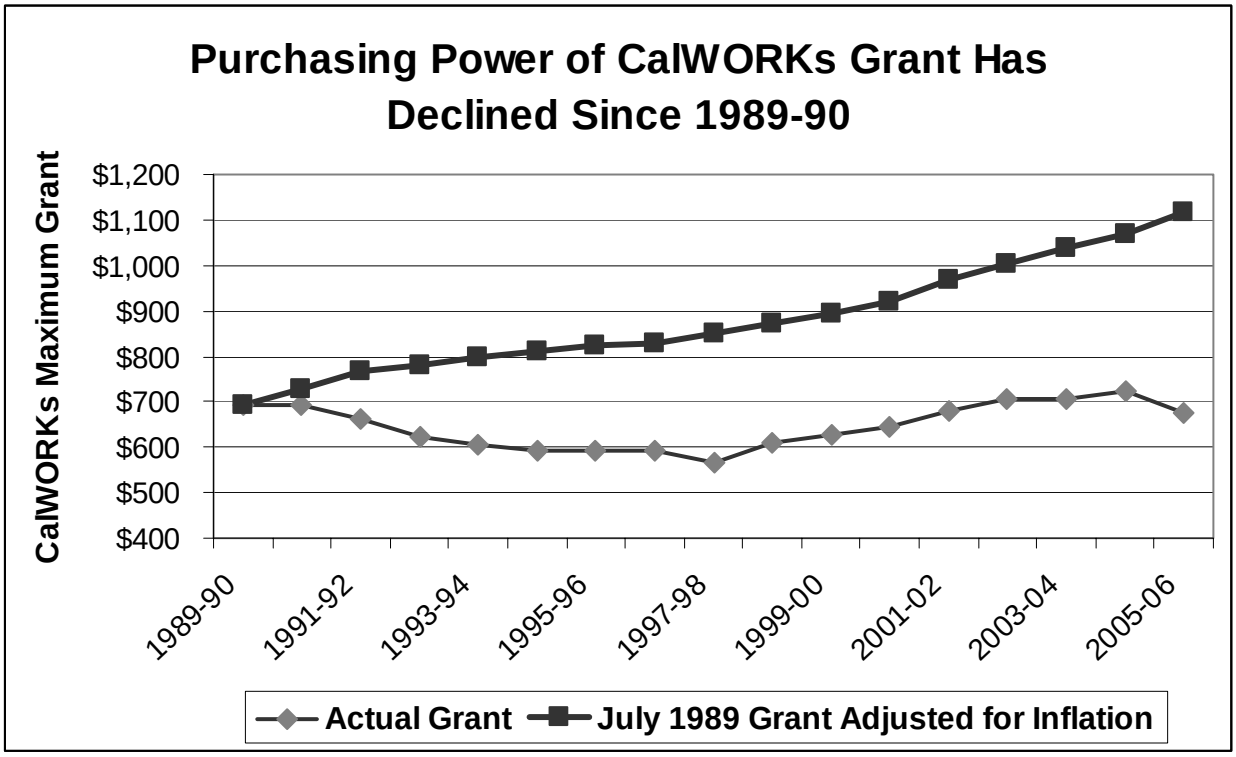
Working Families Ineligible for CalWORKs: In addition to decreasing resources available to low-income families, the grant reductions and decrease in the earned income disregard will make 13,639 working families ineligible for CalWORKs cash assistance, a caseload reduction of 2.8 percent. The average monthly number of children in families that would no longer receive grants is 35,092.

The families that would lose eligibility for CalWORKs under these proposals would be working families with earnings that exceed the reduced CalWORKs limit. These families may still be

eligible for health coverage under Medi-Cal and Food Stamps for a period of time, depending on their income level.

Impact on CalWORKs Work Participation Rate: The department indicates that California may have trouble meeting the revised federal work participation rate under certain versions of federal TANF reauthorization bills that are currently pending in Congress. Failure to meet required work participation rates may result in federal sanctions. However, the families that would lose CalWORKs eligibility under this proposal are working families that would help the state maintain a higher federal work participation rate.

Figure 6



As shown in Figure 6 above, since 1990 the net result of suspended COLAs and reductions to CalWORKs grants have reduced the purchasing power of the grant by 39.5 percent.

Grant Payments Compared to Other States and Housing Costs: The Administration indicates that even with these actions, California's grant payment would remain the fourth highest of all 50 states and the second highest of the 10 most populous states.

However, CalWORKs recipients spend much of their grants on rent, due to the high cost of housing in California. According to the U.S. Department of Housing and Urban Development (HUD), fair market rents for a one-bedroom apartment in California average $904 per month and range from $425 in Glenn County to $1,229 in San Francisco County. The proposed maximum monthly grant is $676 for a family of three.

Figure 7

State	1 Bedroom Rent	Current MAP	Current Rent Gap	Rent Gap with Proposed MAP	Proposed MAP/Rent
California	**$902**	**$723**	**-$179**	**-$226**	**75%**
Ohio	$505	$579	$74	$74	115%
Pennsylvania	$596	$606	$10	$10	102%
Michigan	$587	$593	$6	$6	101%
Texas	$590	$579	-$11	-$11	98%
Illinois	$696	$579	-$117	-$117	83%
Georgia	$651	$579	-$72	-$72	89%
Florida	$674	$579	-$95	-$95	86%
New York	$832	$666	-$166	-$166	80%
New Jersey	$905	$610	-$295	-$295	67%

Rent Gap Currently $179, But Would Increase to $226: As shown in Figure 7 above, California's current CalWORKs grant (MAP) is $179 less than the average fair market rent for a one-bedroom apartment in the state. Among the ten largest states, California currently has the second-highest rent gap. In Ohio, Pennsylvania, and Michigan, grants are actually higher than the one-bedroom fair market rate. Under the Governor's proposed grant reduction, the rent gap would increase to $226, and the maximum grant would decline to only 75 percent of the average rent for a one-bedroom apartment.

Subsidized housing is not available for all qualifying families. According to a National Low Income Housing Coalition report on large public housing authority waiting lists, the 14 California housing authorities that reported in the survey had a total of 454,515 applicants on the waiting lists. Nationally, the federal Department of Health and Human Services reports that just 20 percent of TANF recipients receive subsidized housing. HUD figures from the late 1990's indicate that in California, 10 to 12 percent of TANF recipients used subsidized housing.

October 2003 COLA Litigation: In the *Guillen* court case, advocates for the state's CalWORKs recipients successfully argued in superior court that the state should provide the October CalWORKs COLA, since the Governor reduced the Vehicle License Fee (VLF). Currently, the administration is appealing this ruling and an appellate court decision is expected sometime during the second half of 2005. The Administration is proposing trailer bill language to delete the October 2003 COLA in the event that the state loses its appeal. If the Guillen ruling is affirmed by the appeals court, the proposed trailer bill language would result in avoided costs of $131 million in 2005-06, although the state would face a budget risk of $222 million in retroactive payments to CalWORKs families.

Questions:

1. DSS, please present the grant reduction and COLA suspension proposals. How much notification to recipients is required before the grant reduction could be implemented?

2. DSS, how would this proposal affect recipients? How would recipients pay for cost increases in rent, food, and utilities?

3. DSS, how would these proposals affect the state's work participation rate?

4. DSS/DOF, please provide an update on the status of the *Guillen v. Schwarzenegger* court case. Please describe the proposed trailer bill language regarding the October 2003 COLA case.

DSS Issue 3: Reduce CalWORKs Earned Income Disregard

Description: The budget proposes to reduce the Earned Income Disregard for CalWORKs families, resulting in $79.4 million net savings in 2005-06, and $109 million in 2006-07. A family of three earning $1,000 per month would see their monthly grant reduced by $93, in addition to the grant reduction noted above in Issue 2. By eliminating CalWORKs eligibility for some working families, this proposal may reduce the state's federal work participation rate.

Background:

Results of Earned Income Disregards: The Earned Income Disregard is a key component of the CalWORKs program, as it provides a work incentive for CalWORKs families, but also improves family well-being. National research conducted by MDRC found that earned income disregards increased work, reduced poverty, increased employment retention, and led to improved educational and behavioral outcomes for elementary school-age children. Earlier findings also showed that, in the short-term, income disregards reduced domestic abuse and increased the stability of two-parent relationships.

Current Law: The maximum CalWORKs grant is the amount of money a family receives if it has no other income. If the family has income, the grant is reduced after a specified amount of income is not counted (referred to as the income disregard). In order to provide an incentive for CalWORKs recipients to work, current law disregards (does not count) the first $225 in earned income and 50 percent of each additional dollar earned when determining a family's grant amount.

The LAO provides the following examples to illustrate current law:

- **Family Earning $225.** Currently, the maximum monthly CalWORKs grant for a family of three in a high-cost county is $723. Under the current income disregard policy, a family of three who earned $225 per month would have 100 percent of their earnings disregarded and would receive the maximum grant of $723 plus their earnings of $225 for a total income of $948 per month (excluding food stamps).

- **Family Earning $1,025.** Figure 8 below shows the disregard and grant calculations for a family of three with $1,025 in monthly earnings. The top portion of the figure shows that $625 in earnings will be disregarded for purposes of determining the family's grant and that $400 will be counted. The bottom portion of the figure calculates the family's grant

by subtracting the $400 in countable earnings from the maximum grant of $723 resulting in a grant of $323. The grant plus earnings would result in total income of $1,348 per month (excluding food stamps) for this family.

Figure 8

CalWORKs Earned Income Disregard
Family of Three, $1,025 in Earnings

Disregard Calculation	Amount
Earnings	$1,025
Initial disregard of $225	225
Remainder	$800
Apply 50% disregard to remainder	50%
Additional Earnings Disregarded	$400
Initial disregard from above	225
Total Earnings:	
Disregarded	**$625**
Counted	**$400**
Grant Calculation	
Maximum grant	$723
Less countable earnings	400
Grant	**$323**

Governor's Budget Proposal: The Governor's Budget proposes to reduce the income disregard to $200 and 40 percent of remaining income, effective October 1, 2005. This proposal would reduce the level at which low-income working families remain eligible for CalWORKs benefits, and would reduce the grants for all working families. This proposal would affect 112,669 families in 2005-06.

Figure 9

Impact of Governor's Income Disregard
Family of Three
High-Cost Counties[a]

		Grant Plus Earnings		Change From Current Law	
Hours/Week, Hourly Wage	Monthly Earned Income	Current Law	Governor's Proposal	Amount	Percent
10 hours, $6.75	$292	$982	$960	-$22	-2.2%
20 hours, $6.75	585	1,128	1,077	-51	-4.5
40 hours, $6.75	1,169	1,420	1,311	-109	-7.7
40 hours, $9.00	1,559	1,615	1,467	-148	-9.2

a Assumes current $723 maximum monthly grant.

In Figure 9 above, the LAO provides examples of how the proposed reduction would affect working family income.

The LAO also notes that reducing the income disregard lowers the point at which families would no longer be eligible for a grant. The exit point at which families are no longer eligible for CalWORKs is currently $1,671 per month for a family of three. Under the Governor's proposal, the exit point for a similar family would drop to $1,405 per month (108 percent of poverty guideline). Reducing the exit point will mean that about 8,900 families will become ineligible for CalWORKs. Such exiting families, however, would remain eligible for food stamps, child care, and Medi-Cal, so long as their income remains below the eligibility thresholds for these programs.

Impact of Reducing the Disregard on Work Incentive and Behavior: The LAO indicates that reducing the disregard could have two impacts on the working behavior of recipients. On the one hand, it could result in a disincentive to work by reducing the amount of income retained from starting work or increasing one's hours of work. Thus, new entrants to CalWORKs who have no income along with currently aided families who are not working would be most affected by this disincentive. On the other hand, reducing the disregard could increase the incentive to work to the extent that families decide to work more hours in order to make up for the grant reduction pursuant to the revised disregard. Families with substantial earnings, but with incomes below the exit point would be most affected by this increase in the incentive. With more hours of work, such a family could make up for the lost income and possibly leave cash assistance. The LAO expects these two effects to in part offset each other.

Impact on CalWORKs Work Participation Rate: The department indicates that California may have trouble meeting the revised federal work participation rate under certain versions of federal TANF reauthorization bills that are currently pending in Congress. Failure to meet required work participation rates may result in federal sanctions. However, the families that would lose CalWORKs eligibility under this proposal are working families that would help the state maintain a higher federal work participation rate.

LAO Options: The LAO describes two alternatives that would probably increase the work incentive, especially the incentive to work more than half-time. However, the LAO notes that they result in less budgetary savings, and reduce grants for families with the lowest earnings.

- **Disregard All Income at a Constant Percentage Rate.** Given that Illinois has the highest level of work participation among the ten largest states, we first examined their disregard. In Illinois, 67 percent of all income is disregarded; however, there is no minimum income amount which is disregarded at 100 percent. (For example, California disregards 100 percent of the first $225 in earnings.) Assuming no change in work behavior, adopting a straight 67 percent disregard in California would actually cost more than current law (at least $40 million per year). It would also raise the exit point for CalWORKs by about $170 for a family of three. A variant on this approach would be to set the disregard rate at 57 percent. This would keep California's exit point near where it is today and would result in annual savings of about $65 million compared to current law. (When welfare reform was first debated in 1997, the Wilson administration initially proposed a 54 percent disregard.)

The main advantage of a constant disregard at a rate higher than the current 50 percent is that is creates a stronger incentive to increase earnings as seems to be illustrated by Illinois. For example, a family earning more than $225 per month who increased their monthly earnings by $100 would keep $67 under the Illinois style disregard compared to just $50 under California's current law. The main disadvantage is that families earning less than $225 would have less of an incentive to work since they could only keep 67 percent of their earnings (instead of the entire amount under California's system). Consequently, such families would be worse off financially.

- **Disregard More Income at Higher Earnings.** Under this approach the 50 percent disregard would apply to all families, but the 100 percent exclusion on the first $225 earned would only be provided to families earning $600 or more per month. Those earning less than $600 (about 20 hours per week at the minimum wage), would receive a flat disregard of 50 percent, but they would not receive the base 100 percent disregard on their first $225 in earnings.

  The reason for selecting the $600 amount is that it corresponds to roughly 20 hours of work per week at the minimum wage. Under current law, adult participants must meet a "core" participation hour requirement of 20 hours per week. Unsubsidized employment is one way to meet the core requirement.

  This approach would result in annual savings of about $48 million compared to current law. The advantage is that it would strongly encourage recipients to work at least 20 hours per week, because they would receive the benefit of the $225 exclusion once their earnings reach $600 per month. The disadvantage is that it would lower the grants for families with earnings below $600 per month because until they earned $600 they would not receive the 100 percent disregard on their first $225 earned. It would also reduce the incentive for those not working to begin work at less than $600. It would not change the exit point for CalWORKs in relation to current law.

Questions:

1. DSS, please present the Governor's proposal. How would this proposal affect work incentives among CalWORKs families?

2. DSS, how would these proposals affect the state's work participation rate?

3. LAO, please describe alternatives to the Governor's earned income disregard proposal.

4. DSS, what are the goals of the CalWORKs program? How well is the program achieving these goals? How would this proposal affect the achievement of those goals?

Senate Budget Subcommittee No. 3
April 7, 2005 Hearing
Trailer Bill Language

Pages	Section	Department	Description
2-3	1	Department of Child Support Services	CCSAS Statewide Disbursement Unit General Fund Loan Authority
68-89, 93-97	18-23, 27	Department of Social Services (DSS)	CalWORKs Grant Reduction, Suspend COLA, Suspend Future Payments for October 2003 COLA. Note: Administration notes technical correction to Section 23 (page 88), to maintain Welfare and Institutions Code Section 11450.018 (a) only. 11450.018 (b), (c), and (d) are proposed for deletion.
89-93	24-26	DSS	Reduce CalWORKs Earned Income Disregard
106-110	32, 33	DSS	TANF transfer to Foster Care

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 17311 of the Family Code is amended to read:

17311. (a) The Child Support Payment Trust Fund is hereby created in the State Treasury. The department shall administer the fund.

(b) (1) The state may deposit child support payments received by the State Disbursement Unit, including those amounts that result in overpayment of child support, into the Child Support Payment Trust Fund, for the purpose of processing and providing child support payments. Notwithstanding Section 13340 of the Government Code, the fund is continuously appropriated for the purposes of disbursing child support payments from the State Disbursement Unit.

(2) The state share of the interest and other earnings that accrue on the fund shall be available to the department and used to offset the following General Fund costs in this order:

(A) Any transfers made to the Child Support Payment Trust Fund from the General Fund.

(B) The cost of administering the State Disbursement Unit, subject to appropriation by the Legislature.

(C) Other child support program activities, subject to appropriation by the Legislature.

(c) The department may establish and administer a revolving account in the Child Support Payment Trust Fund in an amount not to exceed six hundred million dollars ($600,000,000) to ensure the timely disbursement of child support. This

amount may be adjusted by the Director of Finance upon notification of the Legislature as required, to meet payment timeframes required under federal law.

(d) It is the intent of the Legislature to provide transfers from the General Fund to provide startup funds for the Child Support Payment Trust Fund so that, together with the balances transferred pursuant to Section 17311.7, the Child Support Payment Trust Fund will have sufficient cash on hand to make all child support payments within the required timeframes.

(e) Notwithstanding any other provision of law, an ongoing loan shall be made available from the General Fund, from funds not otherwise appropriated, to the Child Support Payment Trust Fund, not to exceed one hundred fifty million dollars ($150,000,000) to ensure the timely disbursement of child support payments when funds have not been recorded to the Child Support Payment Trust Fund or due to other fund liabilities, including, but not limited to, Internal Revenue Service negative adjustments to tax intercept payments. Whenever an adjustment of this amount is required to meet payment timeframes under federal law, the amount shall be adjusted after approval of the Director of Finance. In conjunction with the Department of Finance and the Controller's office, the department shall establish repayment procedures to ensure the outstanding loan balance does not exceed the average daily cash needs. The ongoing evaluation of the fund as detailed in these procedures shall occur no less frequently than monthly.

SEC. 2. Section 1522 of the Health and Safety Code is amended to read:

1522. The Legislature recognizes the need to generate timely and accurate positive fingerprint identification of applicants as a condition of issuing licenses,

~~Nothing~~

(c) Nothing in this section shall be construed as preventing a county from seeking judicial review under Section 1094.5 of the Code of Civil Procedure of any final decision of the director made after a hearing conducted under this section. This review shall be the exclusive remedy available to the county for review of the director's decision.

~~Nothing~~

(d) Nothing in this section shall be construed as preventing the director from bringing an action for writ of mandamus or any other action in court as may be appropriate to insure that there is no interruption in the provision of benefits to any person eligible therefor under the provisions of this code or the regulations of the department.

SEC. 18. Section 11450 of the Welfare and Institutions Code, as amended by Section 18 of Chapter 147 of the Statutes of 1999, is repealed.

~~11450. (a) (1) Aid shall be paid for each needy family, which shall include all eligible brothers and sisters of each eligible applicant or recipient child and the parents of the children, but shall not include unborn children, or recipients of aid under Chapter 3 (commencing with Section 12000), qualified for aid under this chapter. In determining the amount of aid paid, and notwithstanding the minimum basic standards of adequate care specified in Section 11452, the family's income, exclusive of any amounts considered exempt as income or paid pursuant to subdivision (c) or Section 11453.1 shall be deducted from the sum specified in the following table, as adjusted for cost-of-living increases pursuant to Section 11453 and~~

~~paragraph (2). In no case shall the amount of aid paid for each month exceed the sum specified in the following table, as adjusted for cost-of-living increases pursuant to Section 11453 and paragraph (2), plus any special needs, as specified in subdivisions (c), (e), and (f):~~

~~Number of eligible needy persons in the same home~~	~~Maximum aid~~
~~1~~	~~$ 326~~
~~2~~	~~535~~
~~3~~	~~663~~
~~4~~	~~788~~
~~5~~	~~899~~
~~6~~	~~1,010~~
~~7~~	~~1,109~~
~~8~~	~~1,209~~
~~9~~	~~1,306~~
~~10 or more~~	~~1,403~~

~~If, when, and during such times as the United States government increases or decreases its contributions in assistance of needy children in this state above or below the amount paid on July 1, 1972, the amounts specified in the above table shall be increased or decreased by an amount equal to that increase or decrease by the United States government, provided that no increase or decrease shall be subject to subsequent adjustment pursuant to Section 11453.~~

~~(2) The sums specified in paragraph (1) shall not be adjusted for cost of living for the 1990–91, 1991–92, 1992–93, 1993–94, 1994–95, 1995–96, 1996–97, and 1997–98 fiscal years, and through October 31, 1998, nor shall that amount be included in the base for calculating any cost-of-living increases for any fiscal year thereafter. Elimination of the cost-of-living adjustment pursuant to this paragraph~~

~~shall satisfy the requirements of Section 11453.05, and no further reduction shall be made pursuant to that section.~~

~~(b) When the family does not include a needy child qualified for aid under this chapter, aid shall be paid to a pregnant mother for the month in which the birth is anticipated and for the three-month period immediately prior to the month in which the birth is anticipated in the amount which would otherwise be paid to one person, as specified in subdivision (a), if the mother, and child if born, would have qualified for aid under this chapter. Verification of pregnancy shall be required as a condition of eligibility for aid under this subdivision. Aid shall also be paid to a pregnant woman with no other children in the amount which would otherwise be paid to one person under subdivision (a) at any time after verification of pregnancy if the pregnant woman is also eligible for the Cal-Learn Program described in Article 3.5 (commencing with Section 11331) and if the mother and child, if born, would have qualified for aid under this chapter.~~

~~(c) The amount of forty-seven dollars ($47) per month shall be paid to pregnant mothers qualified for aid under subdivision (a) or (b) to meet special needs resulting from pregnancy if the mother, and child, if born, would have qualified for aid under this chapter. County welfare departments shall refer all recipients of aid under this subdivision to a local provider of the Women, Infants and Children program. If that payment to pregnant mothers qualified for aid under subdivision (a) is considered income under federal law in the first five months of pregnancy, payments under this subdivision shall not apply to persons eligible under subdivision (a), except for the month in which birth is anticipated and for the three-month period immediately prior~~

~~to the month in which delivery is anticipated, if the mother, and the child if born, would have qualified for aid under this chapter.~~

~~(d) For children receiving AFDC-FC under this chapter, there shall be paid, exclusive of any amount considered exempt as income, an amount of aid each month which, when added to the child's income, is equal to the rate specified in Section 11460, 11461, 11462, 11462.1, or 11463. In addition, the child shall be eligible for special needs, as specified in departmental regulations.~~

~~(e) In addition to the amounts payable under subdivision (a) and Section 11453.1, a family shall be entitled to receive an allowance for recurring special needs not common to a majority of recipients. These recurring special needs shall include, but not be limited to, special diets upon the recommendation of a physician for circumstances other than pregnancy, and unusual costs of transportation, laundry, housekeeping service, telephone, and utilities. The recurring special needs allowance for each family per month shall not exceed that amount resulting from multiplying the sum of ten dollars ($10) by the number of recipients in the family who are eligible for assistance.~~

~~(f) After a family has used all available liquid resources, both exempt and nonexempt, in excess of one hundred dollars ($100), the family shall also be entitled to receive an allowance for nonrecurring special needs.~~

~~(1) An allowance for nonrecurring special needs shall be granted for replacement of clothing and household equipment and for emergency housing needs other than those needs addressed by paragraph (2). These needs shall be caused by sudden and unusual circumstances beyond the control of the needy family. The~~

~~department shall establish the allowance for each of the nonrecurring special need items. The sum of all nonrecurring special needs provided by this subdivision shall not exceed six hundred dollars ($600) per event.~~

~~(2) Homeless assistance is available to a homeless family seeking shelter when the family is eligible for aid under this chapter. Homeless assistance for temporary shelter is also available to homeless families which are apparently eligible for aid under this chapter. Apparent eligibility exists when evidence presented by the applicant or which is otherwise available to the county welfare department and the information provided on the application documents indicate that there would be eligibility for aid under this chapter if the evidence and information were verified. However, an alien applicant who does not provide verification of his or her eligible alien status, or a woman with no eligible children who does not provide medical verification of pregnancy, is not apparently eligible for purposes of this section.~~

~~A family is considered homeless, for the purpose of this section, when the family lacks a fixed and regular nighttime residence; or the family has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary living accommodations; or the family is residing in a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.~~

~~(A) (i) A nonrecurring special need of forty dollars ($40) a day shall be available to families for the costs of temporary shelter, subject to the requirements of this paragraph. County welfare departments may increase the daily amount available~~

~~for temporary shelter to large families as necessary to secure the additional bed space needed by the family.~~

~~(ii) This special need shall be granted or denied immediately upon the family's application for homeless assistance, and benefits shall be available for up to three working days. The county welfare department shall verify the family's homelessness within the first three working days and if the family meets the criteria of questionable homelessness established by the department, the county welfare department shall refer the family to its early fraud prevention and detection unit, if the county has such a unit, for assistance in the verification of homelessness within this period.~~

~~(iii) After homelessness has been verified, the three-day limit shall be extended for a period of time which, when added to the initial benefits provided, does not exceed a total of 16 calendar days. This extension of benefits shall be done in increments of one week and shall be based upon searching for permanent housing which shall be documented on a housing search form; good cause; or other circumstances defined by the department. Documentation of housing search shall be required for the initial extension of benefits beyond the three-day limit and on a weekly basis thereafter as long as the family is receiving temporary shelter benefits. Good cause shall include, but is not limited to, situations in which the county welfare department has determined that the family, to the extent it is capable, has made a good faith but unsuccessful effort to secure permanent housing while receiving temporary shelter benefits.~~

~~(B) A nonrecurring special need for permanent housing assistance is available to pay for last month's rent and security deposits when these payments are reasonable conditions of securing a residence.~~

~~The last month's rent portion of the payment (1) shall not exceed 80 percent of the family's maximum aid payment without special needs for a family of that size and (2) shall only be made to families that have found permanent housing costing no more than 80 percent of the family's maximum aid payment without special needs for a family of that size, in accordance with the maximum aid schedule specified in subdivision (a).~~

~~However, if the county welfare department determines that a family intends to reside with individuals who will be sharing housing costs, the county welfare department shall, in appropriate circumstances, set aside the condition specified in clause (2) of the preceding paragraph.~~

~~(C) The nonrecurring special need for permanent housing assistance is also available to cover the standard costs of deposits for utilities which are necessary for the health and safety of the family.~~

~~(D) A payment for or denial of permanent housing assistance shall be issued no later than one working day from the time that a family presents evidence of the availability of permanent housing. If an applicant family provides evidence of the availability of permanent housing before the county welfare department has established eligibility for aid under this chapter, the county welfare department shall complete the eligibility determination so that the denial of or payment for permanent housing assistance is issued within one working day from the submission of evidence~~

~~of the availability of permanent housing, unless the family has failed to provide all of the verification necessary to establish eligibility for aid under this chapter.~~

~~(E) (i) Except as provided in clauses (ii) and (iii), eligibility for the temporary shelter assistance and the permanent housing assistance pursuant to this paragraph shall be limited to one period of up to 16 consecutive calendar days of temporary assistance and one payment of permanent assistance. Any family that includes a parent or nonparent caretaker relative living in the home who has previously received temporary or permanent homeless assistance at any time on behalf of an eligible child shall not be eligible for further homeless assistance. Any person who applies for homeless assistance benefits shall be informed that the temporary shelter benefit of up to 16 consecutive days is available only once in a lifetime, with certain exceptions, and that a break in the consecutive use of the benefit constitutes permanent exhaustion of the temporary benefit.~~

~~(ii) A family that becomes homeless as a direct and primary result of a state or federally declared natural disaster shall be eligible for temporary and permanent homeless assistance.~~

~~(iii) A family shall be eligible for temporary and permanent homeless assistance when homelessness is a direct result of domestic violence by a spouse, partner, or roommate; physical or mental illness that is medically verified that shall not include a diagnosis of alcoholism, drug addiction, or psychological stress; or, the uninhabitability of the former residence caused by sudden and unusual circumstances beyond the control of the family including natural catastrophe, fire, or condemnation. These circumstances shall be verified by a third-party governmental or private health~~

~~and human services agency and homeless assistance payments based on these specific circumstances may not be received more often than once in any 12-month period. A county may require that a recipient of homeless assistance benefits who qualifies under this paragraph for a second time in a 24-month period participate in a homelessness avoidance case plan as a condition of eligibility for homeless assistance benefits.~~

~~(iv) The county welfare department shall report to the department through a statewide homeless assistance payment indicator system, necessary data, as requested by the department, regarding all recipients of aid under this paragraph.~~

~~(F) The county welfare departments, and all other entities participating in the costs of the AFDC program, have the right in their share to any refunds resulting from payment of the permanent housing. However, if an emergency requires the family to move within the 12-month period specified in subparagraph (E), the family shall be allowed to use any refunds received from its deposits to meet the costs of moving to another residence.~~

~~(G) Payments to providers for temporary shelter and permanent housing and utilities shall be made on behalf of families requesting these payments.~~

~~(H) The daily amount for the temporary shelter special need for homeless assistance may be increased if authorized by the current year's Budget Act by specifying a different daily allowance and appropriating the funds therefor.~~

~~(I) No payment shall be made pursuant to this paragraph unless the provider of housing is a commercial establishment, shelter, or person in the business of renting properties who has a history of renting properties.~~

~~(g) The department shall establish rules and regulations assuring the uniform application statewide of this subdivision.~~

~~(h) The department shall notify all applicants and recipients of aid through the standardized application form that these benefits are available and shall provide an opportunity for recipients to apply for the funds quickly and efficiently.~~

~~(i) Except for the purposes of Section 15200, the amounts payable to recipients pursuant to Section 11453.1 shall not constitute part of the payment schedule set forth in subdivision (a).~~

~~The amounts payable to recipients pursuant to Section 11453.1 shall not constitute income to recipients of aid under this section.~~

~~(j) For children receiving Kin-GAP pursuant to Article 4.5 (commencing with Section 11360) of Chapter 2, there shall be paid, exclusive of any amount considered exempt as income, an amount of aid each month, which, when added to the child's income, is equal to the rate specified in Section 11364.~~

SEC. 19. Section 11450 of the Welfare and Institutions Code, as amended by Section 328 of Chapter 62 of the Statutes of 2003, is amended to read:

11450. (a) ~~(1)~~ Aid shall be paid for each needy family, which shall include all eligible brothers and sisters of each eligible applicant or recipient child and the parents of the children, but shall not include unborn children, or recipients of aid under Chapter 3 (commencing with Section 12000), qualified for aid under this chapter. In determining the amount of aid paid, and notwithstanding the minimum basic standards of adequate care specified in Section 11452, the family's income, exclusive of any amounts considered exempt as income or paid pursuant to

subdivision (e) or Section 11453.1, averaged for the prospective quarter pursuant to Sections 11265.2 and 11265.3, and then calculated pursuant to Section 11451.5, shall be deducted from the sum specified in the following table, as adjusted for cost-of-living increases pursuant to Section 11453~~and paragraph (2)~~. In no case shall the amount of aid paid for each month exceed the sum specified in the following table, as adjusted for cost-of-living increases pursuant to Section 11453~~and paragraph (2)~~, plus any special needs, as specified in subdivisions (c), (e), and (f):

Number of eligible needy persons in the same home	Maximum aid
1	~~$ 326~~
	$ 372
2	~~535~~
	611
3	~~663~~
	755
4	~~788~~
	899
5	~~899~~
	1,023
6	~~1,010~~
	1,149
7	~~1,109~~
	1,262
8	~~1,209~~
	1,377
9	~~1,306~~
	1,488
10 or more	~~1,403~~
	1,598

~~If, when, and during such times as the United States government increases or decreases its contributions in assistance of needy children in this state above or below the amount paid on July 1, 1972, the amounts specified in the above table shall be~~

~~increased or decreased by an amount equal to that increase or decrease by the United States government, provided that no increase or decrease shall be subject to subsequent adjustment pursuant to Section 11453.~~

~~(2) The sums specified in paragraph (1) shall not be adjusted for cost of living for the 1990–91, 1991–92, 1992–93, 1993–94, 1994–95, 1995–96, 1996–97, and 1997–98 fiscal years, and through October 31, 1998, nor shall that amount be included in the base for calculating any cost-of-living increases for any fiscal year thereafter. Elimination of the cost-of-living adjustment pursuant to this paragraph shall satisfy the requirements of Section 11453.05, and no further reduction shall be made pursuant to that section.~~

(b) When the family does not include a needy child qualified for aid under this chapter, aid shall be paid to a pregnant mother for the month in which the birth is anticipated and for the three-month period immediately prior to the month in which the birth is anticipated in the amount that would otherwise be paid to one person, as specified in subdivision (a), if the mother, and child, if born, would have qualified for aid under this chapter. Verification of pregnancy shall be required as a condition of eligibility for aid under this subdivision. Aid shall also be paid to a pregnant woman with no other children in the amount which would otherwise be paid to one person under subdivision (a) at any time after verification of pregnancy if the pregnant woman is also eligible for the Cal-Learn Program described in Article 3.5 (commencing with Section 11331) and if the mother, and child, if born, would have qualified for aid under this chapter.

(c) The amount of forty-seven dollars ($47) per month shall be paid to pregnant mothers qualified for aid under subdivision (a) or (b) to meet special needs resulting from pregnancy if the mother, and child, if born, would have qualified for aid under this chapter. County welfare departments shall refer all recipients of aid under this subdivision to a local provider of the Women, Infants and Children program. If that payment to pregnant mothers qualified for aid under subdivision (a) is considered income under federal law in the first five months of pregnancy, payments under this subdivision shall not apply to persons eligible under subdivision (a), except for the month in which birth is anticipated and for the three-month period immediately prior to the month in which delivery is anticipated, if the mother, and the child, if born, would have qualified for aid under this chapter.

(d) For children receiving AFDC-FC under this chapter, there shall be paid, exclusive of any amount considered exempt as income, an amount of aid each month which, when added to the child's income, is equal to the rate specified in Section 11460, 11461, 11462, 11462.1, or 11463. In addition, the child shall be eligible for special needs, as specified in departmental regulations.

(e) In addition to the amounts payable under subdivision (a) and Section 11453.1, a family shall be entitled to receive an allowance for recurring special needs not common to a majority of recipients. These recurring special needs shall include, but not be limited to, special diets upon the recommendation of a physician for circumstances other than pregnancy, and unusual costs of transportation, laundry, housekeeping service, telephone, and utilities. The recurring special needs allowance for each family per month shall not exceed that amount resulting from multiplying the

sum of ten dollars ($10) by the number of recipients in the family who are eligible for assistance.

(f) After a family has used all available liquid resources, both exempt and nonexempt, in excess of one hundred dollars ($100), the family shall also be entitled to receive an allowance for nonrecurring special needs.

(1) An allowance for nonrecurring special needs shall be granted for replacement of clothing and household equipment and for emergency housing needs other than those needs addressed by paragraph (2). These needs shall be caused by sudden and unusual circumstances beyond the control of the needy family. The department shall establish the allowance for each of the nonrecurring special need items. The sum of all nonrecurring special needs provided by this subdivision shall not exceed six hundred dollars ($600) per event.

(2) Homeless assistance is available to a homeless family seeking shelter when the family is eligible for aid under this chapter. Homeless assistance for temporary shelter is also available to homeless families which are apparently eligible for aid under this chapter. Apparent eligibility exists when evidence presented by the applicant or which is otherwise available to the county welfare department and the information provided on the application documents indicate that there would be eligibility for aid under this chapter if the evidence and information were verified. However, an alien applicant who does not provide verification of his or her eligible alien status, or a woman with no eligible children who does not provide medical verification of pregnancy, is not apparently eligible for purposes of this section.

A family is considered homeless, for the purpose of this section, when the family lacks a fixed and regular nighttime residence; or the family has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary living accommodations; or the family is residing in a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

(A) (i) A nonrecurring special need of forty dollars ($40) a day shall be available to families for the costs of temporary shelter, subject to the requirements of this paragraph. County welfare departments may increase the daily amount available for temporary shelter to large families as necessary to secure the additional bed space needed by the family.

(ii) This special need shall be granted or denied immediately upon the family's application for homeless assistance, and benefits shall be available for up to three working days. The county welfare department shall verify the family's homelessness within the first three working days and if the family meets the criteria of questionable homelessness established by the department, the county welfare department shall refer the family to its early fraud prevention and detection unit, if the county has such a unit, for assistance in the verification of homelessness within this period.

(iii) After homelessness has been verified, the three-day limit shall be extended for a period of time which, when added to the initial benefits provided, does not exceed a total of 16 calendar days. This extension of benefits shall be done in increments of one week and shall be based upon searching for permanent housing which shall be documented on a housing search form; good cause; or other

circumstances defined by the department. Documentation of housing search shall be required for the initial extension of benefits beyond the three-day limit and on a weekly basis thereafter as long as the family is receiving temporary shelter benefits. Good cause shall include, but is not limited to, situations in which the county welfare department has determined that the family, to the extent it is capable, has made a good faith but unsuccessful effort to secure permanent housing while receiving temporary shelter benefits.

(B) A nonrecurring special need for permanent housing assistance is available to pay for last month's rent and security deposits when these payments are reasonable conditions of securing a residence.

The last month's rent portion of the payment (1) shall not exceed 80 percent of the family's maximum aid payment without special needs for a family of that size and (2) shall only be made to families that have found permanent housing costing no more than 80 percent of the family's maximum aid payment without special needs for a family of that size, in accordance with the maximum aid schedule specified in subdivision (a).

However, if the county welfare department determines that a family intends to reside with individuals who will be sharing housing costs, the county welfare department shall, in appropriate circumstances, set aside the condition specified in clause (2) of the preceding paragraph.

(C) The nonrecurring special need for permanent housing assistance is also available to cover the standard costs of deposits for utilities which are necessary for the health and safety of the family.

(D) A payment for or denial of permanent housing assistance shall be issued no later than one working day from the time that a family presents evidence of the availability of permanent housing. If an applicant family provides evidence of the availability of permanent housing before the county welfare department has established eligibility for aid under this chapter, the county welfare department shall complete the eligibility determination so that the denial of or payment for permanent housing assistance is issued within one working day from the submission of evidence of the availability of permanent housing, unless the family has failed to provide all of the verification necessary to establish eligibility for aid under this chapter.

(E) (i) Except as provided in clauses (ii) and (iii), eligibility for the temporary shelter assistance and the permanent housing assistance pursuant to this paragraph shall be limited to one period of up to 16 consecutive calendar days of temporary assistance and one payment of permanent assistance. Any family that includes a parent or nonparent caretaker relative living in the home who has previously received temporary or permanent homeless assistance at any time on behalf of an eligible child shall not be eligible for further homeless assistance. Any person who applies for homeless assistance benefits shall be informed that the temporary shelter benefit of up to 16 consecutive days is available only once in a lifetime, with certain exceptions, and that a break in the consecutive use of the benefit constitutes permanent exhaustion of the temporary benefit.

(ii) A family that becomes homeless as a direct and primary result of a state or federally declared natural disaster shall be eligible for temporary and permanent homeless assistance.

(iii) A family shall be eligible for temporary and permanent homeless assistance when homelessness is a direct result of domestic violence by a spouse, partner, or roommate; physical or mental illness that is medically verified that shall not include a diagnosis of alcoholism, drug addiction, or psychological stress; or, the uninhabitability of the former residence caused by sudden and unusual circumstances beyond the control of the family including natural catastrophe, fire, or condemnation. These circumstances shall be verified by a third-party governmental or private health and human services agency and homeless assistance payments based on these specific circumstances may not be received more often than once in any 12-month period. A county may require that a recipient of homeless assistance benefits who qualifies under this paragraph for a second time in a 24-month period participate in a homelessness avoidance case plan as a condition of eligibility for homeless assistance benefits.

(iv) The county welfare department shall report to the department through a statewide homeless assistance payment indicator system, necessary data, as requested by the department, regarding all recipients of aid under this paragraph.

(F) The county welfare departments, and all other entities participating in the costs of the AFDC program, have the right in their share to any refunds resulting from payment of the permanent housing. However, if an emergency requires the family to move within the 12-month period specified in subparagraph (E), the family shall be allowed to use any refunds received from its deposits to meet the costs of moving to another residence.

(G) Payments to providers for temporary shelter and permanent housing and utilities shall be made on behalf of families requesting these payments.

(H) The daily amount for the temporary shelter special need for homeless assistance may be increased if authorized by the current year's Budget Act by specifying a different daily allowance and appropriating the funds therefor.

(I) No payment shall be made pursuant to this paragraph unless the provider of housing is a commercial establishment, shelter, or person in the business of renting properties who has a history of renting properties.

(g) The department shall establish rules and regulations assuring the uniform application statewide of this subdivision.

(h) The department shall notify all applicants and recipients of aid through the standardized application form that these benefits are available and shall provide an opportunity for recipients to apply for the funds quickly and efficiently.

(i) Except for the purposes of Section 15200, the amounts payable to recipients pursuant to Section 11453.1 shall not constitute part of the payment schedule set forth in subdivision (a).

The amounts payable to recipients pursuant to Section 11453.1 shall not constitute income to recipients of aid under this section.

(j) For children receiving Kin-GAP pursuant to Article 4.5 (commencing with Section 11360) of Chapter 2, there shall be paid, exclusive of any amount considered exempt as income, an amount of aid each month, which, when added to the child's income, is equal to the rate specified in Section 11364.

(k) Should a court determine that the state must provide a cost-of-living adjustment pursuant to the Guillen v. Schwarzenegger case, grants shall be increased to provide the retroactive cost-of-living adjustment for eligible recipients only for the period from October 1, 2003, to the effective date of the act that added this subdivision. On and after the effective date of the act that added this subdivision, the ongoing grant amount shall revert to the grants amounts specified in subdivision (a).

SEC. 20. Section 11450.01 of the Welfare and Institutions Code is repealed.

~~11450.01. (a) Notwithstanding any other provision of law, commencing October 1, 1992, the maximum aid payments specified in paragraph (1) of subdivision (a) of Section 11450 in effect on July 1, 1992, shall be reduced by 4.5 percent.~~

~~(b) (1) The department shall seek the approval from the United States Department of Health and Human Services that is necessary to reduce the maximum aid payments specified in subdivision (a) by an additional amount equal to 1.3 percent of the maximum aid payments specified in paragraph (1) of subdivision (a) of Section 11450 in effect on July 1, 1992.~~

~~(2) The reduction provided by this subdivision shall be made on the first day of the month following 30 days after the date of approval by the United States Department of Health and Human Services.~~

SEC. 21. Section 11450.015 of the Welfare and Institutions Code is repealed.

~~11450.015. Notwithstanding any other provision of law, the maximum aid payments in effect on June 30, 1993, in accordance with paragraph (1) of subdivision (a) of Section 11450 as reduced by subdivisions (a) and (b) of Section 11450.01, shall~~

~~be reduced by 2.7 percent beginning the first of the month following 60 days after the enactment of this section.~~

SEC. 22. Section 11450.017 of the Welfare and Institutions Code is repealed.

~~11450.017. Notwithstanding any other provision of law, the maximum aid payment in effect on June 30, 1994, in accordance with paragraph (1) of subdivision (a) of Section 11450 as reduced by subdivisions (a) and (b) of Section 11450.01 and Section 11450.015, shall be reduced by 2.3 percent beginning the first of the month following 50 days after the effective date of this section.~~

SEC. 23. Section 11450.018 of the Welfare and Institutions Code is repealed.

~~11450.018. (a) Notwithstanding any other provision of law, the maximum aid payment in accordance with paragraph (1) of subdivision (a) of Section 11450 as reduced by subdivisions (a) and (b) of Section 11450.01, Section 11450.015, and Section 11450.017, shall be reduced by 4.9 percent for counties in Region 2, as specified in Section 11452.018.~~

~~(b) Notwithstanding any other provision of law, through October 31, 1998, the maximum aid payment in accordance with paragraph (1) of subdivision (a) of Section 11450, as reduced by subdivision (a) and (b) of Section 11450.01, Section 11450.015, Section 11450.017, and subdivision (a) shall be reduced by 4.9 percent.~~

~~(c) Prior to implementing the reductions specified in subdivisions (a) and (b), the director shall apply for and obtain a waiver from the United States Department of Health and Human Services of Section 1396a(c)(1) of Title 42 of the United States Code. The reduction shall be implemented to the extent the waiver is granted and only so long as the waiver is effective. This subdivision shall not apply if either the~~

~~federal waiver process set forth at Section 1315 of Title 42 of the United States Code or Section 1396a(c) is repealed or modified such that a waiver is not necessary to implement subdivision (a) or (b).~~

~~(d) This section shall become operative and the reductions specified in subdivisions (a) and (b) shall commence on the first day of the month following 30 days after the receipt of federal approval or on the first day of the month following 30 days after a change in federal law that allows states to reduce aid payments without any risk to federal funding under Title XIX of the Social Security Act, whichever is earlier, but no earlier than October 1, 1995.~~

SEC. 24. Section 11451.5 of the Welfare and Institutions Code, as amended by Section 4 of Chapter 933 of the Statutes of 2000, is repealed.

~~11451.5. (a) Notwithstanding Section 11008 and except as provided by subdivision (f) of Section 11322.6, the following amounts shall be exempt from the calculation of the income of the family for purposes of subdivision (a) of Section 11450:~~

~~(1) If disability-based unearned income does not exceed two hundred twenty-five dollars ($225), both of the following amounts:~~

~~(A) All disability-based unearned income plus any amount of not otherwise exempt earned income equal to the amount of the difference between the amount of disability-based unearned income and two hundred twenty-five dollars ($225).~~

~~(B) Fifty percent of all not otherwise exempt earned income in excess of the amount applied to meet the differential applied in subparagraph (A).~~

~~(2) If disability-based unearned income exceeds two hundred twenty-five dollars ($225), both of the following amounts:~~

~~(A) All of the first two hundred twenty-five dollars ($225) in disability-based unearned income.~~

~~(B) Fifty percent of all earned income.~~

~~(b) For purposes of this section:~~

~~(1) Earned income means gross income received as wages, salary, employer provided sick leave benefits, commissions, or profits from activities such as a business enterprise or farming in which the recipient is engaged as a self-employed individual or as an employee.~~

~~(2) Disability-based unearned income means State Disability Insurance benefits, private disability insurance benefits, Temporary Workers' Compensation benefits, and social security disability benefits.~~

~~(3) Unearned income means any income not described in paragraph (1) or (2).~~

SEC. 25. Section 11451.5 of the Welfare and Institutions Code, as amended by Section 329 of Chapter 62 of the Statutes of 2003, is amended to read:

11451.5. (a) Except as provided by subdivision (f) of Section 11322.6, the following income, averaged over the quarter pursuant to Sections 11265.2 and 11265.3, shall be exempt from the calculation of the income of the family for purposes of subdivision (a) of Section 11450:

(1) If disability-based unearned income does not exceed two hundred twenty-five dollars ($225), both of the following amounts:

(A) All disability-based unearned income plus any amount of not otherwise exempt earned income equal to the amount of the difference between the amount of disability-based unearned income and two hundred twenty-five dollars ($225).

(B) Fifty percent of all not otherwise exempt earned income in excess of the amount applied to meet the differential applied in subparagraph (A).

(2) If disability-based unearned income exceeds two hundred twenty-five dollars ($225), both of the following amounts:

(A) All of the first two hundred twenty-five dollars ($225) in disability-based unearned income.

(B) Fifty percent of all earned income.

(b) For purposes of this section:

(1) "Earned income" means gross income received as wages, salary, employer provided sick leave benefits, commissions, or profits from activities such as a business enterprise or farming in which the recipient is engaged as a self-employed individual or as an employee.

(2) "Disability-based unearned income" means state disability insurance benefits, private disability insurance benefits, temporary workers' compensation benefits, and social security disability benefits.

(3) "Unearned income" means any income not described in paragraph (1) or (2).

(c) This section shall become inoperative October 1, 2005, and as of that date is repealed.

SEC. 26. Section 11451.5 is added to the Welfare and Institutions Code, to read:

11451.5. (a) Except as provided by subdivision (f) of Section 11322.6, the following income, averaged over the quarter pursuant to Sections 11265.2 and 11265.3, shall be exempt from the calculation of the income of the family for purposes of subdivision (a) of Section 11450:

(1) If disability-based unearned income does not exceed two hundred dollars ($200), both of the following amounts:

(A) All disability-based unearned income plus any amount of not otherwise exempt earned income equal to the amount of the difference between the amount of disability-based unearned income and two hundred dollars ($200).

(B) Forty percent of all not otherwise exempt earned income in excess of the amount applied to meet the differential applied in subparagraph (A).

(2) If disability-based unearned income exceeds two hundred dollars ($200), both of the following amounts:

(A) All of the first two hundred dollars ($200) in disability-based unearned income.

(B) Forty percent of all earned income.

(b) For purposes of this section:

(1) Earned income means gross income received as wages, salary, employer provided sick leave benefits, commissions, or profits from activities such as a business enterprise or farming in which the recipient is engaged as a self-employed individual or as an employee.

(2) Disability-based unearned income means state disability insurance benefits, private disability insurance benefits, temporary workers' compensation benefits, and social security disability benefits.

(3) Unearned income means any income not described in paragraph (1) or (2).

(c) This section shall become operative October 1, 2005.

SEC. 27. Section 11453 of the Welfare and Institutions Code is amended to read:

11453. (a) Except as provided in subdivision (c), the amounts set forth in Section 11452 ~~and subdivision (a) of Section 11450~~ shall be adjusted annually by the department to reflect any increases or decreases in the cost of living. These adjustments shall become effective ~~July 1 of each year~~ October 1 of each year or the first day of the month following 90 days after the annual Budget Act becomes effective, whichever is later, unless otherwise specified by the Legislature. The amounts set forth in subdivision (a) of Section 11450 shall be adjusted only in those years in which amounts for this purpose are expressly allocated in the annual Budget Act. Adjustment to the amounts set forth in subdivision (a) of Section 11450 shall become effective the first day of the month following 90 days after the annual Budget Act becomes effective. For the 2000–01 fiscal year to the 2003–04 fiscal year, inclusive, ~~these~~ the adjustments to the amounts in Section 11452 and subdivision (a) of Section 11450 shall become effective October 1 of each year. The cost-of-living adjustment shall be calculated by the Department of Finance based on the changes in the California Necessities Index, which as used in this section means the weighted average changes for food, clothing, fuel, utilities, rent, and transportation for

low-income consumers. The computation of annual adjustments in the California Necessities Index shall be made in accordance with the following steps:

(1) The base period expenditure amounts for each expenditure category within the California Necessities Index used to compute the annual grant adjustment are:

Food	$ 3,027
Clothing (apparel and upkeep)	406
Fuel and other utilities	529
Rent, residential	4,883
Transportation	1,757
Total	$10,602

(2) Based on the appropriate components of the Consumer Price Index for All Urban Consumers, as published by the United States Department of Labor, Bureau of Labor Statistics, the percentage change shall be determined for the 12-month period ending with the December preceding the year for which the cost-of-living adjustment will take effect, for each expenditure category specified in subdivision (a) within the following geographical areas: Los Angeles-Long Beach-Anaheim, San Francisco-Oakland, San Diego, and, to the extent statistically valid information is available from the Bureau of Labor Statistics, additional geographical areas within the state which include not less than 80 percent of recipients of aid under this chapter.

(3) Calculate a weighted percentage change for each of the expenditure categories specified in subdivision (a) using the applicable weighting factors for each area used by the State Department of Industrial Relations to calculate the California Consumer Price Index (CCPI).

(4) Calculate a category adjustment factor for each expenditure category in subdivision (a) by (1) adding 100 to the applicable weighted percentage change as determined in paragraph (2) and (2) dividing the sum by 100.

(5) Determine the expenditure amounts for the current year by multiplying each expenditure amount determined for the prior year by the applicable category adjustment factor determined in paragraph (4).

(6) Determine the overall adjustment factor by dividing (1) the sum of the expenditure amounts as determined in paragraph (4) for the current year by (2) the sum of the expenditure amounts as determined in subdivision (d) for the prior year.

(b) The overall adjustment factor determined by the preceding computation steps shall be multiplied by the schedules established pursuant to Section 11452 and subdivision (a) of Section 11450 as are in effect during the month of June preceding the fiscal year in which the adjustments are to occur and the product rounded to the nearest dollar. The resultant amounts shall constitute the new schedules which shall be filed with the Secretary of State.

(c) ~~(1) No adjustment to the maximum aid payment set forth in subdivision (a) of Section 11450 shall be made under this section for the purpose of increasing the benefits under this chapter for the 1990–91, 1991–92, 1992–93, 1993–94, 1994–95, 1995–96, 1996–97, and 1997–98 fiscal years, and through October 31, 1998, to reflect any change in the cost of living. For the 1998–99 fiscal year, the cost-of-living adjustment that would have been provided on July 1, 1998, pursuant to subdivision (a) shall be made on November 1, 1998. Elimination of the cost-of-living adjustment~~

~~pursuant to this paragraph shall satisfy the requirements of Section 11453.05, and no further reduction shall be made pursuant to that section.~~

~~(2)~~ No adjustment to the minimum basic standard of adequate care set forth in Section 11452 shall be made under this section for the purpose of increasing the benefits under this chapter for the 1990–91 and 1991–92 fiscal years to reflect any change in the cost of living.

~~(3) In any fiscal year commencing with the 2000–01 fiscal year to the 2003–04 fiscal year, inclusive, when there is any increase in tax relief pursuant to the applicable paragraph of subdivision (a) of Section 10754 of the Revenue and Taxation Code, then the increase pursuant to subdivision (a) of this section shall occur. In any fiscal year commencing with the 2000–01 fiscal year to the 2003–04 fiscal year, inclusive, when there is no increase in tax relief pursuant to the applicable paragraph of subdivision (a) of Section 10754 of the Revenue and Taxation Code, then any increase pursuant to subdivision (a) of this section shall be suspended.~~

~~(4) Notwithstanding paragraph (3), an adjustment to the maximum aid payments set forth in subdivision (a) of Section 11450 shall be made under this section for the 2002–03 fiscal year, but the adjustment shall become effective June 1, 2003.~~

(d) For the 2004–05 fiscal year, the adjustment to the maximum aid payment set forth in subdivision (a) shall be suspended for three months commencing on the first day of the first month following the effective date of the act adding this subdivision.

(e) Adjustments for subsequent fiscal years pursuant to this section shall not include any adjustments for any fiscal year in which the cost of living was suspended pursuant to subdivision (c).

SEC. 28. Section 12201 of the Welfare and Institutions Code is amended to read:

12201. (a) Except as provided in subdivision (d), the payment schedules set forth in Section 12200 shall be adjusted annually to reflect any increases or decreases in the cost of living. Except as provided in subdivision (e), these adjustments shall become effective January 1 of each year. The cost-of-living adjustment shall be based on the changes in the California Necessities Index, which as used in this section shall be the weighted average of changes for food, clothing, fuel, utilities, rent, and transportation for low-income consumers. The computation of annual adjustments in the California Necessities Index shall be made in accordance with the following steps:

(1) The base period expenditure amounts for each expenditure category within the California Necessities Index used to compute the annual grant adjustment are:

Food	$ 3,027
Clothing (apparel and upkeep)	406
Fuel and other utilities	529
Rent, residential	4,883
Transportation	1,757
Total	$10,602

(2) Based on the appropriate components of the Consumer Price Index for All Urban Consumers, as published by the United States Department of Labor, Bureau of

minimum wage and 100 percent of the nonfederal share above the state minimum wage.

SEC. 32. Section 15200 of the Welfare and Institutions Code, as amended by Section 7 of Chapter 1055 of the Statutes of 1998, is repealed.

~~15200. There is hereby appropriated out of any money in the State Treasury not otherwise appropriated, and after deducting available federal funds, the following sums:~~

~~(a) To each county for the support and maintenance of needy children, 95 percent of the sums specified in subdivision (a), and paragraphs (1) and (2) of subdivision (c) of Section 11450.~~

~~(b) To each county for the support and maintenance of pregnant mothers, 95 percent of the sums specified in subdivisions (b) and (c) of Section 11450.~~

~~(c) To each county for the support and maintenance of needy children, 40 percent of the sum necessary for the adequate care of each child pursuant to subdivision (d) of Section 11450.~~

~~(d) Notwithstanding subdivision (c), the amount of funds appropriated from the General Fund in the annual Budget Act that equates to the amount claimed under the Emergency Assistance Program that has been included in the state's Temporary Assistance for Needy Families block grant for foster care maintenance payments shall be considered federal funds for the purposes of calculating the county share of cost, provided the expenditure of these funds contributes to the state meeting its federal maintenance of effort requirements.~~

~~(e) To each county for the support and care of hard-to-place adoptive children, 75 percent of the nonfederal share of the amount specified in Section 16121.~~

~~(f) To each county for the support and care of former dependent children who have been made wards of related guardians, an amount equal to 50 percent of the Kin-GAP payment under Article 4.5 (commencing with Section 11360) of Chapter 2 minus the federal TANF block grant contribution specified in Section 11364.~~

~~(g) This section shall remain in effect only until July 1, 1995, or until two years after the implementation of the Child Welfare Services Case Management System as specified in Section 16501.5, whichever occurs last, and as of that date is repealed, unless a later enacted statute which is chaptered before July 1, 1990, or two years after the implementation of the Child Welfare Services Case Management System, deletes or extends that date.~~

SEC. 33. Section 15200 of the Welfare and Institutions Code, as amended by Section 8 of Chapter 1055 of the Statutes of 1998, is amended to read:

15200. There is hereby appropriated out of any money in the State Treasury not otherwise appropriated, and after deducting federal funds available, the following sums:

(a) To each county for the support and maintenance of needy children, 95 percent of the sums specified in subdivision (a), and paragraphs (1) and (2) of subdivision (e), of Section 11450.

(b) To each county for the support and maintenance of pregnant mothers, 95 percent of the sum specified in subdivisions (b) and (c) of Section 11450.

(c) For the adequate care of each child pursuant to subdivision (d) of Section 11450, as follows:

(1) For any county that meets the performance standards or outcome measures in Section 11215, an amount equal to 40 percent of the sum necessary for the adequate care of each child.

(2) For any county that does not meet the performance standards or outcome measures in Section 11215, an amount which shall not be less than 67.5 percent of one hundred twenty dollars ($120), and multiplied by the number of children receiving foster care in the county, added to an additional twelve dollars and fifty cents ($12.50) a month per eligible child.

(3) The department shall determine the percentage of state reimbursement for those counties that fail to meet the requirements of subparagraph (1) according to the regulations required by subdivision (b) of Section 11215.

(d) Notwithstanding subdivision (c), the amount of funds appropriated from the General Fund in the annual Budget Act that equates to the amount claimed under the Emergency Assistance Program that has been included in the state's Temporary Assistance for Needy Families block grant for foster care maintenance payments shall be considered federal funds for the purposes of calculating the county share of cost, provided the expenditure of these funds contributes to the state meeting its federal maintenance of effort requirements.

(e) To each county for the support and care of hard-to-place adoptive children, 75 percent of the nonfederal share of the amount specified in Section 16121.

(f) The State Department of Social Services shall not implement any change in the current funding ratios to counties as a reimbursement for out-of-home care placement until the development of a new performance standard system. The State Department of Social Services shall notify the Department of Finance when the new performance standard system is developed and ready for implementation. The Department of Finance, pursuant to the provisions of Section 28 of the Budget Act, shall notify the Joint Legislative Budget Committee in writing of its intent to implement a new performance standard that would impact the counties' funding allocation. The notification shall include the text of the draft regulations to implement the performance standards. Any adjustment in the county funding allocation shall not be implemented sooner than 60 days after receipt and review of the new performance standard by the Joint Legislative Budget Committee and a review of the proposed changes by the Legislative Analyst.

(g) To each county for the support and care of former dependent children who have been made wards of related guardians, an amount equal to 50 percent of the Kin-GAP payment under Article 4.5 (commencing with Section 11360) of Chapter 2 minus the federal TANF block grant contribution specified in Section 11364.

(h) ~~This section shall become operative on July 1, 1995, unless the Child Welfare Services Case Management System is not implemented statewide July 1, 1993, as specified in Section 16501.5. If the Child Welfare Services Case Management System is implemented later than July 1, 1993, this section shall become operative two years after the implementation of the Child Welfare Services Case Management System~~ Federal funds received under Title XX of the federal

Social Security Act (42 U.S.C. Sec. 1397 et seq.) and appropriated by the Legislature for the Aid to Families with Dependent Children-Foster Care (AFDC–FC) program shall be considered part of the state share of cost and not part of the federal expenditures for purposes of subdivision (c).

SEC. 34. Section 15204.6 is added to the Welfare and Institutions Code, to read:

15204.6. (a) For the 2006-07, 2007-08, and 2008-09 fiscal years, the State Department of Social Services shall implement a CalWORKs pay for performance project that will measure increases in recipient employment and participation in welfare-to-work activities in each county from one year to the next.

(b) The State Department of Social Services shall consult with the County Welfare Directors' Association and other interested stakeholders in the development of the pay for performance project and the measures to be used.

(c) Each county's CalWORKs single allocation under Section 15204.2, excluding child care, shall be adjusted in subsequent years based on each county's performance in reaching the project outcomes.

(d) The State Department of Social Services may implement this section through all county letters or similar instructions from the director.

SEC. 35. (a) The State Department of Social Services shall adopt regulations to implement Sections 18, 19, 20, 21, 22, 23, 24, 25, 26, and 27 of this act. The department shall adopt, no later than July 1, 2006, emergency regulations pursuant to subdivision (b), as necessary to implement those sections of this act. The department shall notify the Chair of the Joint Legislative Budget Committee of any delay in the

Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda
Health & Human Services

Chair, Senator Denise Ducheny

Senator George Runner
Senator Tom Torlakson

April 11, 2005

1:30 PM

Room 4203

(Diane Van Maren)

Item	**Department**
4300	**Department of Developmental Services**

- **Community-Based Services *(Selected Issues)***
- **State Developmental Centers *(Selected Issues)***

PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. Additional issues regarding this department will also be discussed at future hearings. *Please* see the Senate File for dates and times of subsequent hearings.

Testimony will be limited due to the volume of issues. Please be direct and brief in your oral comments so that others may have the opportunity to testify. Written testimony is also welcomed. Thank you for your cooperation.

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

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

Item 4300 Department of Developmental Services

I. BACKGROUND OVERALL

Description of Eligibility & Purpose of Department

The Department of Developmental Services (DDS) administers services in the community through 21 Regional Centers (RC) and in state Developmental Centers (DC) for persons with developmental disabilities as defined by the provisions of the Lanterman Developmental Disabilities Services Act. To be eligible for services, the disability must begin before the consumer's 18th birthday, be expected to continue indefinitely, present a significant disability and be attributable to certain medical conditions, such as mental retardation, autism, and cerebral palsy.

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

Description and Characteristics of Consumers Served

The department occasionally produces a Fact Book which contains pertinent data about persons served by the department. The sixth annual edition, released in December 2004 contains some interesting data, including the following facts:

Department of Developmental Services—Demographics Data from 2004

Age	Number of Persons	Percent of Total	Residence Type	Number of Persons	Percent of Total in Residence
Birth to 2 Yrs.	21,424	11.0%	Own Home-Parent	138,141	71.0%
3 to 13 Yrs.	56,681	29.1%	Community Care	26,3760	13.6%
14 to 21 Yrs.	32,024	16.5%	Independent Living /Supported Living	16,583	8.5%
22 to 31 Yrs.	27,144	14.0%	Skilled Nursing/ICF	8,728	4.5%
32 to 41 Yrs.	23,079	11.9%	Developmental Center	3,467	1.8%
42 to 51 Yrs.	19,648	10.1%	Other	1,159	0.6%
52 to 61 Yrs.	9,899	5.1%			
62 and Older	4,555	2.3%			
Totals	***194,454***	***100%***		***194,454***	***100%***

Summary of Governor's Proposed Budget Overall

The budget proposes total expenditures of $3.7 billion ($2.3 billion General Fund), for a *net* increase of $166.4 million ($129.8 million General Fund) over the revised 2004-05 budget, to provide services and supports to individuals with developmental disabilities living in the community or in state Developmental Centers. The proposed $166.4 million ($129.8 million General Fund) augmentation represents an increase of 4.7 percent over the revised current year.

Of the total amount, $2.954 billion ($1.947 billion General Fund) is for services provided in the community, $699.2 million ($373.2 million General Fund) is for support of the state Developmental Centers, $36.4 million ($24.1 million General Fund) is for state headquarters administration, and $502,000 (General Fund) is for state-mandated local programs.

Table: Department of Developmental Services Budget

Summary of Expenditures (dollars in thousands)	2004-05	2005-06	$ Change	% Change
Program Source				
Community Services Program	$2,766,542	$2,953,691	$187,149	6.8
Developmental Centers	$721,541	$699,232	($22,309)	(3.1)
State Administration	$35,324	$36,427	$1,103	3.1
State Mandated Local Program	$4	$502	$498	125
Total, Program Source	$3,523,411	$3,689,852	$166,441	4.7
Funding Source				
General Fund	$2,214,571	$2,344,424	$129,853	5.9
Federal Funds	$53,908	$55,730	$1,822	3.4
Program Development Fund	$1,497	$2,268	$771	51.5
Lottery Education Fund	$2,204	$2,204	--	--
Developmental Disabilities Services	$300	$0	($300)	(100)
Reimbursements: including Medicaid Waiver, Title XX federal block grant and Targeted Case Management	$1,250,931	$1,285,226	$34,295	2.7
Total Expenditures	$3,523,411	$3,689,852	$166,441	4.7

II. COMMUNITY BASED SERVICES

Background on Regional Centers

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

RCs also purchase services for consumers and their families from approved vendors and coordinate consumer services with other public entities.

Summary of Funding and Funding Sources

The budget proposes expenditures of $2.953 billion ($1.9 billion General Fund) for community-based services, provided via the RCs, to serve a total of 208,000 consumers living in the community. This funding level includes $461.7 million for RC operations and $2.471 billion for the purchase of services, including funds for the Early Start Program and habilitation services.

The budget reflects a *net* overall increase of $187.1 million ($142.6 million General Fund), or 6.8 percent, over the revised current year budget for RCs. Most of this increase is attributable to: (1) an increase in enrollment — 8,765 new consumers; (2) an increase in the utilization of services by consumers; (3) restoration of a one-time $29.9 million adjustment associated with the availability of reimbursements for South Central Los Angeles Regional Center; (4) updated community placement plan funding to reflect some consumers transitioning from Agnews Developmental Center to the community; and (5) an increase for RC operations pertaining to activities associated with the Home and Community-Based Wavier.

Summary of Key Federal Fund Sources (Waiver and others)

Over the years the DDS has been successful in attaining the receipt of federal funds for community-based services. Unlike the state's Developmental Centers, which receive a 50 percent federal match for every $1 dollar of state General Fund expenditures, community-based services rely primarily on state General Fund support, along with certain limited federal funds, most notably the Home and Community-Based Waiver.

Under the Home and Community-Based (HCB) Waiver, the DDS is able to obtain federal funds for certain eligible consumers who are receiving RC-purchased services. Without these services, these eligible consumers would require the level-of-care provided in an Intermediate Care Facility. Enrollment in this Waiver is capped by the federal government at 70,000 eligible individuals as of October 1, 2005. The budget assumes receipt of about $615 million in federal funds from this source in 2005-06. These federal funds do require a state General Fund match (i.e., the match is 50/50 percent).

Summary of Enrollment

The following chart depicts consumer enrollment for RC services over the last five-years.

Regional Center Enrollment Chart

Fiscal Year	RC Enrollment	Yearly Difference in Consumers	Percent Increase
2000-01	163,613	8,651	5.6%
2001-02	172,714	9,101	5.6%
2002-03	182,175	9,461	5.5%
2003-04	190,116	7,941	4.4%
2004-05 (Estimated)	199,255	9,139	4.8%
2005-06 (Proposed)	208,020	8,765	4.4%

- The DDS notes that several key factors appear to be driving caseload growth trends, including the following:
- Improved medical care and technology has increased life expectancies for individuals with developmental disabilities;
- Significant increase in the diagnosed cases of autism, the causes of which are not yet fully understood; and
- Likelihood that medical professionals are identifying more developmentally disabled individuals at an earlier age.

A. ITEMS FOR VOTE ONLY

1. Regional Center Affordable Housing Projects—Consultant Services

Issue: The Subcommittee is in receipt of a Finance Letter. This letter requests two distinct actions regarding housing projects and identifies $69,000 in General Fund savings.

First, it proposes to save $69,000 in General Fund support by backfilling with Developmental Disabilities Services Account Funds (DDSA). A total of $90,000 (General Fund) was proposed in the Governor's January budget for an interagency agreement between the DDS and the state Department of Housing and Community Development (HCD). The HCD monitors 16 housing projects for the DDS. The Finance Letter would now appropriate $90,000 with only $21,000 from General Fund support.

These housing projects occurred pursuant to the Coffelt Settlement Agreement of 1993. The Coffelt Settlement Agreement required the DDS to develop a five-year plan to reduce the resident population of the Developmental Centers by a net of 2,000 individuals. As such, funds were allocated to create affordable housing options.

Second, in the current year, the DDS received $300,000 (one-time only General Fund) for housing-related consulting services. The DDS states that the contract for this was executed in January 2005. However because the long-term deliverables will require additional time beyond 2004-05 to complete, a reappropriation is being requested.

The proposed Budget Bill Language for the reappropriation is as follows:

> "Item 4300-490—Reappropriation, Department of Developmental Services.
> Notwithstanding any other provision of law, as of June 30, 20005, the balances specified below of the appropriations provided in the following citations are reappropriated for the purposes specified and shall be available for encumbrances or expenditure until June 30, 2006, unless otherwise stated.
>
> 0496—Developmental Disabilities Services Account
> (1) Balance of Item 4300-101-0496, Budget Act of 2004 (CH. 208, Stats. 2004)"

It should be noted that creation of affordable housing is an objective pursuant to the 1994 court decision commonly referred to as the Coffelt Agreement. Specifically, $3.7 million was allocated to create affordable housing for individuals with developmental disabilities through the Affordable Housing Program.

Subcommittee Staff Recommendation: The Finance Letter proposal is reasonable. No issues have been raised. It is recommended to adopt the Finance Letter.

B. ITEMS FOR DISCUSSION

1. Regional Center Caseload—Over Estimated *(Technical Discussion)*

Issue: In her *Analysis*, the Legislative Analyst recommended a reduction of $9 million (General Fund) in *both* 2004-05 and 2005-06 due to the over budgeting of caseload in the DDS' Regional Center estimate package.

Since the release of the *Analysis*, the LAO has learned that while the DDS did not adjust for lower-than-projected caseload levels for 2004-05 (current year), the caseload trend was indeed adjusted for 2005-06. The LAO notes that while the DDS has said they did adjust for 2005-06, the LAO could not conclusively confirm the DDS' claims that the budget year adjustments were made based on the display of information contained in the DDS' Regional Center estimate package. However, the DOF has confirmed this fact.

The LAO has serious concerns about the way caseload data and related fiscal adjustments are displayed in the estimate package. As such the LAO and DDS will be working to update the estimate formats in order to more clearly display data.

Therefore, the LAO recommends a reduction of $8.6 million (General Fund) (i.e., $7.2 million from RC Purchase of Services, and $1.4 million from RC Operations) for 2004-05. Further, the LAO notes that they will be reviewing the budget year caseload adjustments at the May Revision.

Subcommittee Staff Comment and Recommendation: Subcommittee staff concurs with the LAO recommendation to reduce by $8.6 million (General Fund) to reflect over budgeting due to lower-than-expected caseload for the current-year.

Questions:

1. DDS, Do you concur with the LAO's estimate for the current-year reduction due to lower-than-expected caseload for 2004-05?

2. Cost Containment--Budget Act of 2003, 2004 & Governor's Proposed Budget

(See Hand Outs)

Issue: The Governor proposes to continue several cost containment actions that were enacted as part of the Budget Acts of 2003 and 2004. The table below provides a summary of the fiscal affects of these prior year actions as they pertain to the revised current-year funding and budget year funding. In total, the actions would save $84.4 million General Fund in 2005-06.

Table: Summary of Existing Cost Containment Proposed to Carry into 2005-06

Previously Implemented Cost Containment Measures	Revised 2004-05		2005-06	
	Total	**General Fund**	**Total**	**General Fund**
RC Operations Total	**-$10,353,000**	**-$10,353,000**	**-$10,011,000**	**-$10,011,000**
1. Delay in Assessment (60 to 120 Days)	-4,465,000	-4,465,000	-4,465,000	-4,465,000
2. Family Cost Participation	570,000	570,000	912,000	912,000
3. 2004-05 Unallocated Level	-6,458,000	-6,458,000	-6,458,000	-6,458,000
RC Purchase of Services Total	**-$70,037,000**	**-$60,498,000**	**-$85,997,000**	**-$73,421,000**
1. Day Program Rate Freeze	-5,771,000	-4,184,000	-16,709,000	-12,114,000
2. Contract Services Rate Freeze	-11,375,000	-8,963,000	-11,565,000	-9,193,000
3. Community Care Facility (CCF) Rate Freeze	-12,389,000	-7,433,000	-12,389,000	-7,433,000
4. Elimination of the SSI/SSP Pass-Through to CCFs	-1,461,000	-877,000	-1,631,000	-978,000
5. Non-Community Placement Start-up Suspension	-5,962,000	-5,962,000	-5,962,000	-5,962,000
6. Family Cost Participation	-570,000	-570,000	-3,143,000	-3,143,000
7. Reduced Growth Trend	-11,357,000	-11,357,000	-11,357,000	-11,357,000
8. 2003-04 Unallocated Level	-10,000,000	-10,000,000	-10,000,000	-10,000,000
9. 2004-05 Unallocated Level	-7,000,000	-7,000,000	-7,000,000	-7,000,000
10. Revision of Eligibility Definition	-4,152,000	-4,152,000	-6,241,000	-6,241,000
11. Habilitation Services Rate Freeze	-1,232,000	-949,000	-1,209,000	-931,000
TOTALS	**-$81,622,000**	**-71,800,000**	**-$97,217,000**	**-$84,363,000**

Specifically, the proposals are as follows (corresponds to the table above):

- *Delay in Assessment (RC operations):* Through the Budget Act of 2002, trailer bill language was adopted to extend the amount of time allowed for the Regional Center's to conduct assessment of new consumers from 60 days to 120 days following the initial intake. The Governor proposes to continue this extension through 2005-06 through trailer bill language. This is the same language as used in previous years.

- *Family Cost Participation (RC operations and purchase of services)*: Through the Budget Act of 2004, trailer bill legislation was adopted to implement a Family Cost Participation Program by January 1, 2005. Under this program, families with incomes greater than 400 percent of poverty based on income and family size, that purchase Respite, Day Care, or Camp services must pay a parental co-payment. This program has been implemented by the DDS.
- *2004-05 Unallocated Reductions (RC operations and purchase of services):* An unallocated reduction of $6.4 million (General Fund) for RC Operations was adopted in the Budget Act of 2004, as well as a reduction of $7 million (General Fund) for the Purchase Of Services.
- *Day Program Rate Freeze:* Day Programs are community-based programs for individuals served by a Regional Center. Types of services available through a Day Program include: (1) developing and maintaining self-help and self-care skills, (2) developing the ability to interact with others, (3) developing self-advocacy and employment skills, (4) developing community integration skills such as accessing community services, and (5) improving behaviors through behavior management. The rate freeze means that provides who have a temporary payment rate in effect on or after June 30, 2003 cannot obtain a higher permanent rate. The Administration's proposed trailer bill language is the same as last year's, with a date extension to include 2005-06.
- *Contract Services Rate Freeze:* Some Regional Centers contract, through direct negotiations, with providers for certain services in lieu of the DDS setting an established rate. Continuation of the rate freeze would mean that Regional Centers cannot provide a rate greater than was in effect as of June 30, 2004. The Administration's proposed trailer bill language is the same as last year's, with a date extension to include 2005-06.
- *Community Care Facility (CCFs) Rate Freeze and Elimination of Pass Through:* The Budget Act of 2003 froze the CCF rates. Further, the SSI/SSP cost-of-living-adjustment that is paid to CCFs by the federal government is being used to off-set General Fund expenditures for these services (off-set is $1.6 million General Fund for 2005-06).
- *Non-Community Placement Start-Up Suspension (RC purchase of services):* Under this proposal, a Regional Center may not expend any Purchase of Services funds for the startup of any new program unless the expenditure is necessary to protect the consumer's health or safety or because of other extraordinary circumstances, and the DDS has granted authorization for the expenditure. The Administration's proposed trailer bill language would continue this freeze through 2006-07, or one-year longer than all of the other proposals.
- *2003-04 Unallocated Reduction (RC Purchase Of Services):* An unallocated reduction of $10 million (General Fund) for RC Purchase of Services was enacted for this year and is continued in the base.

- *Revision of Eligibility:* The Budget Act of 2003 and accompanying trailer bill language prospectively implemented the use of the federal standard for "substantial disability" to existing state Lanterman Act eligibility criteria. This revision, effective July 1, 2003, requires a person to have deficits in at least three of the seven life domains (i.e., communication skills, learning, self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency.
- *Habilitation Services Rate Freeze:* The Habilitation Services Program consists of the (1) Work Activity Program (WEP), and (2) Supported Employment Program (SEP). The WAP services are primarily provided in a sheltered setting and are reimbursed on a per-consumer-day basis. SEP enables individuals to work in the community, in integrated settings with support services provided by community rehabilitation programs. The Administration's proposed trailer bill language would continue the rate freeze into 2005-06.

Subcommittee Staff Comment and Recommendation: It is recommended to adopt the Governor's proposal regarding these items, *except* for one trailer bill language change. With respect to the "non-community placement start-up" issue, it is recommended to extend this proposal for 2005-06 only, and not include 2006-07 in the language.

Questions:

1. DDS, Please briefly describe the budget proposal.
2. DDS, Has the DDS identified any significant reduction in services that has occurred due to these actions?
3. DDS, Please describe the exemptions that have been provided for health and safety concerns (See Hand Outs).

3. Finance Letter—Reappropriation of Cost Containment Consultant Services

Issue: The Subcommittee is in receipt of a Finance Letter that requests to reappropriate $488,000 (General Fund) from the Budget Act of 2004 to continue certain cost containment activities related to the following:

- Development of a rate-setting methodology for rates that are negotiated between RCs and providers;
- Improvements to the reporting of service delivery data; and
- Automation of the submission of vendor cost information.

The Budget Act of 2004 provided a one-time only appropriation of $600,000 (General Fund) for the DDS to conduct various cost containment functions. Of this amount, $112,000 is expected to be used in the current year.

Specifically, the DDS intends to use $112,000 for consultation services related to the federal Waiver ("Independence Plus") for the Self-Directed Services Program. The Legislature did provide approval for the DDS to proceed with this Waiver. The $112,000 is to be used for developing training materials and to provide various types of technical assistance.

DDS is requesting to reappropriate the remaining $488,000 (General Fund) for consultation services related to: (1) automating cost statements for Day Programs, In-Home Respite Agencies and Work Activity Programs; (2) analyzing and developing recommendations for standardizing 16 RC Purchase Of Services areas experiencing high rates of growth; and (3) researching geographic cost issues to be considered when developing or revising rate-setting processes.

Subcommittee Staff Comment and Recommendation: The request to reappropriate the remaining $488,000 (General Fund) provided in the Budget Act of 2004 is consistent with the original legislative intent of the appropriation. It should be noted that any recommendations the DDS may develop regarding rates would need to be discussed and reviewed by the Legislature as part of the budget process. It is therefore recommended to adopt the Finance Letter.

Questions:

1. DDS, Please explain how the initial $112,000 (General Fund) has been spent, and how the remaining $488,000 is to be used.

4. Governor's Proposed Additional Cost Containment Issues *(See Hand Out)*

Issue: The Governor proposes substantial policy changes through trailer bill legislation to grant Regional Centers (RCs) broad authority for reducing Purchase of Services (POS) expenditures. For 2005-06, a *net* savings of $7.8 million ($4.3 million General Fund) is assumed from these changes.

For RC POS, savings of $14 million ($10.5 million General Fund) are assumed in 2005-06 with total savings of at least $41.9 million ($31.4 million General Fund) annually once the phase-in has been completed.

It should be noted that the Legislature has rejected similar proposals for the past three years.

It is assumed that RCs would apply these new requirements at the time of an individual's program plan (IPP) development or scheduled review. An individual's IPP is to be reviewed no less than once every three years. As such, the budget assumes that one-third of the RC population (208,000 people) would have their plans reviewed each year. The proposed cumulative savings from these new requirements are as follows:

Table: Summary of Governor's Additional Reductions for Further Cost Containment

Fiscal Year and Cumulative Effect	Total Proposed POS Reductions Due to New Requirements	Proposed Savings in General Fund
2005-06 One-third of population is reviewed.	$14 million	$10.5 million
2006-07 Continue 2005-06 savings and review next one-third of population.	$28 million	$20.9 million
2007-08 Continue 2005-06 and 2006-07 savings and review next one-third of population.	$41.9 million	$31.4 million

The Governor is also proposing an augmentation of $6.2 million (General Fund) to RC operations for implementation of the proposed POS requirements. This increased funding is to be used as follows: (1) 52 new positions; (2) $302,000 for office rent; (3) $500,000 for increased administrative law hearings; (4) $240,000 for annual statements of POS; and (5) $170,000 in other operating expenditures.

The Governor's proposed POS requirements and their anticipated component savings are as follows:

- *1. Vendor Selection Based On Lowest Cost:* The cost of providing services by different vendors, if available, would be reviewed by an RC and the least costly vendor who is able to meet the consumer's needs, as identified in the consumer's IPP, would be selected. This provision is assumed to save $25 million ($18.4 million General Fund) annually when fully implemented.

- *2. Statement of RC Services:* RCs would annually provide the consumer or their parent/guardian a statement of RC purchased services and supports. This statement would include the type, unit, and cost of the services and supports. This provision of the guidelines is intended to serve as a validation that the described services and supports are indeed being provided to the consumer by the designated vendor. This guideline is intended to save $6.2 million ($4.6 million General Fund) annually when fully implemented.

- *3. Directs RCs to Adhere to Existing Laws and Regulations In Purchasing Services:* RCs would be directed to establish internal processes to ensure that (1) their staff is following all laws and regulations when purchasing services and supports for consumers, and (2) other services, such as generic services provided by other agencies in the community, are pursued and used prior to authorizing the expenditure of RC funds for consumers. It is anticipated that $6.2 million ($4.6 million General Fund) in savings would be obtained annually when fully implemented.

- *4. Services to a Minor Child:* Under the Governor's proposal, legislation would be enacted to require RCs to take into account the family's responsibility for providing similar services to a minor child without disabilities when determining which services or supports would be purchased by the RC for the child. It is assumed that $2.7 million ($2.4 million General Fund) would be achieved annually when fully implemented.

- *5. RC Clinical Review:* RCs would be required to have a clinician review all requests for certain services and supports prior to the RC authorizing their purchase for the consumer. This review would pertain to certain supplemental program supports, assistive technology and environmental adaptations, behavioral services, specialized medical or dental services, and therapeutic services. The Administration assumes savings of $1 million ($750,000 General Fund) annually when fully implemented.

- *6. Use of Group Modality:* RCs would be directed to give preference for purchasing a service or support using a group modality, in lieu of an individual intervention, if a consumer's needs, as identified in their IPP, could be met using a group modality for the following services: Behavioral Services, Social and Recreation Activities, and Non-Medical Therapy Services. This provision is assumed to save $800,000 annually when fully implemented.

Background—Individualized Program Plan (IPP): The provision of services and supports to consumers is coordinated through the Individualized Program Plan (IPP). The IPP is prepared jointly by an interdisciplinary team consisting of the consumer, parent/guardian/conservator, persons who have important roles in evaluating or assisting the consumer, and representatives from the Regional Center and/or state Developmental Center. Clinicians or others are to be involved in the IPP process when needed to complete the IPP.

Services included in the consumer's IPP are considered to be entitlements (court ruling).

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

Constituency Concerns: The Subcommittee is in receipt of numerous letters opposing the Governor's additional cost containment strategies. Of particular concern is: (1) the "assault" on the IPP process; (2) the belief that the proposals violate federal Medicaid "freedom of choice" protections provided under the Home and Community-Based Waiver, and (3) the belief that the state's quality assurance obligations under the Home and Community-Based Waiver would be violated.

Subcommittee Staff Comment: The Legislature has rejected similar proposals for the past three years. First and foremost is that the proposed trailer bill language gives the Administration carte blanche authority in making programmatic decisions. The Legislature needs to maintain both the policy and fiscal integrity of the program.

Second, several of the Governor's proposals are perplexing in that existing state statute already addresses some aspects of the proposal. For example, the Lanterman Act already has language requiring cost effectiveness as noted in Section 4512 of the Welfare and Institutions Code as follows:

> "(b) The determination of which services and supports are necessary for each consumer shall be made through the individual program plan process. The determination shall be made on the basis of the needs and preferences of the consumer or, when appropriate, the consumer's family, and shall include consideration of a range of service options proposed by the individual program plan participants, the effectiveness of each option in meeting the goals stated in the individual program plan, and the cost-effectiveness of each option."

Therefore, the Regional Center is supposed to take cost-effectiveness into consideration already.

Another example of this is the Administration's proposal to "direct RCs to adhere to existing laws and regulations in purchasing services". Why aren't RCs following the law and regulations now? Sections 4630 and 4631 of the Welfare and Institutions Code provide the DDS with broad authority to require the RCs to contract with the state and to meet specific requirements. Therefore, why is this not being done now? What is the purpose of the contract process?

Yet another example of this is the Administration's proposal to require Regional Center's to provide the consumer or their parent/guardian with annual statements of the services and supports which were obtained for them. The intent is to serve as a validation that the described services were indeed provided. In essence, it is a provider anti-fraud measure. Why is trailer bill language needed for this? Why can't the DDS either direct the RCs to

do this through contract language or why don't the RCs do it now as a good business practice?

Lastly, it is unclear how an individual's IPP would be affected by these proposals.

Questions:

1. DDS, Please briefly describe each aspect of the proposal.
2. DDS, Why can't some of these cost-containment issues be addressed with contract language between the state and the Regional Centers?
3. DDS, How may an individual's IPP be affected by this proposal?
4. DDS, Would any services have to be eliminated? If so, which ones?
5. DDS, What may be the unintended consequences of this proposal?
6. How may this proposal interact with the other cost containment proposals?

5. Proposed Augmentation for RC Operations *(See Hand Outs)*

Issue: The Governor is seeking a $10.6 million (General Fund) increase for RC Operations contending that this level of funding is needed to help RCs maintain compliance with the federal Centers for Medicare and Medicaid Services (CMS) for the Home and Community-Based Services Waiver.

The Administration contends that funds are available for this purpose because in the current-year additional federal funds were provided to the state by the federal government for expenditures related to the Home and Community-Based Waiver and the Targeted Case Management Program. However, as noted by the LAO, the increase of $19.4 million (federal funds) provided by the federal government pertained to repayments for past expenses (i.e., General Fund monies were spent and the federal government provided reimbursement).

In essence the Administration was seeking to spend $10.6 million of the $19.4 million received instead of using the entire $19.4 million to offset General Fund expenditures completely.

As noted by the table below, the $10.6 million proposed increase represents a *36 percent increase* in Waiver funding for RC Operations. The DDS has allocated a total of $29.5 million (total funds) to the RCs for operations expenditures relating to the Home and Community-Based Waiver in 2004-05.

Table: *Current* DDS Allocations to RCs for Operations related to Waiver

Description of Key Waiver Component	2004-05 Amount Allocated to RCs (Total Funds)
1. Waiver Operations	$21.1 million
2. Federal Program Coordinator & Support Staff	$1.7 million
3. Federal Compliance Specialist & Related Staff	$3.9 million
4. Accelerated Enrollments for new consumers (RC staff)	$2.7 million
TOTALS	$29.4 million

Table Notes: 1= Funding for operations costs for Medicaid activities.
2= Funding to coordinate federal programs (including Waiver and others).
3= Funding for ongoing tasks, such as reviewing choice statements, handling notice of action issues, completing annual Wavier certification/recertification forms, determining billable services, data reconciliation, maintaining records and related items.

The proposed increase of $10.6 million (General Fund) is the exact same dollar amount that constitutes "prior-year unallocated reductions". In fact, the DDS acknowledges that this $10.6 million (General Fund) "prior-year unallocated reductions" is indeed the basis for the requested increase.

Originally, the DDS was seeking this funding increase in the current-year through a Section Letter adjustment. But as noted in the **Hand Out package** (letter dated March 1, 2005), the Joint Legislative Budget Committee (JLBC) denied the current-year request and deferred the issue to budget-year deliberations.

The JLBC Letter noted that (1) the dollar amount was the same as the unallocated RC Operations amount, (2) no explanation had been provided on how these funds would be distributed to, and expended by Regional Centers, in order to ensure compliance with the Home and Community-Based Waiver requirements.

Specifically, the DDS' RC Estimate Package for the budget states that the $10.6 million (General Fund) is needed for the RC's to maintain compliance with federal CMS caseload ratio requirements for the Home and Community-Based Waiver. The DDS declares that at least 11 of the 21 RCs are out of compliance with one or more of the federal CMS caseload requirements based on their survey data which is *self-reported by the Regional Centers.* (A ratio of 1 case manager to 62 consumers is required for Home and Community-Based Waiver consumers.)

However even if the increased funding was provided, the DDS states in budget documents that the additional funding will not fully remove the state's exposure when the federal CMS conducts their Waiver compliance audit, anticipated to be sometime within the next year.

Background—RC Operations Expenditures Overall: The DDS developed the RC Operations "Core Staffing" formula in 1978. The purpose of this formula was to estimate personnel and related expenditures across all 21 RCs in order to ensure accurate budgeting and facilitate fiscal equity at the RCs across the state. Since this time, the formula has been periodically modified to account for certain changes or trends. However it has been well documented (Citygate and Associates Report of 1998) that the Core Staffing formula no longer accurately reflects the costs of Operations at the RCs. That said, it is still the tool DDS uses for the development of the RCs Operations budget.

As noted in the table below, the RC Operations budget consists of several "core" functions for which the DDS provides a fiscal allocation. (The 2004-05 fiscal year was used for illustration purposes since the DDS has already allocated these funds and since it is anticipated that few adjustments would be made to the current year.)

Summary of *2004-05* DDS Allocation for RC Operations

RC Operations Description	Statewide Positions	DDS Allocation	Core Functions % to Total	% to Total
Personal Services:				
I. Direct Services				
a. Clinical	791.6	$40,954,827	11.09%	
b. Intake/Case Management	3,953.7	139,293,904	37.70	
c. Quality Assurance & Monitoring	369.6	13,195,123	3.57	
d. Early Intervention	797.4	12,612,411	3.41	
e. Community Services	140.8	6,448,960	1.75	
f. Special Incident Reporting	96.7	3,900,621	1.06	
g. Mediation	2.5	116,462	.04	
Subtotal Direct Services	**6,152.3**	**$216,522,308**	**58.61%**	
2. Administration				
a. Executive Staff	63	$3,275,790	.89	
b. Fiscal	436.9	8,974,180	2.43	
c. Computer Systems & Human Resources	147	7,912,695	2.14	
d. Clerical Support	1,129.5	22,855,293	6.19	
Subtotal Administration	**1,776.4**	**$43,017,958**	**11.65%**	
Total Positions and Salaries	**7,928.7**	**$259,540,266**	**70.26%**	
Fringe Benefits		59,122,083	16.0	
Salary Savings		-10,307,885	-2.79	
TOTAL Personal Services		**$308,354,464**	**83.47%**	
Rent		32,491,653	8.80	
Operating Expenses		28,552,471	7.73	
Subtotal Operating Expenses		**$61,044,124**	**15.53%**	
TOTAL "Core" Functions		**$369,398,588**	**100%**	
Other Functions:				
Home & Community-Based Waiver		$29,451,752		7.43%
Targeted Case Management		4,129,000		1.04
Nursing Home Reform		423,000		.11
Community Placement Plan		10,938,000		2.76
Foster Grandparent		1,118,359		.28
Sherry S.		603,674		.15
Family Resource Centers		1,095,677		.28
Real Choice Systems Grant		176,000		.04
Wellness		5,000		--
Prior Unallocated Reduction		-5,968,000		-1.51
2004-05 Unallocated Reduction		*-10,559,000*		*-2.66*
Intake and Assessment 60 to 120 Days		-4,465,000		-1.12
Subtotal Other Functions		**$26,948,462**		**6.8%**
TOTAL RC Operations		**$396,347,000**		**100%**

Subcommittee Staff Comments and Recommendations: According to the DDS caseload survey data, which is self-reported by the Regional Centers, *some* of the RCs have not been consistently meeting their RC case manager to consumer ratios. However it is unclear as to why some of the RCs meet their ratios and others do not. Though the DDS allocates funds based on "Core" formulas, the RCs do not have to expend funds in this manner.

Further it is not clear as to how the proposed funds would be allocated across Regional Centers, and there is no controlling language (either Budget Bill Language or trailer bill legislation) that is being proposed by the DDS. Yet these are the same Regional Centers that need to be told to comply with existing laws and regulations (as contained in the Governor's additional cost containment measures discussion, above).

It should also be noted that the DDS is in the process of crafting a Quality Management System (see Agenda item 6, below). As such, it is unclear as to how these proposed additional funds of $10.6 million would link into this developing QMS.

Further, the DDS has not yet provided the Legislature with its report regarding Regional Center Operations which was due as of January 10, 2005.

The DDS should report back to the Subcommittee as to how these funds would be allocated, and how accountabilities would be undertaken by the Regional Centers for the expenditure of these funds, as well as how the DDS will monitor case manager to client ratios more directly. It is recommended to hold this issue "open" pending receipt of information as requested.

Questions:

1. LAO, Please provide a summary of the issue including the concerns expressed in the JLBC letter and any other pertinent information.
2. DDS, Please present the budget proposal.

6. DDS Headquarters' Request—Quality Management System for HCB Waiver & Developmental Centers to Meet federal CMS Requirements

Issue: The DDS requests an increase of $522,000 ($290,000 General Fund) to fund 4 new positions and operating expenses to support the development of a statewide Quality Management System (QMS) consistent with federal CMS requirements. Of this amount, $12,000 (total funds) is for one-time only expenditures for computers and software.

In May 2004, the federal CMS issued updated interim procedures for states to follow regarding a quality assurance "framework" whereby states with Home and Community-Based Waivers will need to meet certain assurances. The "framework" defines quality through the delineation of desired outcomes for consumers across seven broad domains and 35 sub-domains. The seven domains include: (1) consumer access; (2) consumer-centered service planning and delivery; (3) provider capacity and capabilities; (4) consumer safeguards; (5) consumer rights and responsibilities; (6) consumer outcomes and satisfaction; and (7) financial integrity and system performance.

The DDS believes that existing structures adequately support a number of the seven domains. However, the domains of provider capacity and capabilities, participant safeguards, and system performance need significant enhancement to address federal CMS concerns.

The "framework" identifies the functions that are necessary for achieving desired outcomes as follows:

- *Design:* Design quality assurance and improvement strategies into the Waiver at the initiation of the program;
- *Discovery:* Collect data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths as well as opportunities for improvement;
- *Remedy:* Taking actions to remedy specific problems or concerns that arise;
- *Continuous Improvement:* Utilize data and quality management information to engage in actions that assure continuous improvement in the program, at the consumer, vendor and systems levels.

DDS further notes that the state's present system of quality assurance efforts rely heavily on the fragmented and varied quality assurance programs of the 21 RC's, the design of which was done in the 1990's. The federal CMS expects that states will move beyond current practice and take action to improve performance based upon information and analysis.

The state's Developmental Centers would also benefit from the proposed "framework". The department's "framework" for the Developmental Centers will be consistent with the DDS' overall design, including quality assurance and improvement strategies, data collection and analysis and continuous improvement. The DDS is including them in an effort to assure continued federal funding, minimize licensing and certification issues, and to improve consumer outcomes.

The four requested staff include the following: (1) one Community Program Specialist III position; (2) two Standards Compliance Coordinators; and (3) one Senior Information Systems Specialist. The Community Program Specialist position would be used to coordinate integration of existing quality assurance activities as well as initiate new functions for quality management, including identification of best practices.

The two Standards Compliance Coordinators would be used to, among other things, focus on the Developmental Centers to standardize consumer and family satisfaction surveys, analyze and manage risk management issues, review and analyze regulatory compliance data and conduct documentation audits. The Senior Information Systems Specialist would be used to provide technical support required to manage data retrieval, compilation, and analysis. They would work to define data requirements, monitor data collection, reporting and maintenance practices to ensure data reliability and validity.

It should be noted that the Budget Act of 2003 provided funding for 14 new DDS positions for auditing, monitoring and quality assurance activities. However, all 14 of these positions and funding were eliminated to meet their DOF unallocated reduction requirements.

Legislative Analyst's Office Comment and Recommendation: In her Analysis, the LAO indicates that the DDS does not sufficiently incorporate quality assurance measurements into the rate-setting methodologies that it uses, nor could it easily do so at this time. As such, the LAO concurs with the DDS proposal to develop statewide Quality Management System (QMS) consistent with federal CMS requirements.

Subcommittee Staff Comment and Recommendation: A more comprehensive Quality Management System that utilizes data and quality management information to engage in actions that assure continuous improvement in the Home and Community-Based Waiver both at the individual level and systems level is needed and warranted. It is recommended to approve the funding request of $522,000 ($290,000 General Fund) and the 4 DDS positions.

Questions:

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

7. Self-Directed Services Delivery Model—Local Assistance and DDS Support *(See Hand Outs)*

Issue: The DDS proposes to proceed with a federal Waiver to expand the existing Self-Directed Services Model (previously referred to as Self-Determination Model), an alternative service model that enables participants to receive an individual budget allocation *if they so choose*, in lieu of having a Regional Center purchase services for the individual. The DDS notes that a consumer enrolled into the Self-Directed Services Model could choose to return to the "traditional" service delivery system at any time.

This budget proposal contains four components as follows: (1) trailer bill language which deletes the existing Pilot Program; (2) trailer bill language which proposes the new program framework; (3) a reduction of $300,000 (General Fund) in RC Purchase Of Services (POS) funds; and (4) an increase of $500,000 ($300,000 General Fund) to fund 5 positions at DDS Headquarters to implement and monitor the Waiver and the Self-Directed Services Model. Based on the DDS fiscal information provided, there would be no *net* General Fund impact in 2005-06.

As authorized through trailer legislation for the Budget Act of 2003, the DDS is proceeding with a federal "Independence Plus" Waiver to expand the existing Self-Directed Services Model. The Self-Directed Services Model is an alternative service model that enables participants to receive an individual budget allocation that will result in a 10 percent cost reduction in the *aggregate* to the state.

Five percent of this savings would be set aside for participating consumers' unanticipated needs, and the remaining five percent is savings to the General Fund. It is assumed that 800 consumers will receive self-directed services in 2005-06 for savings of $300,000 (General Fund).

It should be noted that *all* services provided to individuals enrolled into this Waiver would be eligible for federal matching funds. As such increased federal reimbursements would be available because not all services for consumers on the Home and Community-Based Waiver are eligible for federal matching funds. The net increase in federal reimbursements under this Waiver is estimated to be $1.3 million in 2005-06, $9.9 million in 2006-07 and $26.5 million in 2007-08.

Table: *Preliminary* DDS Fiscal Assessment for Out Years

Fiscal Year	# of Consumers	DDS Staff (General Fund)	RC POS Savings/Cost Avoidance (General Fund)	RC Operations (General Fund)	Estimated *Net* General Fund Impact
2005-06	800	$339,000	-$2,231,000	$900,00	$245,000
2006-07	3,250	$533,000	-$12,338,000	$1,988,000	-$5,556,000
2007-08	10,460	$729,000	-$32,448,000	$2,191,000	-$16,987,000

The Self-Directed Services Model would be available to all Regional Center consumers who meet Waiver eligibility requirements and are over the age of 3 years. Unlike the Regional Center's traditional service delivery model, this Waiver would provide an array of flexible, non-congregate services.

The DDS notes that self-determination offers consumers a person-centered planning process. Consumers would be able to arrange services in a manner that best suits their needs, and negotiate the service volume, cost and provider. For example, consumers could arrange part-day services rather than those that are offered for a full day.

A finite individual budget allocation would be used to purchase services. "Support brokerage" and financial management service entities would be available to assist consumers to arrange for needed services, as well as determine if prospective service providers meet the requisite qualifications.

Background on the Model: SB 1038 (Thompson), Statutes of 1998, created three "Self-Determination" Pilot Projects. These original pilot projects, including their respective Area Boards, were as follows: (1) Eastern Los Angeles Regional Center; (2) Tri-Counties Regional Center; and (3) Redwood Coast Regional Center. In addition to these, two more pilots were added at Kern Regional Center and San Diego Regional Center. Currently, about 145 consumers participate in these pilots.

Based on an independent evaluation done on these projects (Conroy, et al, March 2002), the evidence supports a positive conclusion: "Self determination is highly beneficial to, and extremely welcome to, participants and their families. The evidence also indicates that self-determination in inherently fiscally conservative." As such the evidence supports a policy move from pilot towards large-scale system efforts.

Senate Bill 481 (Chesbro): Legislation has been introduced to implement the Self-Directed Services Program in a slightly different manner than proposed by the Administration in their trailer bill language. SB 481 is set to be reviewed next week in Senate Health Committee.

Subcommittee Staff Comment and Recommendation: As noted by the independent evaluation on the Pilot Projects, the Self-Directed Services Model offers many benefits to consumers and is overall cost-beneficial to the state. The Administration's progression into a statewide program makes good policy and fiscal sense. It is proposed to be a voluntary program and a consumer may opt out of enrollment and return to the existing service system (i.e., RC system).

However there are a number of issues, mostly technical, that need to be worked out with both the Administration and constituents regarding the trailer bill language. It is believed that this can occur over the next month, prior to the Governor's May Revision. As such it is recommended to keep this issue open pending these discussions.

Questions:

1. DDS, Please briefly describe how the Self-Directed Services Model would operate.

2. DDS, Please briefly describe the budget request, including the trailer bill language, implementation schedule and need for positions.
3. DDS, How would the consumers enrolled in this Waiver be monitored?
4. DDS, Have the existing Pilot Projects been successful?

8. Community-Based Preparation for Agnews Closure—Several Components Issues "A" Through "B"

***ISSUE "A"*—Presentation of Plan & Update on Current Year Housing of $11.1 million**

Issue: The Governor proposes to close Agnews Developmental Center, located in San Jose, by June 30, 2007, if the community is ready. The Governor's budget contains certain components of this closure Plan, while Administration sponsored policy legislation associated with other components of the Plan is proceeding through the Policy Committee process.

As justification for its policy, the Administration cites the need for the state to comply with the 1999 U.S. Supreme Court decision ("Olmstead"), in which the court ruled that keeping persons in institutions who could transition to a community setting constituted discrimination under the Americans with Disabilities Act. The Administration also cites as reasons to close Agnews the high capital improvement costs that would have to be incurred if the facility were left open, and the high cost of institutional care at Agnews as compared to community-based care. According to recent DDS data, the average cost per person residing at a DC is about $228,000 annually. In addition, due to the level of fixed costs at the DCs and the need to maintain minimum staffing levels, the cost per resident will continue to increase as the total resident population decreases.

It should be noted that the Agnews Developmental Center Plan closure is different than the two most recent closures of Developmental Centers—Stockton DC in 1996 and Camarillo DC in 1997—both of which resulted in the transfer of large numbers of individuals to other state-operated facilities. In contrast, the Agnews Plan relies on the development of an improved and expanded community service delivery system in the Bay Area that will enable Agnew's residents to transition and remain in their home communities. The DDS proposes to achieve this by:

- Establishing a permanent stock of housing dedicated to serving individuals with developmental disabilities.
- Establishing new residential service models for the care of developmentally disabled adults.
- Utilizing Agnew's state employees on a transitional basis in community settings to augment and enhance services including health care, clinical services and quality assurance.
- Implementing a Quality Management System (QMS) that focuses on assuring that quality services and supports are available in the community.

The Plan provides for the development of new resources and innovative programs. Key components are as follows:

Housing Development: Through the use of $11.1 million (one-time) from the Budget Act of 2004 and the passage of AB 2100, Statutes of 2004, the DDS proposes to authorize the Bay Area RCs to fund predevelopment costs (escrow deposit, environmental impact,

various fees and related matters) to establish a permanent stock of housing for individuals with developmental disabilities transitioning from Agnews. The Bay Area RCs will contract with a local non-profit housing coalition to administer the fund. Housing will be developed using a lease/purchase/donate model facilitated by the Bay Area RCs and the local housing coalition.

Family Teaching Home Model: AB 2100, Statutes of 2004, also added a new "Family Teaching Home" model to the list of residential living options. This new model is designed to support up to three adults with developmental disabilities by having a "teaching family" living next door (usually using a duplex). The teaching family manages the individuals' home and provides direct support when needed. Wrap-around services, such as work and day program supports, are also part of this model.

Bay Area Unified Community Placement Plan. The three Bay Area RCs (Golden Gate, San Andreas, and East Bay) have a unified plan for community placement whereby extensive individual assessment and person-centered planning is conducted. A regional approach (i.e., the greater Bay Area) is then taken for the planning and development of services and supports for individuals with developmental disabilities.

By taking a unified approach to housing, health services, quality assurance, and residential living options, resources can be used more efficiently and effectively, and more individuals can be transitioned to the community, when appropriate. The RCs note that intensive planning is in process to transition about 90 individuals to the community in 2005-06. Funds for this placement plan are contained in the Governor's budget. This aspect of the Plan will be discussed under **ISSUE B**, below in this agenda.

Pilot Projects for Adults with Special Health Care Needs. Through policy legislation—SB 962 (Chesbro), as introduced-- the DDS is proposing to establish a new pilot residential project designed for individuals with special health care needs and intensive support needs. This pilot would be a joint venture with the Department of Social Services (DSS) and would serve up to 120 adults, with no more than five adults residing in each facility. This pilot would be limited to individuals currently residing at Agnews.

Use of State Employees to Facilitate Transition. Through policy legislation—AB 1378 (Lieber), as introduced--the DDS proposes to use up to 200 Agnew's employees to augment and enhance services provided in the community. These state employees would be used to provide direct care, resolve crises, train and provide technical assistance to new providers, and other functions. The employees would operate under special contracts between the state and either an RC or service provider. These arrangements would continue through 2009.

Overall Background and Actions Taken in Budget Act of 2004: The Administration's Plan reflects the results of a broad based advisory committee, along with six planning teams and numerous work groups, which provided input to the DDS in planning the closure. These efforts first commenced in early 2003, when Governor Davis first proposed the closure of Agnews.

The decision to postpone the initial closure date was based on the limited capacity of the Bay Area community to provide the range and types of services needed to transition residents living at Agnews.

As such, through the Budget Act of 2004 the Legislature identified $11.1 million (one-time only General Fund support) to facilitate the initial development of community-based living options for the current residents of Agnews. AB 2100, Statutes of 2004 (Steinberg and Richman), served as implementing legislation for the expenditure of the $11.1 million, as well as established the new "Family Home Teaching Model" to the list of residential living options. .

Background—Demographics of Residents. As of June 30, 2004, Agnews had 376 residents. Of these residents, over 90 percent are served by one of the three Bay Area RCs (17 percent by Golden Gate; 22 percent by East Bay; and 52 percent by San Andreas). Over 55 percent of the residents have lived at Agnews for more than 20 years. The DDS notes that in recent discussions with residents and their families, almost two-thirds of the persons interviewed identified the Bay Area as being their location of choice.

About 80 percent of the residents have severe to profound mental retardation, with the majority of the individuals having more than one developmental disability including epilepsy, cerebral palsy, and autism. In addition, one-third of the residents have a diagnosed mental disorder, and over one-fourth of the population requires medication for psychiatric conditions or behavioral challenges. The Agnews population is also aging, with 65 percent of the residents being over the age of 40, and 8 percent at 65 years or older.

Background--Agnews Land (East Campus): Agnews currently resides on 87 acres in San Jose. Other acreage once associated with the DC has been sold or transferred in previous years. There are 51 buildings on the campus, comprising 692,800 gross square feet of space. A cogeneration plant provides energy to Agnews and markets electricity through a complex agreement with a third party. The agreement expires in 2020.

The Department of General Services (DGS) is the lead agency in facilitating the future use of the real estate, existing leases, structures and infrastructure of the campus. The DDS has responsibility for maintaining the property for up to one-year from the date or closure, or until the DGS transfers or otherwise disposes of the asset.

Subcommittee Staff Comment and Recommendation: The state has gradually been transitioning from the operation of large, congregate living arrangements as offered through Developmental Centers to providing services and supports to individuals with developmental disabilities to live in community-based settings. To-date, two Developmental Centers have been closed and the Agnews DC has been consolidated from two campuses to the single campus that it is today.

This transition has occurred due to many factors, including (1) the Coffelt Settlement Agreement of 1993 which required the DDS to develop a five-year plan to reduce the resident population of the Developmental Centers by a net of 2,000 individuals; (2) state and national trends toward the declining use of large facilities; (3) the increased availability of Home and Community-Based Waiver funds to pay for community services; and (4) the 1999 U.S. Supreme Court decision ("Olmstead"), in which the court ruled that keeping persons in institutions who could transition to a community setting constituted discrimination under the Americans with Disabilities Act.

During its creation, the principle components of what constitutes the overall Plan have been vetted with many stakeholders (as noted in the Plan's list of attachments). Some aspects of the Plan, such as the Housing Development piece, were adopted by the Legislature last year. Yet other aspects of the Plan are proceeding through legislative Policy Committee discussions this Session through Administration-sponsored legislation—SB 962 (Chesbro) and AB 1378 (Lieber). Further, other aspects of the Plan are proposed to be funded through the budget process.

Components of the Plan have proceeded in this manner because the Plan relies on the development of an improved and expanded community service delivery system for the greater Bay Area. This community-based system necessitates the development of new service delivery models, the building of service capacity, and the gradual transition of funding to support the newly developing infrastructure.

Other aspects of the Plan will not proceed until next year as the closure date approaches, community-based resources are further developed, consumer transition plans are done, and other key components proceed as necessary. The DDS' "Major Implementation Steps and Time Lines" schedule (see Hand Out package) notes these various activities.

Therefore, in order to monitor progress on the various Plan components and to ensure quality access to services for consumers, it is recommended to adopt the following Budget Bill Language:

> Item 4300-001-001 (Department of Developmental Service, State Support)
>
> "The department shall provide the fiscal and policy committees of the Legislature with a comprehensive status update on the Agnews Plan, on January 10, 2005 and May 15, 2005, which will include at a minimum the following:
>
> (1) A description and progress report on all pertinent aspects of the community-based resources development;
>
> (2) An aggregate update on the consumers living at Agnews and consumers who have been transitioned to other living arrangements;

(3) An update to the Major Implementation Steps and Timelines;

(4) A comprehensive update to the fiscal analyses as provided in the original plan; and

(5) An update to the plan regarding Agnews' employees.

The above requested information may be provided through the department's budget process, as part of the Regional Center and Developmental Center estimates packages. The updated information shall be made available to the public upon request."

Does the Subcommittee want to adopt the proposed Budget Bill Language?

Questions:

1. DDS, Please provide a brief summary of the Agnews Plan, including a summary of the fiscal implications using the table provided in the hand out (page 45 of DDS Agnews Plan).
2. DDS, Please provide a brief status update on implementation of the Housing Development component and expenditure of the $11.1 million (General Fund).

ISSUE "B"— Bay Area Unified Community Placement Plan

Issue: The budget proposes total expenditures of $39.7 million ($31 million General Fund) for community placement, including deflection, related to Agnews for a *net* increase of $6.7 million ($1.4 million General Fund) over 2004-05 as shown in the table below. These proposed expenditure amounts assume that (1) the current-year based continues with some baseline adjustments, (2) 57 additional consumers are deflected from being admitted to Agnews in 2005-06, and (3) 90 additional consumers from Agnews are transitioned to the community.

Table: Community Placement, Deflection, and Placement Continuation--Agnews

Description	Governor's 2004-05 Budget	Governor's 2005-06 Budget	Proposed Increase for 2005-06
I. Community Placement Plan			
A. Operations Total	**$3,422,000**	**$6,558,000**	**$3,136,000**
Unified Operations Costs	$3,422,000	$4,339,000	$900,000
State Employees in Community (Clinical and Quality Assurance Teams)		$1,689,000	$1,689,000
Consultant Services (housing)		$280,000	$280,000
Evaluation of Licensing Pilots		$250,000	$250,000
B. Purchase of Services	**$24,376,000**	**$19,488,000**	**-$4,888,000**
Resource Development	$18,890,000	$9,300,000	-$9,590,000
Assessments	$77,000 (19 consumers)		-$77,000
Placements (property mgmt & lease)	$5,409,000 (57 consumers)	$7,202,000 (90 consumers)	$1,793,000
State Employees in Community (36 employees for 90 consumers)		$2,986,000 (90 consumers)	$2,986,000
Total Community Placement Plan	**$27,798,000**	**$26,046,000**	**-$1,752,000**
II. Placement Continuation			
A. Operations Total		**$349,000**	**$349,000**
Client Program Coordinators		$70,000	$70,000
Nurse Coordinator		$53,000	$53,000
Added Access to Oral Health Care		$226,000	$226,000
B. Purchase of Services	**$5,209,000**	**$13,318,000**	**$8,109,000**
Unified Placement Continuation	$5,209,000	$13,318,000	$8,109,000
Total Placement Continuation	**$5,209,000**	**$13,667,000**	**$8,458,000**
GRAND TOTALS (I and II)	**$33,007,000**	**$39,713,000**	**$6,706,000**
General Fund	$29,630,000	$31,025,000	$1,395,000
Other Funds	$3,377,000	$8,688,000	$5,311,000

According to the DDS, this estimate reflects the RC Operations and POS resources needed to:

- Facilitate movement from Agnews;
- Stabilize current community living arrangements;

- Deflect the admission of individuals to Agnews; and
- Work with families in identifying individuals for movement.

Generally, the RC Operations resources are used for the following purposes:

- *Resource Development:* These are the positions needed to develop community living arrangements for consumers moving from Agnews into the community.
- *Assessment:* These are the positions needed to identify Agnew's residents ready for placement in community living arrangements (proper comprehensive assessment is critical).
- *Placement:* These are the positions used for placement activities (often more complex, unique placements are required).
- *Crisis Service Teams:* These are the positions for crisis services which include a behavioral team, a clinical team and an emergency response team.
- *State Employees in Community:* Clinical and Quality Assurance Teams comprised of Agnew's employees will be established to resolve crises, provide direct care staffing, train and provide technical assistance to new providers, collaborate with Regional Centers on enhanced quality assurance initiatives, and if necessary ("last resort"), directly operate a residential facility until such time as a private provider can be located. These employees have had long-term relationships with the transitioning consumers.
- *Consultant Services—Housing:* The DDS is using consultant services from the Department of Housing and Community Development, California Housing Finance Agency and others to implement the requirements of AB 2100.

Generally, the RC Purchase of Services (POS) resources are used for the following: purposes:

- *Resource Development:* These expenditures are related to development of new facilities, new programs, and program expansion. This also includes housing corporation costs associated with increasing the stock of affordable Bay Area housing through purchase, rehabilitation or construction of real property.
- *Assessment:* This is individualized and comprehensive identification of consumer supports and services needs for stabilized community living.
- *Placement:* This is the phase-in of consumers to community settings based on consumer-specific information.
- *Deflection:* This is the placement POS for residential expenditures of facilities developed with current-year start-up to deflect admission from Agnews. These facilities are developed based on a comprehensive analysis of Developmental Center admission data, current trends in needed services specific to the Regional Center catchment area, and other local aspects.

Subcommittee Staff Comment and Recommendation: The proposed Bay Area Community Placement Plan, as outlined above, is generally consist with previously used assumptions for Community Placement Plans that have been contained in the budget for the past two-years, except for: (1) the use of state employees, (2) the evaluation of the licensing pilot (longitudinal evaluation), and (3) the oral health funds.

Overall, the proposal seems reasonable. It should be noted that many individuals living at Agnews have intensive medical needs and often require unique assistance for community living arrangements. With the average cost of an individual residing at a Developmental Center being about $228,000 annually, transitions to community-based arrangements, *when appropriate for the individual*, make fiscal sense.

Due to likely technical adjustments that may occur at the May Revision, such as updates for costs and caseload, it is recommended to hold this issue open pending the Governor's May Revision.

Questions:

1. DDS, Please provide a brief description of the budget proposal, including how this Community Placement Plan is uniquely different and why.

III. State Developmental Centers

Summary of Funding and Enrollment

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

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

State operated facilities are entitled to payment for Intermediate Care Facility (ICF) services at actual allowable costs for services for individuals with developmental disabilities. Reimbursement levels for payment of services are based on rates developed by the DDS and approved by the DHS. Medi-Cal reimbursement is available for most DC services, except for nine residential units at Porterville DC (no longer eligible due to forensic-related issues). According to recent DDS data, the average cost per person residing at a DC is about $228,000 annually.

The revised current-year budget reflects total expenditures of $721.5 million ($387.1 million General Fund) for the DCs or an increase of $16.4 million ($8.3 million General Fund) over the Budget Act of 2004. Most of this increase is due to rising employee compensation costs.

The budget proposes expenditures of $699.2 million ($373.2 million General Fund), excluding state support, to serve 3,071 residents who reside in the state DC system. This reflects a caseload decrease of 206 residents, or 7.1 percent, and a net reduction of $22.3 million, or 3.1 percent, as compared to the revised 2004-05 budget.

Developmental Center Residents

Fiscal Year	DC Residents	Yearly Difference in Residents	Percent *Decrease*
2000-01	3,768		
2001-02	3,676	-92	2.4%
2002-03	3,583	-93	2.5%
2003-04	3,417	-166	4.6%
2004-05 (Estimated)	3,307	-110	3.2%
2005-06 (Proposed)	3,101	-206	6.2%

ITEMS FOR DISCUSSION

1. Developmental Center Adjustments for Population

Issues: The budget assumes a decrease of $25.1 million ($13.7 million General Fund) and 397 positions resulting from a projected decline in population of 206 residents (from 3,307 residents to 3,101 residents) in 2005-06. This overall population adjustment includes a reduction of $9.5 million (total funds) to the Agnews Developmental Center baseline as contained in the Agnews Plan.

In addition to this proposed budget adjustment, the Legislative Analyst's Office (LAO) contends that the current-year population reflects a lower-than-anticipated caseload and should be reduced for savings of $4 million (General Fund). Specifically, they note that the current-year is over estimated by 87 clients.

The estimated budget year adjustment has been verified through discussions with the department, LAO and Subcommittee staff. However, the LAO has verified that a current-year adjustment for population needs to be made. This is the same issue raised by the LAO regarding the DDS' Regional Center estimate package.

Background: Each year, the budget is adjusted to reflect direct care and non-level-of-care staffing requirements in order to meet resident needs and licensing requirements. These staffing adjustments are based on the projected number of individuals living at the DCs and their individual program needs based on the Client Developmental Evaluation Report (CDER) process.

The DC population is based on three components—admissions, placements from the DCs and deaths.

Subcommittee Staff Comment and Recommendation: Based on updated information, it is recommended to (1) reduce by $4 million (General Fund) in 2004-05 as identified by the LAO, and (2) adopt the budget year adjustment pending receipt of the Governor's May Revision.

Questions:

1. DDS, Please provide a brief summary of the adjustments.

2. Conforming Adjustments

Issue: The Governor's budget assumes net savings of $2.8 million (total funds), beyond the Agnews baseline adjustment as contained in the above overall DC population estimate, due to the transition of 30 individuals into community-based living arrangements. This is consistent with the Governor's Agnews Plan.

This is a conforming action in that if the Bay Area Community Placement Plan is adopted, this reduction is assumed to be taken because of the interaction of the DDS assumptions and design of the Agnews Plan.

Subcommittee Staff Comment and Recommendation: It is recommended to take action on this item when the Bay Area Community Placement Plan adjustment is taken.

LAST PAGE of AGENDA

Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda
Health & Human Services

Chair, Senator Denise Ducheny

Senator George Runner
Senator Tom Torlakson

April 25, 2005

9:00 AM

Room 4203

(Diane Van Maren)

Item	Department
4280	**Managed Risk Medical Insurance Board—*Selected Issues***
4260	**Department of Health Services—*Selected Issues***

PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. Additional issues regarding these departments will also be discussed at future hearings. *Please* see the Senate File for dates and times of subsequent hearings.

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

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

A. ITEMS FOR VOTE ONLY—Department of Health Services

1. Medical Marijuana Identification Card Program

Issue: The budget proposes an increase of $489,000 (Medical Marijuana Program Fund) to continue with implementation of SB 320 (Vasconcellos), Statutes of 2003, whose purpose is to establish and maintain a voluntary medical marijuana identification card and registry program. If this increase is approved, a total of $1.2 million (Medical Marijuana Program Fund) would be budgeted for 2005-06. Current year expenditures are anticipated to be about $1.1 million (Medical Marijuana Program Fund).

Of the $489,000 requested, $355,000 is related to card production (about $3 per card), $98,000 is for communication functions and the remaining $36,000 is for various activities, such as internet access and supplies.

The DHS received authorization to borrow up to $1.5 million from the Health Statistics Fund to commence with implementation of SB 420. This amount was transferred to the Medical Marijuana Program Fund and was to account for the first 18 months of program implementation. It was anticipated that this funding level would sustain the program until fees collected from card users began to flow to offset program costs and to repay the loan. According to the DHS, fees will begin to be collected in 2005.

A few aspects of implementation have changed since last year. First, some additional expenditures have been identified since the original implementation commenced, including the purchasing of card stock, card mailing costs, and travel expenditures to counties to assist with implementation.

Second, some aspects of program implementation were changed. A key change is that in lieu of using a 24 hour/7 days a week Interactive Voice Response System for round-the-clock verification for law enforcement and the public regarding the validity of the card, an internet-based system will be used. The on-going costs for maintaining this internet-based system is $10,152 annually.

The DHS states that they have drafted regulations, protocols, procedures, forms, scope of work for card production, and system requirements for the automated verification system and registry. It is anticipated that 5 pilot counties will be implemented on May 1, 2005 with two additional pilot counties operational by July 1, 2005. The remaining counties will be implemented beginning August 1, 2005.

Fees for the program will be collected from both patients and caregivers, as applicable. The fee will be about $13 per card for non-Medi-Cal eligible individuals and $6.50 for those individuals enrolled in Medi-Cal.

Background—Summary of SB 420: SB 420 requires a medical marijuana identification card to be issued to qualified patients and caregivers. Qualified patients are patients with acquired immune deficiency syndrome (AIDS), anorexia, arthritis, cachexia, cancer, chronic pain, glaucoma, migraine, seizures, severe nausea, persistent muscle spasms including those associated with, but not limited to, multiple sclerosis, and any other chronic condition that limits the person's ability to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990. In addition, SB 420 allows designated primary caregivers to possess or cultivate marijuana for medical use.

Subcommittee Staff Comment and Recommendation: No issues have been raised with this proposal. There is no General Fund support proposed for this program. It is recommended to approve as budgeted.

2. Implementation of Targeted Case Management for Tribal Organizations

Issue: The Subcommittee is in receipt of a Finance Letter to implement SB 308 (Figueroa), Statutes of 2003 which enables Native American groups to be considered "local government agencies" to participate in the Targeted Case Management (TCM) Program and Medi-Cal Administrative Activities (MAA). The Finance Letter requests an increase of $487,000 ($243,000 in Reimbursements from the Tribal Organizations and $244,000 in federal matching funds) to fund nine positions at the DHS. No General Fund support is requested.

The DHS states that there are a significant number to tribes who want to participate in the program. While that participation will take a while to grow, it is also a new constituency group, with new rules that need to be developed. Therefore, program development and implementation will need to take place. The DHS cannot just fold them into the existing TCM and MAA programs.

With respect to the requested 9 positions, the DHS requests to add 5 permanent positions as of July 1, 2005 to support the additional workload required by SB 308. The other 4 positions contained in the Finance Letter would be established as of June 30, 2006, only if justified by the workload. It is expected that the program will transition from development and training to implementation during 2005-06 and that the 9 total positions will be necessary by 2006-07.

The nine positions will provide additional resources to allow 20 percent of the 107 federally recognized tribes to participate in TCM and MAA. The DHS will need to phase in the 20 percent participation to enable development of the program , negotiation with the federal CMS and the Native Americans to develop the program guidelines, and develop training and provide technical assistance to accommodate the unique requirements of the Native Americans.

Background—TCM and MAA Programs: Under these programs, local government agencies and local education consortia can obtain federal matching funds through the Medi-Cal Program for certain activities. For MAA related activities, examples include: facilitating Medi-Cal application; contracting for Medi-Cal services; program planning and development; claims administration; certain types of training; and other various administrative activities. For TCM related activities, examples include: providing assistance for Medi-Cal enrollees to access needed medical, social, education and other services; conducting needs assessments; developing individualized service plans; crisis assistance planning; and related activities.

Background—SB 308, Statutes of 2003: This Legislation enables Native American tribes, tribal organizations, and tribal subgroups within the definition of a "local governmental agency" to contract for administrative and case management activities.

Subcommittee Staff Comment and Recommendation: The Finance Letter implements the legislation as required. No General Fund support is necessary. The Tribal organizations would benefit by obtaining the federal matching funds for these TCM and MAA services. The receipt of federal funds for these services is greater than the amount needed to reimburse for the positions. No issues have been raised.

B. Item 4280 Managed Risk Medical Insurance Board

I. BACKGROUND OVERALL

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

The budget proposes total expenditures of $1.048 billion ($355.9 million General Fund, $620 million Federal Trust Fund, $1.7 million County Health Initiative Matching Funds, $40 million Major Risk Medical Insurance Fund, and $30.1 million in other funds) for *all* programs administered by the Managed Risk Medical Insurance Board.

Of the total amount, $9.3 million is for state operations.

This funding level represents an increase of 11.4 percent over the revised current-year. Most of this proposed net increase is due to increased enrollment into the Healthy Families Program. Significant adjustments are also proposed for the Access for Infants and Mothers (AIM) Program.

Summary of Expenditures (dollars in thousands)	**2004-05**	**2005-06**	**Dollar Change**	**Percent Change**
Program Source *(Local Assistance)*				
Major Risk Medical Insurance Program	$39,144	$39,144	--	--
Access for Infants & Mother	$123,176	$99,758	($23,418)	(19.0)
Healthy Families Program	$806,778	$894,948	$88,170	10.9
County Health Initiative Program	$5,489	$4,663	($826)	15.0
Unallocated Reduction—State Support	--	($937)	($937)	(100)
Totals Expenditures	**$974,587**	**$1,038,513**	**$63,926**	**11.4**
Fund Sources:				
General Fund	$303,286	$313,592	$10,306	3.4
Federal Funds	$617,860	$639,162	$21,302	3.4
County Health Initiative Matching Fund	$53,846	$53,846	--	--
Other Funds	$146,094	$149,707	$3,613	2.4
Total Funds	$1,121,086	$1,156,307	$35,221	3.1

C. ITEMS FOR DISCUSSION—Managed Risk Medical Insurance Board

1. Healthy Families Program Estimate—*ISSUES "A" to "D"*

Background—Overall on the HFP (See Hand Out): The Healthy Families Program (HFP) provides health, dental and vision coverage through managed care arrangements to uninsured children (through age 18) in families with incomes up to 250 percent of the federal poverty level, who are not eligible for Medi-Cal but meet citizenship or immigration requirements.

The benefit package is modeled after that offered to state employees. Eligibility is conducted on an annual basis.

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

Summary of Eligibility for Healthy Families

Type of Enrollee	Family Income Level	Comment
AIM infants (born to AIM mothers)	200 % to 300 %	Up to 2-years only, if above 250 %. Otherwise, through age18.
Children 1 to 5 years of age	Above 133% to 250%	Children this age who are under 133% are eligible for Medi-Cal.
Children 6 years up through age 18.	101 % to 250%	Children this age who are 100% and below are eligible for Medi-Cal.
Some children enrolled in county "healthy kids" programs (AB 495 projects, discussed below)	250% to 300%	State provides federal S-CHIP funds to county projects as approved by MRMIB.

Families pay a monthly premium and copayments as applicable. The amount paid varies according to a family's income and the health plan selected. Families that select a health plan designated as a "community provider plan" receive a $3 discount per child on their monthly premiums.

The Budget Act of 2004 and accompanying trailer bill language increased the premiums paid by higher income families effective as of July 1, 2005. Specifically, as of July 1, 2005, families with incomes between 200 percent and 250 percent of poverty will pay $12 to $15 per child per month (currently it is $4 to $9 per child). The family maximum per month will be $45 (currently it is $27 per family) for these families.

Families below 200 percent of poverty pay premiums ranging from $4 to $9 per child per month, up to a family maximum of $27 per month. This premium level has not changed.

California receives an annual federal *allotment* of Title XXI funds (federal State-Children's Health Insurance Program) for the program for which the state must provide a 35 percent General Fund match. The federal allotment slightly varies contingent upon appropriation by Congress. This is *not* a federal entitlement program.

Background—Overall Governor's Proposed Budget: A total of $894.9 million ($325.2 million General Fund, $559.1 million Federal Title XXI Funds, $1 million Proposition 99 Funds, and $9.7 million in Reimbursements) is proposed for the HFP, excluding state administration. This reflects an increase of $88.2 million ($33.3 million General Fund) or 10.9 percent over the revised current-year.

The budget assumes a total enrollment of 789,301 children as of June 30, 2006, for an increase of 75,425 children over the revised current year enrollment level. This represents a budget year enrollment growth rate of 10.6 percent.

This projected enrollment growth rate reflects a higher growth trend due to the (1) proposed restoration of the HFP and Medi-Cal Application Assistance Program, (2) proposed changes to the Medi-Cal to HFP Bridge process, and (3) the shift of infants from the Access for Infants and Mothers (AIM) Program to the HFP.

The total enrollment figure of 789,301 children is based on the sum of five population segments as follows:

- Children in families up to 200 percent of poverty: 516,207
- Children in families between 201 to 250 percent of poverty: 190,775
- Children in families who are legal immigrants: 16,222
- Child Health Disability Prevention (CHDP) Gateway Access: 33,901
- Access for Infants and Mothers (AIM) Program shift 7,917

The Governor' budget assumes that payments to health, dental and vision plans remain unchanged from the Budget Act of 2004. However, it is likely that rate increases will be proposed at May Revision since the health plan contracts are opened for a reprocurement.

Presently, for children from one through 18 years the average cost is $91.46 per month for all benefits. For infants 0 to 1 years with family income between 200 percent and 250 percent of poverty the average cost is $214.99 per month for all benefits. For infants born to AIM moms who enrolled on or after July 1, 2004, a negotiated lump sum rate of $2,910 is used for the first two months of enrollment and then the HFP infant rate will be used for the remaining ten months.

(Issues "A" through "D' begin on the next page, below).

ISSUE "A"—Status Update on New Contracts *(Informational)*

Issue: On March 2, 2005, the MRMIB awarded new, three-year contracts for the delivery of health, dental and vision plan services for the Healthy Families Program for the period of July 1, 2005 through June 30, 2008.

With respect to these new contracts the following should be noted:

- 24 health plan contracts were selected.
- 7 dental plans were selected.
- 3 vision plans were selected.

The MRMIB notes that expenditure adjustments will be needed at the Governor's May Revision to reflect the new contract costs. According to the MRMIB, an overall net increase of 1.5 percent (in the aggregate) was approved.

Questions:

1. MRMIB, Please provide a brief summary of the revised contracts. Were there any key changes to the contract requirements? Why are fewer health care plans participating in this cycle?
2. MRMIB, Are there any coverage concerns geographically, or with the provision of specialty care services?

ISSUE "B"—Proposal to Re-Establish Outreach Activities

Issue: The budget proposes a total increase of $14.5 million ($6 million General Fund, $5.8 million federal funds, and $2.7 million in Reimbursements) to re-establish certain outreach activities to improve enrollment in both the HFP and Medi-Cal for Children programs. Prior to 2003, there had been an outreach program which was quite successful at enrolling children into these programs. Generally, this budget proposal would re-establish the same program framework as previously implemented. However, the HFP Administrative Vendor would be processing the payments under this proposal, whereas before, it was the Medi-Cal Program's fiscal intermediary.

In addition, as discussed further below, funds have been made available for this purpose through the WellPoint Health Networks and Anthem merger.

The specific program components and costs are as follows:

- ***State Administrative Support:*** An increase of $263,000 ($92,000 General Fund) to fund three new positions (one Office Technician, one Associate Governmental Program Analyst, and one Staff Services Manager II) is proposed.

  MRMIB states the positions are needed to: (1) Provide expertise in the development of business rules; (2) Test the Administrative Vendor system for operational readiness and accuracy of payments to Certified Application Assistors; (3) Oversee implementation and ongoing monitoring of the Administrative Vendor functions; and (4) Review and approve all outreach activities and promotional materials.

- ***Certified Application Assistance Fees:*** An increase of $11.8 million ($4.9 million General Fund) is proposed to: (1) Provide a $50 fee for each successfully enrolled HFP application upon request by a Certified Application Assistor; (2) Provide a $50 fee for each completed Medi-Cal application transmitted to a county upon request by a Certified Application Assistor; and (3) Provide a $25 fee for each successful annual eligibility redetermination for the HFP that results in ongoing coverage for an eligible child. These fees are at the same level as done under the prior outreach program.

  The proposed amount of $11.8 million (total funds) assumes the following:

  - 103,000 HFP applications at $50;
  - 106,000 Medi-Cal applications at $50; and
  - 51,600 are annual eligibility redeterminations for HFP at $25.

  The MRMIB notes that use of Certified Application Assistance is a time-tested method that has proven effective in ensuring that HFP/Medi-Cal for Children applicants are successful in enrolling and remaining in the programs.

- ***Additional Enrollees in the HFP:*** An increase of $2.4 million ($878,000 General Fund) is proposed to fund increased enrollment into the HFP of about 14,372 children (by June 30, 2006) attributable to the new outreach activities. This enrollment increase represents a 9 percent historical growth rate experienced just prior to elimination of the Certified Application Assistance funding.

According to the MRMIB and their tracking data, utilizing Certified Application Assistance significantly improves the completeness of applications and the success rate for enrollment into these programs. For example, they note the following:

- The number of incomplete applications has increased from 40 percent in 2003 to 70 percent now.
- Prior to the Certified Application Assistor's funding being eliminated the monthly average disenrollment for not returning the annual eligibility re-determination or not following up on an incomplete application was about 8,000 children. As of October 2004, the monthly average disenrollment was over 12,000 children (a 50 percent increase).
- Children are experiencing delays in obtaining health insurance coverage. The length of time it takes a child to be enrolled is much longer (about two months) because the Administrative Vendor must contact the applicant and collect information that is missing due to incomplete applications.
- There has been a dramatic increase in appeals (from 130 per month to over 600 per month) since the Certified Application Assistor's funding was eliminated.

Background—Previous Outreach Efforts: When the HFP was launched in July 1998, an outreach program for both the HFP and Medi-Cal for Children was implemented. This original outreach program included: (1) toll-free telephone access, (2) media campaigns, (3) local grants to community-based organizations and schools, and (4) payments to Certified Application Assistants for the successful enrollment of applicants. Program funding peaked at $50 million ($20 million General Fund) in 2001-02.

Due to funding constraints, the education and outreach expenditures and grants were eliminated in 2001, and funding for Certified Applicant Assistants was eliminated in 2003. The toll-free telephone access has always been maintained.

Background—Merger of WellPoint Health Networks and Anthem: As part of the agreement with Insurance Commissioner Garamendi, it was determined that Anthem, Incorporated would make certain donations to demonstrate their commitment to serve the uninsured and medically underserved in California. Among other donations, Anthem is to provide $15 million to the state for outreach and enrollment for the HFP and Medi-Cal for Children programs. These funds are to be placed in the General Fund and appropriated for this purpose. The state can then receive a federal match of 65 percent through federal S-CHIP funding.

Subcommittee Staff Comment and Recommendation: The outreach program has been successful in the past and funds from the merger have been made available for this purpose. It is therefore recommended to approve the proposal but with one change.

It is recommended to downgrade the Staff Services Manager II position to a Staff Services Manager I position for savings of $7,900 ($2,780 General Fund).

This is recommended as part of an overall approach to address the MRMIB's unallocated reduction of $937,000 ($328,000 General Fund), as discussed under Issue "D", below in the Agenda.

Questions:

1. MRMIB, Please provide a brief summary of the budget request.
2. MRMIB, When would the Certified Application Assistance component be operational?

ISSUE "C"—Medi-Cal to Healthy Families Accelerated Enrollment

Issue: In the Subcommittee hearing of April 4th during discussions regarding the "bridge" between Medi-Cal and the HFP, an issue was raised regarding the temporary enrollment of children into Medi-Cal pending their HFP eligibility.

Specifically, County Welfare Departments encounter children who are either not eligible for Medi-Cal or would have a high share-of-cost in Medi-Cal but would most likely be eligible for enrollment into the HFP. However presently, the counties cannot enroll these children into the HFP because they do not have the authority to do so. Therefore, these children often have to wait, uninsured, for 4 to 8 weeks for a formal eligibility determination by the HFP.

As such it has been suggested to create a Medi-Cal to HFP accelerated enrollment program which would authorize counties to temporarily enroll children into the **no-cost** Medi-Cal Program if a county deems that they are eligible for the HFP. The temporary enrollment would only be for the period during which the HFP is conducting the formal determination of the child's eligibility for that program (not more than 60-days).

Under such an accelerated program, the state could receive the S-CHIP federal matching rate of 65 percent, versus the Medi-Cal federal matching rate of 50 percent. Temporary enrollment into Medi-Cal would enable the child to receive immediate necessary services.

This issue has been discussed previously in legislation during the 2003-04 Session (i.e., SB 142, Alpert, as amended March 24, 2003). This legislation was discussed in both the Senate Health and Human Services Committee, as well as Senate Insurance and Senate Appropriations. Though the bill was moving it eventually was amended and used for another purpose.

A substantial effort has been made by the Legislature to create a seamless system of health care coverage, whereby individuals can move easily between Medi-Cal and the HFP without losing coverage for any period of time. A Medi-Cal to HFP accelerated enrollment would fill-in a present gap in services.

Subcommittee Staff Comment and Recommendation: Based on previous analyses of the SB 142 legislation, it appears this change would cost about $1.5 million (General Fund) *annually*, assuming the temporary enrollment of about 3,600 children. However, it is recommended to hold this issue "open" pending receipt of additional information to be provided by the MRMIB and DHS regarding potential expenditures.

According to prior information, it appears that the proposed change could be done through a State Plan Amendment and would not require substantial administrative work. Further, state statute would be needed for implementation. This language would be very similar to language contained in SB 142.

Questions:

1. MRMIB, From a "technical assistance" or policy basis, would this approach make sense?

ISSUE "D"—Request for New State Staff for Oversight of Contractor

Issue: The Governor proposes an increase of $2.2 million ($775,000 General Fund) to support 24.5 new state positions. The MRMIB contends these positions are needed to provide increased oversight of contractor and customer service functions. This reflects a 52 percent increase in positions over the revised current year.

In addition, the budget proposes an unallocated reduction of $937,000 ($328,000 General Fund) from state support. MRMIB states that 10 of the requested positions would need to be left unfunded and one other would need to be downgraded (from a Staff Services Manager II to I) in order to "fund" the unallocated reduction. This is shown in the table below.

Presently, MMRIB has 62.7 total authorized positions in the current year (includes three positions administratively established for the "buy-in", Agenda Item 2, below). Presently there are 9 vacant positions, of which 3 are to be filled by May, 2005.

Summary Table 1: Budget Request & Unallocated Reduction Interaction

MRMIB Function	MRMIB's Requested Positions	MRMIB's Estimate of Unallocated Reduction	Actual Funded Positions
• On-Site Administrative Vendor Coordination & Quality Assurance	8.0 Positions	-2.0 Positions	6.0 Positions
• Application & Subscriber Complaints and Appeals	8.0 Positions	-4.0 Positions	4.0 Positions
• Contract & Fiscal Management of Program Expenditures	5.5 Positions	-3.0 Positions	2.5 Positions
• Executive Management Structure	3.0 Positions	-1.0 Positions	2.0 Positions
Total Positions	**24.5 Requested**	**-10.0 Deleted ($328,000 GF)**	**14.5 Positions**

The following discussion outlines the MRMIB's 24.5 new positions request by "function" area.

On-Site Administrative Vendor Coordination & Quality Assurance: MRMIB notes that recent experience with Administrative Vendor (Maximus) errors and lack of adequate oversight indicates that MRMIB is not adequately providing the core oversight needed at its Administrative Vendor site. MRMIB currently has no dedicated staff to monitor the Administrative Vendor *at its site*.

Therefore, the MRMIB is requesting the following 8 positions:

- 6 Associate Governmental Program Analysts;
- One Staff Services Manager II; and
- One Office Technician

According to the MRMIB, these positions would perform the following core tasks:

- Detect billing errors, disenrollments and application processing system problems in a timely fashion and address them before costly errors occur.
- Provide adequate quality control and oversight of the Administrative Vendor.
- Conduct activities to ensure that eligibility determinations are being done correctly.

Application & Subscriber Complaints and Appeals: MRMIB presently has 8 positions that perform functions related to eligibility appeals and subscriber complaints. They used to have a total of 16 positions; however the MRMIB states that 8 positions were eliminated over the past two years due to unallocated reductions in state support.

MRMIB notes there is a backlog in appeals (1,000) and that the appeal rate for "ineligible" determinations is high.

The requested 8 positions (all Associate Governmental Program Analysts) would be used to do the following:

- Respond timely to appeals from applicants, subscribers and advocates;
- Resolve misdirected provider claims and address overall provider inquiries;
- Follow up on third party liability issues; and
- Respond to public record requests.

Contract & Fiscal Management of Program Expenditures: MRMIB is requesting 5.5 positions (2.5 Associate Administrative Analysts for Accounting, one Associate Governmental Program Analyst, one Associate Programmer Analyst, and one Research Program Specialist I) for this function.

MRMIB contends that with cutbacks in state staff they have not been able to effectively and consistently monitor the performance of contracting health, dental and vision plans. Each year the MRMIB audits each plan for their loss ratios to determine if rates are set appropriately. MRMIB states that in the past, only a third of the plans have been audited and at most only one plan could be audited in the current year due to staff shortages. In addition, MRMIB uses loss ratios as a tool for diagnosing performance problems of plans. Of the total requested positions, 4.5 positions would be used for this purpose.

The requested Research Program Specialist I position would be used to develop research protocols and statistical reports to provide MRMIB with information necessary to evaluate and measure progress towards federal and state quality improvement goals.

Executive Management Structure: MRMIB is requesting three positions (one Deputy Director—CEA II, one Associate Governmental Program Analyst), and one Staff Counsel III for certain functions.

The Deputy Director (CEA II) position would be used to manage press inquires, work with the CHHS Agency and Governor's Office on press events and coordinate MRMIB's responses to legislation.

The Associate Governmental Program Analyst would be used to provide technical support to the legislative unit. The legislative unit has a Legislative Coordinator positions presently but no other staff.

The Staff Counsel III position would be used to (1) review and approve contracts, (2) review public record act requests and subpoenas, (3) conduct legal analyses of federal and state legislation and regulations, (4) conduct legal research and perform activities related to the Health Insurance Portability and Accountability Act, (5) document and formalize legal advice for executive and program staff, and (6) handle legal complaints arising from protected health information disclosures or the withholding of such information

Legislative Analyst's Office Recommendation: The LAO's recommendation would be to take the following actions, for a net overall reduction of $84,000 ($29,000 General Fund) and an increase of 13.5 positions:

- Eliminate the MRMIB's unallocated reduction of $937,000 ($328,000 General Fund);
- Delete two of the positions proposed for the executive management infrastructure.
- Shift two of the Associate Governmental Program Analyst positions requested for the on-site Administrative Vendor coordination & quality assurance function to work on the contract and fiscal management function. This would provide a total of 4.5 positions for the contract and fiscal management function, and four positions for the on-site Administrative Vendor coordination & quality assurance function.
- Downgrade one of the Staff Services Manager II positions to Staff Services Manager I position, as the MRMIB noted for helping to "fund" a portion of the unallocated reduction.

Subcommittee Staff Comment and Recommendation: Due to concerns with the Administrative Vendor, the need to respond to consumer (applicant and subscribers) and provider inquiries on a timely basis, and the need to properly and effectively monitor fiscal oversight of the program, it is reasonable for the MRMIB to receive some additional positions. However, in addition to the state's fiscal situation, there are also other factors that need to be considered with this request.

First, the re-establishment of the Certified Application Assistance process will significantly improve the application processing and reduce the number of appeals. The three positions proposed under this request will also provide some oversight of the Administrative Vendor.

Second, funding and positions should not be appropriated to then use to "fund" the unallocated reduction. This approach denigrates the budget process and leads to false representation as to positions actually available to be filled and funded. Legislative oversight is significantly weakened by this approach proposed by the Administration.

Third, if problems persist regarding the Administrative Vendor, the Board should consider making changes in the contract to require *additional* performance measures.

Fourth, two of the "executive management structure" positions are not warranted. Specifically, the Deputy Director (CEA II) position to perform primarily press-related activities, and the Associate Governmental Analyst for the legislative unit should be deleted.

Therefore, it is recommended to (1) provide an increase of $930,000 ($325,000 General Fund) to eliminate the unallocated reduction (adjusted for the downgraded position), (2) provide funding for 7.5 new positions as noted in the table below, and (3) reduce the budget by a *net* $ 594,000 ($208,000 General Fund) to reflect these actions.

The Table 2 presents a summary of the recommendations. It should be noted that the MRMIB wants all of the requested 24.5 positions ($2.215 million total funds) but could only fund 14.5 of them due to the unallocated reduction proposed by the Governor (Summary Table 1, above, depicts this aspect).

Summary Table 2: Perspectives on the Requested Positions

MRMIB Function & Positions	**Positions Adjusted for Unallocated**	**LAO Recommendation**	**Subcommittee Staff**
On-Site Administrative Vendor Oversight	6.0 Positions	4 Positions	2 Positions
Downgrade SSMII to SMMI	1	1	--
Associate Governmental Prog. Analysts	4	2	2
Office Technician	1	1	--
Application & Subscriber Appeals	4.0 Positions	4 Positions	2 Positions
Associate Governmental Prog. Analysts			
Contract & Fiscal Management	2.5 Positions	4.5 Positions	2.5 Positions
Associate Administrative Analysts	1.5	1.5	1.5
Associate Governmental Prog. Analysts	--	2	--
Research Program Specialist I	1	1	1
Executive Management Structure	2.0 Positions	1 Position	1 Position
Deputy Director (CEA II)	--	--	--
Staff Counsel III	1	1	1
Associate Governmental Prog. Analyst	1	--	--
Total Positions	**14.5 Positions**	**13.5 Positions**	**7.5 Positions**
Total Proposed Expenditure (Adjusted for Unallocated Reduction)	**$1.287 million ($450,000 GF)**	**$1.226 million ($430,000 GF)**	**$693,000 ($243,000 GF)**
Total Proposed Savings off Budget	**$0**	**$60,000 ($22,000 GF)**	**$594,000 ($208,000 GF)**

Questions:

1. MRMIB, Please provide a brief summary of the budget request by function area.

2. County Health Initiative Matching Fund (CHIM) Program

Issue: The budget proposes to provide a total of $5.5 million ($1.9 million County Health Initiative Matching Fund and $3.6 million federal S-CHIP Funds) in the current year and $4.7 million ($1.6 million County Health Initiative Matching Fund and $3 million federal S-CHIP Funds) in 2005-06 under the CHIM Program. These funding levels represent a substantial reduction in anticipated funding levels as compared to the Budget Act of 2004.

The Budget Act of 2004 appropriated a total of $115.1 million ($40.3 million County Health Initiative Matching Fund and $74.8 million federal S-CHIP Funds). This funding request included funding for four counties that were included in the initial State Plan Amendment approved in June, 2004. These counties were: Alameda, San Francisco, San Mateo and Santa Clara.

According to the MRMIB, the reason for the reduced funding level is that the caseload has not yet materialized from the counties.

Background—County Health Initiative Matching Fund (CHIM) Program: AB 495, Statutes of 2001, allow county governments and public entities to provide local matching funds to draw down federal S-CHIP funds for their Healthy Kids Programs (i.e., children 250 to 300 percent of poverty who are citizens). The State Plan Amendment approved by the federal CMS provided for four pilot counties (i.e., Alameda, San Francisco, San Mateo, and Santa Clara) with a phase-in of additional counties (i.e., Santa Cruz and Tulare) in 2005-06.

Subcommittee Staff Comment and Recommendation: The proposed budget reflects a revised estimate for the CHIM Program. Specifically, the MRMIB assumes an enrollment level of 3,820 children as follows:

- Alameda = 265children
- San Mateo = 278 children
- San Francisco = 1,209 children
- Santa Clara = 954 children
- Santa Cruz = 164 children
- Tulare = 950 children

No issues have been raised. It is recommended to approve as budgeted.

Questions:

1. MRMIB, Please provide a brief description of the budget request.

3. HFP Linkage with County "Healthy Kids" Programs Through "Buy-In" *(See Hand Out)*

Issues: The budget proposes (1) an increase of $261,000 ($91,000 Proposition 10 Funds and $170,000 federal funds) to fund three two-year limited-term positions at MRMIB, and (2) trailer bill legislation to develop an HFP "buy-in" option. The three positions include an Office Technician, a Research Program Specialist I, and a Staff Services Manager I. No General Fund support is requested.

Under this proposal the MRMIB would use staff to provide technical assistance and support to local counties in the development and expansion of their locally funded "Healthy Kids Programs" and to work with interested counties to develop an HFP "buy-in" option. As discussed below, while some counties have implemented their own Healthy Kids Programs, other counties may like to use their local funds to "buy-in" to the HFP directly.

In essence, this "buy-in" proposal is a subset of the overall existing County Health Initiative Matching Fund (CHIM) Program (as discussed above).

The proposed staff would determine how the "buy-in" concept should be designed and would work with county staff to implement any of the approved "buy-in" programs.

The proposed trailer bill language does the following (See Hand Out):

- ***Section 3:*** Deletes obsolete language which granted the Board authority to contract with county-based plans that were either not licensed or not fully licensed. This language was applicable to the HFP when initially implemented but is now obsolete and is inconsistent with the Board's current contracting practices which require health plans to be licensed by the Department of Managed Care (DMHC) or the Department of Insurance (DOI).
- ***Section 4:*** Amends existing statute to include the HFP "buy-in" option as part of the overall County Health Initiative Matching Fund projects.
- ***Section 5 (Section 12699.53 (b)):*** Amends existing statute to clarify that the "applicant" (county) for the intergovernmental transfer funding (federal S-CHIP funds transferred by the state to a county) must comply with requirements as stated.
- ***Section 5 (Section 12699.53 (g)):*** Adds a new provision that provides for the "buy-in" and specifies that approved applicant's must provide for children's health coverage through the health, dental and vision plans participating in the HFP.
- ***Section 6:*** Makes technical conforming changes.
- ***Section 7:*** Adds a new provision that provides for the MRMIB to be reimbursed by applicants (counties) for any reasonable start-up costs, ongoing administrative costs and related expenditures that are not reimbursed by the federal government for the operation of this program.

- ***Section 8:*** Amends existing statute to clarify that HFP "buy-in" projects must use health plans licensed by the DMHC or DOI.
- ***Section 9:*** Amends existing statute to enable MRMIB administrative expenditures, as stated, to be paid by a governmental entity participating in the HFP "buy-in" or by a not-for-profit group or foundation.
- ***Section 10:*** Amends existing statute to hold the state harmless for any federal disallowances or other liabilities as specified, including HFP "buy-in" grant appeals.

Background—County Healthy Kids Programs: Several counties have established or are planning to establish programs to provide coverage to uninsured children who are not eligible for full-scope coverage under Medi-Cal or the HFP. Funding for this county coverage has come from a variety of sources, including local Proposition 10 funds, county Tobacco Settlement Funds, grants from foundations, and federal funds obtained from the MRMIB through the County Health Initiative Matching Fund (CHIM) Program established by AB 495, Statutes of 2001. Counties with Healthy Kids programs include Santa Clara, Alameda, San Francisco, San Mateo, San Joaquin, San Bernardino, Riverside, Santa Cruz, Tulare, and Los Angeles.

Other counties are interested but either require technical assistance in developing their own programs or would simply like to use local funds to "buy-in" to the Healthy Families Program.

Subcommittee Staff Comment and Recommendation: It is recommended to approve the budget and trailer bill legislation as proposed. The California Children and Families First Commission has approved funding for the MRMIB to work with the counties to develop the "buy-in" option. The "buy-in" would enable counties to utilize the advantages of the HFP marketplace and it would provide comprehensive health care to children in need of medical services.

Questions:

1. MRMIB, Please provide a brief description of the HFP "buy-in" concept, including a summary of the proposed trailer bill legislation.
2. MRMIB, What is the estimated timeframe for proceeding with the HFP "buy-in", including obtaining federal approvals?

D. ITEMS FOR DISCUSSION—Department of Health Services

1. Proposition 50—Request for Staff Due to Workload *(See Hand Out)*

Issue: The Subcommittee is in receipt of a Finance Letter which requests an increase of $761,000 (Proposition 50 Bond Funds) to support 7 new, two-year limited-term, positions (six Associate Sanitary Engineers and one Environmental Scientist). The DHS states these positions are needed in order to meet workload needs related to Chapter 4 mandates as contained in Proposition 50 (see background below).

Presently the DHS utilizes 13.5 positions for Chapter 4 activities at an expenditure of $1.8 million (Proposition 50 Bond Funds). Adding these proposed 7 positions (two-year limited-term) would provide them with a total of 20.5 positions at an expenditure level of about $2.5 million (Proposition 50 Bond Funds) for 2005-06.

The DHS required water systems to submit "pre-applications" for Proposition 50 funding by December 1, 2004. By this date, 920 pre-applications had been received. The DHS then needs to review and rank the proposals. Once this is done, full applications with technical detail are submitted by the water systems. As such, the DHS states that additional resources are needed to conduct various complex analyses and work with the water systems to implement the various projects and fully utilize the bond funds.

The DHS contends that if this Finance Letter is approved, they will be able to fully commit the Proposition 50 Bond Funds within 6 to 10 years. Without these positions, the process will be substantially delayed and funds wouldn't be committed for at least 15 years.

Background on Proposition 50 and Chapters Applicable to the DHS: Proposition 50—the Water Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002—was approved by the voters to provide $3.4 billion in funds to the consortium of state agencies and departments to address a wide continuum of water quality issues. The bond measure contains 11 chapters, or subdivisions, which delineates the funding level to be provided over the course of the bond and the activities and functions which are to be addressed.

Several chapters within the Proposition 50 Bond measure pertain to functions conducted by the DHS as it pertains to the Drinking Water Program, including Chapter 3 and Chapter 4. The DHS anticipates receiving as much as $485million over the course of the bond measure. This funding is discussed below.

Background on Chapter 4—Safe Drinking Water: Proposition 50 provides that $435 million be available to the DHS for expenditure for grants and loans for infrastructure improvements, and related actions to meet safe drinking water standards.

About $100 million will be used as the state's matching funds to access the federal capitalization grants for public water system infrastructure improvements. These state matching funds will be spent over 6 years and will draw down an additional $85 million (federal funds) for the 6 year period. These funds are expended through the Safe Drinking Water State Revolving Fund Program.

Of the remaining funds, $261 million in grants is directed to Southern California water agencies to reduce their reliance on water from the Colorado River. California has exceeded the water rights it is entitled to from the Colorado River and therefore must reduce its use of this source to 4.4 million acre feet.

The remaining $70 million in grants is to be divided into five general categories to improve water quality. These categories include improvements to: (1) drinking water sources; (2) treatment facilities for contaminant reduction/removal; (3) monitoring facilities; (4) transmission and distribution infrastructure; and (5) meeting new federal rules such as the disinfection-by-products rule.

Background on Chapter 3—Water Security: Proposition 50 provides a total of $50 million for functions that pertain 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; and (7) other projects designed to prevent damage to water treatment, distribution, and supply facilities.

Background—Safe Drinking Water State Revolving Fund Program: Senate Bill 1307, Statutes of 1998, enacted the Safe Drinking Water State Revolving Fund. It established the framework to implement the Safe Drinking Water State Revolving Fund (SDWSRF) and authorized the DHS to enter into assistance agreements for capitalization grants with the federal government. These state matching funds will be spent over 6 years and will draw down an additional $85 million (federal funds) for the 6 year period.

The SDWSRF provides subsidized funding to Public Water Systems so that they can make needed improvements to water system infrastructure to eliminate deficiencies in water treatment, storage and delivery that put consumers at risk of waterborne illnesses.

Subcommittee Staff Comment and Recommendation: The requested 7 new, two-year limited-term positions, seem reasonable due to the workload and substantial technical analyses that are needed to appropriately allocate and expend Proposition 50 Bond funds. No issues have been raised.

Questions:

1. DHS, Please provide a brief update on the status of Proposition 50 implementation as it pertains to Chapter 4 activities.
2. DHS, Please describe the budget request and need for the positions.

2. Proposition 50—Request for CA Bay-Delta Authority Funding

Issue: The DHS proposes an increase of $125,000 (Proposition 50 Bond Funds) to fund a position at the California Bay –Delta Authority (CBDA) provided through an interagency agreement. The DHS states that the CBDA subcontracts with the Santa Clara Valley Water District for a "Water Quality Program Manager" who oversees and coordinates the Drinking Water Quality Improvement Program for the DHS.

It should be noted that this activity is funded in the current year with one-time only funds (Proposition 50 Bond Funds) that were available due to delays in hiring DHS staff in the current year. However the DHS notes that all staff have now been hired so in order to continue this subcontract, an appropriation is needed for the budget year.

Senate Bill 1654 (Costa), Statutes of 2003, requires the DHS, a participating member of the CA Bay-Delta Program, to develop a water quality program. Resources were not provided to the DHS to carry out this program. As such, the DHS has an interagency agreement with the CBDA for this purpose.

The position will primarily be used to coordinate a variety of water quality projects proposed for funding under Proposition 50 Bond Funds that are in the CA Bay-Delta Program solution area to ensure that they are consistent with the "Record of Decision". (Among other things, the Record of Decision lays out the roles and responsibilities of each participating agency in CAL-FED, sets goals for the program and types of projects to be pursued)

Subcommittee Staff Comment and Recommendation: It is recommended to approve this request as budgeted.

Questions:

1. DHS, Please provide a brief summary of the budget request, including a description as to how the position will be used by the CBDA.

3. Capacity Development for Small Water Systems

Issue: The DHS requests an increase of $400,000 (Water System Reliability Account Funds) to fund three contract positions for technical assistance for the Capacity Development Program within the Safe Drinking Water State Revolving Fund Program (SDWSRF Program). According to the DHS, there are presently two DHS positions used for the Capacity Development Program and more resources are needed to meet workload demands.

There are about 5,000 Small Drinking Water systems in California that serve less than 1,000 persons. Without additional support, the DHS states that many of these systems would not be able to comply with the numerous and technically complex federal and state requirements that are necessary to secure funding to achieve a safe drinking water supply.

They note that about 1, 257 Small Drinking Water systems are currently listed on the DHS' Project Priority List and have submitted pre-applications for 2,070 projects to potentially receive funds from the SDWSRF Program.

Among other things the $400,000 in contract positions would be used to do the following:

- Provide technical assistance to Small Water Systems for capacity development including conducting physical, operational, managerial, and financial assessments;
- Assist Small Water Systems to obtain funding for infrastructure improvements;
- Provide guidance to document compliance with CEQA;
- Assist in completing operational plans and emergency response plans;
- Coordinate co-funding projects with other funding agencies;
- Provide technical information to various stakeholders; and
- Assist in consolidating Small Water Systems into more viable systems.

The federal government allows for funds to be used for technical assistance.

Background—Safe Drinking Water State Revolving Fund Program: Senate Bill 1307, Statutes of 1998, enacted the Safe Drinking Water State Revolving Fund. It established the framework to implement the Safe Drinking Water State Revolving Fund (SDWSRF) and authorized the DHS to enter into assistance agreements for capitalization grants with the federal government. In order to draw down these federal capitalization grants, the state must provide a 20 percent match. This state match is provided using Proposition 50 Bond Funds, as discussed under Agenda, item one, above.

The SDWSRF provides subsidized funding to Public Water Systems so that they can make needed improvements to water system infrastructure to eliminate deficiencies in water treatment, storage and delivery that put consumers at risk of waterborne illnesses.

The SDWSRF Program includes *four set-aside funds* that are all supported by the federal capitalization grant and loan fund. The Water Systems Reliability Account is one of

these funds. The federal government allows states to use up to 10 percent of the annual federal capitalization grants to provide technical assistance to Public Water Systems.

Subcommittee Staff Comment and Recommendation: The DHS states that due to the technical nature of the work to be completed, they sometimes use an "interagency" agreement process to contract with another governmental entity, such as the UC system. However in discussions with the DHS they note that if an interagency agreement cannot be completed for the work, they *may* need to proceed with a Request for Application process and competitively bid for a contract.

Therefore, in order to avoid any potential legal issues regarding the use of state staff, it is recommended to adopt Budget Bill Language which enables the DHS to use these funds only for an interagency agreement, and not for contract staff. The recommended Budget Bill Language is as follows:

> Of the amount appropriated in this Item, up to $400,000 shall be used for an interagency-agreement to conduct work related to small drinking water systems. The funds shall not be used for any other purpose.

Questions:

1. DHS, Please describe the budget request and why contract funds are needed?

4. Home Medical Device Retailer Facilities

Issue: The Subcommittee is in receipt of a Finance Letter in which the DHS is seeking an increase of almost $1.2 million (Drug and Device Safety Fund) to fund 11 new positions (9 Senior Food & Drug Investigators and two Supervising Food & Drug Investigators). There are currently three positions used for this purpose.

According to the DHS, about 2,000 Home Medical Device Retailer facilities (retailers of prescription medical oxygen and medical equipment) must be inspected annually and licensed. The DHS contends they are understaffed to perform these functions and have a backlog of over 200 new license applicants. Only 20 percent of the state mandated inspections of these facilities can be conducted at the current staffing levels.

Effective January 1, 2002, the DHS was required to inspect and license Home Medical Device Retailer facilities (per AB 1496, Statutes of 2000). Specifically, the DHS must inspect all new drug and medical device manufacturers before a license can be issued. Thereafter, the DHS must do an inspection every two-years for license renewals.

Legislation created a special fund and established the Home Medical Device Retailers Licensing Program. The special fund combines licensing fees from three program areas—drug safety, medical device safety, and home medical device retailers. The fees paid by Home Medical Device Retailers are noted below. *No* fee increases are being proposed.

Home Medical Device Retailer Program

Type of Fee	2005 Fee
Exemptee Applicant Fee (one time, new)	$100
Exemptee Annual License Fee	$150
Home Medical Device Retailer Warehouses	$425
Out of State Facilities	$150
Home Medical Device Retailer (new & renewals)	$850

(To sell prescription products, a Home Medical Device Retailer facility must have a knowledgeable and trained person on site whenever they are open. This person is called an "exemptee".)

It should be noted that the DHS enrolled bill analysis for the legislation did identify a need of 15 positions at a cost of $1.4 million. Therefore, their budget request is consistent with their previous analysis of workload impact.

Subcommittee Staff Comment and Recommendation: The budget is consistent with the DHS enrolled bill analysis regarding the legislation. AB 1496 established fees that would fun ongoing program costs, and includes provisions to annually adjust fees, to assure that fees cover actual program costs. No issues have been raised. Therefore, it is recommended to approve as budgeted.

Questions:

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

5. Clinical Laboratory Improvement Fund—Fund Existing Positions

Issue: The Subcommittee is in receipt of a Finance Letter in which the DHS requests an increase of $644,000 (Clinical Laboratory Improvement Fund) to fund 8 *existing* positions (three Program Technicians, four Examiner I, and one Examiner II). Presently the DHS has 56 authorized positions in this area and of these, 45 are presently filled.

The requested $644,000 (Clinical Laboratory Improvement Fund) would fill 8 vacant positions to bring the total to 53 funded positions.

The DHS is requesting to fund these 8 positions in order to conduct work related to the following:

- *Medi-Cal Contract Support:* Two of the requested positions would be used to (1) conduct onsite audits of Medi-Cal laboratories and take enforcement action for those not complying with state and federal law, (2) process and review Medi-Cal applications, and (3) consult with the laboratories on Medi-Cal billing issues. Presently three positions are used for these purposes.

- *Phlebotomy Certification:* Four of the requested positions would be used to handle workload associated with this certification. The DHS anticipates that 25,000 people will be either certified or seeking certification in 2005-06. Presently four positions conduct these and related activities. Therefore, the request would double the DHS' workload capacity.

- *Genetic Scientist Licensure:* Recent legislation enacted in 2003 requires genetic scientist licensure. The DHS states that two staff were redirected to this effort after filing of emergency regulations. Currently 500 license applications and renewals are in process and are expected to bring in revenue of about $37,000. This revenue is expected to increase as the number of genetic scientists level off at about 1,000. The DHS is seeking to fund two positions to conduct these activities with the understanding that this program will not be totally fee supported for three to five years.

Further, the DHS notes that a laboratory cannot legally operate without a state license and a person cannot be legally employed in a laboratory without a license.

Subcommittee Staff Comment and Recommendation: According the DHS, fee revenues are available to support the additional staff. Additional staff have been needed in this area to address issues regarding the timely licensing of individuals and facilities. No issues have been raised.

Questions:

1. DHS, Please explain your budget request and the need for the positions.

6. Continuation of Pilots—AB 359 (Aroner), Statutes of 1999 *(See Hand Out)*

Issue: The budget proposes to (1) continue four positions (two-year limited-term) at the DHS, and (2) extend the existing Intermediate Care—Developmentally Disabled/Continuous Nursing (ICF-DD/CN) pilots for two more years through trailer bill legislation (January 1, 2006 to January 1, 2008). It should be noted that these positions as well as the legislation have both been extended once before (two year period the last time as well) through the budget process.

The budget proposes an increase of $196,000 ($76,000 General Fund) for continuation of the positions (January 1, 2006 to January 1, 2008). The positions are presently filled and working on this project.

As with all Waivers, this Waiver is required to demonstrate federal cost neutrality. According to the DHS, as more recipients are moved t pilot facilities from higher cost facilities such as hospitals, Developmental Centers, and Subacute facilities, the Waiver is showing cost neutrality and savings to the state. For the period of October 1, 2003 through March 31, 2004, with an average of 32 beds filled, the ICF-DD/CN Pilot Project achieved about $850,000 in savings, which should increase with the closure of Developmental Centers.

Background—AB 359 (Aroner), Statutes of 1999: This legislation required the DHS to institute a Waiver pilot program to provide continuous, 24-hour skilled nursing care to medically fragile persons with developmental disabilities in Waiver facilities—ICF-DD/CNs—as a Medi-Cal benefit. The goal of the pilot program is to explore licensure of a less restrictive health facility model for providing continuous skilled nursing for this population. The ICF-DD/CN services are being provided in small, home-like, community-based residential settings.

This ICF/DD-CN pilot program began enrolling recipients on April 3, 2002. The pilots presently have an expiration date of January 1, 2006. This sunset date was adjusted through the omnibus health trailer bill that accompanied the Budget Act of 2002. The date was moved back due to the late start in getting the pilots designed and implemented.

Background—Evaluation of the ICF-DD/CN Pilot Project: A recent evaluation conducted by researcher nurses at California State University at Sacramento (CSUS) found the projects overall to be a useful model to continue.

Subcommittee Staff Recommendation: It is recommended to approve the budget proposal and trailer bill language as proposed.

Questions:

1. DHS, Please describe the ICF-DD/CN Pilot Projects and the results from the evaluation.
2. DHS, Please describe the budget request and need for the positions.

Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda

Chair, Senator Denise Moreno Ducheny
Senator George C. Runner
Senator Tom Torlakson

Thursday, April 28, 2005
(Upon Adjournment)
John L. Burton Hearing Room (4203)
Consultant, Anastasia Dodson

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Please Note: Only those items and issues contained in this agenda will be discussed at this hearing. Issues pertaining to these items may be reviewed again. Please see the Senate File for dates and times of subsequent hearings.

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

Vote-Only Agenda

4260 Department of Health Services

Vote-Only Issue 1: Medical Marijuana Identification Card Program

Description: The budget proposes an increase of $489,000 (Medical Marijuana Program Fund) to continue with implementation of SB 320 (Vasconcellos), Statutes of 2003, whose purpose is to establish and maintain a voluntary medical marijuana identification card and registry program. If this increase is approved, a total of $1.2 million (Medical Marijuana Program Fund) would be budgeted for 2005-06. Current year expenditures are anticipated to be about $1.1 million (Medical Marijuana Program Fund).

Of the $489,000 requested, $355,000 is related to card production (about $3 per card), $98,000 is for communication functions and the remaining $36,000 is for various activities, such as internet access and supplies.

Recommendation: It is recommended to approve as budgeted.

Vote-Only Issue 2: Proposition 50—Request for CA Bay-Delta Authority

Description: The DHS proposes an increase of $125,000 (Proposition 50 Bond Funds) to fund a position at the California Bay –Delta Authority (CBDA) provided through an interagency agreement. The DHS states that the CBDA subcontracts with the Santa Clara Valley Water District for a "Water Quality Program Manager" who oversees and coordinates the Drinking Water Quality Improvement Program for the DHS.

Recommendation: It is recommended to approve as budgeted.

Vote-Only Issue 3: Capacity Development for Small Water Systems

Description: The DHS requests an increase of $400,000 (Water System Reliability Account Funds) to fund three contract positions for technical assistance for the Capacity Development Program within the Safe Drinking Water State Revolving Fund Program (SDWSRF Program). According to the DHS, there are presently two DHS positions used for the Capacity Development Program and more resources are needed to meet workload demands.

There are about 5,000 Small Drinking Water systems in California that serve less than 1,000 persons. Without additional support, the DHS states that many of these systems would not be able to comply with the numerous and technically complex federal and state requirements that are necessary to secure funding to achieve a safe drinking water supply.

Among other things the $400,000 in contract positions would be used to do the following:

- Provide technical assistance to Small Water Systems for capacity development including conducting physical, operational, managerial, and financial assessments;
- Assist Small Water Systems to obtain funding for infrastructure improvements;
- Provide guidance to document compliance with CEQA;
- Assist in completing operational plans and emergency response plans;
- Coordinate co-funding projects with other funding agencies;
- Provide technical information to various stakeholders; and
- Assist in consolidating Small Water Systems into more viable systems.

In discussions with the DHS they note that if an interagency agreement cannot be completed for the work, they *may* need to proceed with a Request for Application process and competitively bid for a contract.

Recommendation: In order to avoid any potential legal issues regarding the use of state staff, it is recommended to adopt Budget Bill Language which enables the DHS to use these funds only for an interagency agreement, and not for contract staff. The recommended Budget Bill Language is as follows:

> Of the amount appropriated in this Item, up to $400,000 shall be used for an interagency-agreement to conduct work related to small drinking water systems. The funds shall not be used for any other purpose.

4280 Managed Risk Medical Insurance Board

Vote-Only Issue 4: Proposal to Re-Establish Outreach Activities

Description: The budget proposes a total increase of $14.5 million ($6 million General Fund, $5.8 million federal funds, and $2.7 million in Reimbursements) to re-establish certain outreach activities to improve enrollment in both the HFP and Medi-Cal for Children programs. Of this amount, an increase of $263,000 ($92,000 General Fund) is requested to fund three new positions (one Office Technician, one Associate Governmental Program Analyst, and one Staff Services Manager II) is proposed.

Recommendation: It is recommended to approve the proposal but with *one* change.

It is recommended to approve the outreach funds but to downgrade the Staff Services Manager II position to a Staff Services Manager I for savings of $7,900 ($2,780 General Fund).

Vote-Only Issue 5: Healthy Kids Program "Buy-In"

Description: The budget proposes (1) an increase of $261,000 ($91,000 Proposition 10 Funds and $170,000 federal funds) to fund three two-year limited-term positions at MRMIB, and (2) trailer bill legislation to develop an HFP "buy-in" option. The three positions include an Office Technician, a Research Program Specialist I, and a Staff Services Manager I. No General Fund support is requested.

Recommendation: It is recommended to approve the budget and trailer bill legislation as proposed.

5180 Department of Social Services (DSS)

Vote-Only Issue 6: LAO Foster Care Caseload Savings

Description: The LAO recommends the following adjustments in the Foster Care program, due to revised estimates that reflect recent caseload trends:

- $2.3 million General Fund savings in Foster Care county administration in 2005-06.
- $10 million General Fund savings in Foster Care grants in 2004-05.
- $20.8 million General Fund savings in Foster Care grants in 2005-06.

Recommendation: 1) Approve LAO savings of $30.8 million General Fund for Foster Care grants, and 2) Recognize Foster Care county administration savings of $2.3 million General Fund and reinvest that savings back into Foster Care administration, as counties have not received cost of doing business adjustments for a number of years.

Vote-Only Issue 7: Child Welfare Services Penalty Pass-Through

Description: The Governor's Budget proposes legislation to allow the state to pass on to counties penalties associated with California being out of compliance with federal or state law regarding Child Welfare Services (CWS). The Governor's Budget does not reflect any savings associated with this proposal.

Recommendation: Due to the need to maintain a collaborative relationship between the state and counties and continue the CWS improvements currently underway, and to prevent the reduction of resources for county child welfare services, staff recommends that the proposed trailer bill language be rejected.

Vote-Only Issue 8: Employment Training Fund Adjustment

Description: A spring finance letter requests a General Fund reduction of $391,000 and an Employment Training Fund increase of $391,000, to reflect revised workers' compensation savings. Control Section 6.60 in the 2004 Budget Act required that savings up to $4,430,000 be transferred to the General Fund and used in lieu of Employment Training Funds in the Department of Social Services' local assistance programs.

Recommendation: Approve the requested decrease of $391,000 in Item 5180-101-0001 and increase of $391,000 in Item 5180-101-0514. The requested adjustments for the Employment Development Department (org 7100) will be heard in Budget Subcommittee No. 5.

4130 Health and Human Services Data Center (HHSDC)
0530 Health and Human Services Agency (HHSA)

Vote-Only Issue 9: Case Management Information and Payrolling System (CMIPS) Budget Bill Language

Description: The Administration requests approval of amendments to budget bill language for development of a replacement system for CMIPS, known as CMIPS II. Counties use CMIPS for In-Home Supportive Services (IHSS) case management and payrolling functions.

The Administration proposes to replace the existing Provision 2 in Item 0530-001-0632 with the following:

(2) Notwithstanding any other provision of law, upon request of the Health and Human Services Agency, the Department of Finance may augment the amount available for expenditure in this item to pay for new contract costs for the In-Home Supportive Services/Case Management Payrolling System. The augmentation may be made no sooner than 30 days after notification in writing of the committee in each house of the Legislature that considers appropriations and the Chairperson of the Joint Legislative Budget Committee, or not sooner than whatever lesser time the chairperson of the joint committee may in each instance determine. The amount of funds augmented pursuant to the authority of this provision shall be consistent with the amount approved by the Department of Finance based on its review and approval of the new contract and Special Project Report, or equivalent document to be submitted at the conclusion of procurement activities.

Recommendation: Adopt proposed amendments to Provision 2 of Item 0530-001-0632.

Vote-Only Issue 10: CWS/CMS System Performance

Description: The budget requests 20.0 positions and $2.0 million to reflect the transfer of the CWS/CMS application from Colorado to the newly-proposed state Department of Technology Services ("DTS," formerly the HHSDC), located in Sacramento. This transfer is part of the CWS/CMS Go Forward plan. The County Welfare Directors Association has requested that CWS/CMS performance commitments be established to ensure system reliability during and after the transition to DTS. The transfer to DTS is scheduled to be completed by January 2006.

Recommendation: Adopt placeholder trailer bill language requiring the establishment of performance standards for both the CWS/CMS application maintenance and hosting.

5175 Department of Child Support Services (DCSS)

Vote-Only Issue 11: Local Child Support Funding

Description: The Governor's Budget proposes to continue holding local child support funding flat at $710 million ($194 million General Fund) in 2005-06. The relationship between local funding and collections was discussed in last year's budget hearings, but is still not entirely clear. The Legislative Analyst's Office recommends that the department lead a workgroup to develop a consistent local administrative cost reporting methodology. The Child Support Directors Association suggests that an administrative cost methodology be developed by January 2006.

Recommendation: Adopt supplemental report language to require that the DCSS lead a workgroup and submit a report to the Legislature by January 10, 2006 with recommendations for a consistent statewide LCSA cost reporting methodology. The language is as follows:

> The Department of Child Support Services shall report to the Legislature on how local child support agency costs should be classified as program costs or administrative costs. In developing this report, the Department should consult with stakeholders including, but not limited to, the Child Support Directors Association of California; local child support agency directors (or their designees) from at least one small, medium, large, and regional local child support agency; the Department of Finance; the Legislative Analyst's Office; and legislative staff from both caucuses of the Senate and the Assembly. The report should examine the feasibility of imposing a cap on administrative expenses for the 2006-07 budget based on the new definitions of administrative costs. To the extent that counties provide sufficient information, the report should include a county-by-county listing of program and administrative expenditures for each county based on the definitions contained in the report. The report shall be submitted to the Legislature no later than January 10, 2006.

Discussion Agenda

4130 Health and Human Services Data Center (HHSDC)
0530 Health and Human Services Agency (HHSA)

HHSDC Issue 1: Transfer Automation Projects to HHS Agency – Information Only

Description: The Governor's Budget proposed to transfer the HHSDC Systems Management Services (including all ten automation projects) to the Health and Human Services Agency (HHS Agency), and rename Systems Management Services as the Office of System Integration (OSI).

Background: Effective July 1, 2005, the Governor's Budget proposes to eliminate the HHSDC and consolidate the HHSDC Operations component and the Teale Data Center into the newly proposed Department of Technology Services. This consolidation proposal is in response to Legislative direction in the Budget Act 2003 to consolidate data center activities. A Governor's Reorganization Plan is pending to implement this consolidation.

Due to concerns about the high level of oversight needed to successfully implement and maintain large automation projects, the Administration proposes to transfer the Systems Management Services program to the HHS Agency. This component includes nine projects sponsored by DSS, and one project sponsored by the Employment Development Department. The proposal would shift 151.8 positions and $203,170,000 from HHSDC Systems Management Services for project management and 24.0 positions and $3,909,000 from HHSDC Operations for administrative support to the HHS Agency.

The Administration indicates that the statutory responsibility for the HHSDC Director's role would be assumed by the Director of OSI, as it pertains to system integration projects. The Director of OSI, with a reporting relationship to the Agency (specifically through the Agency Information Officer), would be responsible for project outcomes in compliance with the State Administrative Manual (SAM) and control agency requirements. The Administration indicates that the administrative overhead charged to the projects would not change.

The Administration indicates that the OSI would be established in a similar fashion as the California Office of HIPAA Implementation (CalOHI). The Director of OSI would be appointed by, and serve at the pleasure of, the Agency Secretary, similar to the Director of CalOHI.

Currently, the Director of HHSDC signs contracts, with the Agency also signing, when required by SAM or control agency requirements. The Administration proposes that the Director of OSI would perform the same duties and functions and have the same authority as the Director of HHSDC regarding OSI contracts.

The LAO recommends that all DSS-sponsored projects be placed in DSS, as DSS should be held accountable for the projects' success. The LAO also notes that agencies are designed to provide policy direction and oversight rather than carry out day-to-day operational responsibilities.

Questions:

1. HHS Agency, who in HHS Agency would be accountable for project activities and outcomes under this proposal?

2. Please provide the proposed new organizational chart for HHS Agency.

5175 Department of Child Support Services (DCSS)

DCSS Issue 1: Child Support Full Collections Program Transfer

Description: The Administration requests the transfer of the Child Support Full Collections Program from the Franchise Tax Board (FTB) to the DCSS, as authorized by AB 2358 (Steinberg) (Chapter 806, Statutes of 2004). This transfer would shift 168.5 positions and $12.4 million ($5.5 million General Fund) from the FTB to the DCSS.

Background: The Child Support Full Collection Program locates non-custodial parents who are delinquent in their child support payments and locates and intercepts the assets of these individuals.

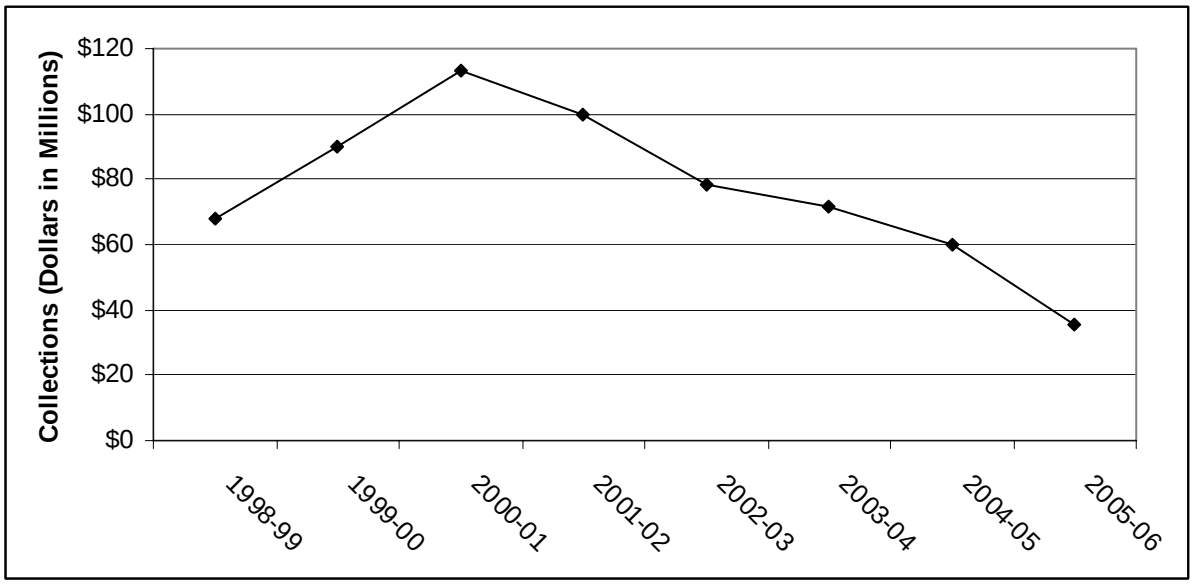
Chapter 806, Statutes of 2004 (AB 2358, Steinberg), requires the DCSS to assume responsibility for collection of child support delinquencies and the Financial Institution Data Match System. This transfer of responsibilities is necessary for the state to receive federal certification of the California Child Support Automation System (CCSAS), and discontinue federal penalties that are currently $218 million in Federal Fiscal Year 2005.

Figure 1: Proposed DCSS and FTB Positions

	2004-05			**2005-06**		
	FTB	**DCSS**	**Total**	**FTB**	**DCSS**	**Total**
CCSAS Positions	135.0	102.5	**237.5**	151.0	138.5	**289.5**
Child Support Full Collections Program	188.0	0.0	**188.0**	19.5*	168.5	**188.0**
Other Child Support Functions	0.0	233.6	**233.6**	0.0	208.1	**208.1**
FTB Non-Child Support Functions	5,255.6	0.0	**5,255.6**	5,269.7	0.0	**5,269.7**
Total Department	5,578.6	336.1	**5,914.7**	5,440.2	515.1	**5,955.3**

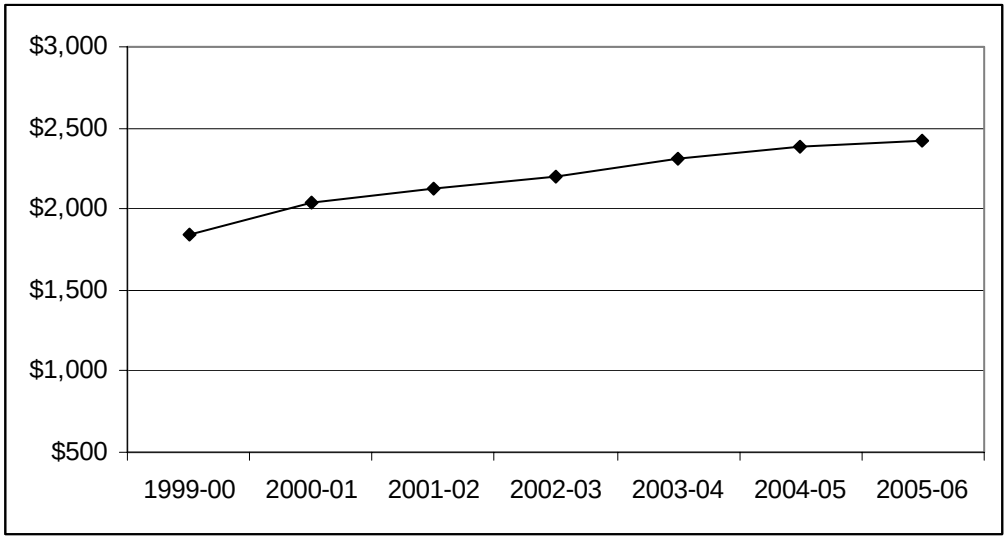
* The department proposes to maintain 19.5 administrative positions in the FTB that support the Full Collections program. These administrative positions performance cashiering, accounting, financial institution data exchange, information technology, call center, and administrative support services. The department indicates that many of these functions will be integrated into CCSAS once that system in implemented. Both the 168.5 positions proposed for transfer and the 19.5 remaining FTB positions would continue to be co-located.

Figure 2: FTB Non-Tax Debt Collections



The department indicates that overall, collections reported by the Full Collections Program (FCP) have declined because local child support agencies have increased their wage attachment efforts. The wage attachment collections formerly reported through the FCP are now captured as basic collections under the Child Support Program Collections. Please note that overall revenue collected by wage levies for Child Support for FTB and the counties has not declined.

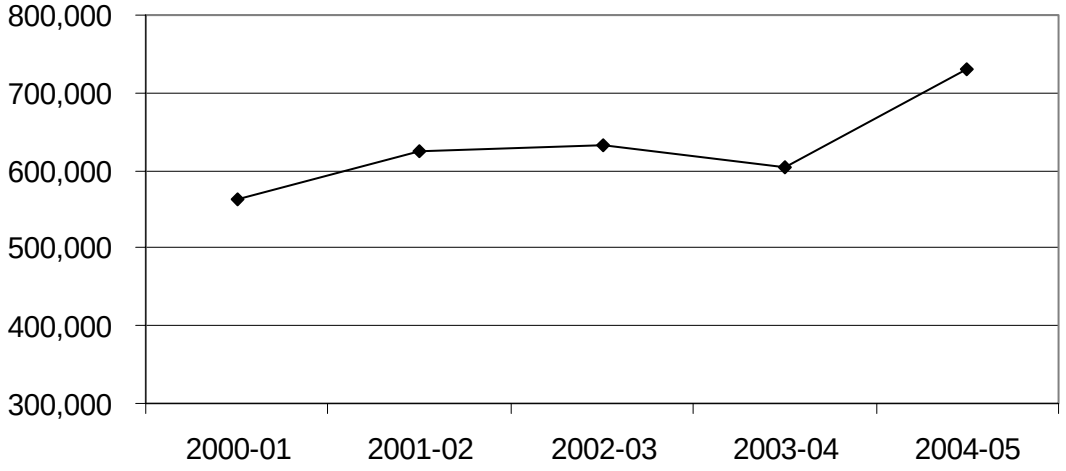
Figure 3: Total Child Support Collections
(dollars in millions)



However, the department indicates that FCP workload has not had a corresponding decline, due to additional workload established by provisions in the 2003 Budget Act trailer bill (AB 1752). These provisions expanded FCP's asset seizure authority and increased case inventories.

Furthermore, non-wage attachment collections at FCP have grown over the last few years due to these new mandates.

Figure 4: FTB Full Collections Program Case Inventory



Questions:

1. DCSS/FTB, please present the proposal. Why have collections recovered by these staff declined?

Recommendation: Adopt the spring finance letter and add placeholder budget bill language to have the DCSS report to the Legislature on the activities and cost-effectiveness of the remaining positions by January 10, 2006.

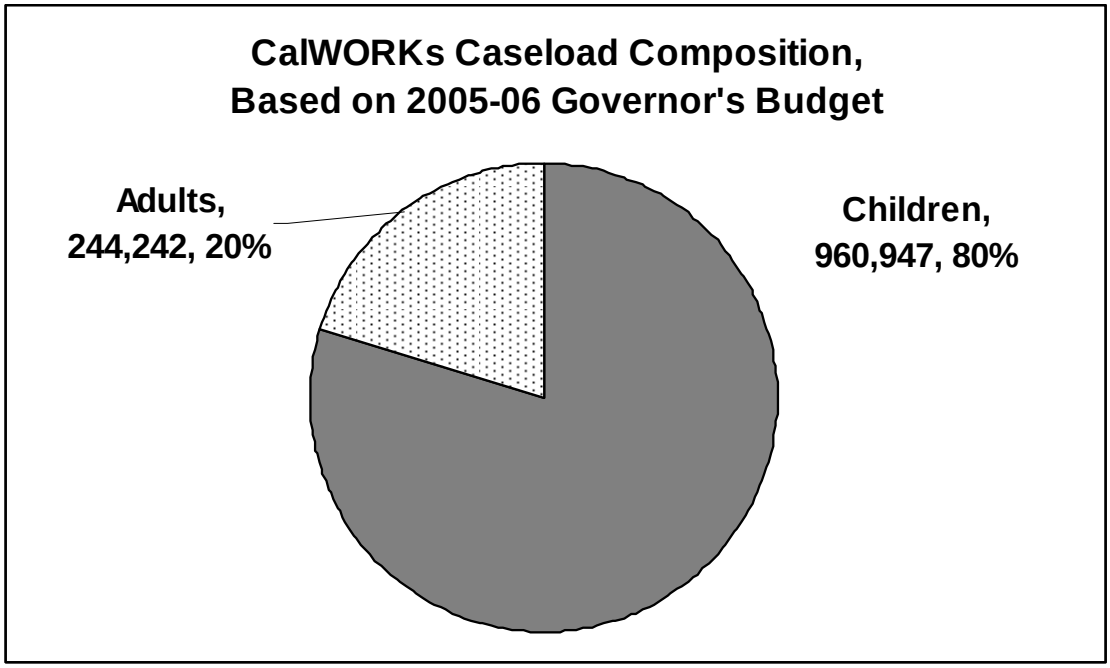
5180 Department of Social Services (DSS)

CalWORKs Program Description. The California Work Opportunity and Responsibility to Kids (CalWORKs) program provides cash benefits and welfare-to-work services to low-income children and their parents or caretaker relatives. The average family of three must have an annual net income below $12,389, or 77 percent of the federal poverty level (FPL), in a low-cost county to be eligible for CalWORKs. A family of three in a high cost county must have income below 81 percent of the FPL to be eligible for CalWORKs. Parents are required to work or participate in work-related activities for at least 32 hours per week, and income above $225 per month offsets a portion of the grant. Adults have a lifetime limit of five years (60 months) in CalWORKs.

Enrollment Summary. After peaking in March of 1995, CalWORKs enrollment dropped by 48 percent through 2004. Enrollment decreased by 33 percent since CalWORKs replaced the former Aid to Families with Dependent Children (AFDC) program in 1998. The caseload decline is due to a combination of demographic trends (such as decreasing birth rates for young women), California's economic expansion, and full implementation of welfare reform. After years of declines, enrollment bottomed out in 2003-04, and is projected to increase by 1.9 percent in 2004-05.

The budget proposes significant reductions in the CalWORKs program, resulting in a caseload decrease of 0.8 percent below the current year. The department estimates CalWORKs average monthly caseload will be 472,786 families in 2005-06, which includes almost 961,000 children (see Figure 3 below). Without the proposed reductions, average monthly enrollment would have been 486,425 families in 2005-06.

Figure 5



CalWORKs Funding Summary: CalWORKs is funded through an annual federal Temporary Assistance for Needy Families (TANF) block grant of $3.7 billion, plus $2.7 billion in state funds to meet a federal Maintenance of Effort (MOE) requirement. The budget proposes total TANF/MOE funding of $5.9 billion ($4.7 billion of which will be spent on the CalWORKs program and $1.2 billion to support non-CalWORKs federally allowable activities).

The Governor's Budget reflects funding for CalWORKs as follows:

- **2005-06:** $4.75 billion total
  - $2.65 billion federal TANF
  - $1.96 billion General Fund MOE
  - $153 million county funding MOE

- **2004-05:** $5.28 billion total
  - $2.96 billion federal TANF
  - $2.17 billion General Fund MOE
  - $144 million county funding MOE

The proposed 2005-06 funding level constitutes a $582 million, or more than 10 percent decrease in CalWORKs expenditures from the current year.

- **Reduce CalWORKs Grants by 6.5 percent.** The budget proposes to reduce CalWORKs grants by approximately 6.5 percent, resulting in savings of $212 million.

- **Eliminate CalWORKs Cost of Living Adjustment (COLA).** The budget proposes to suspend the July 2005 COLA, and permanently suspend all future CalWORKs COLAs, resulting in savings of $143 million.

- **Reduce Earned Income Disregard.** The budget proposes to reduce the Earned Income Disregard for CalWORKs families, resulting in $82 million savings.

- **Child Care Reform.** The budget proposes to reduce license-exempt child care reimbursement levels, and establish a tiered reimbursement structure for all child care providers, resulting in savings of $61 million in the DSS, and $53 million Prop 98 savings in the California Department of Education (CDE).

- **Reduce Employment Services Funding.** The budget proposes to eliminate $50 million in 2005-06 that was included in the 2004 Budget Act for CalWORKs employment services.

- **County Pay for Performance Proposal.** The budget proposes to tie county administration funding to CalWORKs client work participation rates, for projected savings of $22 million.

- **Increase Sanctions and Work Requirements.** The budget proposes to expand the CalWORKs work participation reforms based a pending evaluation of CalWORKs sanction policies, for estimated savings of $12 million.

DSS Issue 1: Federal Reauthorization of Temporary Assistance to Needy Families (TANF) Program

Description: The federal Temporary Assistance to Needy Families (TANF) program provides federal funding for the state's CalWORKs program, as well as child care and other programs to help low-income families. Current federal law authorizes TANF through June 30, 2005. Legislation is pending in Congress to revise and reauthorize the TANF program and child care funding. Federal approval of TANF reauthorization before the Congressional Budget Reconciliation process may avoid reductions in TANF program funding.

Background: The US Senate Finance Committee recently adopted S. 667, a bipartisan compromise TANF reauthorization bill known as the Personal Responsibility and Individual Development for Everyone (PRIDE) bill. The House of Representatives is considering TANF reauthorization under HR 240.

The Senate bill generally provides more flexibility for state welfare-to-work programs than the House bill. In particular, the Senate bill includes the incentive for program improvement, which allows states that are improving their work participation rates and have a corrective compliance plan to avoid the financial penalties they would otherwise face if they fall short in their efforts to meet the new higher standards in the bill. While it raises the bar for states, the work rate structure of the bill provides states with flexibility. This includes tiered work hours, an employment credit to reward states that succeed in moving people into the workplace, reduced hours for mothers with children under six, and credit for part-time work.

In addition, the Senate bill provides a greater increase in child care funding ($6 billion over five years) than the House bill ($1 billion).

CalWORKs program changes approved in the 2004 Budget Act trailer bill, SB 1104, reflect elements of both the House and Senate versions of TANF reauthorization. Implementation of the reforms in SB 1104 has strengthened California's ability to meet the new requirements of either version of TANF reauthorization.

Questions:

1. LAO, please provide a brief description of the status of TANF reauthorization.

2. DSS, what efforts has the Administration made at the federal level to support the Senate version of TANF reauthorization?

DSS Issue 2: CalWORKs Employment Services Funding

Description: The Governor's Budget proposes a reduction of $50 million for CalWORKs employment services.

Background: County welfare departments are responsible for the local development and implementation of CalWORKs. They receive a block grant from the state and are given substantial flexibility to design and carry out the CalWORKs program within the state and federal program guidelines. Counties develop and implement employment preparation and family support programs. County staff members determine eligibility for the program, provide case management services, develop welfare-to-work plans, and provide referrals to services such as child care and transportation.

In the 2004 Budget Act the Legislature restored $50 million in CalWORKs employment services funding to counties to address an overestimation of savings in various CalWORKs program changes. This was intended to help counties maintain their current welfare-to-work infrastructures.

Questions:

1. DSS, please present the proposed reduction.

2. DSS, how would the proposed employment services funding reduction affect counties' ability to improve their work participation rates?

DSS Issue 3: CalWORKs Prospective Budgeting

Description: The Governor's Budget reflects $185 million ($181 million TANF/General Fund) in grant costs and $186 million ($146 million TANF/General Fund) in administrative savings in 2005-06 due to implementation of prospective budgeting/quarterly reporting for the CalWORKs, Food Stamps, California Food Assistance Program, and Refugee Assistance programs. The California Welfare Directors Association indicates that actual savings as result of prospective budgeting is significantly less than the amount estimated by the department.

Background: The 2002 Budget trailer bill authorized the replacement of the Retrospective Budgeting/Monthly Reporting system with the Prospective Budgeting/Quarterly Reporting system. This change was intended to reduce the Food Stamp error rate. Counties transitioned to prospective budgeting between November 2003 and June 2004.

2004-05 Prospective Budgeting Impact, per November 2004 Estimate:

- Grant Costs: $186 million ($181 million TANF/General Fund)
- Admin Savings: $113 million ($87 million TANF/General Fund)

2005-06 Prospective Budgeting Impact, per 2005-06 Governor's Budget:

- Grant Costs: $185 million ($181 million TANF/General Fund)
- Admin Savings: $186 million ($146 million TANF/General Fund)

The California Welfare Directors Association indicates that administrative savings are overstated because:

- County time studies conducted before Quarterly Reporting was implemented indicate that much less administrative time is devoted to processing monthly reports than the department assumes in its estimate. County time studies after Quarterly Reporting was implemented support this assumption.

- Department assumptions regarding the cost per hour of staff time after Quarterly Reporting was implemented understate county costs. For example, counties may not be able to reduce facility, supervisor, and clerical costs at the same rate as line staff.

- County data suggests much higher costs to process mid-quarter reports than assumed by the department. Although counties and the department have similar assumptions regarding the number of mid-quarter reports to process, they do not assume the same costs/person to process the reports.

Questions:

1. DSS, please present the proposed costs and savings for prospective budgeting.

DSS Issue 4: CalWORKs Sanction Report

Description: The 2004 Budget Act human services trailer bill (SB 1104) required that DSS examine the CalWORKs sanction policy, develop recommendations to improve the effectiveness of sanctions, and report to the Legislature by April 1, 2005. This report has not yet been submitted. The Governor's Budget includes $12 million savings for anticipated grant savings as a result of strengthening the CalWORKs sanction process for non-compliant participants.

Background: SB 1104, the 2004 Budget Act human services trailer bill, included the following provisions:

Welfare and Institutions Code 11486.3.

> (a) The department, in consultation with system stakeholders, including county welfare departments, shall examine the CalWORKs sanction policy, its implementation, and effect on work participation, including but not limited to all of the following:
> (1) The characteristics of the persons being sanctioned.
> (2) The reason participants are being sanctioned.
> (3) The length of time in sanctioned status.
> (4) Positive and negative sanction outcomes.
> (5) County variances in sanction policies, rates, and outcomes.
> (6) The relationship between sanction rates and work participation.
> (7) The impact of sanctions on families and their ability to become self-sufficient.
> (8) Adequacy of procedures to resolve noncompliance prior to the implementation of sanctions.

(b) The department shall develop recommendations to improve the effectiveness of sanctions in achieving participant compliance, assisting families in becoming self-sufficient, and other desired program outcomes.

(c) The department shall report its findings and recommendations to the appropriate fiscal and policy committees of the Legislature by April 1, 2005.

Questions:

1. DSS, what is the status of the report?

DSS Issue 5: CalWORKs Pay for Performance Proposal

Description: The Governor's Budget proposes trailer bill language and $22.2 million savings for a "pay for performance" county incentive proposal, intended to increase the state's work participation rate.

Background:

- **Proposal:** The Governor's Budget proposes to tie CalWORKs county administration funding to CalWORKs client work participation outcomes. County allocations for 2006-07 would be adjusted based on employment and work participation rates in 2005-06. The Administration estimates that this proposal would result in savings of $22 million, due to lower grant costs as clients increase earnings and the number of hours worked.

  This proposal would set aside five percent of the non-child care CalWORKs Single Allocation and award this funding to counties that meet certain performance goals during the prior fiscal year. Counties use the CalWORKs Single Allocation to pay for Stage 1 Child Care, employment services and eligibility expenses. With this proposal, counties that meet certain goals would receive the full amount of their Single Allocation, while counties that fail could receive only 95 percent of that amount. In certain cases, counties that exceed their goals could receive a bonus, so their final allocation could be up to 105 percent of their single allocation. This proposal would be a three-year pilot beginning with the fiscal year 2006-07 single allocation.

- **Work Participation Rate:** The Administration indicates that this proposal is intended to improve the state's work participation rate and avoid federal penalties under pending TANF reauthorization proposals. However, the department estimates that SB 1104 CalWORKs reforms from the 2004 budget trailer bill would increase the state's work participation rate by 10 percent. Based on this adjustment, under the Senate version of TANF reauthorization the state would likely avoid federal work participation rate sanctions through at least 2009, and under the House version the state would likely avoid sanctions through 2007.

Questions:

1. DSS, please present the pay for performance proposal.

5180 Department of Social Services (DSS)

CalWORKs Child Care Overview

California's subsidized child care system is primarily administered through the California Department of Education (CDE) and the Department of Social Services (DSS). A limited amount of child care is also provided through the California Community Colleges. Figure 6 summarizes the funding levels and estimated enrollment for each of the state's various child care programs as proposed by the Governor's Budget. Note that absent the Governor's Budget proposals, CalWORKs Stage 3 funding would be $335.6 million in 2005-06.

Figure 6 – Prepared by the Legislative Analyst's Office

California Child Care Programs

2005-06
(Dollars in Millions)

Program	State Control [a]	Estimated Enrollment	Governor's Budget
CalWORKs [b]			
Stage 1[c]	DSS	98,000	$498.8
Stage 2[c]	SDE	94,000	575.4
Community colleges (Stage 2)	CCC	3,000	15.0
Stage 3[d]	SDE	14,500	87.6
Subtotals		(209,900)	($1,167.8)
Non-CalWORKs[b,e]			
General child care	SDE	88,000	$632.1
Alternative Payment programs	SDE	71,000	430.0
Preschool	SDE	101,000	325.4
Other	SDE	18,700	54.2
Subtotals		(278,800)	($1,441.6)
Totals—All Programs		**488,700**	**$2,609.4**

a Department of Social Services, State Department of Education, and California Community Colleges.
b California Work Opportunity and Responsibility to Kids.
c Includes holdback of reserve funding which will be allocated during 2005-06 based on actual need.
d Significantly reduced due to Governor's reform proposal to move current Stage 3 recipients to general child care.
e Does not include after school care, which has a budget of $250 million and is estimated to provide care for 249,500 school-aged children.

As Figure 6 shows, the budget proposes about $2.6 billion ($1.3 billion General Fund) for the state's child care programs. This is an increase of about $33 million from the estimated current-year level of funding for these programs. About $1.2 billion (46 percent) of total child care funding is estimated to be spent on child care for current or former California Work Opportunity and Responsibility to Kids (CalWORKs) recipients. Virtually all of the remainder is spent on child care for non-CalWORKs low-income families. The total proposed spending level will fund child care for approximately 488,700 children statewide in the budget year.

Families receive subsidized child care in one of two ways: either by (1) receiving vouchers from county welfare departments or Alternative Payment (AP) program providers, or (2) being assigned space in child care or preschool centers under contract with CDE.

Eligibility Depends On Family Income and CalWORKs Participation. CalWORKs and non-CalWORKs families have differential access to child care in the current system. While CalWORKs families are guaranteed access to child care, eligible non-CalWORKs families are not guaranteed access, are often subject to waiting lists, and many never receive subsidized care, depending on their income.

CalWORKs Guarantees Families Child Care. State law requires that adequate child care be available to CalWORKs recipients receiving cash aid in order to meet their program participation requirements (a combination of work and/or training activities). If child care is not available, then the recipient does not have to participate in CalWORKs activities for the required number of hours until child care becomes available. The CalWORKs child care is delivered in three stages:

- **Stage 1.** Stage 1 is administered by county welfare departments (CWDs) and begins when a participant enters the CalWORKs program. While some CWDs oversee Stage 1 themselves, 32 contract with AP providers to administer Stage 1. In this stage, CWDs or APs refer families to resource and referral agencies to assist them with finding child care providers. The CWDs or APs then pay providers directly for child care services.

- **Stage 2.** The CWDs transfer families to Stage 2 when the county determines that participants' situations become "stable." In some counties, this means that a recipient has a welfare-to-work plan or employment, and has a child care arrangement that allows the recipient to fulfill his or her CalWORKs obligations. In other counties, stable means that the recipient is off aid altogether. Stage 2 is administered by CDE through a voucher-based program. Participants can stay in Stage 2 while they are in CalWORKs and for two years after the family stops receiving a CalWORKs grant.

- **Stage 3.** In order to provide continuing child care for former CalWORKs recipients who reach the end of their two-year time limit in Stage 2, the Legislature created Stage 3 in 1997. Recipients timing out of Stage 2 are eligible for Stage 3 if they have been unable to find other subsidized child care. Assuming funding is available, former CalWORKs recipients may receive Stage 3 child care as long as their income remains below 75 percent of the state median income level and their children are below age 13.

DSS Issue 6: Governor's Budget Child Care Reforms

Description: The Administration proposes a number of reforms to the state's subsidized child care programs that would result in a total of $164.2 million General Fund savings, including $62.6 million in the DSS CalWORKs budget. The proposals that would most directly affect CalWORKs families are the tiered reimbursement rates and the one-year limit on Stage 3 child care.

Background: The Governor's Budget includes a number of child care reforms.

- **Stage 3 Child Care Reform.** Permanently expand the general Alternative Payment (AP) program by shifting all current CalWORKs Stage 3 child care recipients, and the associated funding, to the AP program, limiting guaranteed child care to a maximum of eight years and limiting Stage 3 to one year. No 2005-06 savings.

- **Centralized Waiting Lists.** Require counties to create a two-tiered waiting list for all subsidized child care: the first tier for families below 138 percent of the federal poverty level (FPL) and the second tier for families above that level. $7.9 million General Fund cost in 2005-06.

- **Tiered Reimbursement Rates.** Reduce the amount the state is willing to pay license-exempt providers. Further, create fiscal incentives for all providers to raise the quality of the care they provide and encouraging additional training. $140.1 million savings (including $60.8 million DSS savings) in 2005-06.

- **Alternate Rate Setting Mechanism.** Adopt regulations establishing an alternative rate setting mechanism for providers that only serve subsidized families. These regulations have been suspended for the last two years. $8.2 million savings in (including $1.8 million DSS savings) in 2005-06.

- **Rebenching Child Care Eligibility.** Shift eligibility determination to federal poverty level measures rather than the current CDE state median income calculations. No 2005-06 savings.

- **After School Care for 11- and 12-Year-Olds.** Designate after school care as the default placement and require parents to submit a reason in writing that they cannot use the available after school program. $23.8 million savings in 2005-06.

Stage 3 Child Care Reform Proposal

Under current law, current and former CalWORKs families are guaranteed child care as long as they meet eligibility requirements and have a need for child care. The Governor proposes shifting all current CalWORKs Stage 3 families (former CalWORKs recipients) into the AP program along with the associated funding and ending the child care guarantee for CalWORKs families. All families who are receiving Stage 3 child care as of June 30, 2005 would in the

future be served by the non-CalWORKs AP voucher program. (Local AP providers assist families in locating child care and distribute vouchers to those families.) This shift would permanently expand the AP program. There would be no impact on families currently receiving service as their child care guarantee would not change. However, any families coming into Stage 3 CalWORKs after this point would be limited to one or two years.

Under this proposal, families who leave CalWORKs after June 30, 2005 would be allowed two years of transitional child care in Stages 1 and 2, and one year in Stage 3. In other words, they would be guaranteed child care for three years after leaving aid. If a family is currently off aid and in Stage 1 or Stage 2, the family would receive two years of Stage 3 child care while they are on the waiting list for a child care slot in the AP child care program. These families' child care guarantee would be for a maximum of four years after leaving aid, depending on the time they have left in Stage 2.

Interaction Between Stage 3 Proposal and Centralized Waiting List Proposal

The Centralized Waiting List proposal allows all CalWORKs families to place their names on the waiting list as soon as they have earned income. Therefore, CalWORKs families would not have to wait until leaving aid before they can compete for SDE's subsidized child care. However, they would need to wait until they have earned income, which would be problematic for the families nearing their CalWORKs time limits who have been participating in welfare-to-work activities other than employment (such as community service or vocational education).

The LAO recommends that CalWORKs families be placed on the waiting list based on the date they first had earned income, in order to avoid placing existing CalWORKs families at the bottom of the waiting lists.

Tiered Reimbursement Rate Proposal

The Governor proposes to implement a tiered reimbursement rate structure for the voucher child care programs. Tiered reimbursement for child care provides differential reimbursement rates that encourage providers to improve program quality by obtaining additional training and education and improving outcomes as measured by independent standards of quality.

The Governor's proposal creates a five-tiered child care reimbursement rate structure that reimburses voucher providers from 55 percent to 100 percent of the current maximum rates, depending on independent quality ratings, licensing, accreditation, education, and health and safety training. The proposal is summarized in Figures 7 and 8 below. The intent of the proposal is to provide higher reimbursement rates to providers that exhibit higher quality. Figures 7 and 8 show the reimbursement rates for three categories of care—license-exempt, family home care, and center-based care. The figures also show the education and training requirements for the various levels of rates under the Governor's proposal. For license-exempt care, there are two levels: license-exempt and license-exempt plus. The FCCHs and centers are rated according to a three-star system whereby the highest quality providers receive three stars and the lowest one star.

Figure 7 - LAO

Governor's Tiered Reimbursement Proposal For License-Exempt Providers

	Percent of FCCH [a] Maximum	Additional Requirements
License-exempt	55 percent	None.
License-exempt plus	60 percent	License-exempt training, assistant teacher permit, or heath and safety training.

a Family child care homes.

Figure 8 - LAO

Governor's Tiered Reimbursement Proposal For Licensed Providers

Star Rating	Maximum Rate	Additional Requirements	
		FCCHs[a]	Centers
*	75 percent of the 85th percentile RMR.b	None.	None.
**	85 percent of the 85th percentile RMR.b	Environmental rating scale average of 4 or associate teacher permit.	Environmental rating scale average of 4 or all teachers have teacher permit.
***	85th percentile RMR.b	Environmental rating scale average of 5.5, teacher permit, associates degree, or accreditation.	Environmental rating scale average of 5.5, all teachers have bachelor's degree, or accreditation.

a Family child care homes.
b Regional Market Rate (RMR) survey of providers in the area offering the same type of child care. The RMR will vary by care type.

License-Exempt Rate Reduction. The Governor's entire 2005-06 savings estimate for the tiered reimbursement proposal is based on reductions to license-exempt care rates. Under the proposal, the rates of license-exempt care providers with no training would be cut to 60 percent of the 85th percentile of the Regional Market Rate. This reduction would take effect on July 1, 2005. These providers would then have 180 days to obtain the specified training for the second reimbursement tier, license-exempt plus, or their rates will be further cut to 55 percent of the 85th percentile.

License-exempt providers also would have the option to become licensed as FCCHs. If current license-exempt providers obtain the 15-hour health and safety training in order to meet the license-exempt plus rating, they will have completed the educational and training component of the FCCH licensing requirements. If licensed, providers would have their rates increased significantly, as shown in Figure 8.

Reimbursement Reforms for FCCH and Center-Based Providers Would Not Affect Rates for Two Years. Currently, FCCHs and centers are reimbursed up to the 85th percentile of the RMR. Under the Governor's proposal, providers' rates would be reduced starting in 2007-08 unless the providers demonstrated high program quality through (1) educational attainment, (2) program quality review, or (3) accreditation. Available data suggest that most providers would need to make significant investments to attain either a two-star or three-star rating.

Questions:

1. DOF, would reduced provider rates result in a reduction in the number of providers for CalWORKs families?

2. DSS, how would any/all of the child care reform proposals affect the state's CalWORKs work participation rate?

3. LAO, please present your recommendations to modify the Stage 3 Reform and Waiting List proposals.

Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda

Chair, Senator Denise Moreno Ducheny
Senator George C. Runner
Senator Tom Torlakson

Thursday, April 28, 2005
(Upon Adjournment)
John L. Burton Hearing Room (4203)
Consultant, Anastasia Dodson

Language

Social Security Act (42 U.S.C. Sec. 1397 et seq.) and appropriated by the Legislature for the Aid to Families with Dependent Children-Foster Care (AFDC–FC) program shall be considered part of the state share of cost and not part of the federal expenditures for purposes of subdivision (c).

SEC. 34. Section 15204.6 is added to the Welfare and Institutions Code, to read:

15204.6. (a) For the 2006-07, 2007-08, and 2008-09 fiscal years, the State Department of Social Services shall implement a CalWORKs pay for performance project that will measure increases in recipient employment and participation in welfare-to-work activities in each county from one year to the next.

(b) The State Department of Social Services shall consult with the County Welfare Directors' Association and other interested stakeholders in the development of the pay for performance project and the measures to be used.

(c) Each county's CalWORKs single allocation under Section 15204.2, excluding child care, shall be adjusted in subsequent years based on each county's performance in reaching the project outcomes.

(d) The State Department of Social Services may implement this section through all county letters or similar instructions from the director.

SEC. 35. (a) The State Department of Social Services shall adopt regulations to implement Sections 18, 19, 20, 21, 22, 23, 24, 25, 26, and 27 of this act. The department shall adopt, no later than July 1, 2006, emergency regulations pursuant to subdivision (b), as necessary to implement those sections of this act. The department shall notify the Chair of the Joint Legislative Budget Committee of any delay in the

Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda
Health & Human Services

Chair, Senator Denise Ducheny

Senator George Runner
Senator Tom Torlakson

May 2, 2005

1:30 PM

Room 3191

(Diane Van Maren)

Item	Department
4120	**Emergency Medical Services Authority—*Selected Issues***
4260	**Department of Health Services—*Selected Issues***
4440	**Department of Mental Health—*Selected Issues***

PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. Additional issues regarding these departments will also be discussed at future hearings. *Please* see the Senate File for dates and times of subsequent hearings.

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

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

I. 4120 Emergency Medical Services Authority

Background and Summary of Budget

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

Summary of Funding

The budget proposes total expenditures of $22 million ($10.8 million General Fund) for the EMS Authority. This reflects a net decrease of $1.1 million primarily due to a decrease in federal fund support.

Summary of Expenditures (dollars in thousands)	2004-05	2005-06	$ Change	% Change
Program Source				
Emergency Medical Services	$23,159	$22,036	($1,123)	-4.8
Unallocated Reduction	--	($12)		NA
Funding Source				
General Fund	$10,778	$10,777	1	--
Federal Funds	$3,808	$2,734	($1,074)	-28.2
Reimbursements	$7,097	$6,931	($166)	-2.3
Other Funds	$1,476	$1,594	$118	8.0
Total, Emergency Medical Services	$23,159	$22,036	($1,123)	-4.8

A. RECOMMENDED FOR VOTE ONLY—EMSA (*Two items*)

1. Child Care Provider Training

Issue: The Emergency Medical Services Authority (EMSA) is requesting an increase of $77,000 (Emergency Medical Services Training Program Fund) to fund a Staff Services Analyst position to staff the Preventive Health Training Program and conduct certain investigations of violations of statutes.

According to the EMSA, there are 1.5 staff presently employed to perform some of the required program functions, as noted below, but there is not sufficient staff to conduct the preventive health and safety training program that is also required, or to conduct needed investigations of violations of statutes.

Licensed childcare facilities are required by state statute to have at least one staff member on site, when children are present, that possesses a current pediatric first aid, CPR and preventive health and safety credential which includes training programs approved by the EMSA. These requirements are in recognition that children in preschool and before and after school care must have rapid access to emergency care as well as continual attention to illness and injury prevention.

Currently, a half-time Associate Governmental Program Analyst reviews the pediatric first aid, CPR and school bus driver first aid courses as well as provides technical assistance and complaint resolution. In addition, a support person processes course completion sticker orders, maintains a database, keeps the web page updated, process training program renewals and keeps accounting records for the fees that are paid into the EMS Training Program Fund.

However, staff is not available to complete the health and safety training programs in a timely manner or to conduct needed investigations of violations of statutes. Currently there is a backlog of one initial review of a training program and five reviews of training program renewals. In addition, there is a backlog of 25 cases needing investigation of violations of statutes and regulations pertaining to pediatric first aid, CPR and preventive health training programs.

The proposed activities of the requested position include the following:

- Review five new primary preventive health and safety training program submissions per year to determine compliance with regulations and correspond with training programs to submit missing items.
- Review training materials for about 28 existing primary preventive health and safety training programs per year that are renewing their approvals.
- Review courses provide by approved training programs and their affiliates to ensure that they are teaching the required topics in the time frames specified in regulations.
- Implement a quality improvement process which will include conducting site visits, developing a survey of students who have completed pediatric first aid, CPR and/or

preventive health and safety training curses to determine if the training programs taken meet the requirements of the regulations and to provide feedback to training programs on survey results, following up with training programs that have deficiencies and making recommendations for meeting minimum requirements as specified.

Subcommittee Staff Recommendation: Subcommittee staff concurs with the request and has raised no issues with this proposal. Fees collected from the training program approvals and course completion sticker sales fund the Child Care Unit and are deposited into the EMSA Training Program Fund

2. Emergency Medical Services Personnel Terrorism Response Training

Issue and Background: The Emergency Medical Services Authority (EMSA) is requesting expenditure authority of $270,000 (Reimbursements from the California Military Department through federal funds received by the Office of Homeland Security) *to continue* a one-year limited-term Associate Governmental Program Analyst and fund a contract to implement a terrorism response training evaluation project and establish training standards for Emergency Medical Services responders. The contract is for $120,000.

According to the EMSA, in the first year of this project, the following key tasks were completed:

- Established interim training standards for terrorism-response training for Emergency medical Technicians that are consistent with existing state and federal recommendations related to weapons of mass destruction and chemical, biological, radiological, nuclear and explosive terrorism-training for first responders;
- Completed an initial review of existing training programs;
- Established a list of approved programs; and
- Drafted proposed permanent guidelines for curriculum and course content of training courses.

The EMSA states that continuation of this project into 2005-06 will allow for the following:

- Completion of the guidelines and the formal adoption of those guidelines by the Commission on EMS;
- Development of an interactive, web-based, learning management system that will facilitate centralized record keeping of terrorism related courses and curricula taken by EMS personnel. It is planned to link the system to the record keeping systems of EMS' primary training partners: law, fire service, the Office of Emergency Services, DHS, and the California Military Department;
- Review of new training programs as they are established by private or pubic entities; and

- Completion of remedial and supplemental training plans for courses previously taken by personnel that did not include all regional topics.

The EMSA is working collaboratively with the California Military Department, the Office of the State Fire Marshal, the DHS and many others to identify and develop the training standards for multiple disciplines of first responders. Further they note that they are using an existing committee established by SB 1350 (McPherson), Statutes of 2002 to provide expert advice and to assist in developing the curriculum content.

The EMSA states that the resulting training standards can be used to prepare those personnel who provide emergency response to terrorism events in a manner that will protect the responders and victims.

Subcommittee Staff Recommendation: Subcommittee staff concurs with the request and has raised no issues with this proposal.

B. DISCUSSION ITEMS--EMSA

1. Medical Terrorism Threat Assessment

Issue: The budget proposes an increase of $311,000 (federal funds from the Office of Homeland Security) for the EMSA to (1) fund two positions, and (2) provide $20,000 for interdepartmental contracts (i.e., $12,000 Medical Director through UC Davis and $8,000 fiscal and personnel services from the DGS.). The two requested positions are a Staff Program Manager I and an Associate Governmental Program Analyst. The federal funds to be used for this purpose are provided by the Federal Office of Domestic Preparedness to the state Office of Homeland Security and then provided as reimbursement to the EMSA.

The funds will be used by the EMSA to provide intelligence analysis, assessment and operations response coordination for medical and health specific issues during normal business hours and during emergencies as part of the new Statewide Terrorism Threat Assessment Center (STTAC).

The EMSA medical intelligence staff will (1) query medical and health databases to provide real-time information on hospital and ambulance status statewide, (2) radio communications channel traffic and public health advisories/alerts, (3) have access to medical and public health experts to quickly secure technical assistance and expert advice to assist the STTAC in assessing implications of developing trends in emergency department visits, (4) monitor communicable disease outbreaks, (5) analyze information to identify credible threats, (6) recommend actions to take in the case of credible threats, and (7) coordinate a wide range of functions with law enforcement and other involved parties.

The EMSA notes that these activities will ensure that the medical and health community and state medical mutual aid system have ongoing access to critical information and analysis necessary for enhanced preparedness.

Background: The STTAC, under the direction of the state Office of Homeland Security and California Highway Patrol, operate from the Governor's Office of Emergency Services in Sacramento. STTAC provides analysis and assessment to law enforcement and other agency response partners of information leading to potential terrorist activities in California. Membership in what has traditionally been law enforcement-only field is being expanded to include other entities, such as local EMS agencies and the EMSA, to provide discipline specific medical and health, terrorism monitoring and analysis and operations response coordination.

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

Questions:

1. EMSA, Please describe the budget request and why the positions are needed.

2. Hospital Bioterrorism Response Preparedness—Finance Letter *(See Hand Out)*

Issues: The Governor's January budget proposed an expenditure of $6 million (federal bioterrorism funds) by the EMSA for activities related to the Hospital Bioterrorism Preparedness Program. Of this total amount, $817,000 was for state support and $5.2 million was for local assistance.

However, the Subcommittee is in receipt of a Finance Letter that now proposes to change the Governor's January budget to be as follows:

- Total expenditures of $6.2 million, for an increase of $200,000 over January;
- $2.9 million for state support, for an increase of $2.1 million over January;
- $3.3 million for local assistance, for a decrease of $1.9 million from January;

First, an increase of $200,000 has been received from the federal Health Resources and Services Administration (HRSA) to set up an Emergency System for the Advanced Registration of Volunteer Healthcare Personnel (ESAR-VHP) Program in California. This increase would provide a total of $1.2 million for this purpose (as shown in the table below).

The mission of this ESAR-VHP Program will be to develop Disaster Medical Personnel Guidelines to address (1) the identification and credentialing of volunteer medical staff in the event of a disaster, (2) liability and reciprocity issues, (3) investigation of statewide registries, and (4) integration of the Medical Reserve Corps Program. HRSA is requiring all states to develop an ESAR-VHP Program but there are numerous licensing, regulatory and legal barriers that must be resolved to create the system.

Second, the proposed $2.9 million for state support consists of several components as shown in the table below. As noted, about $1.9 million was shifted from local support to state support to provide for contract activities.

Table 1: Summary of State Support Expenditures ***(See Hand Out for description)***

Description	**2005-06 Amount**	**Type of Expenditure**
Six Positions (two-year limited-term)	$817,000	EMSA state support
Emergency Medical Services for Children	$150,000	Consulting & Professional--external
Austere Medical Care Guidelines	$100,000	Consulting & Professional--external
Hospital Surge Mgmt System	$100,000	Consulting & Professional--external
Emergency Sys for Advanced Registration of Volunteer Healthcare Personnel & Medical Reserve Corp	$1,200,000	Consulting & Professional—external, or interagency
Field Management Support System	$100,000	Consulting & Professional--external
Clinic Incident Command System	$338,000	Consulting & Professional--external
EMS Patient Tracking System	$100,000	Consulting & Professional--external
Total Amount for State Support	**$2,905,000**	

The budget proposes to provide $817,000 (federal bioterrorism funds) to continue 6, two-year limited-term positions to continue the development and implementation of a comprehensive, coordinated bioterrorism response system within California. These positions will be used to continue the following *key* activities:

- Develop statewide guidelines, protocols and plans for establishing field treatment sites (at the site of the emergency or at the hospital).
- Update and revise the Hospital Emergency Incident Command System, Version III (from 1998), and develop a training program with instructor certification associated with the activity.
- Investigate the feasibility of developing a clinic Incident Command System (ICS). The emergency management community uses such a system to manage response and recovery. However, clinics do not have a standardized ICS. The development of a Clinic ICS will enhance the interoperability with hospital and community emergency management operations.
- Develop strategies for the enhancement of trauma and burn surge capacity during an emergency, to prepare for a minimum of 50 burn or trauma patients per day during an emergency.
- Investigate and develop recommendations to address the mobilization of healthcare personnel during an emergency. This activity will include identification of regulatory barriers that inhibit the ability of licensed health care providers to participate in effective surge capacity response plans, and develop a standard definition and measurement of patient care personnel surge capacity.
- Develop a statewide emergency medical system mass casualty incident plan. Currently a plan for mass casualty events exists for the fire discipline but there is no standard, consistent plan for emergency medical services to manage mass casualty events.

The EMSA states that the $3.3 million for local assistance would be used as shown in the Table below.

Table 2: Summary of Local Assistance Expenditures

Program Area	**2005-06 Amount**	**Description**
Trauma & Burn	$500,000	Enhance trauma/burn capacity by purchasing equipment and supplies for regional caches throughout the state.
Poison Control	$300,000	Expand surveillance to detect chemical and other events
EMS for Children	$200,000	Two pilot projects to implement standards
Communications	$1.3 million	Expand communications systems and backup capabilities
Hospital Emergency Incident Command Sys	$500,000	Update materials for incident command program to include plan, training and process for certifying instructors
Ambulance Equipment	$500,000	Provide supplies and equipment caches placed in strategic locations across the state.
Total Local Assistance	**$3.3 million**	

Background Overall on HRSA Hospital Funds: The Emergency Supplemental Appropriations for Recovery & Response to Terrorist Attacks on the US Act (Public Law 107-117 of 2002), among many other things, provided states increased federal support to address both local and state concerns regarding the threat of bioterrorism. The funds provided to California were obtained by submitting two comprehensive applications--one to federal HRSA and one to the federal CDC.

The federal HRSA funds are to be expended to develop and implement regional plans to improve the capacity of hospitals, their emergency departments, outpatient centers, emergency medical service systems and other collaborating healthcare entities for responding to situations requiring mass immunization, treatment, isolation and quarantine in the event of infectious disease outbreaks or bioterrorism.

Subcommittee Staff Comment and Recommendation: It is recommended to approve the request since it is consistent with the intent and purpose of the federal HRSA funds. No issues have been raised.

Questions:

1. EMSA, Please provide a brief description of the various projects, using Table 1 and Table 2, above, as a reference.
2. EMSA, Please describe the need for the positions.

II. Department of Mental Health

A. RECOMMENDED FOR VOTE ONLY—Mental Health

1. Transfer Department of Corrections GF Support to DMH for CDC Inmates

Issue and Background: The Subcommittee is in receipt of a Finance Letter which requests to transfer $61 million (General Fund) from the California Department of Corrections (CDC) to the DMH State Hospital appropriation to reflect a mutually agreed to decision by both departments.

Specifically, the DMH provides care and treatment to certain CDC inmates at Vacaville and Salinas Valley, as well as at the proposed 50-bed unit that will open at Coalinga State Hospital in September 2005. Presently the CDC reimburses the DMH for these services. Under this proposal, the DMH would receive the General Fund support directly.

The CDC budget presently reflects expenditures of $61 million for this population. As such this is the amount to be transferred to the DMH for this purpose. Additional adjustments may be needed at the May Revision when the State Hospital estimate is updated but this should represent only technical adjustments (such as for caseload).

The DMH notes that they will still continue their relationship with the CDC regarding requests for additional resources for CDC inmates and Memorandums of Understanding will be developed to identify each department's continued responsibility to identify inmates in need of mental health treatment and facilitate the transfers of those inmates between the CDC and the DMH.

Subcommittee Staff Comment and Recommendation: By transferring the General Fund support for CDC inmates in the DMH State Hospital and psychiatric programs from the CDC to the DMH, a number of administrative problems will be eliminated. Each year the DMH goes several months without receiving timely reimbursements for the services provided to CDC inmates. This has resulted in cash flow problems for the State Hospitals and has required the DMH to utilize loan authority that is provided for in Section 17601.10 of the Welfare and Institutions Code.

Subcommittee staff concurs with the request and has raised no issues with this proposal.

The proposed action conforms to Senate Subcommittee #5 on Corrections.

2. Projects for Assistance in Transition from Homelessness (PATH) Federal Grant

Issue: The Subcommittee is in receipt of a Finance Letter which requests an increase of $750,000 (federal PATH funds) based on the formula grant. These additional funds would be allocated to County Mental Health Plans (County Plans) as provided for in statute (See Hand Out package for distribution levels). This proposed increase would mean that a total of $7.4 million (federal funds) would be allocated in 2005-06.

Background: PATH provides funding to assist persons who are homeless (or at risk of becoming homeless) and have a mental illness. Counties receiving PATH funds must annually develop a service plan and budget for utilization of the funds. The service plan must describe each program setting and the services and activities to be provided. Allowable services include service coordination, alcohol and drug treatment, community mental health, housing services, supportive services in residential settings, and staff training. Presently 37 counties participate in PATH.

Subcommittee Staff Recommendation: Subcommittee staff concurs with the request and has raised no issues with this proposal.

3. Limited-Term Position for Disaster Preparedness

Issue: The budget proposes an increase of $94,000 (Reimbursements from federal bioterrorism funds from the DHS—federal CDC grant) to fund a Staff Mental Health Specialist position (two-year limited-term) to assist in implementing bioterrorism preparedness and capacity building.

The DMH is responsible for administering disaster response and recovery programs following natural disasters or human caused (terrorist) events that result in a Presidential disaster declaration. The DMH is the lead agency for mental health support in the event of a bioterrorism attach in California.

The DMH states that the position will conduct the following key activities: (1) Develop a bioterrorism plan for behavioral health hospital preparedness and training; (2) Work with local mental health disaster assistance staff and others to assess the need for mental health training competencies for health care professionals responding to bioterrorism or other public heath emergencies; (3) oversee the delivery of training and technical assistance to health care personnel on bioterrorism planning, preparedness, and mitigation issues; and (4) Participate in federal, state and local bioterrorism planning groups and advisory committees and assume the lead for mental health related responsibilities.

Subcommittee Staff Comment and Recommendation: Subcommittee staff concurs with the request and has raised no issues with this proposal.

4. Metropolitan State Hospital—Satellite Serving Kitchens

Issue: The budget proposes to shift $5 million from lease revenue bond funding to General Fund support to renovate all existing Satellite Kitchens and Dining Facilities at Metropolitan State Hospital. This is being proposed to meet requirements of DHS licensing and the "cook-chill" system. As noted below in the background, renovation of the six Satellite Kitchens must now use General Fund support.

The six Satellite Kitchens must be remodeled to include new kitchen equipment, seamless epoxy floors, ceramic tile walls, and acoustical ceiling tiles (asbestos abatement and related environmental aspects are a concern). According to the DMH, the scope of the remodel remains the same as contained in the Budget Act of 2003.

The DMH notes that this proposed solution would complete the project as originally submitted, while eliminating the problems identified in selling the lease revenue bonds, as noted below.

Background: The Budget Act of 2003 appropriated $18.7 million (Lease Revenue Bond Funds) to construct a new kitchen and remodel the six Satellite Kitchens at Metropolitan State Hospital. However, the DGS, DOF and DMH later recognized that selling bonds for the Satellite Kitchen component could not really be done. First, in order to sell the bonds, the entire building where each of the Satellite Kitchens are located would need to be used as collateral to secure the bond, rather than just the portion of the building planned for the Satellite Kitchen.

Second, one of the Satellite Kitchens is in a building that is rated at a seismic risk level 4 and other proposed Satellite Kitchens are in buildings which may need fire-life-safety improvements within the next 5 to 10 years, well before the term of the lease revenue bond would expire.

With these problems identified, it was determined to reduce the scope of the lease revenue bond project to just the new main kitchen building at Metropolitan and make the renovation of the Satellite Kitchens a General Fund project.

Subcommittee Staff Comment and Recommendation: Subcommittee staff concurs with the request and has raised no issues with this proposal.

5. Napa State Hospital—Expand Security Alert System

Issue and Background: The budget proposes an increase of $392,000 (General Fund) to expand the security alert system into the courtyards at Napa State Hospital. Currently there are six 24-hour patient (penal code-related) occupied buildings with adjoining court yards that do not have security alert systems. The security alert systems on the units are used any time staff needs assistance, and in the case of confrontation and/or behavioral problems with patients or the need for medical assistance

The funds would be used to install conduit, receivers, wiring and strobe lights, resulting in a complete and reliable alert system when staff needs assistance during emergency situations.

Subcommittee Staff Comment and Recommendation: Subcommittee staff concurs with the request and has raised no issues with this proposal.

6. Substance Abuse and Mental Health Services Administration (Grant)

Issue: The Subcommittee is in receipt of a Finance Letter that requests an increase of $303,000 (federal SAMHSA grant funds) to reflect a modest increase to the grant. These funds are proposed to be allocated by the DMH to the 58 counties receiving block grant dollars. The total amount of the federal SAMHSA grant funds will be about $55 million with this increase.

Historically, increases in federal SAMHSA grant funds have often been allocated based on the Cigarette and Tobacco Products Surtax formula to expand or enhance existing programs that serve adults with serious mental illness and children with serious emotional disturbance.

Subcommittee Staff Comment and Recommendation: It is recommended to approve the Finance Letter. Additional federal grant funds have been provided and the allocation proposed by the DMH is consistent with past practices. The County Mental Health Plans can use these funds to provide additional services through contracts with local providers of services. No issues have been raised.

B. DISCUSSION ITEM—Department of Mental Health

1. DMH Request for Staff for Proposition 63 Implementation *(See Hand Outs)*

Issue: The Subcommittee is in receipt of a Finance Letter requesting an increase of $14.6 million (Mental Health Services Fund) to the DMH to fund 109 new positions to administer Proposition 63—the Mental Health Services Act (Act). Of these requested positions, 51 positions are in the process of being administratively established in the current-year. The Mental Health Services Act allows for the immediate expenditure of funds to implement the Act, including the hiring of staff. Up to 5 percent of the total revenues can be used for state support.

The request for the 109 positions is summarized in the Table below. As shown, the current-year established a total of 51 positions (20 permanent and 31 *three-year*, limited-term). The budget year then continues these current-year positions and adds additional positions for a total of 109 positions (55 permanent and 54 three-year, limited-term).

Table--Summary of DMH Proposal: Division and Description	**2004-05 February 1**	**2004-05 April 1**	**2005-06 (Permanent)**	**2005-06 (3-yr Term)**
I. Systems of Care Division				
Deputy Director's Office	6.0	1.0	3.0	2.0
Office of Multicultural Services		1.0	1.0	1.0
Adult & Older Adult Policy Section	1.0	2.0	4.0	4.0
Children & Family Policy Section	1.0	3.0	3.0	3.0
County Support & Administration			1.0	1.0
County Operations Sections	2.0	2.0	2.0	6.0
Prevention Policy Section		1.0	4.0	4.0
Performance Outcomes & Quality	3.0	1.0	3.0	2.0
Statistics and Data Section	2.0	1.0	2.0	2.0
Epidemiology, Allocation & Support		5.0	3.0	3.0
Human Resources, Education & Training	1.0		2.0	2.0
Subtotal	**16.0**	**17.0**	**28.0**	**30.0**
II. Division of Program Compliance				
Audit Section			3.0	5.0
Medi-Cal Oversight Section			3.0	3.0
Licensing & Certification		1.0	4.0	3.0
Subtotal		**1.0**	**10.0**	**11.0**
III. Administrative Services Division				
Financial Services	1.0	2.0	4.0	1.0
Human Resources	2.0	2.0	6.0	1.0
Information Technology Section		6.0	3.0	3.0
Legal Office		1.0	1.0	2.0
Subtotal	**3.0**	**11.0**	**14.0**	**7.0**
IV. CA Mental Health Planning Council			**2.0**	**2.0**
V. Mental Health Srv Oversight & Acct Commission	**1.0**	**2.0**	**1.0**	**4.0**
TOTALS	**20.0**	**31.0**	**55.0**	**54.0**

The DMH contends that the staff resources requested are needed and are commensurate with such a significant redesign of the mental health funding and service delivery system. They further state that as they complete more planning and more clearly understand the full impact of the Mental Health Services Act, they may request additional resources.

In addition to the position request, the Finance Letter proposes Budget Bill Language as shown below. This DOF recommended Budget Bill Language will enable both the DOF and the Legislature to more closely track state support expenditures. This language is particularly important since the Mental Health Services Act funds are continuously appropriated.

> 4444-001-3085 (DMH State Support)
>
> **"**Funds appropriated in this Item are in lieu of the amounts that otherwise would have been appropriated for administration pursuant to Section 5892 (d) of the Welfare and Institutions Code.
>
> Nothwithstanding any other provision of law, the Director of Finance may increase the funding provided in this Item to further the implementation of the Mental Health Services Act. Any increase would occur no sooner than 30-days after written notification has been provided to the Chairperson of the committee in each house of the Legislature that considers appropriations, the Chairpersons of the Committees, and appropriate Subcommittees, in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee identifying the need for such increase and the expenditure plan for the additional funds.**"**

Background—Summary of Key Aspects of Mental Health Services Act: A new Mental Health Services Oversight and Accountability Commission is to be established to implement this measure, and would have the role of reviewing and **approving** certain county expenditures authorized by the Act.

Appointments by the Governor are still pending, and as such, the Mental Health Services Oversight and Accountability Commission has not as yet been constituted. Both the Senate and Assembly have made their two appointments.

Each county is to submit for State review and approval a three-year plan for the delivery of mental health services within their jurisdiction. Counties are also required to provide annual updates and expenditure plans for the provision of mental health services.

Revenues generated by the Act are to be used to create new community mental health programs and to expand some existing programs. Funds cannot be used to supplant existing public mental health funding based upon a "maintenance-of-effort" provision defined in the Act.

Generally, the Act would provide funds to support the following programs/component areas:

- Children's System of Care: Expansion of system of care services for children who lack other public or private health coverage to pay for mental health treatment.
- Adult System of Care: Expansion of existing system of care services for adults with serious mental disorders or who are at serious risk of such disorders if they do not receive treatment.
- Prevention and Early Intervention: New county prevention and early intervention programs to get persons showing early signs of a mental illness into treatment before their illness becomes more severe.
- "Wraparound" Services for Families: A new program to provide state assistance to counties, where feasible, to establish wraparound services providing various types of medical and social services for families (such as counseling) where the children are at risk of being placed in group homes.
- "Innovation" Programs: New county programs to experiment with ways to improve access to mental health services, including for underserved groups, to improve program quality, or to promote interagency collaboration in the delivery of services to clients.
- Mental Health Workforce Education and Training: Stipends, loan forgiveness, scholarship programs, and other steps to (1) address existing shortages of mental health staffing in community programs, and (2) help provide additional staffing to carry out the program expansions in the Act.
- Capital Facilities and Technology: A new program to allocate funding to counties for technology improvements and capital facilities for the provision of mental health services.

The Act gives the Legislature limited authority to assist in its implementation. It specifies that it can be amended by the Legislature by a two-thirds vote so long as any amendments are "consistent with and further the intent" of the Act.

The Act also provides an exception to the two-thirds vote rule. Specifically, the Legislature can add provisions by majority vote to clarify procedures and terms of the measure.

Background—Summary of Proposition 63 Funding Provisions (See Hand Out): The Mental Health Services Act provides for a continuous appropriation of the funds. As such, the DMH is authorized to allocate funds for various purposes without appropriation by the Legislature in the annual Budget Act.

As shown in the DMH prepared hand out, the Mental Health Services Act allocates the revenues across the program areas, based upon a percentage of total revenues received for each fiscal year. The Table below provides a summary of the DMH estimate for three fiscal years.

Table—Summary of *Estimated* Funds (By Percentage Allocation as Contained in the Act)

Program Area	2004-05	2005-06	2006-07
Education & Training	$114.3 million	$68.3 million	$69 million
Capital Facilities & Technology	$114.3 million	$68.3 million	$69 million
Local Planning	$12.7 million	--	--
State Implementation/Admin	$12.7 million	$34.2 million	$34.5 million
Prevention Services	--	$136.6 million	$138 million
Community Services & Supports	--	$375.7 million	$379.5 million
Total Funding for the Act	**$254 million**	**$683 million**	**$690 million**
Prevention		$129.8 million	$131.1 million
Prevention Innovation		$6.8 million	$6.90 million
Subtotal Prevention		**$136.6 million**	**$138 million**
Community Services & Supports		$356.9 million	$360.5 million
Community Services Innovation		$18.8 million	$18.9 million
Subtotal Community Services		**$375.7 million**	**$379.5 million**

The revenues, which are deposited into the Mental Health Services Fund, are obtained from a personal income tax surcharge of 1 percent that applies to taxpayers with annual taxable incomes of more than $1 million. The State Controller transfers specified amounts of state funding each year on a monthly basis. The amounts deposited into the fund are to be adjusted later to reflect the revenues actually received from the tax surcharge.

Background—Summary of Existing Public Mental Health Funding: County Mental Health Plans are currently the primary providers of mental health services for persons who lack private coverage. Counties provide a range of services that are supported with a mix of state, local and federal funds.

County Realignment revenues are currently the largest revenue source for community mental health services in California. Counties use these revenues to provide necessary mental health care services to Medi-Cal recipients, as well as indigent individuals. It is estimated that almost $1.220 billion will be available in the Mental Health Subaccount (County Realignment Funds) which does not directly flow through the state budget. The second largest revenue source is federal Medicaid (Medi-Cal) dollars.

Specifically counties are responsible for: (1) All mental health treatment services provided to low-income, uninsured individuals with severe mental illness, within the resources made available; (2) The Medi-Cal Mental Health Managed Care Program; (3) The Early Periodic Screening Diagnosis and Testing (EPSDT) Program for adolescents; and (4) Mental health treatment services for individuals enrolled in other programs, including special education, CalWORKs, and Healthy Families.

Legislative Analyst's Office Recommendation—Regarding State Staff Request: The LAO recommends for the Legislature to do the following:

- Reduce the requested 109 positions by 19 positions for a savings of $1.225 million (Mental Health Services Fund);
- Increase the DMH request for staffing of the Mental Health Services and Oversight Commission by three permanent positions and $266,000 (Mental Health Services Fund);
- Change the three-year limited-term positions to two-year limited-term positions as directed by existing state statue;
- Since 6 new audit positions are being added, assume an increase to the state's General Fund revenue of $1 million (General Fund) due to audit offsets;
- Adopt the Budget Bill Language, modified for the appropriation level, as proposed by the Administration; and
- Adopt placeholder trailer bill language directing the DMH to provide ongoing information to the Legislature regarding expenditure of the Mental Health Services Fund and implementation of the overall Act (See proposed trailer bill language below).

The LAO notes that the 109 requested positions represents a 60 percent increase in the DMH's overall headquarters' staffing. As such, it is unlikely that the department would accomplish the hiring by the end of 2005-06.

Further the LAO notes that (1) part of the new workload can be accommodated by current DMH staff instead of adding new staff, (2) a small part of the requested positions is for work unrelated to the new Act, and (3) insufficient workload justification has been provided to date for some of the positions.

The LAO's proposed placeholder trailer bill language is as follows:

> "At the time of the release of the January 10 budget plan and the May Revision, the Director of the Department of Mental Health shall submit to the Legislature information regarding the projected expenditure of Proposition 63 funding for each state department, and for each major program category specified in the measure, for local assistance. This would include actual past-year expenditures, estimated current-year expenditures, and projected budget-year expenditures of local assistance funding.
>
> During each fiscal year, the Director of the Department of Mental Health shall submit to the fiscal committees of the Legislature, 30-days in advance, written notice of the intention to expend Proposition 63 local assistance funding in excess of the amounts

presented in its May Revision projection for that fiscal year. The written notice shall include information regarding the amount of the additional spending and its purpose."

Subcommittee Staff Comment and Recommendation: It is recommended to concur with the LAO recommendation. The number of positions proposed by the LAO makes sense, particularly given the number of positions that need to be hired within the year and the many, as yet unknown, aspects of what workload is going to be for this new Act.

Funds not spent on state administration are funds that can be used for local assistance. As such, a more moderate approach to state support is warranted at this time.

The LAO's recommendation to capture General Fund revenue from the new audit positions also makes sense. The Administration should have recognized the need and opportunity for General Fund savings to be achieved through this audit process.

Further, the Governor has not yet made his appointments to the Mental Health Services Oversight and Accountability Commission. These appointments need to be made in order for the Commission to be constituted and provide recommendations and approval for certain funding as required by the Act.

Questions:

1. DMH, When will the Mental Health Services Oversight and Accountability Commission be constituted?
2. DMH, Please provide a brief status update on Proposition 63 implementation.
3. DMH, Please provide a brief summary of the need for positions.
4. LAO, Please present your recommendation.

III. Department of Health Services

A. ITEMS RECOMMENDED FOR VOTE ONLY

1. Richmond Laboratory Phase III

Issue: The budget reflects a *net* savings of $1.640 million ($820,000 General Fund) for implementation of the "Phase III Office Building" of the Richmond Laboratory which is scheduled for completion by March 2005. This net savings reflects the interaction of savings from rent related to a building move and potential expenditures related to operating the new building.

The DHS states that occupancy of the new building will begin in late 2004-05 with the relocation of 170 staff from the DHS' old facility. This initial relocation is to be accomplished with existing funds. In 2005-06, the majority of the 625 staff will be moved from various leased space into the new building during the Summer of 2005.

Specifically, this budget-year proposal consists of a request to establish 6 new state positions and to fund certain operating equipment.

The proposed *net savings* result from the following adjustments:

- *Savings of $3.629 million* ($1.8 million General Fund, and $1.8 million in various special funds) from reduced rent due to the vacated lease from the old building.
- *An increase of $2 million* ($996,000 General Fund, and $979,000 special funds) for the following adjustments:
    - $457,000 ($229,000 General Fund, and $228,000 special funds) to support 6 new state positions. This includes the following personnel: (1) an Office Building Manager I, (2) a Staff Services Analyst, (3) three Stationary Engineers, and (4) an Office Technician. This also includes their operating expenses.
    - $77,000 one-time only for the purchase of equipment, including (1) electric carts (2 carts at $8,000 each), (2) various ladders, tools and tool carts ($5,000), (3) parking lot lighting repair service unit (1 at $50,000), and (4) electronic security cameras (3 at $2,000).
    - $188,000 for a moving contract.
    - $350,000 for utilities.
    - $917,000 for other contracts including landscaping, janitorial and security.

The DHS states that of the $2 million increase, $1.7 million will be on-going and $265,000 will be one-time only.

Additional Background Information: According to the DHS, the construction of the 200,000 square foot building is to be completed as of June 2005.

Presently there are 46.6 DHS maintenance staff that manage the Richmond Laboratory complex. The 6 new positions being requested would be an addition to this staff.

Subcommittee Staff Comment and Recommendation: The Subcommittee discussed this issue in its March 14 hearing and held the issue "open" pending receipt of additional information from the DHS. This information has been provided (that the savings would be ongoing). Therefore, it is recommended to approve as budgeted.

2. Health Services and Proposition 63—Request for One Staff

Issue: The Subcommittee is in receipt of a Finance Letter for implementation of Proposition 63—the Mental Health Services Act.

For the Department of Health Services, the Administration is requesting an increase of $105,000 ($52,000 Mental Health Services Fund and $53,000 federal funds) to support one new Staff Services Manager I position (*three-year*, limited-term).

This position would be used to build upon existing collaborative efforts with the Department of Mental Health to ensure that the state maximizes the availability of federal funds relating to the provision of mental health services.

The Finance Letter also proposes Budget Bill Language to account for the DHS state appropriation. This language is as follows:

> "Funds appropriated in this Item are in lieu of the amounts that otherwise would have been appropriated for administration pursuant to Section 5892 (d) of the Welfare and Institutions Code."

This language is proposed because the Mental Health Services Fund, established by Proposition 63, is a continuous appropriation and allows for a higher level of expenditure that what is being appropriated in the budget. This language will assist both the DOF and Legislature in tracking and accounting for state administrative expenditures.

Subcommittee Staff Comment and Recommendation: It is recommended to approve this request but **to utilize a two-year limited-term appointment** in lieu of three years.

This recommendation is consistent with the Legislative Analyst's Office recommendation regarding the overall Proposition 63 positions.

B ITEMS FOR DISCUSSION

1. New Born Screening Program Adjustments *("Open" issue)*

Issue: SB 142 (Alpert), Statutes of 2004, expanded the existing Newborn Screening Program from 39 conditions to 76 conditions through the use of Tandem Mass Spectrometry. This expansion is the product which resulted from a Pilot Project (AB 2427, Kuehl, Statutes of 2000) which operated from January 2002 through June 2003. The pilot ended when one-time funding from the Genetic Disease Testing Fund was expended.

The DHS was authorized to spend $2.7 million (Genetic Disease Testing Fund) in the current-year for the expansion of the Newborn Screening Program.

For the budget year, the DHS is requesting an increase of $15 million (Genetic Disease Testing Fund) to (1) support three new positions, and (2) purchase $14.8 million in equipment and related services, including Tandem Mass Spectrometry equipment and software, laboratory services, and information processing system modifications.

The three requested positions include one Public Health Chemist, one Research Scientist IV, and one Staff Services Analyst.

The enabling statute provided the DHS with authority to increase fees for this program, if required for the expansion effort. As such, the DHS is proceeding with emergency regulation authority to increase the fee from $60 to a total of $78, effective January 1, 2005.

According to statute as contained in SB 142 (Alpert), Statutes of 2004, the expanded program is to be up and operational by August 1, 2005.

Previous Subcommittee #3 Hearing and DHS Response to Questions: In the March 14th hearing, the Subcommittee requested additional information regarding fees and the notification process used under the program when there is a positive result in the screen.

- *DHS Response to Fees:* The enabling legislation (SB 142, Statutes of 2004) mandated that the Newborn Screening Program be fully supported from fees collected and authorized the DHS to charge a fee for tests, or activities, performed for the proposed expansion. Activities include the start-up costs associated with implementing statewide expanded screening, which costs must be paid in advance of actual screening activities. These start-up costs include equipment, reagents for development of clinical parameters to ensure effective identification of affected infants, training contractors, the purchase of blood collection forms and various other details.

The additional $18 per test in fees collected under the Newborn Screening Program are to cover the costs of all program activities, including startup costs, and are not tied directly to the number of tests performed, nor to the date the actual expanded screening begins. In order to implement expanded screening by the statutory deadline of August 2005, the DHS faced the necessity of raising the fees prior to implementation in order to adequately fund the myriad start up costs associated with the expanded newborn screening. All the fees collected are spent for services in support of newborns and their families.

The Administration states there are many instances where fees have been raised before services have begun. For example, developers can be charged fees today for services which will be provided at a later time. This includes fees for transit, sewer, park and lighting services which will be provided at a later date. The DHS states that the relationship between these examples and the expanded Newborn Screening Program is that all take time to develop and implement and there are expenses associated with these activities.

- ***DHS Response to Processing of Positive Results:*** When a baby has a positive screen, the testing laboratory contacts the appropriate follow-up center and informs the case coordinator. The case coordinator then contacts the physician who in turn contacts the family directly. The case coordinator follows up with a letter to the physician confirming the discussion and another letter is sent to the family. The letter to the family outlines the next steps.

  The case coordinator tracks the baby, ensuring any follow up tests are performed, and continues to follow the case until evidence of a proper referral and treatment is received.

Background—Newborn Screening Program: The Newborn Screening Program screens about 525,000 infants, or 99 percent of the annual births, in about 325 maternity hospitals. Newborns are screened for a series of heritable preventable metabolic disorders. At the time of birth, the heel of the infant is pricked and a drop of blood tested for different disorders. Birth defects often have no immediate visible effects on a baby but unless detected and treated early, can cause physical problems, mental retardation, and death.

When test results are abnormal, early diagnosis and proper treatment can make the difference between lifelong impairment and healthy development. Further, significant cost savings can be achieved through early detection and in some cases, simple dietary treatment of some disorder. Cost benefit analyses have found that expanded newborn screening produces significant net benefits. The DHS estimates that for every dollar spent on expanded screening, two dollars and fifty-nine cents ($2.59) is saved in average lifetime medical costs alone.

All screening is fee supported and is voluntary. Fees are collected from individuals, their health insurance, hospitals, birthing centers and the Medi-Cal Program. All fee collections are deposited in the Genetic Disease Testing Fund.

Subcommittee Staff Comment and Recommendation: The proposal is consistent with the enacted legislation. It is recommended to approve as budgeted.

Questions:

1. DHS, Please provide an update on the *key* components of the Newborn Screening Program expansion that have been completed and what is pending.
2. DHS, Please briefly explain the budget proposal.

2. Medi-Cal Provider Enrollment *(See Hand Out)*

Issue: The DHS is seeking (1) an increase of $1.7 million ($414,000 General Fund and $1.2 million federal funds) to fund 13 new Associate Governmental Program Analyst positions and an information technology project, *and* (2) Budget Bill Language regarding information technology projects.

First, the DHS proposes to hire 13 new Associate Governmental Program Analyst positions for *three-year* limited-term appointments. The purpose of these positions is to reduce the existing provider enrollment **backlog from 6 months to 5 months**.

Second, the DHS proposes to use $500,000 (total funds) in one-time only funding to develop a "front-end" application process for the submission of physician applications. This electronic application process will ensure that all required fields are completed online prior to submission to the DHS. The DHS states there is a 40 percent error rate on the part of physicians submitting their provider applications.

Third, since *no* Feasibility Study Report (FSR) has been completed by the DHS for this proposed information technology project, the DOF is proposing Budget Bill Language. Specifically, this Budget Bill Language says the following:

> "Of the funds appropriated for new information technology projects, including but not limited to the provider enrollment automation project, no funds may be expended prior to approval of feasibility study reports by the Director of Finance.

The DHS presently has about **120 positions** who conduct enrollment and re-enrollment efforts within the DHS. This includes staff who: (1) Process provider applications and return calls; (2) Perform secondary reviews on applications; (3) Review legislation; (4) draft regulations; (5) draft policy; (6) work on correspondence; (7) perform data entry in to the Provider Master File; (8) re-enroll providers; and (9) process mail and conduct related administrative work.

According to the DHS there are currently about 140,000 Medi-Cal providers who serve the medical needs of Medi-Cal enrollees throughout California. The DHS states that it receives about 36,000 applications (3,000 per month), along with thousands of miscellaneous documents that require that require research and clerical support. These applications represent submissions from more than 78 provider types, along with applications for re-enrollment. However it should be noted that some of these applications are submitted only due to a change in address or other related administrative reasons.

The DHS states that it can take from one to five hours to adequately review an application. On average, the DHS can process 2,600 applications per month. This leaves on average about 400 pending applications each month, adding to the inventory.

The DHS states that prior to an application being finalized, it must be reviewed by at least *four* different staff as it goes through the checks and balances necessary to process the application, input the provider information into the Provider Master File system, and issue a Medi-Cal billing number.

Background—Medi-Cal Provider Enrollment (See Hand Out): The DHS is required by statute to process Medi-Cal provider enrollment within 180-days (about 6 months), except for (1) those providers that request and are approved for "preferred provider" status within 90-days, or (2) applications referred to the DHS Audits and Investigations Branch for secondary review. Providers not enrolled within their respective timeframes are deemed "forced provisional" and receive a Medi-Cal billing number without a thorough review or background check.

It should be noted that the DHS only rejects about one to two percent of the applications. Therefore, over 98 percent of the applicants are approved to receive a Medi-Cal provider number.

Pending Legislation to Simplify Medi-Cal Provider Enrollment: There are several legislative proposals which are proceeding through the policy committee process which would revamp and simplify the provider enrollment process.

For example, Senate Bill 770 (Romero), as amended on March 30, 2005, would provide that a physician enrolled and in good standing in the Medi-Cal Program who is changing locations within the same county is eligible to continue enrollment at the new location by filing a change of location form, in lieu of submitting a complete application package.

Presently, a full application must be submitted and approved by the DHS for something so straightforward.

Legislative Analyst's Office Comment and Recommendation: The LAO recommends the following:

- Deny all of the requested 13 additional positions for a savings of $1.154 million ($289,000 General Fund);
- Approve the $500,000 ($125,000 General Fund) for the "front-end" information technology project (internet application for submission of the provider application) as proposed and
- Approve Budget Bill Language, as modified by Subcommittee staff, to require approval of a Feasibility Study Report. (See below).

The LAO believes the front-end, internet application to streamline the provider enrollment process would significantly reduce the number of errors currently found in the provider applications, and thereby, reduce the time the DHS spends processing applications. The LAO also believes that the DHS can redirect some existing staff within the Medi-Cal Provider Enrollment Branch and utilize this staff more effectively.

For example, following an initial staff analysis and recommendation for every provider application, a different staff member currently performs a secondary analytical review. The LAO suggests that performing such secondary review on a sample basis would be adequate instead of performing a secondary review on all of the applications.

Subcommittee Staff Comment and Recommendation: Subcommittee staff concurs with the LAO recommendation to deny the 13 requested positions and to approve the automating the Medi-Cal enrollment application form. Automation of the Medi-Cal enrollment application form, as well as "redesigning" their Medi-Cal provider enrollment process should result in a more efficient and effective system.

With respect to the Budget Bill Language, it is recommended to adopt the language with a modification as shown below:

> "Of the funds appropriated for new information technology projects, including but not limited to the provider enrollment automation project, no funds may be expended prior to approval of feasibility study reports by the Director of Finance. The Department of Health Services shall provide notification to the fiscal committees of both houses of the Legislature within 30 days of the approval by the Director of Finance, along with a copy of the approved feasibility study report as consistent with the Director of Finance's changes.

Questions:

1. DHS, Please briefly describe the existing Medi-Cal Provider Enrollment process.
2. DHS, Please explain the budget proposal, including both the need for the positions and the information technology project.
3. DHS, What work has been done to date regarding the development of the Feasibility Study Report (FSR)?

3. Hospital Financing Waiver—Status Update from Administration

Issue: The Administration has been working since June, 2004 to craft a new Hospital Financing Waiver with the federal CMS. California's existing Waiver will expire as of June 30, 2005. The Subcommittee has discussed this issue in three prior Subcommittee hearings (February 17th, March 2nd, and March 23rd). The Administration continues to assume no additional General Fund support for hospitals, other than what is presently provided. There are still many moving parts to the Administration's proposal.

Update From the DHS: Based on information obtained as of April 25th, the following tables outline the **(1)** amount of federal funds the Governor is requesting from the federal CMS, **(2)** potential sources of "certified public expenditures" (CPE), and **(3)** other programs that can be used to draw done federal funds.

As noted in **Table 1,** below, the "maximum" amount the Administration is seeking is $671 million. This consists of three core components.

The first component—the Disproportionate Share Hospital (DSH) "swap"—consists of shifting private hospitals out of the DSH funding arrangement and instead, using "regular" Medi-Cal funds (i.e., General Fund and federal fund match) to support these hospitals. The General Fund match for this to occur would come from the public hospitals. According to the DHS, this "swap" would enable the state to obtain about $226 million more in additional federal funds than our existing DSH allotment.

This swap would mean that the public hospitals would be reliant on "certified public expenditures" (CPEs), limited Intergovernmental Transfers (IGTs) and federal funds for their primary support. DSH funding (i.e., SB 855) would only be used for the public hospitals.

The second component is the $180 million which is presently part of California's existing federal Waiver. This $180 million represents the five-year average of funds provided for indigent care in Los Angeles County through the expiring Los Angeles County Waiver (expires as of June 30, 2005). This component is in question with the federal government even though it is clearly a critical funding piece for California. The DHS states that these funds, if approved as part of the new Waiver, would be used to support hospitals statewide and not only those located in Los Angeles County.

The third component is the "growth factor" which assumes an eight to nine percent escalator of certain baseline funds. This growth factor is based upon the federal government's assumptions and could conceivably change in future years.

Other aspects regarding the proposed five-year federal Waiver remain the same at this time, including provisions regarding: (1) Federal budget neutrality (i.e., a federal funding cap or limit); (2) The de-linking of Medi-Cal Managed Care Program inpatient hospital day payments from the receipt of supplemental federal funds; and (3) Continuation of the hospital contracting program (i.e., Selective Provider Contracting Program).

Table 1—Governor's Federal Fund Request for California to Federal CMS for 2005-06

Description of Component	Potential Federal Fund Amount	Subcommittee Staff Comment
Move private hospitals from DSH to regular Medi-Cal (i.e., DSH "swap") and eliminate the state's existing $85 million "administrative fee".	$226 million (solid)	This proposal "frees-up" federal funds and is something that we could be doing now. This piece has not changed since February and is *not* in question with the federal CMS.
5-year average of funds provided for indigent care under Los Angeles Waiver (Los Angeles Waiver expires 6/30/05)	$180 million (unknown)	Federal approval of this component is unknown. Federal OMB did not previously capture these costs in their federal budget projections.
Waiver Growth Funding	$265 million (fluctuates and contingent on base level funding)	Certain components of this Waiver would be increased at a rate of 8 to 9 percent annually.
Maximum Amount Available	**$671 million**	Still pending federal approval
Amount without the $180 million	**$491 million**	

Table 2 below is the Administration's illustration of potential sources for obtaining necessary "certified public expenditures" that will be needed to draw down the federal match. Public hospitals and UC hospitals would "certify" they have expended public funds to provide services to indigent individuals and Medi-Cal enrollees. The CPEs would be used within the "Safety Net Pool" to draw down supplemental federal funds. In addition, a limited-Intergovernmental Transfer (IGT) mechanism could be used for those public hospitals above 100 percent of uncompensated costs up to 175 percent of such costs.

Table 2—Potential Sources of "Certified Public Expenditures" to Match Federal Funds

Description of Component	Amount Available for Match	Subcommittee Staff Comment
A. Hospital-Based CPEs		
University of CA System Hospitals	*minus* $15 million	CPE is needed here
Los Angeles County Hospitals	$72 million	
Other large public Hospitals	$126 million	
Private and District Hospitals	$67 million	
Amount Available for Match--Hospitals	**$251 million**	
B. Public Clinic CPEs		
University of CA System Clinics	*Pending*	
Los Angeles County Clinics	$107 million	
Other Public Clinics	$14 million	Estimate of clinics associated with large county hospitals other than Los Angeles.
Amount Available for Match--Clinics	**$121 million**	
TOTAL Amount Available for Match	**$372 million**	
Range of *Shortfall* for Federal Match (i.e., additional "CPE" needed)	**$119 million to $299 million**	Other sources of "CPE" are needed.

It should be noted that based on information obtained from the DHS, there are at least five county hospitals that do not have enough "CPE" in order to draw down their existing amount of federal funds that they presently receive through the existing IGT process.

Therefore, the complexities of the CPE process will need to include how "available or excess" CPE's will be used or distributed to others in order to keep California's public hospital whole.

Table 3 displays where other public funds could be used to draw down the federal match. These other public funds have to be funds that are not being used to match existing Medi-Cal federal funds.

Table 3—"Other" State and County Programs Available

Description of Component	Amount Available for Match	Subcommittee Staff Comment
State and County Funds for CA Children'' Services (CCS) Program & Genetically Handicapped Persons Program (CHGGP)	$150 million	These are funds that are used for services that are not Medi-Cal related.
Increase rates for private and other public hospitals (PEACHs and Districts)	$134 million	Requires $134 million in state General Fund support. This dollar figure is the maximum amount of federal spending room available for these hospitals at present.
State Funds for Clinics	$45 million	This includes state funds for the Expanded Access to Primary Care Clinics, rural clinics and American Indian clinics.
AIDS Drug Assistance Program (ADAP) state-only portion of existing funding	$91 million	This is the state General Fund portion for this program currently.
County indigent care programs, including county clinics	$500 million	
Total "Other" Funds to Use to Draw Federal Match under Waiver	**$920 million**	Administration wants to show that if needed, other sources of funds can be counted to draw down the federal match

Summary of California's Existing System: Federal Medicaid financing, presently provided through the state's Disproportionate Share Hospital Program (SB 855 funds), the Emergency Services and Supplemental Payments Program (SB 1255 funds), Graduate Medical Teaching Program, and the Capital Project Debt Reimbursement Program, is an essential ingredient to California's overall health care system. Without these supplemental federal funds, California's hospital system would indeed collapse. California currently receives just over $2 billion for these supplemental federal funds as shown below:

(1) $1.033 billion Disproportionate Share Hospitals;
(2) $806 million for the Emergency Services and Supplemental Payments Program;
(3) $66.2 million for Graduate Medical Teaching Program; and
(4) $97.4 million for the Capital Project Debt Reimbursement Program.

Presently these supplemental federal fund programs operate through the use of "Intergovernmental Transfers" (IGT) and the state's existing Selective Provider Contract Waiver. Under the IGT process, governmental entities which operate hospitals—counties, the UC system, and hospital districts—transfer a specified amount of funds to the state by means of intergovernmental transfers. The state places these transfers into a special fund and then obtains federal matching funds. No General Fund support is provided for this purpose.

Necessary Next Steps for the State: As noted, California's existing Waiver expires as of June 30, 2005 unless the federal CMS grants California anther extension (we are presently operating on a six-month extension). Though discussions continue, the Administration has not been able to achieve closure on the level of federal financing to be available. As such, the Administration has clearly stated that any new federal Waiver agreement must be done through the policy committee process due to the unknown timing of closure on the proposal, as well as the need to craft many complex details which will take time.

State statutory changes will be needed, along with the actual crafting and approval of the complete federal Waiver package. Any legislation will require a 2/3rds vote of the Legislature. The Administration would not have the ability to do new payments for DSH, supplemental federal funding (i.e., SB 1255) or the Graduate Medical Education Program until legislation was in effect. As such, the end of Session (September 9, 2005) is the latest date for enactment.

Distribution of the funds to both the public and private hospitals will of course be key to the crafting of the legislation. The Administration has stated that they are working on criteria but have yet to share any drafts on this.

It should also be noted that the federal Office of Management and Budget maybe weighting in on the discussions as well. If issues with the federal CMS cannot be resolved soon, California may be at-risk of losing certain baseline federal funding that is presently available under our existing Waiver. **This federal funding loss could be at least $368 million.**

Questions:

1. DHS, Please provide an update as to the key components of the Administration's proposed federal Waiver. Any news on the potential timing of the Waiver agreement with the federal government?
2. DHS, Is any of portion of our baseline program at-risk, such as our transition period on the Upper Payment Limit, or any other aspect?
3. DHS, Please explain how the "limited" IGT's would work.
4. DHS, How may safety net hospitals be held harmless from a loss in federal funds?
5. DHS, When will more comprehensive data be available regarding the CPE's?
6. DHS, What discussions with the DSH Taskforce (public and private hospital coalition) are planned?

4. DHS Staff for Oversight of Existing SB 1732 Hospital Construction Program and Disproportionate Share Hospital Program (SB 855)

Issue: The DHS is requesting an increase of $387,000 ($99,000 General Fund, $95,000 reimbursements from public hospitals via the Medi-Cal Inpatient Payment Adjustment Fund, and $193,000 federal funds) to (1) extend two limited-term positions for eighteen months (from July 1, 2005 to December 31, 2007), *and* (2) hire two new permanent positions.

The DHS states that the two *existing* limited-term positions (a Research Program Analyst II and a Research Specialist I) would need to be extended to provide assistance to the existing DSH Hospital Program (i.e., SB 855) to (1) conduct research, (2) develop methodology and data sources, (3) write programming changes, (4) prepare State Plan Amendments, and (5) coordinate with the DSH Hospital Taskforce.

The DHS contends that the requested two *new* positions (an Associate Accounting Analyst and a Health Program Auditor III) would be needed to provide assistance in the existing Hospital Construction Program (SB 1732) to (1) calculate reimbursements related to bond debt service, (2) allow for timely and accurate payments of debt service requests, and (3) allow for in-depth reviews of eligible bond and project costs.

Background on SB 1732, Statutes of 1988—Hospital Construction Program: Under this program, certain hospitals are eligible to receive Medi-Cal federal funds for the reimbursement of general obligation bond debt for principal and interest costs incurred in the construction renovation and replacement of qualifying hospital facilities. For 2005-06 the budget reflects expenditures of $194.8 million ($97.4 million General Fund and $97.4 million federal funds).

Background on Disproportionate Share Hospital Program: The DSH Program is a special supplemental federal fund program aimed at making up the funding shortfall for safety-net hospitals that serve a disproportionate share of California's low-income, under-insured and medically indigent populations. As discussed above, this program is slated to be changed under the Hospital Financing Waiver.

Subcommittee Staff Comment and Recommendation: It is recommended to approve these requested positions due to workload.

Questions:

1. DHS, Please describe the budget request and need for the positions.

5. DHS Staff Proposed for Hospital Financing Waiver Purposes

Issue: The DHS is requesting an increase of $1.5 million ($686,000 General Fund and $804,000 federal funds) to **(1)** support 12 new positions, and **(2)** provide $270,000 for contract expenditures to make system changes.

Specifically, the proposal requests the following positions:

DHS Positions = 10 (9 permanent, 1 two-year limited-term)

- *Two* Staff Counsels (two-year limited-term)
- *Two* Research Analyst II's
- Research Specialist
- *1.5* Research Specialist II's
- Health Program Auditor III
- *Two* Research Specialist II's (two-year limited-term)
- Half-time Associate Governmental Program Analyst

CMAC Positions = 2 (permanent)

- Research Associate II
- Senior Hospital Negotiator

The DHS and CMAC state that these positions will be needed to address the following workload:

- Developmental of Waiver protocols and systems;
- Development of a revised methodology for the distribution of supplemental payments, DSH payments and other certified public expenditure (CPE) payments;
- Creation of new formulas and the design of internal data management systems to monitor the redistribution of supplemental payments, DSH payments and other CPE payments;
- Development and maintenance of data bases used to set interim per diem rates under the new system;
- Calculation of applicable Upper Payment Limits;
- Incorporation of hospital finance restructuring costs into the Medi-Cal estimate on an on-going basis;
- Renegotiation of current hospital contracts to implement new contract language;
- Implementation of the overall Waiver;
- Administration, monitoring and oversight of the overall Waiver;
- Development of new training materials to facilitate the new reimbursement methodology;
- Conduct expanded data analyses and modeling required to support creative approaches to difficult hospital contract negotiations;
- Process anticipated legal issues and lawsuits commencing from implementation of the Waiver; and
- Evaluation of the overall impact of the Waiver on the UC hospital system, hospitals under the Medi-Cal Program, affected counties and Medi-Cal recipients.

The DHS is also requesting a one-time only augmentation of $270,000 (total funds) to make changes to its existing "re-verification" processing for federal compliance and reporting on DSH payments made to hospitals. The DHS states that they will require two contractors for at least one-year to complete any system changes.

Legislative Analyst's Office Comment and Recommendation: In her Analysis, the LAO recommends to approve a total of five positions (one permanent and four limited-term). The LAO notes that due to the proposed restructuring, workload for some of the requested positions would replace existing tasks rather than be new workload.

Other requested positions would likely be needed only in transition to a new system.

Therefore, the LAO recommends the following actions to save a total of $992,000 ($437,000 General Fund):

- Establish one permanent Health Program Auditor III to handle the "certified public expenditure" (CPE) work;
- Establish one Staff Counsel III (two-year limited-term);
- Establish three Research Analyst II positions (two-year limited-term); and
- Delete the $270,000 ($68,000 General Fund) for one-time request for information technology contract because the LAO believes the DHS has sufficient resources for this purpose.

Subcommittee Staff Comment and Recommendation: Subcommittee staff concurs with the LAO regarding the number of positions at this time, but would recommend providing the $270,000 ($68,000 General Fund) for the one-time request for the information technology contract. According to the DHS, the information technology funds would be used to do system changes to re-calculate the disproportionate share hospital formulas for public hospitals once the pending Waiver is approved.

It is recommended to provide some positions to the DHS now so that hiring can commence as soon as feasible even though the Waiver is still pending.

It should be noted that any new hospital Waiver will require state statutory change and a 2/3rds vote. As such, if needed, additional resources can be provided to the DHS and CMAC at that time, when a clearer vision may be available to better discern workload needs.

Questions:

1. DHS, Please explain the budget proposal.
2. DHS, Will the filing of these positions be a priority for the DHS? If so, how will the hiring of these positions be expedited?

6. Medi-Cal Managed Care –ISSUES "A" to "C"

Background—Summary of the Administration's Proposed Managed Care Expansion: The Administration's Medi-Cal Managed Care expansion would be achieved through a phased-in process over a twelve to eighteen month period commencing in January 2007. The Administration's proposal would require (1) state statutory changes, (2) approval of a federal Waiver, and (3) adoption of state regulations (though the Administration may choose not to use the regulation process for some or all program components).

It is anticipated that 816,000 *additional* Medi-Cal enrollees, including the *mandatory enrollment* of aged, blind and disabled individuals, would be added to managed care through this proposed expansion.

Of these proposed new enrollees, **554,000 would be aged, blind or disabled**. There are about 280,000 aged, blind or disabled individuals presently enrolled in the existing Medi-Cal Managed Care Program. As such, the 554,000 represents an increase of about 100 percent.

The proposed expansion assumes the following **key components**:

- ***Expansion to 13 New Counties:*** The Administration would expand Medi-Cal Managed Care to 13 additional counties, including El Dorado, Imperial, Kings, Lake, Madera, Marin, Mendocino, Merced, San Benito, San Luis Obispo, Sonoma, Placer and Ventura. Enrollment would include families, children and the mandatory enrollment of aged, blind and disabled individuals.

  The Administration assumes the following Managed Care model configurations for these new counties:

  - Include El Dorado and Placer counties in the existing Sacramento GMC;
  - Include Imperial County in the existing San Diego GMC;
  - Convert Fresno County (now a Two Plan) to a GMC and include Madera, Merced, and potentially Kings counties;
  - Expand existing COHS to include the counties of Marin, Mendocino, San Benito, San Luis Obispo, Sonoma, Ventura and possibly Lake. For example, San Luis Obispo County could merge with the existing Santa Barbara COHS.

  The Administration assumes that all of these counties are up and operational (ready for enrollment) by no later than April 2008.

- ***Aged, Blind and Disabled Individuals (Mandatory Enrollment):*** The DHS has identified 36 Medi-Cal aid codes which they would require to enroll into a managed care plan. Dual eligibles (Medicare and Medi-Cal) would not be included in this mandated group but could be voluntarily enrolled at the individual's option. It is assumed that about 554,000 or so aged, blind and disabled individuals would be enrolled in a managed care plan by the end of 2007-08 and beginning of 2008-09.

The 554,000 new enrollees represents a 100 percent increase over the number of aged, blind and disabled individuals presently enrolled (i.e., 280,000 persons).

The 13 new managed care counties as referenced above would immediately enroll these individuals as part of their implementation plan along with families and children enrollees. The existing Two-Plan and GMC plans would phase-in this new population over a period of 12 months.

- ***Acute and Long-Term Care Integration (ALTCI) Proposal:*** Under this proposal, health plans would provide comprehensive Medi-Cal services to enrolled seniors and adults with disabilities (i.e., Medi-Cal and Medicare eligibles) and would incorporate primary, acute and long-term care services, and home and community-based services and providers in their networks (such as mental health services, social services, personal care services provided under IHSS, nursing facility services, and others). The integration of Medi-Cal and Medicare funding and services would occur at the health plan level. As such, the participating health plans must also be federally approved as Medicare Plans ("Medicare Advantage plans), and must include Medicare prescription drug coverage.

  This proposal was discussed at length in the Subcommittee's April 4th hearing. At this point in time the Subcommittee is waiting for a response from the Administration regarding their perspective on potential modifications, such as creating a pilot project and other factors.

ISSUE "A"—Administration's Proposed Trailer Bill *(See Hand Out)*

Issue: The Administration has proposed trailer bill language for implementation of their expansion for Medi-Cal Managed Care (See Hand Out).

The Administration's proposed language does the following (Section 20, page 24):

- *Section 14094.4 (a):* This section provides the Director of Health Services the authority to expand Medi-Cal Managed Care subject to appropriation.
- *Section 14094.4 (b):* This section broadly defines the terms "managed care plan contracts" and "managed care health plan" to also mean acute and long-term care integration plans. It also defines "seniors and persons with disabilities".
- *Section 14094.4 (c):* This section provides complete authority for the Director of Health Services to expand Medi-Cal Managed Care and enter into exclusive contracts (i.e., bid or non-bid basis, and exclusive or non-exclusive basis) on a statewide or more limited geographic basis.

  It requires the mandatory enrollment of aged, blind and disabled individuals.

  It enables the Director of Health Services to convert *any* geographic service area within the state from one Medi-Cal service model (such as Geographic Managed Care

or Two Plan Model) to another Medi-Cal service model (potentially including any new model that may be developed as well).

It enables the Director of Health Services to develop or procure (through bid or non-bid basis, and exclusive or non-exclusive basis) a uniform assessment protocol and data set for individuals with chronic care needs that may be required be used by some or all of the Medi-Cal Managed Care plans as designated by the Director of Health Services.

- *Section 14094.4 (d):* This section provides carte blanche authority to the DHS to implement, interpret, or make specific this article, and any applicable federal waivers by means of all county letters, all plan letters, plan or provider bulletins, or similar instructions. Thereafter, the department *may* adopt regulations.
- *Section 14094.4 (e):* This section exempts all Medi-Cal Managed Care contracts, including amendments, or change orders to existing Medi-Cal Managed Care plan contracts, from the Public Contract Code, the State Administrative Manual Management Memo 03-10, and Government Code requirements.
- *Section 14094.4 (f).* Directs the DHS to submit any State Plan Amendment or federal waiver as necessary to carry out the provisions of this article. Directs that the article shall be implemented only to the extent that federal funds are available.
- *Section 14094.4 (g):* Clarifies that this article will not in any way limit CMAC's authority.
- *Section 14094.4 (h):* Exempts any amendments or change orders to the External Quality Review Organization (EQRO) contract from the Public Contract Code and the State Administrative Manual Management Memo.

Background—Existing State Statute on Medi-Cal Managed Care: Existing state statute enables the Director of the DHS to expand the Medi-Cal Managed Care Program to include the mandatory enrollment of **families and children** in additional counties or services areas. However, for the existing Geographic Managed Care counties (i.e., Sacramento and San Diego), any expansion of these two areas would require amending that section of state law dealing specifically with their operation of that model.

Any conversion of the aged, blind or disabled populations from voluntary to mandatory enrollment status would require state statutory change. In addition, a federal Waiver (or Waivers) would also be needed for this purpose.

It should be noted that the original implementing legislation for Medi-Cal Managed Care was Senate Bill 485, Statutes of 1992. SB 485 was the Omnibus Health Trailer Bill to the Budget Act of 1992. These were very difficult fiscal times and broad authority was provided to the DHS to commence with a Managed Care Program for children and families.

Through-out most of the 1990's, the Medi-Cal Managed Care Program struggled with various Medi-Cal enrollment issues, complex contract issues, rate development, lawsuits, and problems with the federal CMS. In fact, the federal CMS required California to halt enrollment for a period of time until certain measures could be put into place.

Subcommittee Staff Comment and Recommendation: In discussion with DHS staff it was said that the DHS has broad authority now to operate the program and the trailer bill language generally codifies their existing authority.

However in the view of Subcommittee staff, there are significant concerns with the DHS trailer bill language. First, this broad authority they are seeking pertains to aged, blind and disabled individuals. These are the most medically needy individuals that the state serves, including individuals with severe mental illness, individuals with developmental disabilities, children with special needs, and frail seniors with dementia. Under the DHS language, the Legislature would have minimal oversight responsibilities regarding the entire Medi-Cal Managed Care Program, other than appropriation responsibilities. All programmatic changes, contracts, policies and administration would be at the sole discretion of the Director of Health Services and administrative decisions as directed by the federal CMS.

Second, the proposed language contains no provisions regarding (1) quality of care standards, (2) performance measures, (3) continuity of care issues and related transition issues, (4) program evaluation components, (5) rate design, (6) obtaining more comprehensive encounter data from plans, as well as other related factors. The DHS has missed an opportunity here to improve the **core** Medi-Cal Managed Care Program. A strong core program would offer a better opportunity from which to expand into additional geographic regions and to more medically needy populations.

Third, extensive stakeholder meetings were convened last year by the Administration to garner perspectives and suggestions from constituency groups about how to improve the Medi-Cal Program, including managed care. However, the proposed trailer bill language does not address or contain any of these items, including those proposed by managed care plans.

Fourth, in her 2004-05 Perspectives and Issues publication, the LAO discussed the need for various program improvements within the Medi-Cal Managed Care Program. However, none of these suggestions have been incorporated into the proposed language.

Questions:

1. DHS, Please walk through each of the component pieces of the proposed trailer bill legislation.
2. DHS, Has any thought been given to adding other components to this language submittal?

ISSUE "B"—Administration's Request for Staff & Contract Funds

Issue: The DHS is requesting a total increase of $7.6 million ($3.3 million General Fund and $4.3 million federal funds) to **(1)** hire 47.5 new state staff as of July 1, 2005, **(2)** provide $1 million for external contracts, and **(3)** provide $1.9 million for "interdepartmental" contracts.

This proposal also assumes the need for additional resources to be obtained in 2006-07.

The table below provides a summary of where the 47.5 requested positions would be located and also displays the 2006-07 anticipated future request for next year. This proposed staffing level by the Administration assumes legislative approval of their entire managed care proposal—13 new counties, mandatory enrollment in all counties of aged, blind and disabled individuals, and implementation of the Alternative Long-Term Care Integration Program.

Table 1: **Summary of Administration's Staffing Proposal**

DHS Divisions & CMAC	New Positions for 2005-06 **(Budget Year)**	New Positions for 2006-07 **(Next Year)**	Total Positions
Medi-Cal Managed Care	22.0	14	36
Payment Systems	8.5	0	8.5
Long-Term Care	8.0	0	8
Administration	5.0	3.0	8
Legal Services	4.0	0	4
CA Medical Assist. Commission	0	3	3
Totals	**47.5 Requested**	20.0 Future	67.5

The following discussion outlines the position request by each area.

Medi-Cal Managed Care Division (22 positions, or 40 percent of the budget request):
The DHS states that existing staffing levels have been significantly depleted over the last 18 months to 24 months as a result of the budget deficit, resulting positions cuts, and the extended hiring freeze instituted by the Governor, which has resulted in about a 30 percent reduction of staff within the DHS Medi-Cal Managed Care Division. As such, they are requesting 22 new positions.

Table 2—Medi-Cal Managed Care Division Request *(22.0 positions)*

Type of Positions Requested	Description of DHS Stated Need	Number of Positions
Staff Services Manager II	Coordinate activities for the expansion	1.0
Staff Services Manager I	Oversee contract development and operational issues	2.0
Associate Gov Prog Analysts	Provide additional contract management for new contracts in the expansion counties.	8.0
Associate Mgmnt Auditor	Conduct ongoing financial monitoring of contracted health plans in the new counties and work with actuary staff in development of experienced-based rates for both the expansion areas *and* aged/blind/disabled	2.0
Office Technician	Perform duties due to expansion	1.0
Nurse Consultant III	Develop new policies and procedures relative to clinical standards, policies, and quality measures for quality of care	1.0
Medical Consultant II	Support special needs services	1.0
Nurse Evaluator II	Develop medical monitoring protocols and tools for expansion population.	2.0
Research Program Spec II	Support rate methodology and encounter data research	1.0
Research Program Spec I	Support rate methodology and encounter data research	1.0
Actuary Positions	Make actuarial valuations and verify capitation rates	2.0
Total for the Division		**22.0**

Payment Systems (8.5 positions):

Table 3—DHS Payment Systems Division *(Two Areas)*

Type of Positions Requested	Description of DHS Stated Need	Number of Positions
A. Health Care Options	Conduct materials development, system modification and contract amendments with Health Care options contractor (Maximus)	**6.0 total**
Staff Info Systms Analyst		2.0
Associate Gov Prog Analysts		2.0
Research Program Specialist I		1.0
Office Technician		1.0
B. Fiscal Intermediary & Provider Relations	Oversee written communications, training materials and serve as DHS resource for provider activities (billing questions and claims processing)	**2.5 total**
Office Technician		0.5
Total for the Division		**8.5 total**

Long-Term Care (8 positions):

Table 4—DHS Long-Term Care Division

Type of Positions Requested	Description of DHS Stated Need	Number of Positions
Staff Services Manager II	To coordinate and provide liaison with other programs and state departments.	1.0
Staff Services Manager I	To supervise 6 staff and to develop ALTCI policies.	1.0
Associate Gov Prog Analysts	To provide ALTCI policy development and oversight.	4.0
Nurse Evaluator II	To provide review and evaluation of current clinical outcome measures and clinical practice guidelines.	1.0
Office Technician	To provide administrative support	1.0
Total for the Division		**8.0**

Administration Division (5 positions):

Type of Positions Requested	Description of DHS Stated Need	Number of Positions
Personnel Specialist	Process workload with the requested positions	0.5
Associate Gov Prog Analyst	Perform contract management	1.0
Research Program Specialist II	Develop and maintain complex data projects for the Fiscal Forecasting Branch	1.5
Account Technician	Process additional workload	1.0
Office Assistant	Support to the contract processing activities	1.0

Legal Services (4 positions):

Type of Positions Requested	Description of DHS Stated Need	Number of Positions
Staff Counsel III	To perform contracting work and drafting procurement documents related to managed care expansion.	1.0
Staff Counsel I	To perform contracting work and drafting procurement documents related to managed care expansion.	1.0
Staff Services Manager I	For the Office of Regulations, though the trailer bill language assumes little if any regulations.	1.0
Associate Gov Prog Analyst	For the Office of Regulations, though the trailer bill language assumes little if any regulations.	1.0

Contract Funding Request: The DHS is also seeking about $3 million (total funds) in additional contract funds for 2005-06. These contract funds would be used as follows:

- Health Care Options Contract ($300,000 for 2005-06): Maximus is the Medi-Cal Managed Care "enrollment broker" who (1) presents the plan choices to the pending managed care enrollee, and (2) defaults enrollees to plans as needed if a choice is not made. The DHS states that costs are calculated based on enrollment. The projected costs for 2005-06 are $300,000 (total funds) for them to (1) develop new enrollment materials, (2) revise existing enrollment materials, and (3) begin system change work for the development of new informing materials specific to the aged, blind and disabled populations. Expenditures for the out-years would increase.

- *Fiscal Intermediary (Electronic Data Systems Contract) (total funds not specified by the DHS):* The DHS states that changes would need to be made to the "adjudicated claim line" process as well as other aspects.

- *External Quality Review Organization ($312,000 total funds):* The EQRO is an accrediting body that is an expert in the scientific review of the quality of health care provided to Medi-Cal enrollees in a state's managed care program. It activities are required by federal law. It is unclear however what specifically would be done with these funds.

- *Translation Services—University of California System ($190,000 total funds):* The DHS presently has a consultant services contract with the UC to translate written Medi-Cal Managed Care informing materials for Medi-Cal enrollees. This would include expenditures for both the proposed geographic expansion as well as the proposed mandatory enrollment of aged, blind and disabled.

- *Independent Assessment of Waivers ($210,000 total funds):* These funds would be needed only if the Legislature grants the DHS authority to seek a federal Waiver for the mandatory enrollment of aged, blind and disabled individuals. Further, it is unclear as to why funds would be needed in 2005-06 when the DHS assertive schedule shows that enrollment would not commence until at least January 1, 2007.

- *Information Technology Contract ($1.215 million total funds):* This proposed expenditure of $1.215 million ($304,000 General Fund) would be for "systems changes" to (1) develop of programming specifications, (2) coordination of the Health Care Options vendor (Maximus), (3) development of materials for training new counties about the Medi-Cal Eligibility Determination System related data, (4) development of changes to plan tables, (5) assessment of HIPAA related changes, (6) assessment of changes to paid claims data, (7) coding of system changes, (8) testing of system changes, and (9) coordination of external testing with counties.

- *Outreach to Aged, Blind and Disabled ($500,000 total funds):* The DHS states that these funds are needed if mandatory enrollment of aged, blind and disabled individuals is done.

- *Long-Term Care Diversion Assessment Tool ($500,000 total funds):* It is the intent of the state to have the ALTCI plans work with a contractor on the development and implementation of a uniform Long-Term Care Diversion and Assessment Protocol for seniors and adults with disabilities. This protocol would be used to determine functional needs and preferences and to ensure that seniors and adults with disabilities receive care that supports maximum community integration and self-direction. This contract is part of the proposed Acute Long-Term Care Integration Program.

Legislative Analyst Office Comment and Recommendation: The LAO notes that once the Legislature has decided what aspects of the Administration's proposed Medi-Cal Managed Care proposal it wants to proceed with, then it can decide what necessary DHS staff components and contract amounts are necessary. For example, if the Legislature wants to proceed with expansion of the existing Managed Care Program (i.e., children and families, and voluntary enrollment of aged, blind and disabled) into new geographic areas, then less DHS resources would be necessary in 2005-06.

However, at a minimum, the LAO would recommend deleting at least 5.5 of the requested DHS 47.5 positions for savings of $469,000 (General Fund), and to make four of the positions two-year limited-term appointments.

Subcommittee Staff Comment and Recommendation: Clearly many issues remain regarding the Administration's proposal. The Subcommittee was only provided with a timeline that contains objectives on Friday, April 29th, just prior to completion of this agenda even though this information was requested over seven-weeks ago. It is recommended to hold the appropriation of resources open until the Subcommittee has received additional requested information and has decided what aspects of the Administration's proposal is to be acted upon through the budget process.

Questions:

1. DHS, Please provide an overview of the budget request.
2. DHS, Please provide a summary of the major milestones and objectives of what would need to be completed when under your proposal.

ISSUE "C"—Managed Care Rate Structure *(Informational)*

Issue: Questions regarding the existing Medi-Cal Managed Care rate structure have been evolving for several years. As noted by the LAO in past Analyses, the existing methodology is outdated.

Though the DHS did change its methodology in 2003 in order to meet federal law requirements to be actuarially based, amongst other things, the DHS does not use encounter data to make rate determinations.

The "base cost" is the part of the rate that relates to experience from the past. Generally, to calculate the base cost, an attempt is made to find a group of individuals that will be similar to the group for which the rates are being set. Claims tapes for four COHS's is used for determining the Two Plan Model rates. Various adjustment factors are applied to the base costs, such as for age/sex population mix, enrollee's duration of Medi-Cal enrollment, trend factors for hospital inpatient and outpatient services, trend factors for pharmacy, and other factors. In addition, changes made through the state budget process are also to be factored in as part of the process.

Currently there are contract provisions that provide for an administrative remedy and an appeals process when disputes are raised by the plans regarding contract issues. These provisions are included in the Two Plan Model, Geographic Managed Care and the COHS contracts. Specifically, there is (1) an initial "notice of dispute" process, (2) an administrative appeals process, and (3) a Writ of Mandate process which is filed with the Superior Court to protest the Administrative Appeal decision. Within the last two-years, 15 plans have filed some form of Administrative Appeal regarding rates. Four cases have been taken to Superior Court.

The DHS notes that they have recently awarded a contract to Mercer which begins May 1, 2005. Expenditures in the current year for this contract are expected to be $300,000 (total funds) and $1 million for 2005-06.

Questions:

1. DHS, Please provide an overview of the existing rate determination process for Medi-Cal Managed Care.
2. DHS, Please provide an overview of the work products to be produced by Mercer.
3. DHS, How may this new information be used to develop a revised rate methodology?

7. DHS Staff for Restructuring ICF-DD Rates

Issue: The Subcommittee is in receipt of a Finance Letter that requests an increase of $145,000 ($72,000 General Fund) to support 1.5 new Associate Governmental Program Analyst positions. These positions would be effective as of September 1, 2005 and are intended to be permanent.

The purpose of these positions would be to work on a State Plan Amendment to include Day Programs and associated non-medical transportation in the per diem rate paid to Intermediate Care Facilities for the Developmentally Disabled (ICF-DD).

Specifically, federal regulations allow a state to create a broader definition of ICF-DD services than those presently used by the DHS, including Day Program services and non-medical transportation. If a broader ICF-DD service definition is used, the state could save tens of millions in General Fund support (due to the receipt of federal funds).

Under the state's existing system, Day Program services for individuals with developmental disabilities are funded through the Department of Developmental Services and purchased by the non-profit Regional Centers. Presently, about 50 percent of expenditures for these Day Program services are funded using 100 percent General Fund support. If Day Program services were reimbursed under a more inclusive ICF-DD rate, a federal match could be received for most of this General Fund expenditure.

The existing DHS cost methodology for ICF-DD facilities is presently defined in California's state Medi-Cal Plan. Therefore, any change to this rate would require a "State Plan Amendment" (SPA) and federal CMS approval.

It should be noted that other states have been successful in covering additional services and supports (i.e., broader definition of ICF-DD services) as noted.

It is not anticipated that any General Fund savings will be available from the restructuring until at least 2006-07.

Prior Subcommittee Hearing—February 23rd: In this hearing, the Subcommittee discussed a January 2003 report (PNP associates), funded by the Department of Developmental Services, that identified the potential for the state to save tens of millions in General Fund if the DHS were to re-structured how it reimburses ICF-DD facilities in the manner identified in the Finance Letter. The LAO also recommended this approach in the Subcommittee hearing.

Additional Background--What Are Intermediate Care-DD Facilities? Generally, ICF-DD facilities are facilities that provide 24-hour assistance, including nursing care, habilitation services, active treatment, and supervision in a structured setting. This type of licensed facility includes the state Developmental Centers, as well as smaller six-bed facilities in various regions of the state.

Subcommittee Staff Comment and Recommendation: It is recommended to approve the positions but to make them two-year limited-term, and not permanent. The activities of these positions do not require permanent positions.

Questions:

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

8. Implementation of the Medicare Modernization Act (MAA)—Affect on California Due to Federal Changes *(See Hand Outs)*

Issue: The MAA makes significant changes to the federal Medicare Program and as such, affects the state's Medicaid (Medi-Cal) Program.

Part D of the MAA is the new outpatient prescription drug benefit that will be implemented as of January 1, 2006. As of this date, Medicare will begin to pay for outpatient prescription drugs through "Prescription Drug Plans (PDPs) or Medicare Advantage plans. Enrollment into these plans will include "dual eligibles"—individuals enrolled in both Medi-Cal and Medicare.

There are about 1 million Medi-Cal/Medicare enrollees (dual eligibles) in California. According to the DHS, about 137,000 of these individuals are enrolled in Medi-Cal Managed Care and 937,000 are enrolled in "fee-for-service" Medi-Cal. Dual eligibles tend to be in poor health due to chronic illnesses and conditions.

According to the DHS and LAO, the scope of this federal legislation is so broad that it may be years before all of its initiatives are fully implemented and its overall ramifications are completely understood.

As noted in Table 1 below, the Governor's budget assumes savings of $100 million (General Fund) in 2005-06.

However beginning in 2006-07, this "savings" is estimated to be reduced to only $17 million and by 2008-09, the state will have increased General Fund expenditures by about $758 million (General Fund) as shown in Table 2. The significant cost increases result due to the "clawback", as well as a loss of drug rebate revenues.

Table 1: Summary of Governor's Budget Due to Part D for Medi-Cal

Description of Component	2005-06 (Half Year) (General Fund)
Reduced Drug Costs: Assumes elimination of dual eligible drug benefits beginning January 1, 2006 with only continuation of barbiturates, weight loss/gain, and benzodiazepines. This assumes that dual eligibles are about 55.2 percent of the Medi-Cal pharmacy expenditures.	-$747 million
"Clawback": Federal law requires states to make a "state contribution" payment to help finance Part D dual eligibles.	$646 million
Proposed Net Impact for Budget Year	**Savings of $101 million**

Table 2-Potential Impact in Future Years

Component	2006-07 (General Fund)	2007-08 (General Fund	2008-09 (General Fund)
Reduced Drug Costs	$1.617 billion	-$1.818 billion	-$2.043 billion
"Clawback"	$1.428 billion	$1.574 billion	$1.737 billion
Reduced Drug Rebates	$273 million	620 million	$705 million
Estimated Annual Cost	**$84 million**	**$376 million**	**$399 million**
Estimated Cumulative	**-$17 million**	**$359 million**	**$758 million**

The California Health and Human Services Agency (CHHS Agency) has established a Taskforce made up of representatives from all of the applicable health and human services departments, including the DHS, Department of Aging (where HICAP is funded), Department of Developmental Services, Department of Mental Health and others. According the CHHS Agency, this Taskforce group has been meeting and discussing system-wide issues.

With respect to fiscal issues regarding the DHS responsibilities, the key issues include the following:

- Working with the federal CMS on the "clawback" provisions and what that means specifically for California. (This is the federal law that requires states to make a "state contribution" payment to help finance Part D dual eligibles.)

- Transition and wrap-around coverage for dual eligibles who would no longer be able to obtain their drugs from the Medi-Cal Program as they presently do and who will need to enroll in a Prescription Drug Plan (PDP) or Medicare Advantage plan as part of the federal Part D-sponsored benefit. The Governor's budget assumes no transition or wrap-around coverage for these individuals.

  As such, the Governor is proposing trailer bill legislation to eliminate the provision of drug benefits under the Medi-Cal Program to those who are dually eligible (Medi-Cal and Medicare), *except* as approved by the Department of Finance.

- Informing dual eligibles about the program and facilitating their enrollment into a PDP or Medicare Advantage Plan.

- Re-calculating drug rebates that are presently collected under the Medi-Cal Program. It is anticipated that the shift from Medi-Cal drug coverage to the Medicare Part D coverage could weaken the DHS' ability to successfully negotiate supplemental rebates with drug manufacturers, potentially increasing program costs by tens of millions.

Subcommittee Staff Comment and Recommendation: The May Revision is anticipated to contain several adjustments to the Governor's budget due to updated discussions with the federal CMS regarding implementation of the Part D Program. As such, it is recommended to leave this issue "open".

Questions:

1. LAO, Please provide a brief summary of the key aspects to the new Medicare Part D drug coverage program.
2. DHS, Please discuss the "clawback" provision and the new information you have received from the federal CMS.
3. DHS, Please provide an update on the key fiscal aspects identified above.

Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda

Chair, Senator Denise Moreno Ducheny
Senator George C. Runner
Senator Tom Torlakson

Thursday, May 5, 2005
(Upon Adjournment)
John L. Burton Hearing Room (4203)
Consultant, Anastasia Dodson

Vote Only Agenda

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Due to the volume of issues testimony will be limited. Please be direct and brief in your comments so that others may have the opportunity to testify. Written testimony is also welcome and appreciated. Thank you for your consideration.

Please Note: Only those items and issues contained in this agenda will be discussed at this hearing. Issues pertaining to these items may be reviewed again. Please see the Senate File for dates and times of subsequent hearings.

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

Vote Only Agenda

5180 Department of Social Services (DSS)

Vote-Only Issue 1: State Participation In-Home Supportive Services (IHSS)

Description: The Governor's Budget proposes to reduce the level of state participation in IHSS provider wages and benefits from $10.10 per hour to the state minimum wage ($6.75), to achieve General Fund savings of $195 million in 2005-06, and $260 million annually. Although the extent to which counties would reduce wages is unknown, a reduction in wages could potentially result in additional General Fund costs for the Medi-Cal, Healthy Families, and CalWORKS programs. Reduced wages would also likely result in increased provider turnover, which may reduce the quality of care for IHSS consumers and lead to increased institutionalization. Further, to the extent that wages are reduced and fewer IHSS providers are available, this proposal may result in legal action against the state under federal Medicaid statute that requires sufficient provider access.

Background:

- **IHSS Program Description:** The IHSS program funds personal care services for low-income aged, blind or disabled individuals that are at risk for institutionalization. IHSS services include domestic services (such as meal preparation and laundry), nonmedical personal care services, paramedical services, assistance while traveling to medical appointments, teaching and demonstration directed at reducing the need for support, and other assistance. Services are provided through individual providers hired by the consumer, county contracts with service providers, or through welfare staff. County welfare department staff visit consumers in their homes to determine the number of authorized hours of service per day.

- **Enrollment Summary:** The budget estimates that IHSS enrollment will increase to 382,000 in 2005-06, an increase of 7.7 percent over 2004-05 caseload. Approximately half of IHSS consumers are age 65 and older. Persons with developmental disabilities constitute more than 12 percent of the IHSS caseload.

- **Funding Summary:** IHSS program costs are currently shared as follows: 50 percent federal funds, 32.5 percent state General Fund, and 17.5 percent county funds. The budget proposes $3.2 billion ($1.02 billion General Fund) for the IHSS program in 2005-06. This represents a decline of $513 million ($160 General Fund) below the current year funding level. The decline is due to proposed provider wage participation reductions of $195 million General Fund, offset by an increase in funding to reflect caseload growth.

Recommendation: Reject the Governor's proposal to reduce state participation in IHSS provider wages and benefits to the state minimum wage: reject proposed trailer bill language and restore $195 million General Fund and $300 million federal funds.

Vote-Only Issue 2: Disability Evaluation Positions

Description: A spring finance letter requests $3.4 million ($1.7 million General Fund) to establish 20.0 new positions and provide additional medical consultation costs to process increased workload of Medi-Cal disability applications. Ongoing costs would be $2.1 million, and one-time costs would be $1.3 million. The department currently has 152.5 positions for the State Disability Evaluation program, which reflects a reduction of 24 positions due to position reduction actions in recent years.

Background:

The Department of Social Services (DSS) Disability and Adult Programs Division (DAPD) is responsible for determining medical eligibility for applicants for Medi-Cal programs that serve persons with disabilities, including the Aged, Blind and Disabled program and the 250 percent of the federal poverty level Working Disabled program. DSS considers medical and vocational evidence to make a determination about a person's disability status according to guidelines developed by the Social Security Administration.

Applications for Medi-Cal disability are taken in the county welfare offices, and then forwarded to the DSS Disability Evaluation Program Division for development of medical and vocational evidence and a determination of medical eligibility based on this evidence.

Increases in the number of low-income working persons with disabilities who apply for the Medi-Cal program has increased the department's workload. DSS estimates a current backlog of 15,000 cases.

Year	Number of Cases
2000-01	44,456
2001-02	52,397
2002-03	58,142
2003-04	58,877
2004-05	59,076
2005-06	61,775

Federal law requires states to complete eligibility determinations for persons alleging disability as a basis for Medi-Cal eligibility within 90 days. DSS reports that Medi-Cal applications generally are 310 days old before the department processes the application, clearly exceeding the federally required timelines.

Recommendation: Approve the spring finance letter for $3.4 million ($1.7 million General Fund) to establish 20.0 new positions and provide additional medical consultation costs to process increased workload of Medi-Cal disability applications.

Vote-Only Issue 3: Community Care Licensing – Spring Finance Letter for Caseload Increase

Description: The department requests $1,140,000 General Fund for 14.5 positions to reflect caseload growth in the number of facilities licensed by DSS Community Care Licensing (CCL). CCL currently has 1,015 positions.

Background:

The Department of Social Services Community Care Licensing (CCL) establishes standards for and oversees eighteen types of community facilities that provide care and supervision to 1.4 million Californians. These facilities include adoption agencies, foster care homes and agencies, childcare homes and centers, and residential care facilities for disabled and elderly adults. In addition, 42 counties license foster homes under contract with the Department of Social Services and 7 counties license family child care homes under similar contracts. The state monitors approximately 85,000 homes and facilities.

CCL activities include provider orientations; applicant screenings; health and safety, staffing and financial regulations; and pre-licensing facility visits to applicants and potential applicants for community care licenses. CCL visits licensed facilities regularly, responds to complaints, and exercises a variety of enforcement actions, including consultation, fines and penalties. As a last resort, CCL pursues license suspension or revocation.

Facility Type	2002-03	2003-04	2004-05	2005-06
Family Child Care Homes	42,949	44,418	44,802	45,833
Child Care Centers	14,547	14,690	14,810	14,938
Child and Adult Residential	18,322	18,827	19,379	19,881
Certified Family Homes*	13,952	14,525	14,230	14,049
Total	**89,770**	**92,460**	**93,221**	**94,701**

*Note that Certified Family Homes are licensed by Foster Family Agencies, but complaints are investigated by CCL.

Recommendation: Approve the spring finance letter for 14.5 positions to address an increase in the number of facilities licensed by DSS.

Vote-Only Issue 4: Food Stamp Program Waiver for Able Bodied Adults Without Dependents (ABAWD)

Description: The Food Stamp Program provides benefits to low-income families and single adults. Benefits are funded entirely by federal funds. Adults without children are known in this program as Able-Bodied Adults Without Dependents (ABAWDs). Although ABAWDs are

generally only eligible for Food Stamps for three months in a three-year period, federal law permits waivers that allow ABAWDs living in areas of high unemployment to receive Food Stamps beyond the three-month limit. California Food Policy Advocates requests that DSS seek an ABAWD waiver for the entire state. The County Welfare Directors Association asks that counties be given the choice to opt-out of the waiver.

Background: As a result of 1996 federal welfare reform, ABAWDs are subject to strict time limits on their Food Stamp benefits. Unless an ABAWD recipient is working 20 hours a week or participating in workfare, they are only eligible for Food Stamps for 3 months out of a 3-year period. California Food Policy Advocates indicates that Food Stamp participation among ABAWDs has plummeted by almost 70 percent since 1996. According to the Urban Institute, low-income adults without children are at serious risk of going hungry, which diminishes their chances of success in the workplace. Almost 40 percent of ABAWDs worry about or have problems affording food.

Federal law includes protections in place to allow ABAWDs living in areas of high unemployment to receive food stamps beyond the 3-month time limit. These areas are ones that have an unemployment rate which exceeds 10 percent or do not have a sufficient number of jobs to provide employment for the individuals.

A list of areas eligible for waivers is generated each year. States that provide extended unemployment benefits in the past year are eligible for a waiver for the entire state in the following year. In 2004, the entire state of California was eligible for a waiver because the state was eligible for extended unemployment benefits in 2003. In addition, over 35 counties were eligible for full or partial waivers. In 2005, 25 full counties and many large cities are eligible for waivers. USDA approved waivers in 45 states in 2004. Many of these waivers covered entire states (e.g. Alaska, D.C., Louisiana, Michigan, New Mexico, North Carolina, Oregon, South Carolina, Washington) while others were obtained for all eligible sub-areas (such as specific counties and zip codes). Twenty-three states have comprehensive ABWAD waiver policies.

California Food Policy Advocates indicates that DSS currently requires that each county Boards of Supervisors take action before an ABAWD waiver request is made. As the waivers are in effect for just one year, the process of waiting for action from Boards of Supervisors meant that ABAWDs have missed out on Food Stamp benefits for a period of time. The Food Policy Advocates also indicate that in 2004, DSS did not request a statewide waiver, even though California was eligible. And although more than 35 counties were eligible for full or partial waivers, only 18 counties received a waiver.

Recommendation: Adopt placeholder trailer bill language to require the state to seek all possible ABAWD waivers, with an option for any county to opt out of the waiver upon a vote of their Board of Supervisors.

5160 Department of Rehabilitation (DOR)
5180 Department of Social Services (DSS)

Vote-Only Issue 5: Proposition 63 Positions

Description: To reflect the activities required by Proposition 63, the Mental Health Services Act, which became effective January 1, 2005, the Administration requests spring finance letters to establish 2.0 two-year limited term positions for the Department of Rehabilitation (DOR) and 4.0 two-year limited-term positions for the Department of Social Services (DSS). These positions would be funded by the new state Mental Health Services Fund established by Proposition 63.

Background:

Proposition 63, the Mental Health Services Act (Act), which became effective January 1, 2005, established a state personal income tax surcharge of one percent on taxpayers with an annual taxable income of more than $1.0 million. The funds from this surcharge are deposited into the new state Mental Health Services Fund, and will be used for state and county planning and implementation consistent with the Act's provisions. The Act provides for the expansion of mental health services and incomes specific provisions related to education and training of the mental health workforce, development of innovative program and integrated plans for prevention, intervention and system of care services, investment in capital facilities and technology needs, and enhanced oversight and accountability.

The estimated revenues in the Fund total $254 million in 2004-05 and $683 million 2005-06. While most of the revenue will be available to county mental health programs, the Act authorizes up to 5 percent of the revenue in the Fund annually for state administration. Funding for state administration is projected to be $12.7 million in 2004-05 and $34.2 million 2005-06.

The Administration has requested a total of 121 positions to implement the Act, including 109 positions in the Department of Mental Health (heard in Budget Subcommittee No. 3 on May 2nd), 1 position in the Department of Health Services (also heard on May 2nd), 3 positions in the Department of Education (heard in Subcommittee No. 1), 2 positions in the Department of Alcohol and Drug Programs (heard in Subcommittee No. 3 on May 9th), and the remaining positions outlined below.

Department	Mental Health Services Fund	Federal Fund	Requested Positions
Department of Rehabilitation	$195,000	0	2.0
Department of Social Services	$515,000	$150,000	4.0
Total	**$710,000**	**$150,000**	**6.0**

The DOR positions would expand mental health cooperative programs, which are contractual relationships between DOR and county mental health agencies intended to provide necessary services to stabilize and prepare individuals with severe mental illnesses for employment. These

programs currently exist in 25 California counties, and the requested positions would work toward expanding these programs to the rest of the state.

The DSS positions would work with other state and county agencies to coordinate and track the effects of enhanced mental health services, particularly in child welfare and foster care programs. Specific activities include:

- Provide ongoing technical assistance to county welfare departments and key community based organizations to support their active participation in local planning efforts.
- Conduct county site visits during the program planning and implementation process.
- Identify opportunities to leverage the Mental Health Services Fund to drawn down matching federal funds.
- Remove regulatory barriers; resolve conflicts related to regulatory requirements and program implementation.

Recommendation: Approve the Proposition 63 spring finance letters for DSS and DOR.

4140 Office of Statewide Health Planning and Development (OSHPD)

Vote-Only Issue 6: Logbook Redesign Project

Description: The department requests a spring finance letter for $223,000 from the Hospital Building Fund for planning and procurement activities related to the Logbook Redesign Project. Total project costs are estimated to be $11.2 million, including $7.6 million in one-time development costs, and $3.5 million in ongoing costs over the five-year project period. Project funding in future years is subject to Legislative appropriation.

Background:

- **Current System:** The Logbook Database System is currently used by the OSHPD Facilities Development Division to track hospital and skilled nursing facility construction projects through the plan review and construction phases. This database also supports the tracking of facility compliance with seismic retrofit projects and facilitates emergency operations in the event of a natural disaster.

  The department indicates that the current Logbook is unstable and more prone to errors, especially when software (including operating system) on user PCs is upgraded to a newer version. Existing system maintenance and enhancements are extremely difficult. Without a redesigned Logbook, the department indicates it will risk losing or corrupting valuable historical data as well as more recent information.

- **Redesign Funding:** Costs to redesign the Logbook System would be financed from the Hospital Building Fund (HBF), a special revenue fund. Fees charged to health facilities for plan review and construction observation support the Hospital Building Fund.

Currently the rate for skilled nursing facilities is 1.5 percent of estimated construction costs and hospitals currently are charged a rate of 1.64 percent of estimated construction costs. The department indicates that the proposed new system would not result in a fee increase to the Hospital Building Fund.

Although an approved Feasibility Study Report (FSR) for this project has not yet been submitted to the Legislature, the Department of Finance (Finance) indicates that funding for procurement activities shall not be expended until Finance approves an FSR for this project.

Recommendation: Approve the spring finance letter for $223,000 from the Hospital Building Fund in 2005-06 for planning and procurement activities related to the Logbook Redesign Project, including Budget Bill Language to prevent expenditure of these funds until an FSR is approved by Finance.

4170 California Department of Aging (CDA)

Vote-Only Issue 7: Older Americans Act Funding

Description: The department requests a spring finance letter for $1,942,000 federal funds to reflect additional Older Americans Act funding awarded by the federal government. This funding will be allocated to local Area Agencies on Aging, which will use this funding to administer Congregate Nutrition, Home-Delivered Nutrition, Supportive Services and Senior Centers, Disease Prevention and Health Promotion, Family Caregiver Support, Ombudsman programs, and Elder Abuse Prevention.

Recommendation: Approve the spring finance letter.

Vote-Only Issue 8: Adult Day Health Care (ADHC) State Plan Amendment

Description: The department requests a spring finance letter for $400,000 to establish 3.0 limited-term positions that would transition the current Adult Day Health Care program to the structure required by the federal government to maintain federal Medicaid funding.

Background:

Adult Day Health Care (ADHC) is a licensed, community-based day care program that provides health, therapeutic, and social services to those at risk of being place in a nursing home. The ADHC is currently a Medi-Cal benefit funded by 50 percent General fund and 50 percent federal funds.

The department indicates that the federal Centers for Medicare and Medicaid Services (CMS) has determined that ADHC does not meet the requirements for a State Plan program under

California's current State Plan. According to the department, CMS has not yet provided a final decision about whether a State Plan Amendment (SPA) or Medicaid waiver will be required to maintain federal funding.

Although it is unknown when CMS will decide what changes are needed to maintain federal funding for the ADHC program, the department indicates that some type of change will be needed which will require additional CDA staff to restructure the ADHC program to ensure compliance with federal requirements. The department also indicates that workload associated with negotiations with CMS is currently being absorbed by existing staff, but that administration and oversight of other CDA programs has been reduced to absorb these activities.

Recommendation: Amend the spring finance letter to establish 1.0 position effective July 1, 2005 to reflect current workload to negotiate with CMS, and adopt Budget Bill language that permits the establishment of the remaining 2.0 positions upon written notification from CMS of the state plan or waiver structure needed to receive federal funding for the ADHC program. The Budget Bill language would read as follows:

> Of the amount available for expenditure in this item, $267,000 for 2.0 positions for the Adult Day Health Care (ADHC) Program shall not be expended until the federal Centers for Medicare and Medicaid Services (CMS) specifies the requirements to maintain federal financial participation for the ADHC as a Medicaid program. These 2.0 positions shall not be established until the Department of Finance has approved the workload necessary to comply with requirements set forth by the CMS.

Discussion Agenda

4700 Department of Community Services and Development (DCSD)

DCSD Issue 1: Naturalization Services Program Elimination

Description: The Governor's Budget proposes to eliminate the Naturalization Services Program (NSP), currently budgeted at $1.5 million General Fund. This program assists legal permanent residents obtain citizenship. The Urban Institute estimates that approximately 2.7 million Californians are eligible for but have not applied for citizenship.

Background:

NSP Program Information: The NSP assists legal permanent residents obtain citizenship. This program funds local organizations that conduct outreach, intake and assessment, citizenship application assistance, citizenship testing and interview preparation. In 2005 the program is expected to assist an average of 12,000 individuals in the completion of citizenship applications. The program spends an average of $166 per client. Total funding for the program in 2004-05 was $1.5 million General Fund. Positive outcomes as a result of NSP and citizenship include improved employment opportunities for citizens, and reduced caseload for state-only programs such as the Cash Assistance Program for Immigrants (CAPI), as citizens may quality for the federally-funded Supplemental Security Income (SSP) program.

Catholic Charities of California provides this additional information about NSP:

- Since the first $2 million budget appropriation for NSP in 1996, the State has committed more than $25 million to the program through the annual budget bill process. Over 90,000 citizenship-eligible residents have been served by the resulting provider network.

- This funding represents "seed money" to the many non-profit community-based organizations throughout the State as they assist citizenship-eligible Californians in the completion of their naturalization applications. These non-profits, in turn, enlist the financial and logistical support and volunteer services of local governments, businesses, community groups, labor unions, and others.

- This funding also complements public and private contributions in support of "one-day one-place" Naturalization Fairs that have assisted more than 100,000 immigrants complete citizenship applications, provide fingerprints, and deliver the completed application with the necessary fees to an on-site INS official. The fairs, conducted throughout the State and supervised by the US Citizenship Action Network brought together county and city governments, community colleges, the private sector, volunteers, and the Immigration and Naturalization Service.

- As a result, the net effect of State funding has been multi-faceted:
    - The cost-per-new citizen was minimized,

- The state "seed money" enabled local agencies and community based organizations to seek and acquire federal and private funds and donations,
- These same organizations established public-private partnerships for a civic good,
- Naturalization assistance programs continued to generate and sustain high levels of volunteerism, and
- Communities experienced social stabilization as individuals, local, State, Federal agencies and community-based organizations worked together to assist citizenship-eligible residents and their extended families in the naturalization process.

Related Programs in Department of Education: The Administration indicates the California Department of Education (CDE) budget includes approximately $660 million in 2004-05 for Adult Education programs that, among other things, authorize naturalization services. Specifically, the CDE indicates current year funding for English Literacy and Civics (EL Civics) Education (which includes Citizenship Preparation Education (CPE)) is approximately $18 million, Federal English as a Second Language (ESL) (which includes ESL-Citizenship) is approximately $42 million, and Adult Secondary Education (of which State ESL-Citizenship is a part) is approximately $600 million. According to the Administration, at this time data detailing spending specifically attributable to naturalization services, as well as the number of immigrants who have completed citizenship applications as a result of these programs, is unavailable. For example, an ESL class may have ten students, but only three may be in the process of becoming naturalized citizens.

However, according to information on the CDE website, enrollment in Adult Education ESL Citizenship classes was less than 5,200 in 2002-03. In addition, Adult Education funding is used for a wide variety of other programs, including High School/GED, vocational education, programs for older adults or adults with disabilities.

Nonetheless, in addition to traditional classroom activities, the CDE indicates the following activities are authorized under this funding:

- Activities that support outreach and recruitment of legal permanent residents who are eligible for citizenship.
- Preparation and assistance activities necessary to successfully complete the naturalization application and interview process.
- Child care and transportation for participants in CPE activities.

The CDE indicates that in addition to being authorized, these activities are encouraged and are taking place statewide at community colleges, adult education centers, faith and community-based organizations (CBOs), and various non-profit entities.

Advocates indicate that NSP is better aligned with the communities it serves than the CDE-sponsored programs. NSP has deeper roots in the communities and immigrants tend to trust their local CBOs as opposed to an adult education center. NSP also differs from the CDE programs because it allows for more services to be provided than just civics classes. NSP allows outreach, application assistance, referrals to classes and in some cases legal assistance.

Questions:

1. DCSD/DOF, please present the proposal to eliminate the Naturalization Services Program.

Recommendation: Reject proposed elimination of the NSP and restore $1.5 million General Fund for this program.

5180 Department of Social Services (DSS)

DSS Issue 1: Community Care Licensing – Eliminate Statutory Trigger to Increase Staffing

Description: The 2003 Budget Act reduced the frequency of Community Care Licensing (CCL) annual visits, but also included a statutory trigger to increase the number of annual visits if the number of annual citations exceed the previous year's total by 10 percent or more. The Governor's Budget proposes to eliminate this trigger, for potential savings of $2.6 million ($2.2 million General Fund). Although the total number of citations are estimated to increase by 9.5 percent in the current year (which is less than the 10 percent trigger), the department estimates that it will only complete 84 percent of the annual and random visits required in the current year.

Background:

- **CCL Responsibilities:** CCL is responsible for licensing adoption agencies, foster care agencies and homes, childcare homes and centers and residential care facilities for disabled and elderly adults. As part of its licensing function, CCL conducts pre- and post- licensing site visits, and visits facilities when conducting investigations regarding incident reports and complaints. Historically, CCL was required to make annual visits to licensed foster family agencies, group homes, residential care facilities for persons with disabilities and elderly individuals, foster family homes, and childcare centers, and to visit childcare homes triennially.

- **CCL Budget Reductions:** Budget reductions sustained by CCL during the 1990s significantly reduced the length and thoroughness of the required annual inspections. According to the department, annual inspections had become procedural in nature and focus. The visits were virtually announced as the department solicited information necessary to conduct the visit in the month preceding the inspection.

  Upon additional budget reductions, the department established priorities among its statutorily required activities. It prioritized the investigation of serious incident reports within the required 24-hour period. It also prioritized conducting site visits for complaint investigations within the required 10-day period. Annual or triennial visits became a lower priority. A

recent workload analysis of the CCL conducted by an independent entity confirmed that department resources were insufficient to meet statutory requirements.

- **Budget Act of 2003 Changed CCL Requirements:** As a result of the imbalance between available resources and required activities, the department proposed and the Legislature adopted significant changes to the existing licensing methodology. Specifically, the Budget Act of 2003 and its implementing legislation eliminated the required annual or triennial visits and instead required the department to visit annually the following facilities:

  - Facilities owned or operated by a licensee on probation or against whom an accusation is pending;
  - Facilities subject to a plan of compliance requiring an annual inspection;
  - Facilities subject to an order to remove a person from a facility;
  - Facilities that require an annual visit as a condition of federal financial participation such as facilities serving adults with developmental disabilities.

  All other facilities are subject to an annual inspection based on a 10 percent random sampling method, with each facility visited at least once every five years. The 2003 Budget Act changes also included an escalator clause to trigger annual visits for an additional 10 percent of facilities if citations increase by 10 percent or more.

- **Recent Data Show Mixed Results:** Although the total number of citations are estimated to increase by 9.5 percent in the current year (which is less than the 10 percent trigger), the department estimates that it will only complete 84 percent of the annual and random visits required in the current year. It is unclear whether these 2,400 additional visits would have resulted in enough additional citations to exceed the 10 percent trigger.

Figure 1: Citations Issued by DSS Community Care Licensing

	2002-03	2003-04	2004-05*	Increase from 2003-04 to 2004-05
Total Type A	28,905	25,524	27,860	9.2%
Total Type B	24,083	16,200	18,088	11.7%
Total All Citations	**53,382**	**42,060**	**46,036**	**9.5%**

* Estimated

Figure 1 above shows that the total number of citations in 2004-05 is estimated to increase by 9.5 percent above the number of citations in 2003-04. The department is currently in the process of estimating the number of citations by program type (Senior Care, Children's Residential, Child Care, and Adult Care).

The overall number of citations may be affected by a variety of factors, including the overall quality of care provided in the state, the number of CCL visits made, the number of complaints, the number and type of facilities, and the number of residents or clients.

The number of deaths not due to natural causes provides another measure for the quality of care in these facilities, although this measure does not reflect the amount of abuse or neglect

that is not severe enough to result in death. As shown in Figure 2 below, the number of deaths increased in 2003-04, but decreased in 2004-05.

Figure 2: Deaths in Community Care Facilities Not Due to Natural Causes

Facility Type	2002-03	2003-04	2004-05*
Child Care (any)	19	23	22
Residential Care (Suspicious)	111	118	101
Total	**130**	**141**	**123**

* Estimated

The department estimates that it will complete 12,256, or 84 percent, of the 14,633 annual and random visits required by statute in the current year. The department indicates that it has not completed the required visits due to CCL staff vacancies, although when these positions are filled the department indicates it will have the resources necessary to meet the 10 percent requirement.

- **Current Improvement Efforts:** The department indicates there has been substantial improvement in the last few months in meeting mandates for visits. Furthermore, additional aggressive efforts are underway to identify and implement efficiencies and focus existing resources on monitoring and oversight responsibilities. The department indicates that it will complete these activities and then re-evaluate the impact they have on their ability to meet mandates for visits within existing resources.

  Examples of activities underway include:
  - An aggressive hiring campaign to fill longstanding vacancies as a result of hiring freezes and salary savings.
  - A new entry level licensing program analyst exam slated for May 2005, with a list available from which to hire beginning in August. This exam has not been given in over 15 years and will generate a fresh pool of potential employees.
  - Efficiencies in automation have begun, so that duplicate entry of visit information will no longer be required of field staff, thus freeing up time for more visits.

- **Cost of Funding the Trigger for 10 Percent Increase in Visits:** The department estimates that increasing the random sample to 20 percent of all facilities not otherwise subject to a visit would result in costs of $2.6 million ($2.2 million General Fund) and 27.5 positions in 2005-06.

  However, this estimate assumes that the increase in the random sample would apply to all facility types and programs. The department indicates that it interprets the current trigger statute to require a 10 percent increase in visits only if the total number of citations across all facility types and programs increases by 10 percent. The department is currently sorting citations by program, and expects to have that information available shortly. Should the number of citations for a particular program, such as Child Care or Senior Care, increase by 10 percent, the Subcommittee may wish to increase the number of random visits for that program.

Questions:

1. DSS, please describe the current efforts underway to improve and fully staff the CCL program.

2. DSS, please present the Governor's Budget proposal to eliminate the statutory trigger to increase staffing if citations increase by 10 percent.

3. DSS, is information available yet on citations for each program (Senior Care, Children's Residential, Child Care, and Adult Care)?

Recommendation: Reject proposed trailer bill language to eliminate the licensing visit increase trigger, and request that the department provide the number of citations by program to determine if additional staffing should be provided for a particular program.

DSS Issue 2: Agency Report on Background Check Efficiency – Information Only

Description: The 2004 Budget Act trailer bill (SB 1104) required the HHS Agency to report to the Legislature this spring on ways to make the criminal background check processes administered by various HHS departments more efficient.

Background:

The Department of Social Services Community Care Licensing Division (CCL) is responsible for licensing adoption agencies, foster care agencies and homes, childcare homes and centers and residential care facilities for disabled and elderly adults. As part of its licensing function, CCL must ensure that persons licensed to operate these facilities, provide care to facility clients, or reside at the facility location, receive a comprehensive criminal background check.

Due to an increase in criminal background check workload, last year the 2004-05 Governor's Budget proposed and the Legislature approved $4.6 million for 58.2 additional DSS positions (including 18.5 in CCL). The Legislature also approved a spring finance letter for $334,000 for an interagency agreement with the Department of Justice to support conviction information processing efficiencies.

Although the Legislature approved the additional resources described above, the Legislature also adopted trailer bill language that required the HHS Agency to report to the Legislature during 2005 budget hearings on ways to streamline the criminal background check process.

Several departments within the Health and Human Services Agency are responsible for licensing, including background checks, for individuals and organizations that provide care to children and elderly or disabled adults. The various departments operate according to different statutory requirements, evidentiary standards, and licensing criteria. The state's decentralized licensing system may lead to unnecessary duplication and inconsistency across programs.

California may benefit from examining its licensing system and developing reforms that reduce duplication and increase standardization in licensing functions, including conducting criminal background checks. The issue of duplicate licensing functions was also raised by the Governor's California Performance Review report in August 2004.

The language adopted in the 2004 trailer bill is the following:

> SEC. 62. (a) To the extent feasible, the California Health and Human Services Agency shall examine the criminal background check requirements for all programs within its purview and the processes to administer and enforce these requirements, and shall report its findings to the Legislature at budget hearings. The agency's report shall include all of the following:
>
> (1) The health and human services programs that require the state to conduct criminal background checks.
> (2) The standards, including evidentiary standards, that govern the background checks.
> (3) The major activities necessary to complete investigations.
> (4) The departments or contracting agencies that perform these activities.
> (5) The costs associated with providing criminal background checks.
>
> (b) The agency shall report on strategies to streamline and standardize criminal background check requirements and their processing, to create administrative efficiency. The agency's analysis shall include a review of programmatic and safety issues associated with streamlining the background check process.

Questions:

1. HHS Agency, please present the requested report.

DSS Issue 3: Community Care Licensing – Fee-Exempt LiveScan – Information Only

Description: Current statute would exempt certain small child care home providers and foster family homes from paying a $40 fee for their fingerprinting and criminal record checks, effective July 1, 2005. This exemption was suspended in 2003-04 and 2004-05, and the Governor's Budget proposes trailer bill language to permanently eliminate the fingerprint fee exemption, which would result in annual General Fund savings of $1.5 million.

Background: California requires persons working or volunteering at community care facilities and family day care facilities to be fingerprinted and have criminal background checks. Generally, licensees are required to pay for the fingerprinting process, although certain providers have been historically exempted or partially exempted from the required fees. These exemptions include providers in any small home that serves 6 or fewer children, including family day care

homes, certified family homes, or foster family homes. The fees that have been exempted include a $16 LiveScan fee and a $24 FBI fee, for a total of $40 per applicant.

In 2003-04 and 2004-05 the Legislature suspended this exemption, and those providers were required to pay fees of $40 for their fingerprinting and background checks.

Questions:

1. DSS, please briefly describe the existing fingerprint fee exemptions, who benefits from the exemption, and how the proposal would affect provider participation in the foster care and child care programs.

DSS Issue 4: CalWORKs Performance Monitoring Proposal – Information Only

Description: The Governor's Budget requests $794,000 for 8.0 positions to develop a system to monitor and improve the measurement of county CalWORKs performance. This proposal includes collecting and validating county work participation data to ensure that the department has accurate data about the participation of CalWORKs recipients in Welfare-to-Work activities throughout the state.

Background: The department indicates that this proposal would allow the state to focus on counties where performance is in need of improvement, and will provide information to help the state meet federal work participation requirements and avoid potential penalties under TANF reauthorization proposals. The department also indicates that this data will allow the state to accurately pass on federal penalties to the counties.

Questions:

1. DSS, please briefly describe the budget proposal.

DSS Issue 5: Interstate Compact on the Placement of Children (ICPC) – Information Only

Description: As a member of the Interstate Compact on the Placement of Children (ICPC), DSS is designated as the entity in all counties (except Alameda, Los Angeles and San Diego) to forward the request from the parent for a child to move to another state for the purpose of adoption. The DSS is not a party to the adoption, but acts in accordance with the requirements of the ICPC to prepare the appropriate documents for the receiving state to approve movement of the child to that state. According to the Yolo County District Attorney's Office, a child was moved to Alabama via an independent adoption process under the ICPC without notification of the child's father. Although the DSS cannot comment on the specific case, the Subcommittee has requested that the department explain its role in such cases.

Background:

California is a member of the Interstate Compact on the Placement of Children (ICPC), which is a binding agreement signed by all states to allow children to safely move between states for the purposes of foster care or adoption. In California, the ICPC is codified at Family Code Section 7900 et seq.

Direct placement by the birth parent to the adoptive parent, is known in California as an Independent Adoption.

As a member of the ICPC, DSS is designated as the entity in all counties (except Alameda, Los Angeles and San Diego) to forward the request from the parent for a child to move to another state for the purpose of adoption. The DSS is not a party to the adoption, but acts in accordance with the requirements of the ICPC to prepare the appropriate documents for the receiving state to approve movement of the child to that state.

DSS staff are required to prepare a package to send to the receiving state that includes:

- placement request signed by one legal parent,
- family history--including but not limited to: composition of the family, marital status of parents, psychosocial history of parents, reason for placement in another state and medical information of the child,
- statement of birth parent that confirms the plan for adoption and meets the requirements regarding personal knowledge of the prospective adoptive parents
- statement of financial and medical care needs of the child pending adoption,
- authorization for the adoptive parents to secure medical treatment of the child pending adoption.

Normally all of the above information is provided to the DSS by the parent's attorney (it is possible for a parent to provide the information but it rarely occurs). Based on the representations of the attorney, the DSS determines completeness and then forwards to the receiving state.

The receiving State ICPC administrator reviews the request, asks for any additional documentation that may be required by that state, approves the request and informs the DSS that the request is approved.

The DSS informs the parent's attorney that the request is approved and the child is then permitted to travel to the receiving state. Once the child is in the new state the parent's attorney informs the DSS.

Questions:

1. What is the role of DSS in Independent Adoptions?

4170 California Department of Aging (CDA)

CDA Issue 1: Medicare Part D and the Health Insurance Counseling and Advocacy Program (HICAP) – Information Only

Description: Beginning in November 2005, approximately 4.1 million California Medicare beneficiaries will make enrollment decisions for Medicare Part D prescription drug benefits. As a result, demand for local Health Insurance Counseling and Advocacy Program (HICAP) services is expected to dramatically increase. The department has submitted a spring finance letter to reflect $1.8 million in additional federal funds for local HICAP organizations to expand Part D education and outreach, as well as 3.0 additional CDA positions.

Background:

- **Medicare Modernization Act (MMA) Enrollment in Late 2005:** The MMA created a new Part D prescription drug benefit for Medicare beneficiaries. The initial enrollment period will run from November 15, 2005 through May 15, 2006 for most beneficiaries, but only from November 15, 2005 through December 31, 2005 for beneficiaries eligible for both Medicare and Medi-Cal (dual eligibles). Over 4.1 million Californians, including 1.7 million dual eligibles, may enroll in Medicare Part D.

- **Health Insurance Counseling and Advocacy Program (HICAP):** HICAP is a volunteer-supported program that provides consumers with information about Medicare, related health care coverage, and long-term care insurance. In 2004, HICAP had over 800 counselors, who fielded 90,000 consumer phone calls, 40,000 of which resulted in insurance counseling appointments. This figure is expected to increase substantially in the last few months of 2005 when 4.1 million Californians receive MMA enrollment information.

- **2005-06 CDA Position Requests:** The Governor's Budget proposes to use $93,000 in existing federal funds to establish 1.0 permanent position to develop training and program standards for the HICAP. A spring finance letter requests $283,000 for 3.0 additional CDA positions in 2005-06 for additional workload associated with MMA, including oversight and coordination of HICAP efforts, implementation of data performance and outcomes measures, analysis of federal MMA regulations, and maintaining HICAP counselor handbooks and program operations manuals. CDA currently has 1.8 positions to support the HICAP program, aside from the 4.0 requested positions.

- **HICAP Program Funding:** The spring finance letter also reflects $1.8 million in additional local assistance federal funds for MMA outreach, which would increase total local assistance funding for HICAP to $7.8 million in 2005-06. Local assistance funding for HICAP in 2004-05 is $6.8 million.

- **Follow-up from March 10th Subcommittee Hearing:** In response to Subcommittee concerns raised at the March 10th hearing, the department now indicates additional planning and outreach activities are occurring at the federal, state, and local level. Some of these activities are joint efforts between government and non-profit organizations.

    - Ongoing coordination meetings are occurring with all of the affected departments.
    - The process for providing HICAP funding to local Area Agencies on Aging (AAAs) has been streamlined.
    - Prototype educational materials have been developed.
    - HICAP trainings and education seminars have been scheduled.

Questions:

1. CDA, please provide an update on current efforts to prepare for implementation of MMA.

2. CDA, how will additional HICAP volunteers be recruited? How many will be needed?

CDA Issue 2: Agency/CDA report on IHSS and AAA coordination – Information Only

Description: The 2004 Budget Act trailer bill, SB 1004, required the Health and Human Services Agency to report during 2005 budget hearings on strategies to coordinate state and federal services for the elderly, including In-Home Supportive Services, programs under the federal Older Americans Act, and the California Department of Aging's Community-based Services programs.

Background: 2004 Budget Act trailer bill language includes the following:

> SEC.63. To the extent feasible, the California Health and Human Services Agency, in consultation with the California Department of Aging, the State Department of Social Services, and appropriate stakeholders, shall consider strategies to coordinate state and federally funded services, including In-Home Supportive Services, programs under the federal Older Americans Act, and the California Department of Aging's Community-based Services programs, in order to maximize cost-effectiveness and programmatic efficiency in the delivery of services to program consumers. The agency shall report during budget hearings for the 2005-06 fiscal year, regarding these strategies and the resulting programmatic effect.

Questions:

1. HHS Agency/CDA, please present the requested report.

Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda
Health & Human Services

Chair, Senator Denise Ducheny

Senator George Runner
Senator Tom Torlakson

May 9, 2005

2:00 PM

Room 3191

Agenda

(Diane Van Maren & Anastasia Dodson)

Item	Department
4200	**Department of Drug and Alcohol—*Vote Only Issue***
0530	**Health and Human Services Agency—*Over Due Reports***
4280	**Managed Risk Medical Insurance Board—*Selected Issues***
4260	**Department of Health Services—*Selected Issues***
4440	**Department of Mental Health—*Capital Outlay Issues***

PLEASE NOTE: Only those items contained in this agenda will be discussed at this hearing. Additional issues regarding these departments will also be discussed at the Governor's May Revision hearings. *Please* see the Senate File for dates and times of these hearings.

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

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

RECOMMENDED FOR VOTE ONLY

A. 4200 Department of Alcohol and Drug Programs (DADP)

1. Proposition 63 Positions

Issue: To reflect the activities required by Proposition 63, the Mental Health Services Act, which became effective January 1, 2005, the Administration request a spring finance letter to establish 2.0 three-year limited term positions for the Department of Alcohol and Drug Programs (DADP). These positions would be funded by the new state Mental Health Services Fund established by Proposition 63.

Background: Proposition 63, the Mental Health Services Act (Act), which became effective January 1, 2005, established a state personal income tax surcharge of one percent on taxpayers with an annual taxable income of more than $1.0 million. The funds from this surcharge are deposited into the new state Mental Health Services Fund, and will be used for state and county planning and implementation consistent with the Act's provisions. The Act provides for the expansion of mental health services and incomes specific provisions related to education and training of the mental health workforce, development of innovative program and integrated plans for prevention, intervention and system of care services, investment in capital facilities and technology needs, and enhanced oversight and accountability.

The estimated revenues in the Fund total $254 million in 2004-05 and $683 million 2005-06. While most of the revenue will be available to county mental health programs, the Act authorizes up to 5 percent of the revenue in the Fund annually for state administration. Funding for state administration is projected to be $12.7 million in 2004-05 and $34.2 million 2005-06.

The requested DADP positions would be used to provide assistance to counties in the planning, implementation, and evaluation of co-occurring mental health and alcohol and other drug programs. This augmentation would enable the DADP to build upon existing collaborative efforts with the Department of Mental Health to provide statewide leadership and coordination of local efforts to implement services for those with co-occurring disorders.

Although the Administration requests 2.0 three-year limited-term positions for the DADP, the LAO notes that current statute only allows for the establishment of two-year limited-term positions. Therefore the LAO recommends that the DADP positions be established as two-year positions.

The Subcommittee previously heard requests for Proposition 63 positions from the Department of Mental Health, the Department of Health Services, the Department of Education, the Department of Rehabilitation, and the Department of Social Services.

Subcommittee Staff Recommendation: Approve the requested positions, but reflect authority for two-year limited term positions, rather than three-year positions.

ITEMS FOR DISCUSSION

A. CA Health & Human Services Agency—*Over Due Reports (See Hand Out)*

Issue: The Administration has several reports due to the Legislature which are late. Discussions regarding some of these reports have occurred through out the Subcommittee process.

During these discussions, it was unclear as to **(1)** how reports are tracked by the Administration, and **(2)** when each report will be provided to the Legislature as required by statute, Budget Bill Language or Supplemental Reporting Language. As such, the CA Health & Human Services Agency (CHHS Agency) has been requested provide an update to the Subcommittee as to their status.

The CHHS Agency has provided the Subcommittee with a list of the reports and is prepared to provide a status update.

Questions:

1. CHHS Agency, Please provide a summary of the list and the intent of the Administration to provide the reports to the Legislature.

B. Managed Risk Medical Insurance Board

1. Managed Risk Medical Insurance Program (MRMIP)

Issue: Through discussions with the MRMIB, it has been found that the MRMIP has a sizable reserve—about $20.2 million (Proposition 99 Funds)--, primarily due to a one-time settlement with certain health plans. According to the MRMIB, only $2 million is needed in order to maintain a prudent reserve. As such, about $18.2 million (Proposition 99 Funds) in *one-time only* funding is available for expenditure. The Governor's budget did not identify this large reserve for any expenditure.

According to the MRMIB, the growth in the fund balance for the MRMIP is primarily attributable to *prior year* claims. As a new program serving people who had been denied health care coverage because of their high risk, there was a concern from the plans that they would incur high loss-ratios for the MRMIP participants. Since the reconciliation of actual cost data would take several years to complete, the monthly payments to the plans were based on negotiated loss-ratios.

A reconciliation of claims data was completed for years 1991-2002 and it was determined that some plans had actual loss-ratios that were lower than anticipated. Therefore, the MRMIB was able to recoup these *over-payments to MRMIP participating plans* and subsequently changed the methodology for the payments. Thus a large recoupment of this type should not be repeated.

It should be noted that existing statute (1) requires a reserve which is "sufficient to prudently operate the program", and (2) enables any excess moneys remaining in the fund at the end of any fiscal year to be carried forward to the next succeeding fiscal year.

The Governor's budget proposes expenditures of $ 40 million (Proposition 99 Funds) for the MRMIP which is the amount at which it has been funded for many years. The $20.2 million reserve is above this amount.

No General Fund money is utilized in the MRMIP and the program is not authorized to access General Fund support. The MRMIP has always been required to operate within the $40 million annual appropriation.

Background—Description of the Managed Risk Medical Insurance Program: The Managed Risk Medical Insurance Program (MRMIP) provides comprehensive health insurance coverage for individuals who are generally unable to obtain coverage in the individual insurance market or are able to obtain insurance only at a very high cost. Typically these individuals are considered by insurers to be high-risk since they have had a pre-existing condition that was diagnosed or treated by a doctor prior to the individual's enrollment in health insurance. While other state programs directly purchase health insurance coverage for individuals, MRMIP reimburses insurers when individuals incur high medical costs that exceed the regular health coverage provided to them by that insurer.

Background—Description of the Steven M. Thompson Physician Corps Loan Repayment Program: The Steven M. Thompson Physician Corps Loan Repayment Program, operated by the Medical Board of California, is used to repay student loans for physicians and surgeons practicing in medically underserved communities.

Existing law creates the Medically Underserved Account for the purposes of the program. The fund consists of private donations and transfers from the Contingent Fund of the Medical Board which is supported by fees. The total amount of the transfers from the Contingent Fund to the Medically Underserved Account is $3.450 million ($1.150 million annually for three consecutive years which began in 2003). As such, the last transfer occurs in 2005-06.

Background—Description of the Rural Demonstration Projects in the HFP: The Rural Demonstration Projects within the Healthy Families Program (HFP) have been operational since the inception of the HFP. These projects have used different strategies, contingent on the rural area's needs, for addressing barriers faced by residents of rural areas in receiving health care. Examples have included (1) purchasing dental equipment; (2) improving patient tracking systems; (3) extending clinic hours during certain seasons; (4) establishing telemedicine capabilities; and (5) improving coordination with local drug and alcohol providers.

The Governor's budget proposes funds of $2.8 million ($991,000 Proposition 99 Funds and $1.8 federal S-CHIP Funds) for the Rural Demonstration Projects. As noted, the state currently obtains a 65 percent federal match for these projects. Proposition 99 Funds are used by this program to draw a federal match as provided in legislation adopted as part of the Budget Act of 2003 (i.e., AB 1763, Statutes of 2003).

Legislative Analyst's Office Recommendation: The LAO recommends the following:

(1) Maintain a $2 million (Proposition 99 Funds) reserve for the MRMIP;
(2) Repeal existing statute that provides for a reserve specifically for the MRMIP;
(3) Repeal existing statute that enables the MRMIP to carry forward any excess moneys remaining in the fund at the end of any fiscal year to the next succeeding fiscal year; and
(4) Appropriate the remaining $18.2 million (Proposition 99 Funds) from the MRMIP reserve to either support other Proposition 99-Funded programs *or* to backfill for General Fund support for activities that are consistent with the specified uses of Proposition 99.

The LAO recommends elimination of the reserve requirement because Proposition 99 Fund accounts maintain a separate reserve which can be accessed when necessary. Therefore, a special MRMIP reserve is not necessary.

Subcommittee Staff Comment and Recommendation: First, Subcommittee staff concurs with the MRMIB and LAO to provide for a prudent reserve of $2 million (Proposition 99 Funds) for the MRMIP for 2005-06.

Second, it is also recommended to concur with the LAO to repeal existing statute regarding the MRMIP to maintain a special reserve for the program. However, based on recent conversations with the MRMIB, it is recommended to *not* repeal existing statute that enables the MRMIP to carry forward a reserve to future fiscal years (i.e., not implement item (3) in the LAO recommendation list, above).

The MRMIB notes that a $2 million (Proposition 99 Funds) reserve would not accumulate from year to year if the carry forward language is maintained because the existing transfer authority (i.e., the transfer of Proposition 99 Funds to the MRMIP Fund) only occurs when funds are needed (up to the $40 million maximum) to support caseload. As such, if a $2 million reserve is provided for 2005-06, this level of reserve would not be increased in future fiscal years due to the carry forward language.

Third, it is recommended to provide $3 million (Proposition 99 Funds) to the Steven M. Thompson Physician Corps Loan Repayment program by transferring these funds to the Medically Underserved Account within the Medical Board of California where they can be continuously appropriated and used for the program until fully expended.

Fourth, it is recommended to provide an *increase* of $5.7 million ($2 million Proposition 99 Funds and $3.7 million federal S-CHIP Funds) to the Rural Demonstration Program. Appropriating $2 million of these one-time only Proposition 99 Funds would be a good use of one-time only funding.

Fifth, it is recommended to use the remaining $13.2 million (Proposition 99 Funds) to backfill for General Fund support in the California Children's Services (CCS) Program. The intent of this action would be to serve as a one-time only offset to General Fund support for 2005-06, and not as an on-going source of funding for the CCS Program.

The following summarizes the fiscal component of the Subcommittee staff recommendation:

• MRMIP reserve available	=$20.2 million
• Maintain a $2 million reserve	=$ 2 million
• **Amount Available for Expenditure**	**=$18.2 million**
• Transfer $3 million to the Steven M. Thompson Physician Corps Loan Repayment program	=$3million
• Appropriate $5.7 million ($2 million Proposition 99 Funds) to Rural Demonstration Projects.	=$2 million
• Shift $13.2 million (Proposition 99 Funds) in one-time only funds to the CCS Program to backfill for General Fund support for 2005-06 only.	=$13.2 million

Further, it is also recommended to adopt Budget Bill Language for Item 4260-111-0001 (i.e., DHS item that governs the CCS Program funding) to reflect the Legislature's intent regarding the $13.2 million backfill. The proposed language is as follows:

> Of the amount appropriated in this item for the California Children's Services (CCS) Program, $13.2 million in Cigarette and Tobacco Product Surtax Fund moneys shall be used on a one-time only basis to support the program. It is the intent of the Legislature to fully support and fund the CCS Program in subsequent fiscal years.

Questions:

1. LAO, Please provide a summary of the key components of the $20.2 million reserve, including your recommendation to eliminate two pieces of state statute.
2. MRMIB, Please provide your perspective.

C. Department of Health Services

1. Medi-Cal to Healthy Families Accelerated Enrollment by Counties

Issue: In the **Subcommittee hearing of April 4th** during discussions regarding the "bridge" between Medi-Cal and the HFP, an issue was raised regarding the temporary enrollment of children into Medi-Cal pending their HFP eligibility. **In the April 25th Subcommittee hearing** this issue was discussed more comprehensively and it was requested for the Administration to provide technical assistance regarding a fiscal analysis.

Specifically, County Welfare Departments encounter children who are either not eligible for Medi-Cal or would have a high share-of-cost in Medi-Cal but would most likely be eligible for enrollment into the HFP. However presently the counties cannot enroll these children into the HFP because they do not have the authority to do so. Therefore, these children often have to wait, uninsured, for 4 to 8 weeks for a formal eligibility determination by the HFP.

It has been suggested to create a Medi-Cal to HFP accelerated enrollment program which would authorize counties to temporarily enroll children into the **no-cost** Medi-Cal Program if a county deems that they are eligible for the HFP. The temporary enrollment would only be for the period during which the HFP is conducting the formal determination of the child's eligibility for that program (not more than 60-days).

Under such an accelerated program, the state could receive the S-CHIP federal matching rate of 65 percent, versus the Medi-Cal federal matching rate of 50 percent. Temporary enrollment into Medi-Cal would enable the child to receive immediate necessary services.

This issue has been discussed previously in legislation during the 2003-04 Session (i.e., SB 142, Alpert, as amended March 24, 2003). This legislation was discussed in both the Senate Health and Human Services Committee, as well as Senate Insurance and Senate Appropriations. Though the bill was moving it eventually was amended and used for another purpose.

A substantial effort has been made by the Legislature to create a seamless system of health care coverage, whereby individuals can move easily between Medi-Cal and the HFP without losing coverage for any period of time. A Medi-Cal to HFP accelerated enrollment would fill-in a present gap in services.

The following assumptions are made regarding this proposal:

Criteria for the Child to Meet for Enrollment

- The child or parent or guardian has submitted a Medi-Cal application directly to the county;
- The child is newly eligible for full-scope Medi-Cal services and has been determined to have a share-of-cost;
- The child is under 19 years of age and has a family income at or below 250 percent of the federal poverty level; and
- The child or parent or guardian has given consent for the application to be forwarded to the Healthy Families Program.

60-Day Health Benefits (Temporary Health Care)

- Federal S-CHIP Funds (65 percent federal match) would be available for this purpose;
- Temporary health benefits would be effective on the first of the month in which the county found that a child met the specified criteria. The temporary health benefits would terminate at the end of the month in which the child was discontinued from the Medi-Cal Eligibility Data System (MEDS) due to the full enrollment in or ineligibility for Healthy Families Program; and
- Temporary health benefits would be identical to the benefits provided to children who received full-scope Medi-Cal benefits without a share-of-cost.

Based on technical assistance obtained from the DHS Fiscal Forecasting Office, it is assumed that 87,456 children would be eligible for 60-days worth of health care coverage in Medi-Cal fee-for-service, pending their application approval at the HFP. This assumes a January 1, 2006 implementation date. Estimated expenditures for 2005-06 would be as follows:

- **Total for administration and health care benefits** =$3.4 million ($1.2 million GF)
  - Health care benefits component =$3.0 million ($1.1 million GF)
  - County administration =$366,000 ($128,000 GF)

- ***Annualized* expenditures** are estimated to be $10.2 million ($3.6 million GF)

Subcommittee Staff Comment and Recommendation: A substantial effort has been made by the Legislature to create a seamless system of health care coverage, whereby individuals can move easily between Medi-Cal and the HFP without losing coverage for any period of time. A Medi-Cal to HFP accelerated enrollment would fill-in a present gap in services. As noted previously by the MRMIB in the April 25th hearing in which they provided technical assistance to the Subcommittee, this proposal makes good policy sense. If the Subcommittee wants to implement this proposal, the following action is recommended:

- Increase the Medi-Cal Program by $3.4 million ($1.2 million General Fund) to reflect funding for health care benefits and eligibility administration; and
- Adopt place holder trailer bill legislation to implement the proposal, including to limit the benefit to 60-days, allowable only with federal S-CHIP funding being available

and other related technical aspects to be worked out with the DHS regarding Medi-Cal processing.

Questions:

1. MRMIB and DHS, From a technical assistance standpoint could you please comment on the proposal.

2. Governor Proposes to Capitate Adult Dental in Denti-Cal at $1,000

Issue: The Governor's January budget proposes to restrict the amount of dental services provided to adults to $1,000 in any twelve-month "rolling" period (versus a calendar-year) for proposed *net* savings of $48 million ($24.5 million General Fund) in 2005-06. This proposal requires trailer legislation to enact. An implementation date of August 1, 2005 is assumed.

It should be noted that the Administration's original savings level of $24.5 million General Fund as contained in the Governor's budget is being recalculated for May Revision and will decrease. This is because the DHS now believes it will be necessary to exempt dental services provided in nursing homes from the cap as well.

In addition, the DHS' original savings estimate will decrease even further because it did not take into consideration the proposals effect on individuals with developmental disabilities. According to the DDS, the DHS cap would affect about 1,680 Regional Center consumers at a cost of $1.160 million General Fund for 2005-06 (11 months). If services are not available through Medi-Cal, then the Regional Centers must purchase them using 100 percent General Fund support. The DDS notes that this estimate will be refined at the time of the May Revision.

It should also be noted that the Administration's cap would be retroactive back to January 1, 2005. In other words their proposal would commence as of August 1, 2005 and then look back to January 1, 2005 to total up the claims. Therefore, a Medi-Cal enrollee could have dental claims exceeding the $1,000 even though the law, if adopted, was effective only as of August 1, 2005. The DHS states that going retroactive is the only way to achieve savings in the budget year.

The Governor's proposed **net** savings in his January budget assumes the following:

- A reduction of $50.2 million ($25.1 million General Fund) in Medi-Cal dental services;
- An increase of $4 million ($1 million General Fund) for a tracking system; and
- An increase of $165,000 ($59,000 General Fund) to fund 1.5 new DHS positions (Information Systems Specialist and a half-time Staff Counsel).

The DHS states that the $1,000 limit would not apply to:

- Emergency dental services within the scope of covered dental benefits defined as a dental condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could result in serious impairment to bodily functions (such as a very severe infection, hemorrhage, or trauma related to a dental origin);
- Medical and surgical services provided by a dentist which, *if provided by a physician*, would be considered physician services, including complex maxillofacial surgical procedures and comprehensive oral reconstruction; and
- Services that are federally mandated under 42 Code of Federal Regulations, Part 440, including pregnancy-related services and services for other conditions that might complicate the pregnancy.

According to the DHS, about 900,000 adults enrolled in Medi-Cal actually access dental services annually. Of these individuals, about 95,000 Denti-Cal enrollees would be affected by the $1,000 limit. As noted in the table below, over 55 percent of these individuals, or 52,900 people, are aged, blind and/or disabled.

Table: Average Monthly Adult Eligibles Impacted by Proposed Cap

Type of Adult Eligible	Total Adult Eligibles	Eligibles Impacted by Cap
Aged, Blind, Disabled	1,447,500	52,900
All Other Adults (21-64 years)	1,552,000	42,000
Total	2,998,500 (about 900,000 access dental annually)	**94,900**

It should be noted that the Administration will still continue to use their existing "treatment authorization request" (TAR) process for the dental program. As such, TAR's will continue to be reviewed and adjudicated regardless of the 12-month rolling period.

The Administration assumes expenditures of $4 million ($1 million General Fund) in 2005-06 for the Denti-Cal fiscal intermediary to track each adult enrollee's dental usage. According to the DHS, system modifications are necessary to accumulate the total dollars spent by enrollee, to then edit the incoming claims for exclusions to the cap, and add a capability for providers to call in and "look-up" the balance available for each enrollee.

Participating Denti-Cal providers would need to access this tracking system to check on the usage status of each and every Denti-Cal patient. The DHS maintains that upon implementation of the proposed cap, dental providers would be able to check the enrollee's level of expenditures through a telephone voice response system. Within six-months, the DHS would include a web-based retrieval system.

According to the DHS, the proposed tracking system would operate as follows:

1. Claim is received by Medi-Cal fiscal intermediary (presently Delta Dental).
2. System checks to see if the billed service is excluded from the $1,000 cap.
3. If the service billed is excluded, the claim moves forward to adjudication.
4. If the service is not on the exclusion list, the system checks the prior 12-month paid claim history (back 12 months from the billed date of service).
5. If claim payment history shows that the dental cap will not be exceeded, the claim will move forward to adjudication.
6. If the cap is met, the claim will be denied.

Dental providers would be encouraged to check the tracking system prior to scheduling or providing any dental services to the enrollee. This is because providers will not be able to directly bill Medi-Cal enrollees that are above the $1,000 cap without a written agreement with the enrollee prior to rendering the service.

With respect to state support, the DHS is seeking an increase of $165,000 ($59,000 General Fund) to hire one Associate Information Systems Analyst and a half-time Staff Counsel to implement the proposal.

Finally, it should be noted that the Administration's proposed trailer bill language provides extremely broad authority to the DHS by enabling them to implement this proposal through all county letters, provider bulletins, or similar instructions. Thereafter, the DHS *may* adopt regulations.

Background—Overview of Existing Denti-Cal Program: Access to dental services for children under age 21 is required by federal law, whereas adult dental services are considered "optional". Generally, covered dental benefits for children and adults include: (1) diagnostic and preventive services such as examinations and cleanings, (2) restorative services such as fillings and (3) oral surgery services. Many services such as crowns, dentures and root canals require prior authorization.

State law requires most Medi-Cal enrollees to pay a co-payment for dental care. A $1 co-payment is required for services provided in a dental office and a $5 co-payment is required for non-emergency care provided in an emergency room. As directed by federal law, services cannot be denied to a recipient if a co-payment is not provided

It is well recognized that the reimbursement rates currently paid under Denti-Cal are very low—generally about 40 to 50 percent of the usual and customary fee charged by dentists in California. In addition, this program has implemented considerable cost containment measures over the past several years. All of these aspects would still be retained under the proposed cap.

Prior Subcommittee Hearings: In the Subcommittee's March 2nd hearing, numerous issues were raised regarding the Administration's dental capitation proposal. In the April 4th Subcommittee hearing, a detailed discussion was had regarding various options.

Subcommittee Staff Comment and Recommendation: The Administration seeks to implement a $1,000 cap (retroactively) in Denti-Cal in an effort to align benefits more closely to the commercial market place. However, Denti-Cal is quite dissimilar to the commercial market place. It serves more medically needy individuals than the commercial market, reimburses at rates which are generally 40 to 50 percent of the usual and customary fee charged by dentists in California, and has eliminated or restricted services to enrollees due to budgetary constraints over the years.

Based on comments received from prior Subcommittee hearings, it is recommended to adopt the following:

- Placeholder trailer bill language to implement a $1,800 cap over a one-year period using a calendar year and ***no* retroactivity**. An implementation date of January 1, 2006 is to be assumed. (The DHS date of August 1, 2005 was not realistic given the need to implement a tracking system and the practicality of using a calendar year such as done in the commercial marketplace.)
- Exclude the following involved procedures from the cap: (1) emergencies, dental services provided in long-term care facilities and related items as contained in the DHS proposal, (2) dentures, and (3) complex oral and maxillofacial surgeries. (This includes the following procedures codes 275, 277, 285, 289, 700 to 724, 900 to 916, and 974 to 985.)

- Provide a three-year sunset date of January 1, 2009, unless extended or a new program is implemented. In this manner the Legislature can revisit the issue and see if any adjustments for rates or services are warranted.

This proposal would restructure the program and provide for savings in 2006-07. It would provide sufficient time for the DHS to implementation the tracking system so Dentists can obtain information about their patient's pending cap level. It also would provide sufficient time for both Dentists and Medi-Cal enrollees to become informed about the pending change. Using a retroactive approach as proposed by the DHS is not good policy.

Questions:

1. DHS, Please explain how the retroactive aspect of your proposal would work?

3. Medi-Cal Managed Care—Discussion of the DHS Timeline *(See Hand Outs)*

Issue: As has been discussed at several Subcommittee hearings, the Administration is proposing to expand Medi-Cal Managed Care (See background below for description).

In the Subcommittee's May 2nd hearing, the DHS provided a timeline of their proposal which contained additional components that were not address in the original timeline released in January. (The numbers shown in shaded boxes of the DHS chart mean that these actions are contingent upon completion of other actions.)

As such, the Subcommittee has requested the DHS to step through this newly provided timeline.

Subcommittee Staff Comment: In reviewing the timeline provided by the DHS on Monday, May 2nd, the following key aspects should be noted. (The number reference corresponds to the DHS timeline hand out.)

- *1. New Rate Methodology:* A contractor—Mercer, Incorporated—is in the process of being hired by the DHS to conduct an analysis of the existing rate system (considerable issues here) and to develop new rate methodologies for the entire Medi-Cal Managed Care system (Two-Plan Model, Geographic Model and County Organized Healthcare System). This activity is estimated by the DHS to be completed in April 2006. This means that the "new" rates will not be available for the first DHS designated expansion counties (i.e., mandatory enrollment of aged, blind and disabled in Los Angeles, Riverside and San Bernardino counties). Further, it is unclear when the Legislature would be provided information regarding the new rate methodology which would be needed for appropriation purposes.
- *2. Current Regulation Revision/Update:* The existing regulations for Medi-Cal Managed Care as it presently operates need to be redone as noted by the DHS and LAO in our May 2nd hearing. This activity is estimated to take from May 2005 to November 2006. A considerable amount of work needs to be completed here.
- *3. Obtain Federal Authority for Additional County Organized Healthcare Systems (COHS):* Existing federal law limits California from having more than 5 COHS'. Presently we have 5 covering a total of 8 counties (See background below regarding our existing system). There are several counties interested in becoming COHS', including Ventura and Merced. Federal approval is needed for any additional county to become their own COHS. However, counties can be added to an existing COHS (such as San Luis Obispo being added to Santa Barbara).
- *6. Standardize all Medi-Cal Managed Care Contracts:* This is a "core" program update that needs to be done whether or not any expansion is adopted. The DHS anticipates that this will commence in July 2005 and be completed by March 2006. Again, this is a considerable amount of work and will require discussions not only with heath care plans but should also include discussions with independent entities who can provide perspectives regarding encounter data reporting, performance measures and quality assurance.

- *8. Final date for County Decisions on Managed Care Model:* The DHS expects that by September 1, 2005, all of the 13 new expansion counties will be able to inform the DHS on which Medi-Cal Managed Care Model they will be implementing. This date appears to be very optimistic and could be viewed as not being considerate of county needs.
- *10 and 11. New Waivers and State Plan Amendments to the Federal CMS:* The DHS shows the period from October 2005 to July 2006 for any Waivers and State Plan Amendments to be crafted, submitted to the federal CMS and approved. Given recent experiences, it is very unlikely that the federal CMS could approve Waivers within 90-days of receipt as shown in the chart.
- *17, 18, and 19. "Boilerplate" Language for Contracts with Health Plans and Federal CMS*: The DHS assumes that from February 2006 to June 2006 that "boilerplate" language for the contracts will have been negotiated with the health plans and that the federal CMS will have approved this language. Again, the time period seems rather optimistic.
- *20. Readiness Review and Contract Monitoring Tools Completed:* This is a very critical aspect of the overall proposal for it is how the DHS will determine whether counties and health plans are ready for enrollment of all Medi-Cal individuals, including the aged, blind and disabled. This is to occur from May 2006 to September 2006. It is not clear at this time what the readiness review will fully encompass or what contract monitoring "tools" will be used.
- *21. New Waiver for COHS Counties:* This Waiver will need to be redone to potentially add new counties to existing COHS' and to develop new COHS areas. This Waiver, which requires federal CMS approval, is assumed to be completed by May 2007.
- Los Angeles, Riverside and San Bernardino are then expected to commence mandatory enrollment of aged, blind and disabled by January 1, 2007.

Background—Summary of the Administration's Proposed New Managed Care Expansion: The Administration's Medi-Cal Managed Care expansion would be achieved through a phased-in process over a twelve to eighteen month period commencing in January 2007.

The Administration's proposal would require (1) state statutory changes, (2) approval of a federal Waiver, and (3) adoption of state regulations (though the Administration may choose not to use the regulation process for some or all program components).

It is anticipated that 816,000 *additional* Medi-Cal enrollees, including the *mandatory enrollment* of aged, blind and disabled individuals, would be added to managed care through this proposed expansion.

Of these proposed new enrollees, **554,000 would be aged, blind or disabled**. There are about 280,000 aged, blind or disabled individuals presently enrolled in the existing Medi-

Cal Managed Care Program. As such, the 554,000 represents an increase of about 100 percent.

The proposed new expansion assumes the following **key components**:

- ***Expansion to 13 New Counties:*** The Administration would expand Medi-Cal Managed Care to 13 additional counties, including El Dorado, Imperial, Kings, Lake, Madera, Marin, Mendocino, Merced, San Benito, San Luis Obispo, Sonoma, Placer and Ventura. Enrollment would include families, children and the mandatory enrollment of aged, blind and disabled individuals.

  The Administration assumes the following Managed Care model configurations for these new counties:

  - Include El Dorado and Placer counties in the existing Sacramento GMC;
  - Include Imperial County in the existing San Diego GMC;
  - Convert Fresno County (now a Two Plan) to a GMC Model and include Madera, Merced, and potentially Kings counties;
  - Expand existing COHS to include the counties of Marin, Mendocino, San Benito, San Luis Obispo, Sonoma, Ventura and possibly Lake. For example, San Luis Obispo County could merge with the existing Santa Barbara COHS.

  The Administration assumes that all of these counties are up and operational (ready for enrollment) by no later than April 2008.

- ***Aged, Blind and Disabled Individuals (Mandatory Enrollment):*** The DHS has identified 36 Medi-Cal aid codes which they would require to enroll into a managed care plan. Dual eligibles (Medicare and Medi-Cal) would not be included in this mandated group but could be voluntarily enrolled at the individual's option. It is assumed that about 554,000 or so aged, blind and disabled individuals would be enrolled in a managed care plan by the end of 2007-08 and beginning of 2008-09. The 554,000 new enrollees represents a 100 percent increase over the number of aged, blind and disabled individuals presently enrolled (i.e., 280,000 persons).

  The 13 new managed care counties as referenced above would immediately enroll these individuals as part of their implementation plan along with families and children enrollees. The existing Two-Plan and GMC plans would phase-in this new population over a period of 12 months.

- ***Acute and Long-Term Care Integration (ALTCI) Proposal:*** As noted under Agenda item 4, below, the Administration is in the process of *changing* this proposal to cover only 3 counties—Orange, San Diego, and Contra Costa.

  Under this proposal, health plans would provide comprehensive Medi-Cal services to enrolled seniors and adults with disabilities (i.e., Medi-Cal and Medicare eligibles) and would incorporate primary, acute and long-term care services, and home and community-based services and providers in their networks (such as social services, personal care services provided under IHSS, nursing facility services, and others).

The integration of Medi-Cal and Medicare funding and services would occur at the health plan level.

Summary of Existing Medi-Cal Managed Care System: The DHS is the largest purchaser of managed health care services in California. Currently, some form of Medi-Cal Managed Care serves about 3.2 million Medi-Cal enrollees, primarily families and children and is in 22 counties. Only 280,000 enrollees, or about 9 percent, are seniors and individuals with developmental disabilities. The state has federal approval to operate this *existing* system under State Medicaid Plan authority.

The Medi-Cal Managed Care system utilizes three types of contract models— (1) the Two Plan, (2) the County Organized Health Systems (COHS), and (3) Geographic Managed Care (GMC). About 74 percent of Medi-Cal managed care enrollees are in a Two Plan model which covers 12 counties. There are five COHS (federal law limit) that serve eight counties. The GMC model is used in two counties.

For people with disabilities, enrollment is *voluntary* in the Two Plan and GMC model, and *mandatory* in the COHS. In addition, certain services are "carved-out" of the Two Plan and GMC models, as well as some of the COHS's. Most notably, Mental Health Managed Care, and the California Children's Services (CCS) Program are "carved-out", except for CCS in some selected counties which operate under the COHS model. Per existing state statute, CCS is carved-out until September 1, 2008.

Background--Two Plan Model (in 12 Counties): The Two Plan model was designed in the late 1990's. The basic premise of this model is that CalWORKS recipients (women and children) are automatically enrolled (mandatory enrollment) in either a public health plan (i.e., Local Initiative) or a commercial HMO. Other Medi-Cal members, such as aged, blind and disabled, other children and families, can voluntarily enroll if they so choose. About 74 percent of all Medi-Cal managed care enrollees in the state are enrolled in this model.

Plan Name	County	June 2003 Enrollment
Alameda Alliance for Health (LI)	Alameda	73,840
Blue Cross of California	Alameda, Contra Costa, Fresno, Kern, San Francisco, San Joaquin, Santa Clara, Stanislaus, Tulare	360,760
Contra Costa Health Plan (LI)	Contra Costa	41,909
Health Net	Fresno, Los Angeles, Tulare	579,588
Kern Health Systems (LI)	Kern	69,432
La Care Health Plan (LI)	Los Angeles	824,271
Inland Empire Health Plan (LI)	Riverside, San Bernardino	232,318
Molina Healthcare of California	Riverside, San Bernardino	91,702
San Francisco Health Plan (LI)	San Francisco	28,796
Health Plan of San Joaquin (LI)	San Joaquin	56,046
Santa Clara Family Health Plan (LI)	Santa Clara	66,812
Two Plan Model Total		**2,425,474**

Background—Geographic Managed Care (GMC): The GMC model was first implemented in Sacramento in 1994 and then in San Diego County in 1998. In this model, enrollees can select from multiple HMOs. The commercial HMOs negotiate capitation rates directly with the state based on the geographic area they plan to cover. Only CalWORKS recipients are required to enroll in the plans. All other Medi-Cal recipients may enroll on a voluntary basis. **Sacramento and San Diego counties contract with nine health plans that serve about 10.6 percent of all Medi-Cal managed care enrollees in California.**

Plan Name	County	June 2003 Enrollment
Blue Cross of California	Sacramento and San Diego	92,173
Community Health Group	San Diego	66,086
Health Net	Sacramento and San Diego	39,558
Kaiser Foundation Health Plan	Sacramento and San Diego	29,049
Molina Healthcare of California	Sacramento	20,208
Sharp Health Plan	San Diego	50,238
Universal Care	San Diego	12,810
UC San Diego Healthcare	San Diego	13,344
Western Health Advantage	Sacramento	15,713
TOTAL		**339,179**

Background—County Organized Health Systems (Eight Counties): Under this model, a county arranges for the provision of medical services, utilization control, and claims administration for *all* Medi-Cal recipients. Since COHS serve all Medi-Cal recipients, including higher cost aged, blind and disabled individuals, COHS receive higher capitation rates on average than health plans under the other Medi-Cal managed care system models (i.e., Two Plan Model and the Geographic model).

It should be noted that the capitation rates for COHS are confidential since the California Medical Assistance Commission (CMAC) negotiates contracts with each county plan and there is only one plan for all Medi-Cal recipients in said county.

As noted in the chart below, about 540,000 Medi-Cal recipients receive care from these plans. This accounts for about 16 percent of Medi-Cal managed care enrollees and about nine percent of all Medi-Cal enrollees. It should be noted that federal law mandates that only 10 percent of all Medi-Cal enrollees can participate in the COHS model.

Plan Name	County	June 2003 Enrollment
Cal Optima	Orange	281,839
Central Coast Alliance for Health	Monterey, Santa Cruz	84,363
Partnership Health Plan	Napa, Solano, Yolo	77,704
Health Plan of San Mateo	San Mateo	45,742
Santa Barbara Regional Health Authority	Santa Barbara	50,276
TOTAL		**539,924**

Questions:

1. DHS, Please describe each *key* component contained in the newly provided timeline.
2. DHS, Which aspects of this schedule do you think will be most difficult to meet?

4. Acute Long-Term Care Projects—Administration's Revised Draft Language
(See Hand Out)

Issue: Based on discussions with the Subcommittee and others, the Administration has revised their proposal for developing Acute and Long-Term Care Integration Projects.

Under their revised language, it is clarified that three projects would be created in three county areas--Contra Costa, Orange and San Diego.

The Administration notes that this new draft language **is still a work in progress** and they would like to continue conversations regarding its content and structure.

The following *key* changes should be noted in the Administration's revised proposal:

- Limits the ALTCI to three counties (to be Orange, San Diego and Contra Costa);
- Describes the integrated services to be provided (paragraph (4) on page 3 of language);
- Requires ALTCI counties to continue their financial maintenance of effort for programs and services integrated under the statute. The amount of a county's maintenance of effort shall be based on the county's share of the non-federal share of annual expenditures for the In-Home Supportive Services (IHHS) Program in state fiscal year 2003-04.
- Enables entities providing personal care services to enter into contracts with an ALTCI entity to provide personal care services;
- Excludes inclusion of services provided by Regional Centers. As such Regional Centers will continue to provide services independent from ;
- Excludes inclusion of County specialty mental health services. As such County Mental Health Plans will continue to operate outside this model;
- Directs that the DHS will perform an evaluation of the model;
- Provides the Director of Health Services with very broad authority to seek any and all federal Waivers, and to contract on a bid or non-bid basis, or exclusive basis, for the ALTCI projects;
- Provides the Director of Health Services with very broad authority to implement the ALTCI projects through county letters, plan letters, provider bulletins, or similar instruction; and
- Provides for a sunset date of January 1, 2012.

Background—Overall Concept of the Three ALTCI Projects: Under the proposal, "Acute and Long Term Care Integration" (ALTCI) health plans would provide comprehensive Medi-Cal services to enrolled seniors and adults with disabilities (i.e., Medi-Cal and Medicare eligibles) and would incorporate primary, acute and long-term care services, and home and community-based services and providers in their networks (such as social services, personal care services provided under IHSS, nursing facility services, and others).

The chart below displays the differences between Medi-Cal Managed Care coverage and the newly proposed ALTCI.

Traditional Managed Care Coverage	ALTCI Project Coverage
Primary Care	Primary Care
Hospital Care, Emergency Room Services, Surgeries	Hospital Care, Emergency Room Services, Surgeries
Case Management of Medical Services	Case Management of Medical Services
Medi-Cal Scope of Benefits (all offered)	Medi-Cal Scope of Benefits
	Expanded Case Management across medical, social and supportive services with consumer participation as a priority and with interdisciplinary team support. Case Management would have a priority to avoid institutional placements.
	Nursing Facility Services
	Adult Day Health Care
	Personal Care Services (IHSS)
	Home and Community-Based Services (home modifications, personal emergency response systems, nutrition, and others necessary to avoid or delay inpatient nursing facility care.

The integration of Medi-Cal and Medicare funding and services would occur at the health plan level. As such, the participating health plans must also be federally approved as Medicare Plans ("Medicare Advantage plans), and must include Medicare prescription drug coverage.

ALTCI Projects would be reimbursed through a capitated payment from the state for Medi-Cal services *and* a capitated payment from the federal CMS for the Medicare services for eligible members. The projects would assume full risk for a comprehensive array of services including acute hospital care, nursing facility care and home and community based services and supports under this funding mechanism. The DHS states that capitated rates across the entire health and social support continuum creates fiscal incentives for the plans to provide proactive and preventive services to avoid higher costs in institutional settings.

Summary Table of ALTCI Enrollment and Start Dates

ALTCI Projects	DHS Estimated Enrollment (Seniors and adults with disabilities)	DHS Proposed Start Dates
Orange County	74,139 adults	September 1, 2006
Contra Costa	27,092 adults	January 1, 2007
San Diego	89,417 adults	March 1, 2007

Enrollment options for individuals would vary contingent upon eligibility for Medicare and the geographic area. For "Medi-Cal-only" individuals (about 40 percent of seniors and adults with disabilities) living in San Diego or Contra Costa, these individuals will have a choice to either (1) enroll or stay in a "traditional" Medi-Cal Managed Care Plan, (2) enroll in an ALTCI plan, or (3) be "defaulted" into an ALTCI plan if no choice is made.

For the dually eligible living in these two areas (60 percent are dually eligible), the individual can (1) enroll in an ALTCI project and maintain Medicare coverage separately, (2) enroll in an ALTCI project and enroll in the same plan for Medicare coverage and Medicare Drug coverage through a "Prepaid Drug Plan", (3) enroll in a Program for All-Inclusive Care for the Elderly (PACE) plan if eligible and one is available, or (4) be "defaulted" into an ALTCI plan if no choice is made.

Since Orange County operates CalOPTIMA, all individuals would enroll into its ALTCI plan but could also maintain Medicare coverage separately if desired.

The DHS will use different approaches in selecting the ALTCI plans for the three areas since each area operates a different Medi-Cal Managed Care Model. In Orange County, CalOPTIMA will develop a service delivery system.

Contra Costa as a Two Plan Model will have Contra Costa Health Plan (local initiative) as well as a competitive procurement to select the second ALTCI plan (commercial plan). If the Contra Costa Health Plan does not want to participate as an ALTCI then a second competitive procurement would be done.

San Diego as a Geographic Managed Care Model would use a Request for Application process. The state would release specifications and requirements for ALTCI plans through the RFA process and would review and select participating ALTCI plans based on meeting both state and county requirements. The number or participating plans would be determined by the number of successful applicants.

Core major milestones that the ALTCI projects will need to meet (as presently identified) include the following:

- Apply to the federal CMS to become a Medicare Advantage Plan (subject to federal CMS timelines for Medicare applications);

- Access current home and community-based services provider capacity and utilization in the county. From this data, develop recommendations to the state regarding provide networks.
- Expand and draft ALTCI care management protocols and submit to DHS.
- Establish cultural competency standards including age and disability issues for enrolled populations.
- Participate with the state on Quality Assurance measures for enrolled populations.
- Establish policies to "operationalize" Quality Assurance measures that ALTCI plans must meet to serve the enrolled population.
- Identify assessment tool/protocol and ALTCI service authorization guidelines.
- Assess and build information technology support for comprehensive care management across medical and social services providers/functions.
- Enroll members.

Subcommittee Staff Comment and Recommendation: The Administration's revised proposal to develop three ALTCI projects in these three counties has merit. Consumers with chronic care needs and long term care needs often must seek services and supports from several distinct health care programs and home and community-based service entities, each with its own separate assessment process and care plan. Discussions regarding the integration of programs that serve this community has been ongoing for several years.

Clearly, considerable work still needs to be done regarding the crafting of statutory language. In addition, the Administration needs to clarify its budget request based on the revised language and scope of the project.

It is recommended to hold this issue "open" pending receipt of May Revision and clarification of the budget request. Any draft, "placeholder" trailer bill language could also be addressed at this time.

Questions:

1. DHS, Please describe the key aspects of the revised, draft language on the ALTCI Projects.
2. DHS, Please describe how IHSS services would be provided under the ALTCI Projects.
3. DHS, Please describe your proposed schedule for implementation.
4. DHS,

5. Adult Day Health Care Program—*Several Issues*

Issues: The Governor's January budget is proposing several changes to the Adult Day Health Care (ADHC) Program. In addition, a Finance Letter has also been submitted to the Subcommittee for consideration. However, recent conversations with the federal CMS, as discussed further below, have clarified that California must eventually submit a federal Waiver (not a State Plan Amendment) in order to maintain our Adult Day Health Care Program. As such, the Governor will need to make modifications to his January budget proposal at the May Revision.

All of the Governor's proposed issues to-date are as follows:

- *Moratorium & Rate Redesign:* The Governor's Medi-Cal budget proposes savings of $49.9 million ($25 million General Fund) to the ADHC by **(1)** continuing the "moratorium" implemented through the Budget Act of 2004 and accompanying trailer bill language, and **(2)** redesigning the existing rate system by "unbundling" it to distinguish certain expenditures from the overall bundled/comprehensive rate.

  Of this total proposed savings amount, **(1)** $45.3 million (total funds) is attributed to continuing the existing moratorium until December 2005 (six months), and **(2)** $13.3 million (total funds) is assumed to be achieved from redesigning the rate to be effective as of January 1, 2006.

- *New Federal Waiver for ADHC Program:* The Governor's budget assumes that a new federal Waiver is in place for the ADHC Program by January 1, 2006.

- *Request for DHS State Staff:* The DHS has submitted a Finance Letter which requests an increase of $48,000 ($24,000 General Fund) to hire an Associate Governmental Program Analyst position beginning January 1, 2006 and ending January 1, 2008. The purpose of this position would be to assist in the restructuring of the ADHC Program by crafting a State Plan Amendment (SPA) for submittal and approval to the federal CMS.

As referenced above, the Budget Act of 2004 implemented a moratorium on the certification of new ADHC Providers (not enrollees) beginning as of August 16, 2004. This moratorium was intended to freeze the existing number of providers in place and not provide for any new licensures. The DHS had desired this action in order to mitigate growth in the program.

In addition, the federal CMS has expressed concerns about the structure of the ADHC Program. In a letter dated December 11, 2003, the federal CMS notified the state that California needs to submit a federal Waiver (1115 or 1915 (c)) in order to continue to receive federal financial participation (i.e., federal matching funds) for ADHC enrollees and services. The federal CMS has made it clear that changes to eligibility, the services offered, and the reimbursement methodology will likely need to be made under a Waiver.

Transitioning to a Waiver Program will require considerable fore thought particularly given federal requirements pertaining to cost-neutrality, eligibility, service structure and relates aspects.

Any federal Waiver proposal by the DHS would require state statutory change prior to implementation. The Administration is sponsoring policy legislation—AB 1258 (Daucher)—on this issue and it is proceeding through that process.

In addition, SB 642 (Chesbro) is also proceeding through the policy committee process and it would, among other things, make statutory changes to enable the DHS to obtain a federal Waiver for the ADHC Program as well.

Background Over All—Existing Program: Adult Day Health Care (ADHC) is a community-based day program which provides nursing, physical therapy, occupational therapy, speech therapy, meals transportation, social services, personal care, activities and supervision designed for low-income elders and younger disabled adults who are *at risk* for being placed in a nursing home.

ADHC has been a successful model for elderly individuals for they can obtain many services in one location. For these individuals, particularly those with mobility challenges, going to one place for health care results in better compliance with therapy, medication, nutrition, and exercise regimens. Under Medi-Cal, individuals can participate in ADHC from one to five days per week, but usually average about three days a week.

The general concept behind providing ADHC services is that they delay or defer individuals from going into nursing homes or other more costly forms of care and therefore, it saves Medi-Cal money**.** Compared to the monthly Medi-Cal cost of a nursing home at about $3,400 per month, ADHC can cost as much as three to four times less. Currently, there are about 43,000 Medi-Cal recipients who receive ADHC services in any given month.

Further, there are about 300 ADHC facilities in the state that are certified in the Medi-Cal Program. Typically, each ADHC has the capacity to serve between 40 and 100 clients per day. According to the LAO, about 56 percent of the total number of ADHCs were located in Los Angeles County.

Recent Concerns with ADHC Growth: Both the DHS and the California Association for Adult Day Services (Association) have noted that the ADHC Program began to grow in 1999 after many years of exceedingly slow growth. Generally, some of the reasons for this growth included: (1) changes in the state's aging and immigrant demographics, and (2) the lifting of statutory restrictions against "for profit" ADHC providers.

Background on Rates: Currently Medi-Cal reimburses ADHCs at a "bundled rate"—a single rate which is paid per recipient, per day (minimum of a four-hour stay required). This rate includes payment for all required ADHC services as specified in Title 22, California Code of Regulations. This rate is set at 90 percent of the state's reimbursement rate for Nursing Facility—Level A ($69.58 per day). This rate structure was the outcome of a legal settlement agreement done in 1993. This list of required services includes, among other, physical therapy, occupational therapy, speech therapy and recipient transportation to and from the ADHC facility.

Constituency Concern and Request of Subcommittee (See Hand Out): The Subcommittee is in receipt of proposed language regarding a modification to the existing "moratorium". According to information provided, the proposed language would:

- Address a specific need in the San Francisco area regarding the Laguna Honda nursing facility and a need to utilize community-based resources;
- Allow ADHC provider expansion in Imperial County due to the number of low-income seniors residing in the county;
- Address a specific need in Napa County, as noted (see page 2 of hand out);
- Address a specific need in Humboldt County, as noted; and
- Enable 25 older adults with developmental disabilities to be phased-in for services as noted.

This language has been shared with the Administration who is presently reviewing it for both policy and fiscal implications.

Subcommittee Staff Commend and Recommendation: The Administration's budget proposal is no longer applicable and must be revised at the Governor's May Revision due to recent clarification regarding our program with the federal CMS.

First, the federal CMS has told the DHS that California must submit a federal Waiver in order to retain the program in perpetuity as a Medi-Cal Program service. The federal CMS has said that our existing federal match that we receive for these services is not at risk as long as we are working towards the crafting of a Waiver.

Second, a rate redesign cannot be done by the state until a comprehensive Waiver is crafted. As such, the rates cannot be "unbundled" and therefore, the Governor's May Revision will need to be adjusted (i.e., the assumed $13.3 million (total funds) in savings cannot be done).

Third, one of the purposes of implementing the "moratorium" was to freeze the program in place until a federal Waiver or State Plan Amendment could be crafted and put into place. The moratorium was meant to be a temporary measure.

Therefore, consideration of adjustments in areas that are very underserved and low-income, or have narrowly described special needs, should be considered pending the crafting of a Waiver. The proposed language is a very modest lessening of the moratorium.

The DHS has committed to providing the Subcommittee with a fiscal estimate regarding the proposed change to the moratorium. This information should be available at the May Revision. Further, the DHS is in the process of re-crafting their proposal as well.

It is recommended to hold this issue "open" pending (1) receipt of fiscal information to be provided by the DHS, as technical assistance, on the proposed modification to the moratorium, and (2) receipt of the Governor's May Revision changes.

Questions:

1. DHS, Please provide a status update regarding your discussions with the federal CMS about restructuring the state's ADHC Program and crafting a Waiver.
2. DHS, Please comment on the proposed modification to the moratorium from a technical assistance basis.

6. Proposition 99 Funded Programs for Budget Year—*Issues "A" to "C"*
(See Hand Outs—multiple charts)

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

Under the provisions of Proposition 99, revenues are allocated across **six accounts** based on specified percentages. Various programs, administered under several different state departments, are funded using revenues deposited in the specified accounts. The accounts are as follows:

- *Hospital Services Account:* This account receives **35 percent** of the annual Proposition 99 revenues. Revenues from this account must be used to supplement and not supplant indigent healthcare services provided in hospital settings.
- *Physician Services Account:* This account receives **10 percent** of the annual Proposition 99 revenues. Revenues from this account must be used to supplement and not supplant indigent healthcare services provided by physicians.
- *Unallocated Account:* This account receives **25 percent** of the annual Proposition 99 revenues. Revenues from this account must be used to supplement and not supplant indigent healthcare services provided by physicians.
- *Research Account:* This account receives 5 percent of the annual Proposition 99 revenues. Revenues from this account must be used to supplement and not supplant research activities associated with anti-tobacco efforts. This account also receives funding from Proposition 10—the California Children and Families First Act of 1998.
- *Health Education Account:* This account receives **20 percent** of the annual Proposition 99 revenues. Revenues from this account are used for various anti-tobacco education efforts. This account also receives funding from Proposition 10—the California Children and Families First Act of 1998.
- *Public Resources Account:* This account receives percent 5 percent of the annual Proposition 99 revenues and the funds are used for specified public resources.

Proposition 99 initially provided total revenues of about $570 million for health care related programs. Since that time, revenues have declined as the use of tobacco products has diminished due to the success of the anti-tobacco media campaign and increased taxes (i.e., Proposition 10 from 1998). Proposition 10 holds harmless the Health Education Account and the Research Account of Proposition 99, but does not provide a backfill for the other health care accounts.

ISSUE "A"—Revised S-CHIP Language & Discussion of Use of Savings, and Related Programs

Issue and Prior Subcommittee Hearing: As discussed in our April 4th Subcommittee hearing, the Governor assumes recognition of recent federal regulations under the State's Children Health Insurance Program (S-CHIP) (Healthy Families in California) that declare an unborn child (from conception) may be considered an eligible child under the program.

Under these federal regulations a state may elect to extend eligibility to unborn children using federal S-CHIP funds (a 65 percent federal match rate) for health benefits coverage, including prenatal care and delivery. California would need to submit an S-CHIP State Plan Amendment (SPA) to the federal CMS for approval in order to obtain the 65 percent federal match.

At the April 4th hearing, the Subcommittee took action to **(1)** adopt trailer bill language regarding the action, **(2)** captured the $68.046 million General Fund savings, and **(3)** captured the $78.440 million in Proposition 99 savings. **These dollar savings are shown below in the table and are also the same savings level as assumed in the Governor's January budget.**

The Subcommittee did not as yet allocate these savings.

Summary of State Dollar Savings and Federal Fund Increases

	2005-06 Fund Shifts		
Governor's Proposed Funding Shifts	**Prop 99 Funds**	**General Fund**	**Federal Funds**
Shift Access for Infants & Mothers Program to GF and federal funds.	-$78,440	$27,454	$50,986
Use S-CHIP federal funds for Prenatal Care to Undocumented Women in Medi-Cal.		-$95,500	$95,500
Net Adjustments Overall by Year (GF and Proposition 99 Savings)	-78,440	-$68,046	$146,486

New Compromise Trailer Bill Language Proposed: The Subcommittee is in receipt of language that has *tentative* agreement (as of Friday, May 6th) from all involved parties. (Final agreement should be known by Monday, May 9th.)

Using the trailer bill language adopted by the Subcommittee in its April 4th hearing, all parties have been meeting to craft a compromise. Based on the most recent discussions, this proposed compromise trailer bill language is as follows:

> (a) Through its courts, statutes, and under its Constitution, California protects a woman's right to reproductive privacy. California reaffirms these protections and specifically its Supreme Court decision in People v. Belous (1969) 71 Cal.2d 954, 966-68.
>
> (b) The State Department of Health Services and the Managed Risk Medical Insurance Board may accept or use monies under Title XXI of the federal Social Security Act (known as the State Children's Health Insurance Program, or S-CHIP), as interpreted in Title 42, Code of Federal Regulations, section 457.10, to fund services for women pursuant to Welfare and Institutions Code section 14007.7 (Medi-Cal) and Insurance Code sections 12695 et seq (Access for Infants and

Mothers (AIM)) only when, during the period of coverage, the woman is the beneficiary. The scope of services covered under Medi-Cal and AIM, as defined in statutes, regulations and state plans, is not altered by this section or the state plan amendment submitted pursuant to this section.

(c) California's S-CHIP plan and any amendments submitted and implemented pursuant to this section shall be consistent with subsections (a) and (b).

(d) This section is a declaration of existing law.

Use of General Fund Savings and Proposition 99 Savings: The Subcommittee captured $68.046 million in General Fund savings, and $78.440 million in Proposition 99 savings. But has not yet designated how these savings will be utilized for the budget year.

The Governor's January budget proposes using these identified savings as follows (See Hand Out chart that shows "Baseline versus Governor's Budget"):

- Uses $13.5 million (Proposition 99 Funds) to backfill for General Fund support in the State Hospitals operated by the Department of Mental Health (for total expenditures of $20.5 million in Proposition 99 Funds for the State Hospitals in 2005-06). Proposition 99 Funds were also used to backfill for some General Fund support in the State Hospitals last year. (No issues have been raised.)
- Increases by $12.8 million (Proposition 99 Funds) for the Breast Cancer Early Detection Program due to caseload needs. (No issues have been raised.)
- Uses $10 million (Proposition 99 Funds) to backfill for General Fund support in the Expanded Access to Primary Care (EAPC) Clinic Program. We have in previous years used Proposition 99 Funds for this purpose. (No issues have been raised.)
- Uses $32.8 million (Proposition 99 Funds) to backfill for General Fund support in the Medi-Cal Program for full-scope services provided to legal immigrants. Proposition 99 Funds have never been used for this program before. (Subcommittee staff has concern.)
- Increases by $1.1 million (Proposition 99 Funds) to correct for a technical error in the DHS state support item related to the Budget Act of 2003. (No issues have been raised.)

Subcommittee Staff Comment and Recommendation: First, it is recommended to adopt the revised trailer bill language that reflects the tentative compromise between interested parities.

Second, it is recommended to utilize the Proposition 99 Fund savings which are available for expenditure due to the federal S-CHIP Fund shifts for a purpose other than the Medi-Cal Legal Immigrants Program. The Medi-Cal Legal Immigrants Program is an important program that should not be destabilized using a declining revenue source such as Proposition 99 Funds. Further, the amount of funds that are being proposed by the Administration raises the issue of "supplanting" versus "supplementing".

Other "backfill" options are available that would better withstand the "supplementing" test. For example, these funds could be used to provide assistance in funding the Orthopedic Hospital Settlement agreement which occurred a few years ago regarding

providing increased reimbursement to hospitals for outpatient services. Yet another option would be to use some of the funds to support the Breast Cancer Treatment Program within the Medi-Cal Program that was implemented in 2000 (under this program the state draws down a 65 percent federal match).

Discussions with the Administration are occurring as to what options may be considered at the May Revision. Therefore, it is recommended to leave the exact funding allocations "open" until the May Revision pending an updating of overall Proposition 99 revenues, caseload adjustments, and considerations of other "backfill" options.

Questions:

1. Administration, Please provide comment regarding the revised language provided in the agenda, above.
2. DHS, Will the May Revision contain changes and adjustments to reflect revised Proposition 99 revenues, caseload and potentially other "backfill" options?

ISSUE "B"—Proposition 99 Funding and Obtaining a Federal Match

Issue: Proposition 99 contains very explicit language regarding the use of the revenues obtained from the Proposition. The Proposition may be amended by a four-fifths vote of the Legislature as long as the amendment is consistent with the purposes of the Proposition.

There has been two occasions where changes have been made to the Proposition. The most recent one being AB 1763, Statutes of 2003, which was a trailer bill to the Budget Act of 2003. This statutory change enabled the Rural Demonstration Projects as operated by the Managed Risk Medical Insurance Board to draw down a federal match using the Proposition 99 funds as the state match.

Subcommittee Staff Recommendation: The three "indigent health care" accounts contained within Proposition 99—the Hospital Services Account, the Physicians Services Account and the Unallocated Account—could be used to draw down a federal match for various health care services.

Specifically, these funds could be more fully utilized to (1) draw down funds for the Medi-Cal Program (such as for the Breast Cancer Treatment Program—65 percent), (2) count towards a "certified public expenditure" (CPE), where applicable, and be used to draw federal funds under the pending Hospital Financing Waiver, and (3) draw down federal S-CHIP funds, where applicable. Overall it would provide increased flexibility for the state and counties, and would enable California to more fully utilize its limited state resources.

It is recommended *not* to include the Health Education Account or Research Account in this proposal because these two accounts receive funds from Proposition 10 as well and this would add a complicating factor. Further, the ability to match federal funds in these areas is more limited than in the "indigent health" accounts.

Therefore, it is recommended for the Subcommittee to adopt placeholder trailer bill legislation to change Proposition 99 to enable the Hospital Services Account, Physicians Account and Unallocated Account to be used to obtain a federal match, when applicable. This language will require a four-fifths vote of the Legislature to enact.

Questions:

1. Administration, Do you have any comment from a technical assistance perspective regarding this recommendation?

ISSUE "C"—Proposed Trailer Bill Language for Emergency Physician Funding (Proposition 99 Funding) ***(See Hand Out)***

Issue: For the past five years, the Legislature has been appropriating about $25 million (Proposition 99 Funds) annually to reimburse emergency and on-call physicians for the costs of providing care to uninsured, indigent patients requiring emergency medical care.

The Governor's budget proposes to continue this appropriation level. No issues have been raised regarding the proposed appropriation. In addition, the Administration has proposed trailer bill language which is needed in order for the DHS to appropriately allocate these funds.

However in recent discussions regarding the current-year allocation of these funds through SB 29 (Perata), Statutes of 2005, it became evident that modification to the budget-year allocation would be in order.

Subcommittee Staff Comment and Recommendation: The Subcommittee is in receipt of language (See Hand Out) which would clarify how the proposed budget amount of $24.8 million (Proposition 99 Funds) would be allocated.

This language has been vetted with the Administration and Subcommittee staff. There is agreement that the proposed language would serve to ensure that reimbursements made using the $24.8 million (Proposition 99 Funds) would be provided to physicians for losses incurred in providing emergency medical services directly to patients in emergency rooms. These physicians would need to submit claims or subsequently reconcile claims in order for the reimbursement to be made.

Therefore, it is recommended to adopt the proposed language as trailer bill legislation to ensure that the appropriation of $24.8 million (Proposition 99 Funds) is utilized as intended.

Questions:

1. DHS, From a technical assistance basis, would the proposed language provide assistance in ensuring that the appropriation is expended as intended?

7. Domestic Violence Shelter Program—Unserved and Underserved (U/U)

Issue: This issue was discussed in the March 14th Subcommittee hearing and was held "open" pending completion of a DHS survey regarding the targeting activities for special populations served by domestic violence shelters. This survey has now been completed and the results are discussed below.

With respect to the Governor's budget, the Administration proposes an increase of $1.1 million ($515,000 General Fund, $235,000 Domestic Violence Training Fund and $350,000 in Nine West Settlement Funds) to **restore** funds used to assist shelters to serve communities of color, teens, disabled women and others that traditionally do not seek shelter services but are at high risk for domestic/intimate partner relationship violence.

Originally, an augmentation of $2.5 million had been provided in the Budget Act of 1999 to focus services on "unserved" or "underserved" populations, with an emphasis on cultural and ethnic populations, so that groups experiencing domestic violence but not traditionally seeking assistance through the shelter program, would also be able to receive assistance. In the Budget Act of 2003, these funds were reduced by 50 percent, or $1.1 million.

The DHS was able to temporarily redirect funds from the Domestic Violence Training and Education Fund to backfill for some funding in 2003-04 and 2004-05. However, this can no longer be fully done because these special funds have been depleted.

As noted in the March 14th hearing, the DHS was still in the process of discerning what would be the most effective use of these funds, pending completion of the survey and its results.

Summary of the DHS Survey Results and Potential Use for Funds: The DHS just released their analysis on May 5, 2005. Among other things, the DHS notes that there are three groups on which it would make sense to focus additional outreach efforts. These are as follows:

- Women with mental illness and substance abuse issues;
- Women with developmental disabilities; and
- Individuals who identify themselves as Lesbian, Gay, Bi-Sexual and Transgender.

Though the DHS would ideally like to release a statewide competitive Request for Proposal (RFP) for these three "priority" areas, it would take the DHS *at least 9 months* in order to proceed through the state's process.

Therefore, in order to use the funds for 2005-06, the DHS is proposing to provide these funds to certain shelters to make shelter modifications for ADA compliance issues which have been identified by some shelters. Then for 2006-07, the funds could be used via an RFP as noted above.

Additional Background—Domestic Violence Shelter Program Overall: A total of $22.9 million ($22.3 million General Fund) is proposed for the DHS program. Of this amount, (1) $21.3 million is allocated to 97 shelters for services, (2) $262,00 is for data management and a women's health survey, (3) $85,000 is for technical assistance and training as required by statute, and (4) $1.1 million is for unserved/underserved individuals. The existing program was established in statute in 1994 (AB 167, Freidman).

It should be noted that as a condition of receiving funds, shelters must, among other things, provide matching funds or in-kind contributions equivalent to not less than 20 percent of the grant they would receive.

Subcommittee Staff Comment and Recommendation: Clearly the intent of these funds is to provide assistance to underserved communities. Further, the DHS survey results have identified a very specific need for these limited resources. As such, it is recommended to utilize the $1.1 million (total funds) for conducting outreach activities to the communities which have been identified in the survey and analysis, and not for the ADA compliance issues.

Further, it is recommended for the DHS to use an "Interagency" process in lieu of an RFP. Use of this mechanism is often done to use available expertise and to facilitate funding certain activities.

According the State Contracting Manual, there are limits on the ability of state agencies to contract with public colleges and universities. However, if the purpose of the Interagency agreement is to provide direct services to the public, as this would be, then an Interagency agreement (with a public college or university) could be done and if appropriate/needed, subcontracts could be done through the college or university for addressing some of the identified needs of these unique populations.

The following Budget Bill Language is proposed for this purpose (Item 4260-111-001):

> Of the amount appropriated in this Item, up to $1.1 million shall be used to fund interagency agreements to address non-traditional users of domestic shelter services as identified by the DHS in their recent survey. These funds shall be used specifically for those non-traditional users identified as being priorities by the DHS.

Questions:

1. DHS, Please describe the results of the recently completed survey.
2. DHS, Please briefly describe your revised proposal.
3. DHS, Please comment on the option of using an Interagency Agreement process (from a technical assistance perspective) as suggested above.

D. Department of Mental Health—Capital Outlay Projects *(Items 1 through 5)*

1. Metropolitan State Hospital—Proposed Multiple Changes to the New Main Kitchen & Satellite Serving Kitchens

Issue: The Subcommittee is in receipt of a DOF Capital Outlay Letter (received on May 2nd) which requests ***all*** of the following changes *(See Table below for a summary)*:

(1) An increase of $237,000 (General Fund) to reflect a revised cost estimate to the **construction phase** of the **6 satellite kitchen remodel** to account for the increased price of stainless steel;

(2) Reappropriation language for the General Fund amount appropriated in the Budget Act of 2004 for the **working drawing phase** of the **6 satellite kitchen remodel** project. This is needed because the Department of General Services estimate for this portion of the project was higher than anticipated.

(3) An increase of $18 million (Lease Revenue Bonds) to fund increased costs resulting from additional seismic safety needs, unanticipated utility relocations, electrical rerouting, the increased costs of materials, and the inclusion of necessary equipment and food management software to the **main kitchen component**.

(4) Proposes to revert existing authority provided by the Budget Act of 2003 for preliminary plans, working drawings and construction for the main kitchen and satellite kitchens.

Table—Summary of Metropolitan Kitchen Items

Budget Act of 2003 (Lease Revenue Bonds)	Budget Act of 2004	Requests Submitted for 20005-06 (Reflects Bond & GF Changes)
Appropriation of $18.9 million for the entire project, including the main kitchen & 6 satellites: $832,000 Preliminary Plans $942,000 working drawings $16.952 million construction	Project needs to be divided into two projects due to issues regarding the bond issuance. Bond funds will now be used for the main kitchen only. Reverts $3.873 million (Bonds) for the project due to this change.	**Main kitchen ($18 million--Bonds):** **1.** Revised working drawings= $886,000. This proposal reflects a reversion of $766,000 and an increase of $120,000 (Bonds). **2.** Revised construction= $17.144 million. This proposal reflects a reversion of $13.255 million and an increase of $3.9 million.
	Provided $259,000 (General Fund) for working drawings.	**Satellite Kitchen** ($5.3 million GF): **1.** Reappropriate $259,000 (GF) for working drawings. **2.** Revised construction= $5.282 million. This proposal reflects a reversion of $5.045 million (Bonds) and an increase of $5.282 million (GF). The January budget shifted the bond amount to GF support, and the Finance Letter reflects an increase of $237,000 (GF).

The DMH states that these cost adjustments are necessary based on updates provided by the Department of General Services and as approved by the DOF..

The DOF is also proposing inclusion of the following "Supplemental Reporting Language" (two pieces as noted) which is traditionally adopted for capital outlay projects when changes have occurred. This proposed language is as follows:

> *Supplemental Reporting Language-- Metropolitan State Hospital-Construct New Kitchen and Remodel Satellite Serving Kitchens: Satellite Serving Kitchen Component. General Fund: (Item 4440-301-0001).*
>
> The amount of $5,541,000 (CCCI 4339) is provided for working drawings ($259,000), and construction ($5,282,000) of six existing satellite kitchens and dining facilities. The satellite kitchen improvements include new kitchen equipment, seamless epoxy floors, ceramic tile walls, and acoustical ceiling tiles. The construction amount includes $4,320,000 for the construction contract, $302,000 for contingency, and $660,000 for project administration. Working drawings will begin in July 2005 and the project bid in March 2006. Construction should be completed in January 2008.
>
> *Supplemental Reporting Language-- Metropolitan State Hospital-Construct New Kitchen and Remodel Satellite Serving Kitchens: New Kitchen Component. Lease Revenue Bond Fund: (Item 4440-301-0660).*
>
> The amount of $18,030,000 (CCCI 4339) is provided for, working drawings ($886,000), and construction ($17,144,000) of a 26,100 square foot (square feet) central kitchen facility. The new main kitchen includes overhead fire sprinkler system, exterior plaster walls, standing seam metal roofing, new kitchen equipment, cook/chill system, high capacity food storage racks, large freezers, 48" high receiving dock with four overhead coiling doors, and a new 300 KVA emergency generator. The construction amount includes $13,859,000 for the construction contract, $693,000 for contingency, and $2,592,000 for project administration. Working drawings will begin in July 2005 and the project bid in March 2006. Construction should be completed in January 2008.

Background—Why the Remodel is Needed: This is being proposed to meet requirements of DHS licensing and the "cook-chill" system. As discussed in our May 2nd hearing, renovation of the six Satellite Kitchens must now use General Fund support but the Main Kitchen remodel can be done with bond funds.

The Budget Act of 2003 appropriated $18.7 million (Lease Revenue Bond Funds) to construct a new kitchen and remodel the six Satellite Kitchens at Metropolitan State Hospital. However, the DGS, DOF and DMH later recognized that selling bonds for the Satellite Kitchen component could not be done.

The six Satellite Kitchens must be remodeled to include new kitchen equipment, seamless epoxy floors, ceramic tile walls, and acoustical ceiling tiles (asbestos abatement and related environmental aspects are a concern). According to the DMH, the scope of the remodel remains the same as contained in the Budget Act of 2003 but the costs have increased.

Prior Subcommittee Action: In the Monday May 2nd hearing, the Subcommittee approved the Governor's January budget to shift $5 million from lease revenue bond funding to General Fund support to renovate all existing Satellite Kitchens and Dining Facilities at Metropolitan State Hospital.

Subcommittee Staff Comment and Recommendation: It is recommended to approve the Finance Letter changes and to adopt the Supplemental Reporting Language as shown in the agenda, as approved by the DOF and LAO. No issues have been raised by the LAO capital outlay specialists.

Questions:

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

2. Metropolitan State Hospital—School Building (Construction Phase)

Issue: The Subcommittee is in receipt of a DOF Capital Outlay Letter (received on May 2nd) which requests expenditure of $8.754 million (Lease Revenue Bonds) to provide the State Hospital with a school building that meets Field Act requirements and provides for the educational needs of children residing at Metropolitan State Hospital. Metropolitan State Hospital is the only State Hospital that serves children and adolescents.

The DMH notes that the design of the school had to be modified to meet the State Fire Marshal requirements. The DMH states that this redesign, combined with the recent increase in material prices has caused the cost of the project to exceed an amount that can be approved within the State Public Works Board's augmentation authority. As a result, a new lease revenue appropriation is requested for the construction phase of this project.

The DOF is also proposing inclusion of the following "Supplemental Reporting Language" which is traditionally adopted for capital outlay projects when changes have occurred. This proposed language is as follows:

Supplemental Reporting Language-- Metropolitan State Hospital—Construct School Building.

The amount of $8,754,000 is provided for construction of a 27,000 square feet school with administrative offices adjacent to the living units of the Youth Treatment Program. The amount for construction includes $375,000 for contingencies, $871,000 for project management, and $7,508,000 for construction contracts. Approval to go to bid is scheduled for July 2005. Construction will begin in January 2006 with the project expected to be completed in May 2007.

Subcommittee Staff Comment and Recommendation: It is recommended to approve the Finance Letter changes and to adopt the Supplemental Reporting Language as shown in the agenda, as approved by the DOF and LAO. No issues have been raised by the LAO capital outlay specialists.

Questions:

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

3. Patton State Hospital—Renovate Admissions Suite

Issue: The Subcommittee is in receipt of a DOF Capital Outlay Letter (received on May 2nd) which requests expenditure of $30.146 million (Lease Revenue Bonds) in a new lease revenue appropriation.

The DMH states that when lease revenue bonds for the first phase of this project were sold, the state was required to perform an immediate seismic retrofit of the building. As a result, funding was provided for the retrofit prior to completing a needs analysis, thereby leading to a project that was under-funded in the original appropriation.

The DOF states that with completion of preliminary plans, it has been determined that the seismic retrofit would require the replacement of all interior walls and ceilings, as well as the installation of sprinklers. As such, the Administration is requesting a new lease revenue appropriation for the working drawings and construction phases of the project.

The DOF is also proposing inclusion of the following "Supplemental Reporting Language" which is traditionally adopted for capital outlay projects when changes have occurred. This proposed language is as follows:

Supplemental Reporting Language--Patton State Hospital—Renovate Admission Suite and FLSEI Phases II & III—EB Building. Lease Revenue Bond (Item 4440-301-0660).

The amount of $ 30,146,000 (CCCI 4339) is provided for working drawings ($1,164,000), and construction ($28,982,000) to renovate the Admission Suite, complete the FLSEI renovations of the EB Building, and to seismically retrofit the building. The construction amount includes $22,548,000 for the construction contract, $2,103,000 for contingency, $3,629,000 for project administration, and $702,000 for agency-retained items. Working Drawings should begin July 2005 and the project bid in June 2006. Construction should be completed in November 2009.

Subcommittee Staff Comment and Recommendation: It is recommended to approve the Finance Letter changes and to adopt the Supplemental Reporting Language as shown in the agenda, as approved by the DOF and LAO. No issues have been raised by the LAO capital outlay specialists.

Questions:

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

4. Budget Bill Language for the DMH Capital Outlay Projects

Issue: The Subcommittee is in receipt of a DOF Capital Outlay Letter that requests approval of five pieces of Budget Bill Language for Item 440-301-0660 (DMH-Capital Outlay-Lease Revenue Bond Funds). The proposed language is as follows:

Provisions:

1. The State Public Works Board may issue lease revenue bonds, notes or bond anticipation notes pursuant to Chapter 5 (commencing with Section 15830) of Part 10b of Division 3 of Title 2 of the Government Code to finance all phases of the project authorized by this item.

2. The State Public Works Board and the Department of Mental Health may obtain interim financing of the project costs authorized in this item from any appropriate source, including, but not limited to, Section 15849.1 of the Government Code and the Pooled Money Investment Account pursuant to Sections 16312 and 16313 of the Government Code.

3. The State Public Works Board may authorize the augmentation of the cost of each phase of the projects scheduled in this item pursuant to the Board's authority under Section 13332.11 of the Government Code. In addition, the Sate Public Works Board may authorize any additional amount necessary to establish a reasonable construction reserve and to pay the cost of financing, including the payment of interest during construction of the project, the costs of financing a debt service fund, and the cost of issuance of permanent financing for the project. This additional amount may include interest payable on any interim financing obtained.

4. This Department is authorized and directed to execute and deliver any and all leases, contracts, agreements, or other documents necessary or advisable to consummate the sale of bonds or otherwise effectuate the financing of the scheduled projects.

5. The State Public Works Board shall not be deemed to be the lead or responsible agency for purposes of the CA Environmental Quality Act (Division 13, commencing with Section 21000, of the Public Resources Code) for any activities under the State Building Construction Act of 1955 (Part 10b, commencing with Section 15800, of the Division 3 of Title 2 of the Government Code). This section does not exempt this department from the requirements of the CA Environmental Quality Act. This section is intended to be declarative of existing law.

The DOF states that the above five provisions of language are standard language necessary for any project financed with Lease Revenue Bonds, regardless of the department. The language provides authority to sell bonds and perform interim financing for project costs. It also authorizes the State Public Works Board to augment projects necessary pursuant to existing law (Section 13332.11 of Government Code). It also

clarifies the role of the DMH when a project is funded through lease revenue bonds. Finally it reaffirms the requirements of the CA Environmental Quality Act regarding these projects.

Subcommittee Staff Comment and Recommendation: It is recommended to approve the five pieces of Budget Bill Language as proposed by the DOF for the DMH identified projects. No issues have been raised by the LAO capital outlay specialists.

Questions:

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

Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda

Chair, Senator Denise Moreno Ducheny
Senator George C. Runner
Senator Tom Torlakson

Thursday, May 19, 2005
(Upon Adjournment)
John L. Burton Hearing Room (4203)
Consultant, Anastasia Dodson

Vote Only Agenda

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Please Note: Only those items and issues contained in this agenda will be discussed at this hearing. Issues pertaining to these items may be reviewed again. Please see the Senate File for dates and times of subsequent hearings.

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Vote Only Agenda

0530 Health and Human Services Agency (HHS Agency)

Issue 1: Transfer Automation Projects to HHS Agency

Description: The Governor's Budget proposed to transfer the Health and Human Services Data Center (HHSDC) Systems Management Services (including all ten automation projects) to the Health and Human Services Agency (HHS Agency), and rename Systems Management Services as the Office of System Integration (OSI). The Administration has submitted April Finance Letters and May Revision proposals to make technical changes to implement this transfer.

Background:

- **Governor's Budget:** Effective July 1, 2005, the Governor's Budget proposes to eliminate the HHSDC and consolidate the HHSDC Operations component and the Teale Data Center into the newly proposed Department of Technology Services. This consolidation proposal is in response to Legislative direction in the Budget Act 2003 to consolidate data center activities. A Governor's Reorganization Plan is pending to implement this consolidation.

  Due to concerns about the high level of oversight needed to successfully implement and maintain large automation projects, the Administration proposes to transfer the Systems Management Services program to the HHS Agency. This component includes nine projects sponsored by the Department of Social Services (DSS), and one project sponsored by the Employment Development Department. The proposal would shift 151.8 positions and $219 million from HHSDC Systems Management Services for project management and operations and 24.0 positions and $4 million from HHSDC Operations for administrative support to the HHS Agency.

- **Spring Finance Letters:** The Administration proposed budget bill language and trailer bill language to implement the transfer of the automation projects to HHS Agency. These proposals would be replaced by language proposed in the May Revision.

- **May Revision:**

  - **Office of Systems Integration Fund:** The May Revision proposes to establish the Office of Systems Integration Fund, which would replace the HHSDC Revolving Fund for the DSS and EDD automation projects. State and federal funds from DSS would be transferred to the Office of Systems Integration Fund for management of specified automation projects. DSS funding for automation projects is currently transferred to the HHSDC Revolving Fund.

  - **Amended Budget Bill Items and Language:** The May Revision proposes various amendments and additions to the budget bill for the HHS Agency and DSS to reflect the transfer of the automation projects to HHS Agency.

- **Revised Trailer Bill Language:** The May Revision proposes updated trailer bill language to establish the Office of Systems Integration and specify that its functions are substantially similar to the HHSDC System Management Services.

- **LAO Recommendations:**

  - **Transfer Projects to DSS:** The LAO recommends that all DSS-sponsored projects be placed in DSS, as the DSS is the primary sponsor of these projects, and should be held accountable for the projects' success. The LAO also notes that agencies are designed to provide policy direction and oversight, rather than carry out day-to-day operational responsibilities.

  - **Trailer Bill Amendments:** Notwithstanding the recommendation above, the LAO recommends that the Administration's proposed trailer bill language be amended to 1) require Legislative approval before additional automation projects can be managed by the HHS Agency and 2) require periodic review of completed projects to determine if they can be transferred back to their sponsor departments.

Recommendation:

1. Adopt the May Revision proposed budget bill language (as amended below) for HHS Agency and DSS, and adopt the May Revision trailer bill language, as amended to reflect the LAO recommendations.

2. Amend Provision 1 of 0530-001-9732 as follows: "Notwithstanding any other provision of law, the Department of Finance may adjust this item of appropriation to correct any technical errors related to the Data Center reorganization plan <u>not sooner than 30 days after notification in writing of the necessity therefore to the chairperson of the committee in each house of the Legislature that considers appropriations and the Chairperson of the Joint Legislative Budget Committee, or not sooner than whatever lesser time the chairperson of the committee, or his or her designee, may in each instance determine.</u>"

Issue 2: Automation System Adjustments

Description: The May Revision proposes a number of adjustments to funding for automation systems, both in the DSS and the HHS Agency.

Background:

- **Case Management Information and Payrolling System (CMIPS) Enhancements (DSS Issue 175)—**An increase of $789,000 ($493,000 General Fund) is requested by DSS due to a delay of CMIPS enhancement activities associated with the IHSS Quality Assurance (QA) Initiative, the federal IHSS Waiver, and the Share-of-Cost Buyout. This augmentation is a carryover of 2004-05 funding and does not result in an increase of the

overall costs of CMIPS enhancements. The delay is not expected to affect QA savings or the receipt of federal funds for the Waiver.

- **CMIPS II Contract Procurement (DSS Issue 180 and HHS Agency Issue 007)—**A decrease of $466,000 ($233,000 General Fund) for DSS is requested to reflect the delay in the CMIPS II project. This delay is not expected to affect federal funding for the project.

  A net decrease of $239,000 Office of Systems Integration Fund is requested for HHS Agency. The Governor's Budget included $12.9 million for the procurement of CMIPS II. However, the Design Development and Implementation (DDI) phase of the project has been delayed by approximately four months. This request is to align HHS Agency expenditure authority with the project schedule. This request includes an augmentation of $222,000 in expenditure authority to contract for 9.0 consultants needed for the DDI phase. It also includes an offsetting reduction of $461,000 of expenditure authority to reflect the project delay. The net change would be a decrease in expenditure authority of $239,000.

- **Los Angeles Eligibility, Automated Determination, Evaluation, and Reporting (LEADER) Project Vendor Rate Reduction (DSS Issue 160)—**A decrease of $3,179,000 (decreases of $891,000 General Fund and $2,324,000 Federal Trust Fund, and an increase of $36,000 Reimbursements) for DSS is requested to reflect reduced LEADER costs resulting from a negotiated rate reduction in the latest vendor contract extension.

- **Welfare Client Data System Project Caseload and Conversions (DSS Issue 165)—**An increase of $15,370,000 ($6,151,000 General Fund) for DSS is requested to reflect increased Welfare Client Data System (WCDS) costs due to increased caseload and conversion of closed cases from the previous Legacy system.

- **WCDS Project Implementation Support (DSS Issue 166)—**An increase of $9,748,000 ($3,901,000 General Fund) for DSS is requested to mitigate implementation difficulties for the bulk of remaining counties yet to convert to the WCDS system. The department indicates these resources would fund a vendor support team, increased training and coaching time for county expert coaches and a higher ratio of 1 coach per 15 caseworkers. For those counties that feel extended support for transition activities is necessary for an additional month following implementation, the state would make available additional funding, for which participating counties would have a 40 percent share-of-cost of the non-federal portion.

- **Electronic Benefits Transfer (EBT) System Reprocurement (DSS Issue 197 and HHS Agency Issue 005)—**An increase of $739,000 ($246,000 General Fund) in DSS is requested to reflect activities associated with the EBT reprocurement. An increase of $723,000 OSI Fund is requested in the HHS Agency. The current contract for the EBT system expires in 2008. This request is to begin a three-year reprocurement project to obtain a new EBT solution prior to contract expiration. Funding would be used to

contract for 4.0 consultants and pay for associated overhead. The consultants would develop technical requirements for a Request for Proposal and oversee implementation of a new EBT system. The Governor's Budget reflects 3.0 DSS positions for EBT reprocurement.

- **LAO Recommendation:** The LAO has no concerns with any of the adjustments above, with the exception of the CMIPS II proposal. The LAO indicates that the administration is requesting to hire nine consultants to perform various functions for the new CMIPS system. Their review found that three of the consultants (the Configuration Management Analyst, the System Engineering/Interface Manager, and the Test Lead) will be performing ongoing tasks that will occur over the life of the new system. The LAO indicates that typically consultants are used for temporary or short term activities, and that state staff should be used for ongoing activities. For this reason, they recommend that the Legislature approve the CMIPS II proposal and also authorize three additional state positions.

Recommendation: Adopt the May Revision proposed adjustments.

4170 California Department of Aging (CDA)

Issue 3: Health Insurance Counseling and Advocacy Project

Description: Beginning in November 2005, approximately 4.1 million California Medicare beneficiaries will make enrollment decisions for Medicare Part D prescription drug benefits. As a result, demand for local Health Insurance Counseling and Advocacy Program (HICAP) services is expected to dramatically increase. The department has submitted a spring finance letter to reflect $1.8 million in additional federal funds for local HICAP organizations to expand Part D education and outreach, as well as 3.0 additional CDA positions.

Background:

- **Medicare Modernization Act (MMA) Enrollment in Late 2005:** The MMA created a new Part D prescription drug benefit for Medicare beneficiaries. The initial enrollment period will run from November 15, 2005 through May 15, 2006 for most beneficiaries, but only from November 15, 2005 through December 31, 2005 for beneficiaries eligible for both Medicare and Medi-Cal (dual eligibles). Over 4.1 million Californians, including 1.7 million dual eligibles, may enroll in Medicare Part D.

- **Health Insurance Counseling and Advocacy Program (HICAP):** HICAP is a volunteer-supported program that provides consumers with information about Medicare, related health care coverage, and long-term care insurance. In 2004, HICAP had over 800 counselors, who fielded 90,000 consumer phone calls, 40,000 of which resulted in insurance counseling appointments. This figure is expected to increase substantially in the last few months of 2005 and the spring of 2006 when 4.1 million Californians begin

enrolling in Part D. Based on conservative estimates, HICAP workload may double in 2005-06, compared to 2004-05.

- **2005-06 CDA Position Requests:** The Governor's Budget proposes to use $93,000 in existing federal funds to establish 1.0 permanent position to develop training and program standards for the HICAP. A spring finance letter requests $283,000 for 3.0 additional CDA positions in 2005-06 for additional workload associated with MMA, including oversight and coordination of HICAP efforts, implementation of data performance and outcomes measures, analysis of federal MMA regulations, and maintaining HICAP counselor handbooks and program operations manuals. CDA currently has 1.8 positions to support the HICAP program, aside from the 4.0 requested positions.

- **HICAP Program Funding:** HICAP is funded by a $1.05 per person assessment on Medicare health care services plans, plus funds from the Insurance Fund matched on a 2-to-1 basis with the health plan assessments. Current statute allows the assessment to range from seventy cents per person to one dollar and twenty cents per person. Current statute also requires the Department of Finance to biennially review demographic information and the Insurance Fund match ratio to determine if changes in this ratio are appropriate. Note that there is currently a $1.9 million reserve in the State HICAP Fund.

- The spring finance letter also reflects $1.5 million in additional local assistance federal funds for MMA outreach, which would increase total local assistance funding for HICAP to $7.8 million in 2005-06. Local assistance funding for HICAP in 2004-05 is $6.8 million.

Recommendation:

1. Adopt the spring finance letter to establish 3.0 positions in CDA for HICAP and provide $1.5 million for local HICAP sites.

2. Conform to Assembly action and adopt placeholder trailer bill language to increase funding for HICAP by $2 million by increasing the HICAP assessment, and allocate the entire $2 million in additional funding to local HICAP agencies and prohibit the use of this funding for the Department of Aging or Area Agency on Aging administrative costs.

4200 Department of Alcohol and Drug Programs (DADP)

Issue 4: Office of Problem Gambling – Culturally Competent Materials

Description: The Office of Problem Gambling (OPG) is funded by $3.0 million from the Indian Gaming Special Distribution Fund in each of the current and budget years. The California Commission on Asian and Pacific Islander American Affairs indicates a need for more

culturally-competent literature on problem gambling in languages other than English, and other culturally appropriate activities to address problem gambling.

Background: The Office of Problem Gambling (OPG) was established in August 2003 to reduce the prevalence of problem and pathological gambling. The first priority of the OPG is to develop a statewide plan for a problem gambling prevention program that includes:

- A toll-free telephone service for immediate crises management and containment.
- Public awareness campaigns.
- Empirically driven research programs.
- Training of health care professionals and educators, and training for law enforcement agencies and nonprofit organizations.
- Training of gambling industry personnel in identifying customers at risk for problem and pathological gambling and knowledge of referral and treatment services.

The department reports about $200,000 in unspent current year funding.

The California Commission on Asian and Pacific Islander American Affairs reports the need for literature that addresses problem gambling translated into widely spoken Asian languages. The Commission believes that unspent current year funding at the OPG could be used for this one-time purpose.

Recommendation: Conform to Assembly action to adopt budget bill language to reappropriate unspent current year Office of Problem Gambling Funds for the creation of culturally-competent literature on problem gambling in languages other than English and other culturally appropriate activities.

Issue 5: Drug Medi-Cal May Revision Adjustments

Description: The May Revision proposes a net General Fund decrease of $1.1 million to reflect revised caseload estimates for Drug Medi-Cal.

Background:

- **May Revision:** The Regular Drug Medi-Cal population is projected to be 174,744 in 2005-06, an increase of 3,229, or 1.9 percent above the Governor's Budget. This net change reflects an increase of 4,409 clients in the Outpatient Drug Free Program, the lowest-cost modality in Regular Drug Med-Cal, and a decrease of 1,110 in the Narcotic Treatment Program, the highest-cost modality in Regular Drug Medi-Cal. In addition to caseload adjustments, the May Revision estimate revises the average units of service upward for the Narcotic Treatment Program and downward for the Outpatient Drug Free and Day Care Rehabilitative programs. The combined effect of the adjustments to caseload and average units of services is a savings $2,250,000 General Fund, or 3.8 percent reduction in costs from the Governor's Budget for Regular Drug Medi-Cal.

The Perinatal Drug Medi-Cal population is projected to be 7,134 in 2005-06, an increase of 534, or 8.1 percent above the Governor's Budget. This net change reflects an increase in caseload in the Outpatient Drug Free, Day Care Rehabilitative, and Narcotic Treatment programs, and a decrease in caseload in the Residential Program, the highest-cost modality in Perinatal Drug Medi-Cal. Notwithstanding this decrease in caseload, costs within the Residential Program are estimated to increase because of an upward revision to the program's average units of service estimate. The increase in costs in the Residential Program, combined with the increase in caseload in the remaining three programs, contributes to the $1,146,000 General Fund cost increase in Perinatal Drug Medi-Cal.

- **Rate Reduction:** The Budget Act of 2004 reduced Drug Medi-Cal provider rates to 2002-03 levels during 2004-05. The Governor's Budget proposes to maintain rates at the 2002-03 level in 2005-06.

  Drug Medi-Cal providers have requested a 5.0 percent rate increase for 2005-06, due to increased costs in recent years associated with the statewide nursing shortage and increased accreditation costs. The department indicates that at an average cost of $11 to $13 per day, methadone maintenance treatment in particular is a cost-effective alternative to incarceration or hospitalization.

Recommendation: Redirect the $2.2 million ($1.1 million General Fund) in caseload savings back to the department to increase Drug Medi-Cal rates as a partial offset for the previous rate reduction.

Replace Provision 4 of Item 4200-102-0001 and Provision 5 of Item 4200-103-0001 with the following language:

> Of the combined amounts appropriated in Items 4200-102-0001 and 4200-103-0001, $1,104,000 General Fund, and corresponding reimbursements, is for the purpose of augmenting Drug Medi-Cal rates above the 2002-03 rate level. The department shall establish increases in maximum reimbursement rates for Drug Medi-Cal services in the fiscal year to reflect the additional General Fund and reimbursements appropriated in this item.

Issue 6: Drug Procurement Savings

Description: The LAO recommends that the department report next year on the feasibility of obtaining greater rebates from drug manufacturers for methadone.

Background: The LAO outlined a series of proposals to reduce state costs for purchasing prescription drugs for state programs. A number of these proposals in being carried in pending policy legislation, but a few proposed actions in the health program area were left for action as part of the state budget. One of these pertained to ensuring that the state paid only the "best price" available under the federal Medicaid law for methadone provided under the Drug

Medi-Cal Program administered by DADP. The LAO believes it is possible the changes proposed in methadone reimbursement could eventually result in a state savings of hundreds of thousands of dollars annually. The LAO proposes budget bill language to require the department to report on this topic.

Recommendation: Adopt the proposed budget bill language.

Issue 7: Dependency Drug Courts

Description: The May Revision proposes a one-time augmentation of $1.1 million for dependency drug court programs, using past year unspent federal Promoting Safe and Stable Families (PSSF) funds. Of this amount, $900,000 would be transferred from DSS to DADP for the local program costs, and the remaining $200,000 would be used by DSS to fund an evaluation in 2005-06.

Background:

- **Dependency Drug Courts:** These drug courts work to reduce foster care costs and increase permanency for children by providing substance abuse treatment to parents who are involved in dependency court cases. Failure to comply with a court-ordered plan could result in termination or limitation of parental rights and placing the child or children in foster care. San Diego, Santa Clara, and Sacramento Counties have well-established dependency drug courts that have demonstrated significant positive results, including: reduced time to reunification, greater reunification rates, shorter stays in out of home care (including Foster Care), and greater participation in substance abuse treatment. Many studies have found that for one-third to two-thirds of children involved with the child welfare system, parental substance abuse is a contributing problem.

- **Dependency Drug Court Funding in 2004-05, with Additional Reporting Language:** The Budget Act of 2004 included $1.8 million federal PSSF funds to expand dependency drug courts, as well as trailer bill language to require DADP and DSS to adopt appropriate data collection and reporting requirements to measure program outcomes and cost-effectiveness, including the amount of foster care savings realized. Of the $1.8 million appropriated in 2004-05, $900,000 will be expended from January through June 2005, and $900,000 will be expended from July 2005 through December 2005.

- **May Revision:** The May Revision proposes $900,000 to maintain annual expenditures at $1.8 million for 2005-06. The May Revision also proposes $200,000 for an independent evaluation of the impact of dependency drug court programs on Child Welfare Services and Foster Care program. The Administration indicates that this full year of funding would allow time for the evaluation of the cost-effectiveness to be completed.

LAO Analysis and Recommendation:

The LAO supports the Administration's proposal, with some modifications. We understand the administration's desire for additional evaluation of program outcomes. However, it seems that an evaluation of participants that entered this program in 2005 will provide only 12 months of data by next year's hearings where ongoing funding will be considered. We are concerned that this level of data may produce insufficient or inconclusive results that will hinder debate on the effectiveness of the program. Therefore, we recommend that this funding be provided for two years, with the intention of receiving a report of evaluation results by January 10, 2007. We are proposing the placeholder trailer bill language to state the intent to fund this program through budget year 2006-07. This would provide time to allow for a more complete evaluation of the program and then review the program evaluation outcomes to consider continued funding. In addition, we are also proposing the addition of specific evaluation guidelines to the trailer bill language. The departments would be requested to designate a research advisory group to develop an evaluation design that focuses on the specific measures that will be helpful in the future funding determination.

Recommendation: Adopt the May Revision proposal in the DADP and DSS budgets, and placeholder LAO recommended trailer bill language.

4700 Department of Community Services and Development (DCSD)

Issue 8: Naturalization Services Program

Description: The Governor's Budget proposes to eliminate the Naturalization Services Program (NSP), currently budgeted at $1.5 million General Fund. This program assists legal permanent residents obtain citizenship. The Urban Institute estimates that approximately 2.7 million Californians are eligible for but have not applied for citizenship. The Subcommittee restored $1.5 million for this program on May 5th. At that hearing NSP service providers testified that NSP allocations were fully expended before the end of the year, and that additional funding would allow additional persons seeking citizenship to be assisted.

Recommendation: Due to the significant need for citizenship services and the benefits to the community of increased citizenship rates, revise the previous action to reflect a total of $2.5 million General Fund for this program.

5160 Department of Rehabilitation (DOR)

Issue 9: Tuition Cost Increases for DOR Consumers

Description: The May Revision requests $908,000 ($193,000 General Fund) to fund an increase in tuition costs for DOR consumers attending the University of California or the California State

University systems, consistent with tuition increases budgeted in both university systems in the 2005-06 Governor's Budget. DOR provides tuitions support for consumers attending education programs intended for reintroduction into employment.

Recommendation: Approve the requested increase of $908,000 ($193,000 General Fund) to fund an increase in tuition costs for DOR consumers.

5175 Department of Child Support Services (DCSS)

Issue 10: Increase Federal Funds to Match Voluntary County Contributions

Description: The May Revision requests $20 million federal funds drawn down as matching funds for $10 million in county funding anticipated to be provided by counties for their local child support agencies. The request also includes budget bill language to require counties to be responsible for any additional federal automation penalty amounts that may result from drawing down additional federal funds.

Background:

- **Additional Federal Funds:** A number of counties have requested to use county general funds to provide for cost of doing business increases incurred over the past two years for the Child Support Program, and to draw down a federal match on these funds. The aggregate amount of county funds that the counties have proposed to use is approximately $10 million. Because the federal government provides a $2 match for each dollar that state or local governments invest into the Child Support Program, the state may draw down an additional $20 million in federal matching funds for the proposed county funding.

- **Budget Bill Language:** The state is currently subject to annual federal automation penalties for its failure to implement a statewide child support automation system by the federally-required date. The penalty is equal to 30 percent of the prior federal fiscal year (FFY) expenditures. The state intends to apply for statewide system certification by September 30, 2006, which would relieve the state of paying further penalties while certification is in progress. If the system is not successfully certified, the state would be subject to any penalties that had been held in abeyance while the certification review was in process. The department is therefore proposing budget bill language that would require local child support agencies that draw down additional federal funds to enter into an agreement with the department to pay their portion of the penalty increase in the event that certification is not successful.

  The proposed budget bill language is as follows:

  > Of the amount appropriated in this item, $20,000,000 is for the purpose of providing a federal match to voluntary county contributions to the Child Support Program. Any county requesting an augmentation of federal

funds for local assistance must enter into an agreement with the Department of Child Support Services that sets forth the amount of augmented federal funds to be received and payment terms, including a provision holding the State harmless for any additional federal penalty costs that might result from this increased spending.

Recommendation: Approve the additional federal fund authority and the proposed budget bill language.

Issue 11: Child Support Recovery Fund

Description: The May Revision requests an increase of $1.9 million federal funds and a corresponding decrease of $1.9 million Child Support Recovery Fund, to reflect updated child support collections estimates.

Background: Pursuant to federal guidelines, the department transfers the federal portion of Child Support Assistance Collections (collections that reimburse the government for the costs of providing public assistance) into a separate account called the Child Support Recovery Fund. The department must first use the federal child support collections for administrative program costs before drawing down federal Title IV-D funds. The department semi-annually estimates the amount of federal child support collections it will receive and adjusts its federal fund and Recovery Fund authority accordingly. Based upon most recent collections estimates, federal collections transferred to the Recovery Fund will decrease by $1,937,000 in 2004-05, creating a need for additional federal fund authority of the same amount.

Recommendation: Approve the requested an increase of $1.9 million federal funds and a corresponding decrease of $1.9 million Child Support Recovery Fund, to reflect updated child support collections estimates.

Issue 12: Child Support Automation System Funding

Description: The May Revision requests to carryover $1.4 million federal funds from the current year to the budget year to reflect delays in deliverables for the California Child Support Automation System (CCSAS). The May Revision also requests $432,000 federal funds in 2005-06 for Franchise Tax Board (FTB) overtime costs, as a result of accelerating the implementation schedule for CCSAS. The General Fund portion of the requested carryover and overtime is reflected in the May Revision for the FTB, which is managing the development of the CCSAS.

Background:

- **Deliverables Delayed:** Two project deliverables that were scheduled to be completed in the current year have been delayed. According to the DCSS and FTB, the delay of these

deliverables will not jeopardize the project schedule as a whole, and specifically, the implementation of CCSAS Version I by September 2006. These deliverables are:

- The conversion of a local automation system to one of the two systems included in the implementation of Version I of CCSAS was delayed due to the need to complete a modification to the local child support automation system to increase the efficiency of the interface it has with other social services systems prior to conversion. The federal fund share of this deliverable is $1,033,000.

- The purchase of software and software licensing agreements for the CCSAS project. The software and software licensing purchases were delayed due to the need for further evaluation of the software needed by the State and vendor for the project. The federal fund share of this deliverable is $366,000.

- **FTB Overtime:** In November 2004, the Legislature was notified that the Child Support Enforcement (CSE) project schedule would be accelerated by five months to provide for sufficient time for system testing to ensure successful implementation of CCSAS Version I in September 2006. The FTB has identified the need for additional overtime support as the result of accelerating the implementation schedule of CSE component of the CCSAS project schedule. The federal fund share of these proposed overtime costs is $432,000.

Recommendation: Approve the requested carryover and increase of federal funds for CCSAS.

5180 Department of Social Services (DSS)

Issue 13: Community Care Licensing Trigger Elimination Proposal

Description: The 2003 Budget Act reduced the frequency of Community Care Licensing (CCL) annual visits, but also included a statutory trigger to increase the number of annual visits if the number of annual citations exceed the previous year's total by 10 percent or more. The Governor's Budget proposed to eliminate this trigger, but the May Revision proposed to rescind the January proposal and maintain the trigger.

Background: Eliminating the trigger could have resulted in savings of $2.6 million ($2.2 million General Fund). Although the total number of citations are estimated to increase by 9.5 percent in the current year (which is less than the 10 percent trigger), the department estimates that it will only complete 84 percent of the annual and random visits required in the current year.

Recommendation: Conform to Assembly: Reinstate the trigger and adopt supplemental reporting language recommended by the LAO to require the department to report to the Legislature in December on the number of citations, complaints, and visits completed.

Issue 14: Gresher v. Anderson Decision on Criminal Background Check Process

Description: The May Revision requests an increase of $596,000 ($392,000 General Fund and $204,000 Federal Trust Fund) in Community Care Licensing (CCL) state operations for 6.0 limited-term positions (5.5 two-year and 0.5 one-year, limited-term) and $847,000 ($837,000 General Fund) in local assistance to comply with the recent *Gresher v. Anderson* court decision ordering the DSS to revise its current criminal background check process to protect the rights of employees working in community care facilities licensed by the DSS. The department indicates that this request would provide resources to implement the specific requirements of the court ruling and ensure that other intake and exemption functions in the Community Care Licensing Division would not be suspended or delayed.

Background: CCL is responsible for licensing adoption agencies, foster care agencies and homes, childcare homes and centers and residential care facilities for disabled and elderly adults. As part of its licensing function, the CCL Criminal Background Check Bureau (CBCB) must ensure that persons licensed to operate these facilities, provide care to facility clients, or reside at the facility location, receive a comprehensive criminal background check.

Recommendation: Approve the request for positions to comply with *Gresher v. Anderson.*

DSS Issue 15: Community Care Licensing – Fee-Exempt LiveScan

Description: Current statute would exempt certain small child care home providers and foster family homes from paying a $40 fee for their fingerprinting and criminal record checks, effective July 1, 2005. This exemption was suspended in 2003-04 and 2004-05, and the Governor's Budget proposes trailer bill language to permanently eliminate the fingerprint fee exemption, which would result in annual General Fund savings of $1.5 million.

Background: California requires persons working or volunteering at community care facilities and family day care facilities to be fingerprinted and have criminal background checks. Generally, licensees are required to pay for the fingerprinting process, although certain providers have been historically exempted or partially exempted from the required fees. These exemptions include providers in any small home that serves 6 or fewer children, including family day care homes, certified family homes, or foster family homes. The fees that have been exempted include a $16 LiveScan fee and a $24 FBI fee, for a total of $40 per applicant.

In 2003-04 and 2004-05 the Legislature suspended this exemption, and those providers were required to pay fees of $40 for their fingerprinting and background checks.

Recommendation: Amend the proposed trailer bill language to suspend the exemption for one additional year.

DSS Issue 16: May Revision Caseload Adjustments

Description: The May Revision proposes adjustments in funding to reflect caseload updates for CalWORKs, Foster Care, IHSS, SSI/SSP, Food Stamps Administration, and Child Welfare Services.

Background: The May Revision proposes a reduction of $197,383,000 ($74,437,000 General Fund, $104,610,000 Federal Trust Fund, $17,854,000 Reimbursements, $532,000 Child Support Collections Recovery Fund, and an increase of $50,000 CWS Program Improvement Fund), due to the impact of caseload changes since the Governor's Budget, as displayed in the following table:

May Revision Caseload Adjustments

Program	Item	Issue #	Change Since Governor's Budget
CalWORKs	5180-101-0001 5180-101-0890 5180-601-0995	101 101 101	$9,744,000 -$106,536,000 $62,000
Foster Care	5180-101-0001 5180-101-0890 5180-101-8004 5180-141-0001 5180-141-0890	101 101 101 141 141	-$18,087,000 -$6,637,000 -$532,000 -$991,000 -$1,554,000
Adoption Assistance Program	5180-101-0001 5180-101-0890	101 101	-$1,033,000 -$6,443,000
Supplemental Security Income/State Supplementary Payment (SSI/SSP)	5180-111-0001	111	-$46,981,000
In-Home Supportive Services (IHSS)	5180-111-0001 5180-611-0995	111 111	-$6,485,000 -$17,882,000
Child Welfare Services	5180-151-0001 5180-151-0890 5180-151-8023 5180-651-0995	151 151 151 151	-$13,322,000 $16,145,000 $50,000 -$774,000
Other Assistance Payments	5180-101-0001 5180-101-0890	101 101	$75,000 -$885,000
County Administration and Automation Projects	5180-141-0001 5180-141-0890 5180-641-0995	141 141 141	$1,941,000 $653,000 $740,000
Remaining DSS Programs	5180-151-0001 5180-151-0890	151 151	$702,000 $647,000

The May Revision also requests that language in Item 5180-402 be modified to decrease the amount of TANF Block Grant funding to be transferred to the Department of Education for CalWORKs child care from $384,250,000 to $349,923,000 due to a decreased Stage 2 child care caseload projection.

LAO Recommendation: Before the May Revision, both the Assembly and the Senate took action to recognize $118.5 million in TANF savings identified by the LAO for 2004-05 and increase that carry-forward balance for 2005-06 by the same amount. At this time, the LAO recommends that the Legislature adopt the May Revision caseload adjustments and rescind the previous action on LAO findings.

In February, the LAO recommended a reduction in funding for the Cash Assistance Program for Immigrants (CAPI) because the caseload was overstated. The May Revision recognizes this caseload overestimate and reduces funding for CAPI by $5 million. However, the LAO's review of the most recent actual data indicates that the caseload is still overstated by about 3 percent as of February 2005. Accordingly, they recommend reducing funding for CAPI, beyond the Governor's May Revision, by $2,450,000 in 2005-06 to account for this caseload reduction.

Recommendation: Adopt the LAO recommendation to rescind previous action on LAO findings and adopt the May Revision caseload adjustments. Adopt the LAO recommendation to reduce CAPI funding by $2,450,000 to reflect reduced caseload. Maintain the Subcommittee's prior action to reinvest Foster Care Administration savings in county Foster Care Administration.

DSS Issue 17: Nursing Initiative

Description: The May Revision requests a decrease of $5.0 million Employment Training Fund in DSS to provide funding for the Administration's Nursing Initiative, under the Employment Development Department. A corresponding General Fund increase is also requested to backfill CalWORKs employment services, which had been scheduled to use the $5.0 million Employment Training Fund monies. This proposal requires trailer bill language.

The Administration's Nursing Initiative will be heard by Senate Subcommittee No. 5, under the Employment Development Department's budget.

Recommendation: Conform to action taken in Senate Subcommittee No. 5, and approve the Employment Training Fund reduction and General Fund backfill.

DSS Issue 18: Food Stamp Simplification Options

Description: The May Revision proposes a reduction of $276,000 General Fund to reflect savings for changes in simplification of Food Stamp eligibility. The Governor's Budget included proposed administrative changes to facilitate the enrollment of eligible persons in Food Stamps by simplifying the eligibility process.

Recommendation: Adopt the May Revision Food Stamp simplification changes.

Issue 19: State and Federal Cost of Living Adjustments (COLAs) for Supplemental Security Income/State Supplemental Payment (SSI/SSP)

Description: The May Revision maintains the Governor's Budget proposal to withhold the January 2006 state and federal Cost of Living Adjustments (COLAs), for savings of $228 million General Fund in 2005-06, and $456 million General Fund annually.

- **Annual COLA Adjustments**: Under current law, both the federal and state grant payments for SSI/SSP recipients are adjusted for inflation each January through Cost of Living Adjustments (COLAs). Federal law provides an annual SSI COLA based on the Consumer Price Index, and state law provides an annual SSP COLA based on the California Necessities Index.

- **May Revision:** The May Revision proposes to withhold the January 2006 2.6 percent federal SSI COLA, for savings of $97 million General Fund in 2005-06, and $194 million annually. This is achieved by reducing the state SSP component of the grant by the same amount as the January 2006 SSI COLA. The budget also proposes to suspend the January 2006 4.07 percent state SSP COLA, for savings of $131 million General Fund in 2005-06, and $262 million General Fund annually.

  The Administration indicates that even with these actions, California continues to provide the highest level of cash grants to SSI/SSP recipients among the ten most populous states.

  The January 2006 COLAs proposed for suspension would have increased the maximum grant for an individual by approximately $33, to $845 per month, and would have increased the maximum grant for a couple by approximately $58 to $1,495 per month. The LAO estimates that approximately 1,200 SSP-only recipients would become ineligible for SSP under this proposal. Becoming ineligible for SSI/SSP may result in a Medi-Cal share of cost for affected individuals.

- **Eroding Value of SSI/SSP Grant:** Grant levels have not kept pace with inflation in recent years due to the suspension of the January 2004 SSP COLA and the deferral of the January 2005 COLA until April 2005. Suspension of the January 2006 COLAs would further erode the ability of grant payments to keep pace with cost of living increases, such as rising food, housing, and transportation costs.

  Since 1990, rent prices have increased by 36 percent and the SSI/SSP purchasing power has declined by 18 percent. Without the COLA, beneficiaries will face additional pressure to reduce spending on food or utilities as housing costs increase.

Recommendation: Reject the Governor's proposal to suspend the federal SSI January 2006 COLA and the state SSP January 2006 COLA.

Issue 20: Delayed Cash Assistance Program for Immigrants (CAPI) Advocacy

Description: The May Revision reflects an increase of $1.6 million due to delayed implementation of the Cash Assistance Program for Immigrants Advocacy program. The Governor's Budget assumed a December 1, 2004 implementation date, which has been delayed to March 2005 as a result of county staffing and workload issues, as well as delays in Supplemental Security Income eligibility decisions.

The department indicates that most, if not all counties have started some sort of CAPI advocacy program during the first few months of the year. For example San Mateo, the Bay Area Consortium leader, started its program in October and indicates all of its member counties have started up some sort of program beginning early this year. Its members include the following targeted counties: Alameda, Contra Costa and Solano. The following counties have some sort of advocacy program: San Francisco, Santa Clara and San Diego. Orange and Riverside counties visited Los Angeles in December to gather information on Los Angeles's advocacy program, so they are pursuing this as well. County staffing and workload issues have caused delays, but based on the information above, counties are making progress towards implementation.

Recommendation: Approve the May Revision adjustment to CAPI Advocacy.

Issue 21: In-Home Supportive Services (IHSS) Share of Cost

Description: The May Revision proposes an increase of $10.6 million General Fund to apply Medi-Cal share of cost rules to IHSS recipients.

Due to the federal IHSS Plus Waiver adopted last year, IHSS recipients must now have a Medi-Cal eligibility determination. Currently they are determined eligible for IHSS based on SSI/SSP eligibility standards. Some recipients who do not currently have an IHSS share of cost may be required to have a share of cost under Medi-Cal standards, since Medi-Cal standards apply a lower maximum income level before a share of cost is required, compared to the SSI/SSP share of cost standards. The proposed funding would allow an average monthly caseload of 8,029 IHSS consumers to maintain IHSS eligibility without a higher share of cost.

Recommendation: Adopt the May Revision adjustment to apply Medi-Cal share of cost rules to IHSS recipients.

Issue 22: Peer Quality Case Reviews

Description: The May Revision proposes an increase of $575,000 ($305,000 General Fund and $270,000 Federal Trust Fund) to provide funding for counties to backfill and cover travel costs for probation officers to travel to other counties and participate in Peer Quality Case Reviews (PQCR) as required by Chapter 678, Statutes of 2001 (AB 636). PQCRs are key components of

California's new Outcomes and Accountability System to evaluate county operations of CWS based on federal performance reviews and the state's current Program Improvement Plan (PIP).

Recommendation: Adopt the May Revision proposal for Peer Quality Case Reviews.

Issue 23: Indian Child Welfare Act

Description: The federal Indian Child Welfare Act (ICWA) governs the proceedings for determining the placement of an Indian child when that child is removed from parental custody. Due to the complexity of ICWA, addition information and support for local entities may be needed to ensure ICWA compliance.

Background: In 1978, Congress enacted the Indian Child Welfare Act (ICWA) to address the systemic problems facing Native American tribes and families concerning their children; the act set out procedures for notice to tribes and families in cases of adoption, foster placement, dependency and neglect proceedings against parents, and other situations where parental rights of Native Americans were at risk. The provisions of the ICWA represent a dramatic departure from the procedural and substantive laws that most states have enacted to govern child custody proceedings. Because Indian children are treated uniquely in the legal system, and because there is an increasing number of court proceedings involving Indian children, the need for lawyers to understand the ICWA is fast becoming imperative.

Recommendation: Approve $150,000 ($75,000 General Fund) and establish 1.0 position to work with stakeholders and support ICWA compliance. Adopt placeholder trailer bill language to specify that the department should coordinate training and technical assistance for counties on ICWA.

Issue 24: Kinship/Foster Care Emergency Funds

Description: The May Revision proposes an increase of $600,000 Federal Trust Fund to provide emergency one-time funds to approximately 1,400 additional relative caregivers and foster parents to assist with housing needs and short-term support services. The federal government recently provided policy clarification that certain administration costs for the Kinship/Foster Care Emergency Funds program are eligible for matching Title IV-E funds.

Recommendation: Adopt the May Revision proposal for Kinship/Foster Care Emergency Funds.

Issue 25: Child Welfare Services (CWS) Outcome Improvement Project

Description: The May Revision proposes a decrease of $5,869,000 ($2,666,000 General Fund and $3,203,000 Federal Trust Fund) for the Child Welfare Services (CWS) Program Improvement Plan (PIP) to reflect a revised implementation strategy.

Background: This revised proposal, developed in consultation with key stakeholders, would:

- Continue the implementation and evaluation of CWS PIP activities in the initial 11 counties funded at the 2004-05 appropriation level;
- Suspend expansion to the second cohort of counties pending a thorough evaluation of measurable data from the first pilot group;
- Redirect resources proposed for PIP expansion to support efforts to improve AB 636 performance and federal improvement measures; and
- Add Item 5180-492 to reappropriate unspent federal Promoting Safe and Stable Families (PSSF) and State Children's Trust Fund (SCTF) funds from 2004-05 to 2005-06 to support county activities associated with implementation of System Improvement Plans (SIP) and ongoing PIP initiatives. This funding would be reallocated to Cohort 1 counties for specified CWS PIP initiatives, to support specified CWS program improvement and AB 636 activities.

Recommendation: Adopt the May Revision proposal, as amended to reflect an additional $3.5 million General Fund for additional CWS Outcome Improvement Project funding, and funding for a Point of Engagement model expansion evaluation.

Issue 26: SB 2030 Caseload Reporting

Description: The Subcommittee will consider adopting reporting language regarding SB 2030 (Costa, Chapter 785, Statutes of 1998).
Background:

In 1998 SB 2030 required the Department of Social Services to commission a study of counties' caseloads. At the time, the study concluded that for most categories the caseloads per-worker were twice the recommended levels. According to the study, it was difficult for social workers to provide services or maintain meaningful contact with children and their families because of the number of cases they were expected to carry.

The LAO believes the Legislature should be informed of the progress that is being made toward reducing social worker caseloads and the steady movement toward the SB 2030 recommendations. Toward this end, they recommend enactment of legislation that requires DSS

to submit a county specific social worker staffing ratio report annually no later than January 31. This report should provide each county the social worker staffing ratios compared to the Child Welfare Services Workload Study's (SB 2030) minimum and optimum caseload standards and the agreed upon 1984 standards. The methodology for measuring the individual county staffing ratios should take into account funding from the CWS augmentation, hold harmless funding, and any other funding that is used for social worker staffing. The LAO believes that the additional workload generated by this requirement would be minimal because the current budget is built individually for each of the 58 counties. Therefore, there should not be any state staffing increases needed to produce this report.

The Subcommittee considered this proposal on April 14th and directed the LAO, CWDA and Department of Social Services to develop Trailer Bill Language requiring an annual update on how county staffing compares to the SB 2030 study standards.

Recommendation: Adopt placeholder Trailer Bill Language requiring the Department of Social Services to report at the time of budget hearings, comparing the Governor's proposed budget for CWS, including the augmentation and hold harmless funds, to the caseload standards recommended by the SB 2030 study updated for cost-of-doing business and the use of CWS funds for non-case-carrying activities.

Issue 27: CalWORKs Program Funding

Description: The May Revision maintains a number of the Governor's proposed reductions in the CalWORKs program, including a 6.5 percent grant reduction, elimination of the CalWORKs Cost of Living Adjustment (COLA), Child Care Reform, and transfers of federal Temporary Assistance to Needy Families (TANF) funding to non-CalWORKs programs. The May Revision also rescinds the Governor's Budget proposal to reduce the CalWORKs Earned Income Disregard, and the proposal to increase CalWORKs sanctions and work requirements.

Background: The May Revision maintains the following CalWORKs reductions:

- **Reduce CalWORKs Grants by 6.5 percent.** The Governor's Budget proposed to reduce CalWORKs grants by approximately 6.5 percent, resulting in savings of $212 million. The May Revision amended this proposal to implement the grant reduction effective October 1, 2005, resulting in savings of $160 million. For a typical family of three, the maximum grant would be reduced from $723 to $676 per month.

- **Eliminate CalWORKs Cost of Living Adjustment (COLA).** The budget proposes to suspend the July 2005 COLA, and permanently suspend all future CalWORKs COLAs, resulting in savings of $135.5 million.

- **Child Care Reform.** The budget proposes to reduce license-exempt child care reimbursement levels, and establish a tiered reimbursement structure for all child care providers, resulting in savings of $163 million in DSS and the California Department of Education (CDE).

- **Reduce Employment Services Funding.** The budget proposes to eliminate $50 million in 2005-06 that was included in the 2004 Budget Act for CalWORKs employment services.

- **County Pay for Performance Proposal.** The budget proposes to tie county administration funding to CalWORKs client work participation rates, for projected savings of $22 million. The May Revision proposes $30 million in the TANF reserve to be used in 2006-07 as an incentive for counties who meet specific CalWORKs program outcomes in 2005-06. This $30 million would be in lieu of the Governor's Budget proposal to hold back 5 percent of the counties' single allocation in 2005-06 as an incentive. The Administration indicates it is continuing to work with stakeholders to develop the outcome measures and criteria for allocation of the funds. Revised trailer bill language is required for this proposal.

- **TANF Transfers.** The May Revision also includes $192 million TANF transfers to Title XX funded programs, which is significantly higher than the $63 million in TANF transfers to Title XX in the 2004 Budget Act. In addition, the May Revision maintains the Governor's Budget proposal to use $201 million in TANF funding for Juvenile Probation. In the current year Juvenile Probation is funded with $67.2 million TANF and $134.3 million General Fund, as the statute that allowed TANF to fund Juvenile Probation expired on October 31, 2004. Trailer bill language is proposed to enable TANF to be used for Juvenile Probation.

The May Revision rescinds the following CalWORKs reductions:

- **Reduce Earned Income Disregard.** The Governor's Budget proposed to reduce the Earned Income Disregard for CalWORKs families, resulting in $82 million savings. The May Revision rescinds this proposal.

- **Increase Sanctions and Work Requirements.** The Governor's Budget proposed to expand the CalWORKs work participation reforms based a pending evaluation of CalWORKs sanction policies, for estimated savings of $12 million. Due to a late report on sanctions by RAND, the May Revision rescinds this proposal. On May 11th the Assembly rejected the proposal due to the late report.

Recommendation:

1. **Reject** the CalWORKs sanctions proposal.

2. Accept the May Revision proposal to rescind the CalWORKs Earned Income Disregard Reduction proposal.

3. Adopt placeholder trailer bill language from County Welfare Directors Association on the Pay for Performance proposal.

4. **Reject** the following proposals (including associated trailer bill language):
    a. Reduce CalWORKs grants (including rejection of proposed trailer bill language to delete the October 2003 COLA in the event that the state loses its appeal in the *Guillen* case).
    b. Eliminate CalWORKs COLAs
    c. Child Care Reductions (conform to Assembly and to Senate Subcommittee No. 1)

5. Redirect $201 million TANF from Juvenile Probation back to CalWORKs grants and child care, and backfill the TANF in Juvenile Probation with General Fund (conforming to action in the Assembly and Senate Subcommittee No. 5).

6. Fund the CalWORKs COLA by replacing $135 million in TANF Transfers to CWS, Department of Developmental Services, and Foster Care for Title XX with General Fund (reject the trailer bill language to allow new TANF transfers to Title XX for Foster Care). Use the $135 million in TANF to restore the CalWORKs COLA.

7. Shift needed funds from the TANF reserve to fund CalWORKs and child care (conform to Assembly).

Issue 28: CalWORKs Performance Monitoring Proposal

Description: The Governor's Budget requests $794,000 for 8.0 positions to monitor and improve the measurement of county CalWORKs performance. This proposal includes collecting and validating county work participation data to ensure that the department has accurate data about the participation of CalWORKs recipients in Welfare-to-Work activities throughout the state. The County Welfare Directors Association (CWDA) has suggested trailer bill language to have the department work with CWDA and the Legislature to develop mutually agreed-upon approaches to improving data collection and management reporting information in the CalWORKs program.

Recommendation: Adopt placeholder trailer bill language to improve CalWORKs data collection and management reporting information.

Issue 29: Quarterly Reporting/Prospective Budgeting

Description: The May Revision reflects $152 million in grant costs and $181 million in administrative savings in 2005-06 due to implementation of prospective budgeting/quarterly reporting for the CalWORKs, Food Stamps, California Food Assistance Program (CFAP), and Refugee Assistance programs. The California Welfare Directors Association (CWDA) indicates that actual savings as result of prospective budgeting is significantly less than the amount estimated by the department.

Background:

The 2002 Budget trailer bill authorized the replacement of the Retrospective Budgeting/Monthly Reporting system with the Prospective Budgeting/Quarterly Reporting system. This change was intended to reduce the Food Stamp error rate. Counties transitioned to prospective budgeting between November 2003 and June 2004.

The California Welfare Directors Association indicates that administrative savings are overstated because:

- DSS assumed that caseworker time would decline by about 55 percent, but CWDA indicates time would decline by about 11 percent, or one-fifth of DSS estimate.

- County time studies conducted before Quarterly Reporting was implemented indicate that much less administrative time is devoted to processing monthly reports than the department assumes in its estimate. County time studies after Quarterly Reporting was implemented support this assumption.

- Department assumptions regarding the cost per hour of staff time after Quarterly Reporting was implemented understate county costs. For example, counties may not be able to reduce facility, supervisor, and clerical costs at the same rate as line staff.

- County data suggests much higher costs to process mid-quarter reports than assumed by the department. Although counties and the department have similar assumptions regarding the number of mid-quarter reports to process, they do not assume the same costs/person to process the reports.

The May Revision assumes $55 million ($20 million General Fund) savings in Food Stamp and CFAP administration for prospective budgeting, but CWDA indicates this savings should only be $11 million ($4 million General Fund). Absent full restoration to reflect the revised savings estimate, CWDA requests that the DSS savings estimate for Food Stamps administration be reduced by $25 million ($10 million General Fund), to $30 million ($9 million General Fund).

The May Revision also assumes $126 million TANF/General Fund savings in CalWORKs administration for prospective budgeting. The CWDA requests trailer bill language to allow unspent prior year TANF to be transferred to the budget year to offset the DSS savings estimate for prospective budgeting in CalWORKs by $50 million.

Recommendation:

1. Adopt placeholder trailer bill language to allocate unspent prior-year TANF funding to counties in 2005-06 for CalWORKs Administration (conform to Assembly).

2. Reduce Prospective Budgeting/Quarterly Reporting savings in Food Stamp and CFAP Administration by $10 million General Fund (conform to Assembly).

Discussion Agenda

5180 Department of Social Services (DSS)

Issue 30: Adoption Assistance Program (AAP) Technical Assistance

Description: The Adoption Assistance Program (AAP) provides grants and benefits to parents who adopt "difficult to place" children. These benefits are intended to help defray costs associated with children's special needs. Concerns have been raised that AAP benefits are being provided inconsistently throughout the state. Sierra Adoption Services requests the establishment of an AAP Training and Technical Assistance Program to meet the federal Child Welfare Program Improvement Plan (PIP) requirements to provide AAP training.

Questions:

1. DSS, what type of AAP and related program training is available for county workers, and is any of that training and information on AAP available for other organizations, judicial officers, foster parents, potential adoptive parents and current adoptive parents?

Recommendation: Approve $100,000 General Fund and matching federal funds for the provision of statewide Adoptions Assistance Program training (conform to Assembly).

Issue 31: Effect of Unallocated Reduction on Community Care Licensing

Description: The Governor's Budget proposed an unallocated reduction of $8.7 million General Fund for DSS state operations, which represents a 13 percent reduction in the total General Fund budget for the department.

Background:

The Governor's Budget included $150 million General Fund savings due to unallocated reductions in state operations budgets. The departments with the largest proposed reductions are:

Dept	GF $ (thousands)	GF state ops Gov Budget (thousands)	Percent Reduction
Department of Corrections	*-95,294	6,053,645	-1.6%
Department of Health Services	-11,259	247,392	-4.8%
Department of Social Services	-8,702	73,718	-13.4%
Franchise Tax Board	-7,840	504,517	-1.6%
Department of Forestry and Fire Protection	-6,696	429,297	-1.6%
Augmentation for Employee Compensation	-2,888		
Department of Developmental Services	-2,219	24,138	-10.1%
Department of Parks and Recreation	-1,567	100,976	-1.6%
Department of Food and Agriculture	-1,159		
Department of Veterans Affairs	-973		
Department of Industrial Relations	-955		
Department of Mental Health	-949		
Augmentation for Contingencies or Emergencies	-764		
Office of Emergency Services	-614		
Department of Food and Agriculture	-597		

*Subsequently reduced to approximately $42 million.

Community Care Licensing (CCL) is funded by $20 million General Fund, which represents 24 percent of the total $82 million General Fund in DSS state operations. At earlier hearings on CCL the department indicated that all required licensing visits had not been completed because CCL positions were held vacant to achieve salary savings from previous unallocated reductions. DSS has committed to fill these positions, and is holding the first Licensing Program Analyst

open exam in many years. However, it is still unknown which positions the department will hold vacant to achieve the unallocated reduction.

The Department of Finance indicates that in addition to specific reductions in major program areas, state operations budgets for departments within the Administration are proposed to be reduced by a total of $150 million General Fund in 2005-06. The departments have the flexibility to use lay-offs, hiring freezes, procurement reductions, or other administrative means to achieve these reductions, at the departments' discretion. These reductions do not apply to entities outside of the Administration. However, in light of the existing State fiscal situation, the Administration invites Constitutional Officers and the other co-equal branches of State government to participate in the endeavor to reduce their General Fund budgets.

The following were exempt from the unallocated reductions: Must-pay/Debt Service type of payments (e.g., GO, LR, POB, RANs, pension contribution, health/dental for retired annuitants) and accounting items (e.g., prorata). Legislature, Judicial, Constitutional Officers (exempt Governor's Office), Fire E-fund, P98, Higher Ed compact.

Questions:

1. DSS, please describe the impact of the unallocated reduction.

Recommendation: Adopt placeholder trailer bill language to require the department to report to the Legislature no later than September 30, 2005 on how the unallocated reduction will be distributed and the resulting programmatic affects, and in particular the expected affect on CCL.

Issue 32: SB 1104 CalWORKs Clarification

Description: SB 1104, the 2004-05 human services budget trailer bill, established a number of changes in the CalWORKs program, including provisions regarding the flexibility of activities that may count toward the required 32/35 work hours to maintain CalWORKs eligibility. The Administration's interpretation of these provisions has been under dispute.

Background: An adult in a one-parent assistance unit is required to participate in Welfare to Work (WTW) activities for an average of 32 hours per week, each month. In two-parent households, one or both adults must participate in WTW activities for a combined total of an average of 35 hours per week, each month, with one participating for at least 20 hours per week. Adults are required to participate in at least 20 hours per week of core work activities and the balance of their 32/35 hour per week participation requirement can be spent in other non-core activities that will aid recipients in obtaining employment. Noncompliance with work requirements results in a grant reduction equal to the adult's portion.

The department indicates that SB 1104 establishes CalWORKs approved Core and Non-Core WTW activities as outlined below. The department's interpretation that is under dispute is that if hours in Non-Blendable Non-Core activities are included in the WTW plan, then hours in *any*

Non-Core activity (including Blendable Non-Core) cannot count towards the core hours requirement.

Core Activities:

a) Unsubsidized Employment
b) Subsidized private sector employment
c) Subsidized public sector employment
d) Work experience
e) On-the-job training
f) Grant-based on the job training
g) Supported work or transitional employment
h) Work study
i) Self-employment
j) Community Service
m) Vocational education and training (up to 12 months)
n) Job search and job readiness assistance

Blendable Non-Core:

k) Adult basic education
l) Job skills training directly related to employment
o) Education directly related to employment
q) Mental health, substance abuse, domestic violence services

Non-Blendable Non-Core:

m) Vocational education and training (post 12 months)
p) Satisfactory progress in a secondary school
r) Other activities necessary to assist an individual in obtaining employment
s) Participation required by the school to ensure the child's attendance
Non-credited study time [pursuant to Section 42-716.272(a)]

Questions:

1. DSS, please present the key elements of SB 1104 with regard to Core and Non-Core WTW hours.

Recommendation: Adopt placeholder trailer bill language that clarifies that activities currently counted toward the 20 hours of core welfare-to-work (WTW) activities not be excluded because a client is engaged in other activities that are not clearly designated as either core or non-core activities. Trailer bill language would also indicate that hours spent making satisfactory progress in a secondary school is an allowable WTW activity under specified conditions (conform to Assembly).

Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda

Chair, Senator Denise Moreno Ducheny
Senator George C. Runner
Senator Tom Torlakson

Thursday, May 19, 2005
(Upon Adjournment)
John L. Burton Hearing Room (4203)
Consultant, Anastasia Dodson

Language for May 19, 2005 Hearing

Issue #27

Delay Implementation of 6.5 Percent CalWORKs Grant Reduction

SEC. 2. Section 11450 of the Welfare and Institutions Code, as amended by Section 328 of Chapter 62 of the Statutes of 2003, is amended to read:

11450. (a) ~~(1)~~ Aid shall be paid for each needy family, which shall include all eligible brothers and sisters of each eligible applicant or recipient child and the parents of the children, but shall not include unborn children, or recipients of aid under Chapter 3 (commencing with Section 12000), qualified for aid under this chapter. In determining the amount of aid paid, and notwithstanding the minimum basic standards of adequate care specified in Section 11452, the family's income, exclusive of any amounts considered exempt as income or paid pursuant to subdivision (e) or Section 11453.1, averaged for the prospective quarter pursuant to Sections 11265.2 and 11265.3, and then calculated pursuant to Section 11451.5, shall be deducted from the sum specified in the following tables, as adjusted for cost-of-living increases pursuant to Section 11453 ~~and paragraph (2)~~. In no case shall the amount of aid paid for each month exceed the sum specified in the following tables, as adjusted for cost-of-living increases pursuant to Section 11453 ~~and paragraph (2)~~, plus any special needs, as specified in subdivisions (c), (e), and (f)~~:~~.

(1) These tables shall be used in computing aid payments through September 30, 2005.

(A) The following table shall be used when all of the parents or caretaker relatives of the aided child, living in the home of the aided child, meet one of following conditions:

(i) The individual is disabled and receiving benefits under Section 12200 or 12300.

(ii) The individual is a nonparent caretaker who is not included in the assistance unit with the child.

(iii) The individual is disabled and is receiving State Disability Insurance benefits or Worker's Compensation Temporary Disability benefits.

Number of eligible needy persons in the same home	Maximum aid
1	$ 398
2	653
3	808
4	961
5	1,094
6	1,229
7	1,350
8	1,473
9	1,591
10 or more	1,709

(B) The following table shall be used when one or more of the parents or caretaker relatives of the aided child, living in the home of the aided child, do not meet any of the conditions listed in paragraph (A).

Number of eligible needy

persons in the same home	Maximum aid
1	$ 359
2	584
3	723
4	862
5	980
6	1,101
7	1,210
8	1,318
9	1,424
10 or more	1,530

(2)These tables shall be used in computing aid payments beginning October 1, 2005.

(A) The following table shall be used when all of the parents or caretaker relatives of the aided child, living in the home of the aided child, meet one of following conditions:
(i) The individual is disabled and receiving benefits under Section 12200 or 12300.
(ii) The individual is a nonparent caretaker who is not included in the assistance unit with the child.
(iii) The individual is disabled and is receiving State Disability Insurance benefits or Worker's Compensation Temporary Disability benefits.

Number of eligible needy persons in the same home		Maximum aid
1	~~$ 326~~	$ 372
2	~~535~~	611
3	~~663~~	755
4	~~788~~	899
5	~~899~~	1,023
6	~~1,010~~	1,149
7	~~1,109~~	1,262
8	~~1,209~~	1,377
9	~~1,306~~	1,488
10 or more	~~1,403~~	1,598

(B) The following table shall be used when one or more of the parents or caretaker relatives of the aided child, living in the home of the aided child, do not meet any of the conditions listed in paragraph (A).

Number of eligible needy persons in the same home	Maximum aid
1	$ 336
2	546
3	676
4	806
5	916

6	1,029
7	1,131
8	1,232
9	1,331
10 or more	1,431

~~If, when, and during such times as the United States government increases or decreases its contributions in assistance of needy children in this state above or below the amount paid on July 1, 1972, the amounts specified in the above table shall be increased or decreased by an amount equal to that increase or decrease by the United States government, provided that no increase or decrease shall be subject to subsequent adjustment pursuant to Section 11453.~~

~~(2) The sums specified in paragraph (1) shall not be adjusted for cost of living for the 1990-91, 1991-92, 1992-93, 1993-94, 1994-95, 1995-96, 1996-97, and 1997-98 fiscal years, and through October 31, 1998, nor shall that amount be included in the base for calculating any cost-of-living increases for any fiscal year thereafter.~~
~~Elimination of the cost-of-living adjustment pursuant to this paragraph shall satisfy the requirements of Section 11453.05, and no further reduction shall be made pursuant to that section.~~

(b) When the family does not include a needy child qualified for aid under this chapter, aid shall be paid to a pregnant mother for the month in which the birth is anticipated and for the three-month period immediately prior to the month in which the birth is anticipated in the amount that would otherwise be paid to one person, as specified in subdivision (a), if the mother, and child, if born, would have qualified for aid under this chapter. Verification of pregnancy shall be required as a condition of eligibility for aid under this subdivision. Aid shall also be paid to a pregnant woman with no other children in the amount which would otherwise be paid to one person under subdivision (a) at any time after verification of pregnancy if the pregnant woman is also eligible for the Cal-Learn Program described in Article 3.5 (commencing with Section 11331) and if the mother, and child, if born, would have qualified for aid under this chapter.

(c) The amount of forty-seven dollars ($47) per month shall be paid to pregnant mothers qualified for aid under subdivision (a) or (b) to meet special needs resulting from pregnancy if the mother, and child, if born, would have qualified for aid under this chapter. County welfare departments shall refer all recipients of aid under this subdivision to a local provider of the Women, Infants and Children program. If that payment to pregnant mothers qualified for aid under subdivision (a) is considered income under federal law in the first five months of pregnancy, payments under this subdivision shall not apply to persons eligible under subdivision (a), except for the month in which birth is anticipated and for the three-month period immediately prior to the month in which delivery is
anticipated, if the mother, and the child, if born, would have qualified for aid under this chapter.

(d) For children receiving AFDC-FC under this chapter, there shall be paid, exclusive of any amount considered exempt as income, an amount of aid each month which, when added to the child's income, is equal to the rate specified in Section 11460, 11461, 11462, 11462.1, or 11463. In addition, the child shall be eligible for special needs, as specified in departmental regulations.

(e) In addition to the amounts payable under subdivision (a) and Section 11453.1, a family shall be entitled to receive an allowance for recurring special needs not common to a majority of recipients. These recurring special needs shall include, but not be limited to, special diets upon the recommendation of a physician for circumstances other than

pregnancy, and unusual costs of transportation, laundry, housekeeping service, telephone, and utilities. The recurring special needs allowance for each family per month shall not exceed that amount resulting from multiplying the sum of ten dollars ($10) by the number of recipients in the family who are eligible for assistance.

(f) After a family has used all available liquid resources, both exempt and nonexempt, in excess of one hundred dollars ($100), the family shall also be entitled to receive an allowance for nonrecurring special needs.

(1) An allowance for nonrecurring special needs shall be granted for replacement of clothing and household equipment and for emergency housing needs other than those needs addressed by paragraph (2). These needs shall be caused by sudden and unusual circumstances beyond the control of the needy family. The department shall establish the allowance for each of the nonrecurring special need items. The sum of all nonrecurring special needs provided by this subdivision shall not exceed six hundred dollars ($600) per event.

(2) Homeless assistance is available to a homeless family seeking shelter when the family is eligible for aid under this chapter. Homeless assistance for temporary shelter is also available to homeless families which are apparently eligible for aid under this chapter. Apparent eligibility exists when evidence presented by the applicant or which is otherwise available to the county welfare department and the information provided on the application documents indicate that there would be eligibility for aid under this chapter if the evidence and information were verified. However, an alien applicant who does not provide verification of his or her eligible alien status, or a woman with no eligible children who does not provide medical verification of pregnancy, is not apparently eligible for purposes of this section.

A family is considered homeless, for the purpose of this section, when the family lacks a fixed and regular nighttime residence; or the family has a primary nighttime residence that is a supervised publicly or privately operated shelter designed to provide temporary living accommodations; or the family is residing in a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

(A) (i) A nonrecurring special need of forty dollars ($40) a day shall be available to families for the costs of temporary shelter, subject to the requirements of this paragraph. County welfare departments may increase the daily amount available for temporary shelter to large families as necessary to secure the additional bed space needed by the family.

(ii) This special need shall be granted or denied immediately upon the family's application for homeless assistance, and benefits shall be available for up to three working days. The county welfare department shall verify the family's homelessness within the first three working days and if the family meets the criteria of questionable homelessness established by the department, the county welfare department shall refer the family to its early fraud prevention and detection unit, if the county has such a unit, for assistance in the verification of homelessness within this period.

(iii) After homelessness has been verified, the three-day limit shall be extended for a period of time which, when added to the initial benefits provided, does not exceed a total of 16 calendar days. This extension of benefits shall be done in increments of one week and shall be based upon searching for permanent housing which shall be documented on a housing search form; good cause; or other circumstances defined by the department. Documentation of housing search shall be required for the initial extension of benefits beyond the three-day limit and on a weekly basis thereafter as long as the family is receiving temporary shelter benefits. Good cause shall include, but is not limited to, situations in which the county welfare department has determined that the

family, to the extent it is capable, has made a good faith but unsuccessful effort to secure permanent housing while receiving temporary shelter benefits.

(B) A nonrecurring special need for permanent housing assistance is available to pay for last month's rent and security deposits when these payments are reasonable conditions of securing a residence.

The last month's rent portion of the payment (1) shall not exceed 80 percent of the family's maximum aid payment without special needs for a family of that size and (2) shall only be made to families that have found permanent housing costing no more than 80 percent of the family's maximum aid payment without special needs for a family of that size, in accordance with the maximum aid schedule specified in subdivision (a).

However, if the county welfare department determines that a family intends to reside with individuals who will be sharing housing costs, the county welfare department shall, in appropriate circumstances, set aside the condition specified in clause (2) of the preceding paragraph.

(C) The nonrecurring special need for permanent housing assistance is also available to cover the standard costs of deposits for utilities which are necessary for the health and safety of the family.

(D) A payment for or denial of permanent housing assistance shall be issued no later than one working day from the time that a family presents evidence of the availability of permanent housing. If an applicant family provides evidence of the availability of permanent housing before the county welfare department has established eligibility for aid under this chapter, the county welfare department shall complete the eligibility determination so that the denial of or payment for permanent housing assistance is issued within one working day from the submission of evidence of the availability of permanent housing, unless the family has failed to provide all of the verification necessary to establish eligibility for aid under this chapter.

(E) (i) Except as provided in clauses (ii) and (iii), eligibility for the temporary shelter assistance and the permanent housing assistance pursuant to this paragraph shall be limited to one period of up to 16 consecutive calendar days of temporary assistance and one payment of permanent assistance. Any family that includes a parent or nonparent caretaker relative living in the home who has previously received temporary or permanent homeless assistance at any time on
behalf of an eligible child shall not be eligible for further homeless assistance. Any person who applies for homeless assistance benefits shall be informed that the temporary shelter benefit of up to 16 consecutive days is available only once in a lifetime, with certain exceptions, and that a break in the consecutive use of the benefit constitutes permanent exhaustion of the temporary benefit.

(ii) A family that becomes homeless as a direct and primary result of a state or federally declared natural disaster shall be eligible for temporary and permanent homeless assistance.

(iii) A family shall be eligible for temporary and permanent homeless assistance when homelessness is a direct result of domestic violence by a spouse, partner, or roommate; physical or mental illness that is medically verified that shall not include a diagnosis of alcoholism, drug addiction, or psychological stress; or, the
uninhabitability of the former residence caused by sudden and unusual circumstances beyond the control of the family including natural catastrophe, fire, or condemnation. These circumstances shall be verified by a third-party governmental or private health and human services agency and homeless assistance payments based on these specific circumstances may not be received more often than once in any 12-month period. A county may require that a recipient of homeless assistance benefits who qualifies under this paragraph for a second time in a 24-month period participate in a

homelessness avoidance case plan as a condition of eligibility for homeless assistance benefits.

(iv) The county welfare department shall report to the department through a statewide homeless assistance payment indicator system, necessary data, as requested by the department, regarding all recipients of aid under this paragraph.

(F) The county welfare departments, and all other entities participating in the costs of the AFDC program, have the right in their share to any refunds resulting from payment of the permanent housing. However, if an emergency requires the family to move within the 12-month period specified in subparagraph (E), the family shall be allowed to use any refunds received from its deposits to meet the costs of moving to another residence.

(G) Payments to providers for temporary shelter and permanent housing and utilities shall be made on behalf of families requesting these payments.

(H) The daily amount for the temporary shelter special need for homeless assistance may be increased if authorized by the current year's Budget Act by specifying a different daily allowance and appropriating the funds therefor.

(I) No payment shall be made pursuant to this paragraph unless the provider of housing is a commercial establishment, shelter, or person in the business of renting properties who has a history of renting properties.

(g) The department shall establish rules and regulations assuring the uniform application statewide of this subdivision.

(h) The department shall notify all applicants and recipients of aid through the standardized application form that these benefits are available and shall provide an opportunity for recipients to apply for the funds quickly and efficiently.

(i) Except for the purposes of Section 15200, the amounts payable to recipients pursuant to Section 11453.1 shall not constitute part of the payment schedule set forth in subdivision (a).

The amounts payable to recipients pursuant to Section 11453.1 shall not constitute income to recipients of aid under this section.

(j) For children receiving Kin-GAP pursuant to Article 4.5 (commencing with Section 11360) of Chapter 2, there shall be paid, exclusive of any amount considered exempt as income, an amount of aid each month, which, when added to the child's income, is equal to the rate specified in Section 11364.

(k) Should a court determine that the state must provide a cost-of-living adjustment pursuant to the Guillen v. Schwarzenegger case, grants shall be increased to provide the retroactive cost-of-living adjustment for eligible recipients only for the period from October 1, 2003, to the effective date of the act that added this subdivision. On and after the effective date of the act that added this subdivision, the ongoing grant amount shall revert to the grant amounts specified in subdivision (a).

SEC. 3. Section 11450.018 of the Welfare and Institutions Code is amended to read:

11450.018. ~~(a)~~ Notwithstanding any other provision of law, the maximum aid payment in accordance with paragraph (1) of subdivision (a) of Section 11450 ~~as reduced by subdivisions (a) and (b) of Section 11450.01, Section 11450.015, and Section 11450.017,~~ shall be reduced by 4.9 percent for counties in Region 2, as specified in Section 11452.018.

~~(b) Notwithstanding any other provision of law, through October 31, 1998, the maximum aid payment in accordance with paragraph (1) of subdivision (a) of Section 11450, as reduced by subdivision (a) and (b) of Section 11450.01, Section 11450.015, Section 11450.017, and subdivision (a) shall be reduced by 4.9 percent.~~

~~(c) Prior to implementing the reductions specified in subdivisions (a) and (b), the director shall apply for and obtain a waiver from the United States Department of Health and Human Services of Section 1396a(c)(1) of Title 42 of the United States Code. The reduction shall be implemented to the extent the waiver is granted and only so long as the waiver is effective. This subdivision shall not apply if either the federal waiver process set forth at Section 1315 of Title 42 of the United States Code or Section 1396a(c) is repealed or modified such that a waiver is not necessary to implement subdivision (a) or (b).~~

~~(d) This section shall become operative and the reductions specified in subdivisions (a) and (b) shall commence on the first day of the month following 30 days after the receipt of federal approval or on the first day of the month following 30 days after a change in federal law that allows states to reduce aid payments without any risk to federal funding under Title XIX of the Social Security Act, whichever is earlier, but no earlier than October 1, 1995.~~

SEC. 4. Section 11450.019 of the Welfare and Institutions Code is repealed.

~~11450.019. Effective the first day of the month following 90 days after a change in federal law that allows states to reduce aid payments without any risk to federal funding under Title XIX of the Social Security Act contained in Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code, the reductions in maximum aid payments specified in Section 11450.01, 11450.015, and 11450.017 shall not be applied when all of the parents or caretaker relatives of the aided child living in the home of the aided child meet one of the following conditions:~~

~~(a) The individual is disabled and receiving benefits under Section 12200 or 12300.~~

~~(b) The individual is a nonparent caretaker who is not included in the assistance unit with the child.~~

~~(c) The individual is disabled and is receiving State Disability Insurance benefits or Worker's Compensation Temporary Disability benefits.~~

Issue #29

Fund Juvenile Probation with Federal Temporary Assistance for Needy Families Block Grant Funds

SEC. 8. Chapter 3.2 of Division 9, commencing with Section 18220, is added to the Welfare and Institutions Code:

18220. (a) The State Department of Social Services, as the single state agency for administration of the State's Temporary Assistance for Needy Families (TANF) program, is hereby authorized to enter into an interagency agreement with the State Board of Corrections (BOC) effective July 1, 2005 to administer funds appropriated for the purposes of this chapter pursuant to this section.

(b)(1) The BOC shall administer the provisions of this chapter including the establishment of agreements with all county probation departments that receive funding under this chapter.

(2)(A) Subject to availability of funds in the annual Budget Act, the BOC shall be responsible for allocating funds to counties and for reporting to the department in a manner, as prescribed by the department, necessary to meet federal financial and data reporting requirements.

(B) Beginning in the 2005-06 fiscal year, the BOC shall allocate funds among counties based on the allocation schedule issued by the department for the 2004-05 fiscal year. In any year when the total amount appropriated by the Legislature for the purposes of this chapter differs from the total amount provided in 2004-05, the amount appropriated shall be apportioned to counties based on the 2004-05 allocation schedule.

Alameda	$7,272,166
Alpine	$584
Amador	$100,667
Butte	$538,712
Calaveras	$103,092
Colusa	$677,943
Contra Costa	$5,121,082
Del Norte	$364,043
El Dorado	$508,807
Fresno	$4,951,621
Glenn	$90,484
Humboldt	$286,072
Imperial	$572,419
Inyo	$241,575
Kern	$6,420,942
Kings	$926,088
Lake	$314,736
Lassen	$91,671
Los Angeles	$82,957,789
Madera	$680,092
Marin	$631,365
Mariposa	$22,394
Mendocino	$333,240
Merced	$584,419
Modoc	$36,005
Mono	$12,013
Monterey	$1,344,865

Napa	$593,942
Nevada	$209,805
Orange	$16,375,528
Placer	$450,012
Plumas	$46,127
Riverside	$6,254,743
Sacramento	$4,877,762
San Benito	$360,418
San Bernardino	$6,354,425
San Diego	$11,691,946
San Francisco	$3,349,739
San Joaquin	$1,828,748
San Luis Obispo	$1,013,424
San Mateo	$3,623,954
Santa Barbara	$3,264,901
Santa Clara	$10,527,279
Santa Cruz	$1,033,949
Shasta	$1,037,717
Sierra	$6,168
Siskiyou	$126,526
Solano	$1,956,201
Sonoma	$2,508,668
Stanislaus	$889,952
Sutter	$226,793
Tehama	$243,674
Trinity	$58,342
Tulare	$2,775,735
Tuolumne	$119,136
Ventura	$3,651,657
Yolo	$429,067
Yuba	$341,776
Total	$201,413,000

18221. (a) Expenditures under this section shall be limited to services allowable under Title IV-A of the Social Security Act (commencing with Section 601) of Subchapter 4 of Chapter 7 of title 42 of the United States Code. Pursuant to these provisions,

(b)(1) Any child who has not been adjudicated and placed in the juvenile justice system is eligible for preventive services for him/herself, or for his/her family members, which are necessary to allow the child to be cared for in his/her own home or in the home of a relative.

Issue #35

CalWORKs Pay for Performance

SEC. 6. Section 15204.6 is added to the Welfare and Institutions Code:

15204.6 (a) Contingent upon a Budget Act appropriation, for the 2006-07, 2007-08, and 2008-09 fiscal years, a Pay for Performance Program shall provide additional funding for counties that meet specified goals in their welfare-to-work programs under Section 11320 et seq..

(b) The maximum funds available to each county each year under this program shall be the lesser of:

(1) The percentage of the total funds available for Pay for Performance that year which is equal to the percentage the county receives of the total funds appropriated, less the amount for child care, under Section 15204.2, or

(2) Five percent of the funds the county receives that year from the single allocation, less the amount for child care, under Section 15204.2.

(c) The funds available to the county under this program will be divided each year into as many equal parts as there are goals established for the year under this subdivision. The county will earn payment of one part for each goal that it achieves for the year. The department shall consult with the County Welfare Directors Association when developing standards for each of the following goals:

(1) The employment rate of county CalWORKs recipients, for the fiscal year prior to payment, increases over the employment rate of county CalWORKs recipients for the fiscal year two years prior to payment, by a statewide standard established by the department.

(2) The federal participation rates for the county CalWORKs recipients, calculated in accordance with 42 USC §607, but without including individuals who are exempt in accordance with Section 11320.3, increases by a statewide standard established by the department. The department may make further adjustments to this measure after consulting with the County Welfare Directors Association. If valid data do not exist to measure this outcome, the funds for this goal will be made available for the program in the following fiscal year.

(A) For fiscal year 2006-07, federal participation rates of CalWORKs recipients in the county for the period July through December, 2005, will be compared with federal participation rates in the county for the period January through June, 2006.

(B) For payment in fiscal years 2007-08 and 2008-09, federal participation rates of CalWORKs recipients in the county for the fiscal year prior to payment will be compared with federal participation rates during the fiscal year two years prior to payment.

(3) The number of county CalWORKs recipients that become ineligible for assistance under Section 11450, due to earned income, for the fiscal year prior to payment, increases over the number of county CalWORKs recipients that became ineligible for assistance under Section 11450, due to earned income, for the fiscal year two years prior to payment, by a statewide standard established by the department.

(4) Additional goals which the department establishes in consultation with the County Welfare Directors Association.

(d) The funds paid in accordance with this section must be used for the CalWORKs program only. Funds earned by a county in accordance with this section are available for expenditure in either the fiscal year that they are received or the following fiscal year. Following the period of availability, any unspent balance shall revert to the Temporary Assistance for Needy Families (TANF) Block Grant.

(e) Any funds appropriated by the Legislature for the Pay for Performance Program, but not earned by a county, shall revert to the TANF Block Grant at the end of the fiscal year for which the funds were appropriated.

SEC. 7. Notwithstanding the rulemaking provisions of the Administrative Procedure Act, Chapter 3.5 (commencing with Section 11340) of Part 1 of division 3 of Title 2 of the Government Code, the department may implement Section 6 of this act through all-county letters throughout the duration of the Pay for Performance program.

Issue #36

Nursing Initiative: Employment Training Fund for CalWORKs

SEC. 1. Section 1611.5 of the Unemployment Insurance Code is amended to read:

1611.5. Notwithstanding Section 1611, the Legislature may appropriate from the Employment Training Fund ~~fifty-six million four hundred thirty-two~~ thirty five million four hundred thirty thousand dollars ~~($56,432,000)~~ ($35,430,000) in the Budget Act of ~~2004~~ 2005 to fund the local assistance portion of welfare-to-work activities under the CalWORKs program, provided for pursuant to Article 3.2 (commencing with Section 11320) of Chapter 2 of Part 3 of Division 9 of the Welfare and Institutions Code, as administered by the State Department of Social Services.

Issue #48

In-Home Supportive Services Share-of-Cost

SEC. 5. Section 12305.1 of the Welfare and Institutions Code is amended to read:

12305.1. (a) Any aged, blind, or disabled individual who is receiving Medi-Cal personal care services pursuant to subdivision (p) of Section 14132.95, and who would otherwise be deemed a categorically needy recipient pursuant to Section 12305, is eligible to receive a supplementary payment under this article to be used towards the purchase of personal care services. Additionally, any aged, blind, or disabled individual who is receiving services pursuant to Section 14132.951, and who would otherwise be deemed a categorically needy recipient pursuant to Section 12305, is eligible to receive a supplementary payment under this article to be used towards the purchase of services under Section 14132.951.

(b) A supplementary payment pursuant to this section shall be the difference between the following amounts:

(1) A beneficiary's excess income as determined under Section 12304.5.

(2) The beneficiary's nonexempt income as determined pursuant to Section 14005.7, in excess of the income levels for maintenance need pursuant to Section 14005.12.

(c) Notwithstanding subdivisions (a) and (b), no supplementary payment shall be made pursuant to this section unless the amount specified in paragraph (2) of subdivision (b) is larger than the amount specified in paragraph (1) of subdivision (b).

(d) In the event of a final judicial determination by any court of appellate jurisdiction or a final determination by the Administrator of the federal ~~Health Care Financing Administration~~ Centers for Medicaid and Medicare that supplemental payments to medically needy persons not receiving services pursuant to subdivision (p) of Section 14132.95 must be made, then this section and subdivision (p) of Section 14132.95 shall cease to be operative on the first day of the month that begins after the expiration of a period of 30 days subsequent to a notification in writing by the Director of Finance to the chairperson of the committee in each house that considers appropriations, the chairpersons of the committees and the appropriate subcommittees in each house that consider the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(e) In the event that the Department of Finance determines that the costs of the supplementary payments made under this section exceed the savings resulting from federal financial participation in providing services under subdivision (p) of Section 14132.95, this section and subdivision (p) of Section 14132.95 shall cease to be operative on the first day of the first month following such a determination and a 30-day notification in writing by the Department of Finance to the chairperson of the committee in each house of the Legislature that considers appropriations, the chairperson of the committees and the appropriate subcommittees in each house that consider the State Budget, and the Chairperson of the Joint Legislative Budget Committee. Persons who had been eligible for a supplementary payment under this section shall be eligible to receive uninterrupted services pursuant to Article 7 (commencing with Section 12300) of Chapter 3, if otherwise eligible.

Implementation of Office of Systems Integration

Proposed Trailer Bill Language:

SEC. 1. Section 12803.3 is added to the Government Code, to read:

12803.3. (a) For the purposes of this section, the following definitions apply:
(1) "Director" means the Director of the Office of Systems Integration.
(2) "Office" means the Office of Systems Integration established in the Health and Human Services Agency.
(3) "Services" means all functions, responsibilities or services deemed to be functions, responsibilities or services of the Systems Management Services or Systems Integration Division of the Health and Human Services Agency Data Center, as determined by the Secretary of the Health and Human Services Agency.

(b) (1)The Systems Management Services of the Health and Human Services Agency Data Center, also known as the Systems Integration Division, is hereby transferred to the California Health and Human Services Agency and shall be known as the Office of Systems Integration, which is the successor to, and is vested with, all of the duties powers, purposes, responsibilities, and jurisdiction of the Systems Management Services or Systems Integration Division of the California Health and Human Services Agency Data Center.

(2) Consistent with state policy, the office shall perform information technology project management activities including, but not limited to, planning and tracking project tasks, conducting procurement activities consistent with state laws and regulations, managing project risks, communicating project activities to stakeholders, and conducting system engineering and oversight functions.

(c) Notwithstanding any other provision of law, all services of the Systems Management Services or Systems Integration Division of the Health and Human Service Agency Data Center shall become the services of the Office of Systems Integration.

(d) No contract, lease, license, or any other agreement to which the Systems Management Services or Systems Integration Division of the California Health and Human Services Agency Data Center is a party shall be void or voidable by reason of this section, but shall continue in full force and effect, with the Office assuming all of the rights, obligations, and duties of the Systems Management Services, or the Systems Integration Division of the California Health and Human Services Agency Data Center. That assumption of rights, obligations, and duties shall not in any way affect the rights of the parties to the contract, lease, license, or agreement.

(e) All books, documents, records, and property of the Systems Management Services or Systems Integration Division of the California Health and Human Services Agency Data Center shall be in the possession and under the control of the Office.

(f) All officers and employees of the Systems Management Services or the Systems Integration Division of the California Health and Human Services Agency Data Center shall be designated as officers and employees of the agency. The status, position, and rights of any officer or employee shall not be affected by this designation, and all officers and employees shall be retained by the agency pursuant to the applicable provisions of the State Civil Service Act (Part 2 (commencing with Section 18500) of Division 5), except as to positions that are exempt from civil service.

(g) The office shall be under the supervision and control of a director, known as the Director of the Office of Systems Integration, who shall be appointed by, and serve at the pleasure of, the Secretary of the Health and Human Services Agency.

SEC 2. Section 11798 is added to the Government Code to read:
11798.(a) There is in the State Treasury, the Office of Systems Integration Fund, subject to appropriation by the Legislature. This fund shall be used for support of the Office of Systems Integration, as established by Section 12803.3.

(b) The fund shall consist of all of the following:
(1) All moneys appropriated to the fund in accordance with law.
(2) The balance of all moneys available for expenditure by the Systems Management Services or the Systems Integration Division of the California Health and Human Services Agency Data Center.

(c) The amount of funding transferred from the Health and Human Services Agency Data Center Revolving Fund and the Department of Technology Services Revolving Fund to this fund shall be determined by the Department of Finance.

(d) Funds appropriated to the Department of Social Services in the annual Budget Act for the management, including as needed, procurement, design, development, testing, implementation, and oversight of the following projects shall be transferred to this fund upon order of the Department of Finance.
(1) Statewide Automated Welfare System (SAWS)
(2) Child Welfare Services/Case Management System (CWS/CMS)
(3) Electronic Benefit Transfer (EBT)
(4) Statewide Fingerprint Imaging System (SFIS)
(5) Case Management Information Payrolling System (CMIPS) Reprocurement

(e) Funds appropriated to the Employment Development Department in the annual Budget Act for the management, including as needed, procurement, design, development, testing, implementation, and oversight of the Unemployment Insurance Modernization project shall be transferred to this fund upon order of the Department of Finance.

SEC. 3. Section 10075.6 of the Government Code shall be amended to read:
10075.6. The ~~Health and Welfare Agency Data Center~~ *Office of Systems Integration* shall be the project manager of the electronic benefits transfer system, and shall be responsible for system planning, procurement, development, implementation, conversion, ~~maintenance and operations~~, contract management, and all other activities that are consistent with a state-managed project and a statewide system.

SEC 4. Section 10823 of the Welfare and Institution Code shall be amended to read:
10823. (a) (1) The ~~Health and Welfare Agency Data Center~~ *Office of Systems Integration* shall implement a statewide automated welfare system for the following public assistance programs:
(A) The CalWORKs program.
(B) The Food Stamp Program.
(C) The Medi-Cal Program.
(D) The foster care program.
(E) The refugee program.
(F) County medical services programs.
(2) Statewide implementation of the statewide automated welfare system for the programs listed in paragraph (1) shall be achieved through no more than four county consortia, including the Interim Statewide Automated Welfare System Consortium, and the Los Angeles Eligibility, Automated Determination, Evaluation, and Reporting System.

(b) Nothing in subdivision (a) transfers program policy responsibilities related to the public assistance programs specified in subdivision (a) from the State Department of Social Services or the State Department of Health Services to the *Office of Systems Integration* ~~Health and Welfare Agency Data Center~~.

~~(c) Beginning February 1, 1998, and on February 1 of each year thereafter, the Health and Welfare Agency Data Center shall provide an annual report to the appropriate committees of the Legislature on the statewide automated welfare system implemented under this section. The report shall address the progress of state and consortia activities and any significant schedule, budget, or functionality changes in the project.~~

SEC 5. Section 10823.1 of the Welfare and Institution Code is repealed.
~~10823.1. The California Health and Human Services Agency Data Center and the State Department of Social Services shall, in consultation with the Department of Finance, the Department of Information Technology, and the Interim Statewide Automated Welfare System (ISAWS) Consortium, develop a plan for the migration of the ISAWS Consortium counties to one or more statewide automated welfare system consortia. This plan shall be submitted to the chairs of the budget committees of each house of the Legislature and the Chair of the Joint Legislative Budget Committee by March 15, 2003.~~

Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda
Health & Human Services

Chair, Senator Denise Ducheny

Senator George Runner
Senator Tom Torlakson

May 20, 2005

10:00 AM

Room 4203

Agenda

(Diane Van Maren)

Item	Department
0530	**Health and Human Services Agency (Medicare Part D)**
4280	**Managed Risk Medical Insurance Board**
4260	**Department of Health Services**
4440	**Department of Mental Health**

PLEASE NOTE:

(1) ALL previous actions taken by the Subcommittee remain, unless the Subcommittee otherwise modifies the proposal at the May Revision hearing.
(2) The "VOTE ONLY" CALENDAR for each department may include the modification or denial of proposals, as well as acceptance of proposals. This will be noted in the Agenda as applicable.
(3) Only those issues in today's agenda are before the Subcommittee.
(4) The Subcommittee will be completely closed out at our *Saturday, May 21st* hearing. All remaining issues and departments will be heard at that time.
(5) Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair. Thank you.

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

I. ISSUES RECOMMENDED FOR "VOTE ONLY"
(Not in Department Item Order)

A. Item 4280--Managed Risk Medical Insurance Board *(Vote Only)*

1. Trailer Bill Language-- Continue Existing HFP Health Plan Enrollment Assistance

Issue: Through the Budget Act of 2001, trailer bill language was enacted that enabled health plans to partner with schools to conduct outreach and enrollment activities for the Healthy Families Program (HFP). A sunset was added to the language primarily because it was a new process. **As such, the existing statute sunsets as of January 1, 2006.**

Subcommittee Staff Recommendation: It **is recommended to amend Section 12693.325 of Insurance Code to delete the sunset as shown below**. No issues have been raised and the Administration has acknowledged that they have no concerns with this proposal.

12693.325.(a) (1) Notwithstanding any provision of this chapter, a participating health, dental, or vision plan that is licensed and in good standing as required by subdivision (b) of Section 12693.36 may provide application assistance directly to an applicant acting on behalf of an eligible person who telephones, writes, or contacts the plan in person at the plan's place of business, or at a community public awareness event that is open to all participating plans in the county, or at any other site approved by the board, and who requests application assistance.
(**2**) ~~**Until January 1, 2006,**~~ a participating health, dental, or vision plan may also provide application assistance directly to an applicant only under the following conditions:
(A) The assistance is provided upon referral from a government agency, school, or school district.
(B) The applicant has authorized the government agency, school, or school district to allow a health, dental, or vision plan to contact the applicant with additional information on enrolling in free or low-cost health care.
(C) The State Department of Health Services approves the applicant authorization form in consultation with the board.
(D) The plan may not actively solicit referrals and may not provide compensation for the referrals.
(E) If a family is already enrolled in a health plan, the plan that contacts the family cannot encourage the family to change health plans.
(F) The board amends its marketing guidelines to require that when a government agency, school, or school district requests assistance from a participating health, dental, or vision plan to provide application assistance, that all plans in the area shall be invited to participate.
(G) The plan abides by the board's marketing guidelines.
(b) A participating health, dental, or vision plan may provide application assistance to an applicant who is acting on behalf of an eligible or potentially eligible child in any of the following situations:
(1) The child is enrolled in a Medi-Cal managed care plan and the participating plan becomes aware that the child's eligibility status has or will change and that the child will no longer be eligible for Medi-Cal. In those instances, the plan shall inform the applicant of the differences in benefits and requirements between the Healthy Families Program and the Medi-Cal program.
(2) The child is enrolled in a Healthy Families Program managed care plan and the participating plan becomes aware that the child's eligibility status has changed or will change and that the child will no longer be eligible for the Healthy Families Program. When it appears a child may be eligible for Medi-Cal benefits, the plan shall inform the applicant of the differences in benefits and requirements between the Medi-Cal program and the Healthy Families Program.
(3) The participating plan provides employer-sponsored coverage through an employer and an employee of that employer who is the parent or legal guardian of the eligible or potentially eligible child.

(4) The child and his or her family are participating through the participating plan in COBRA continuation coverage or other group continuation coverage required by either state or federal law and the group continuation coverage will expire within 60 days, or has expired within the past 60 days.
(5) The child's family, but not the child, is participating through the participating plan in COBRA continuation coverage or other group continuation coverage required by either state or federal law, and the group continuation coverage will expire within 60 days, or has expired within the past 60 days.
(c) A participating health, dental, or vision plan employee or other representative that provides application assistance shall complete a certified application assistant training class approved by the State Department of Health Services in consultation with the board. The employee or other representative shall in all cases inform an applicant verbally of his or her relationship with the participating health plan. In the case of an in-person contact, the employee or other representative shall provide in writing to the applicant the nature of his or her relationship with the participating health plan and obtain written acknowledgment from the applicant that the information was provided.
(d) A participating health, dental, or vision plan that provides application assistance may not do any of the following:
(1) Directly, indirectly, or through its agents, conduct door-to-door marketing or telephone solicitation.
(2) Directly, indirectly, or through its agents, select a health plan or provider for a potential applicant. Instead, the plan shall inform a potential applicant of the choice of plans available within the applicant's county of residence and specifically name those plans and provide the most recent version of the program handbook.
(3) Directly, indirectly, or through its agents, conduct mail or in-person solicitation of applicants for enrollment, except as specified in subdivision (b), using materials approved by the board.
(e) A participating health, dental, or vision plan that provides application assistance pursuant to this section is not eligible for an application assistance fee otherwise available pursuant to Section 12693.32, and may not sponsor a person eligible for the program by paying his or her family contribution amounts or copayments, and may not offer applicants any inducements to enroll, including, but not limited to, gifts or monetary payments.
(f) A participating health, dental, or vision plan may assist applicants acting on behalf of subscribers who are enrolled with the participating plan in completing the program's annual eligibility review package in order to allow those applicants to retain health care coverage.
(g) Each participating health, dental, or vision plan shall submit to the board a plan for application assistance. All scripts and materials to be used during application assistance sessions shall be approved by the board and the State Department of Health Services.
(h) Each participating health, dental, or vision plan shall provide each applicant with the toll-free telephone number for the Healthy Families Program.
(i) When deemed appropriate by the board, the board may refer a participating health, dental, or vision plan to the Department of Managed Health Care or the State Department of Health Services, as applicable, for the review or investigation of its application assistance practices.
(j) The board shall evaluate the impact of the changes required by this section and shall provide a biennial report to the Legislature on or before March 1 of every other year. To prepare these reports, the State Department of Health Services, in cooperation with the board, shall code all the application packets used by a managed care plan to record the number of applications received that originated from managed care plans. The number of applications received that originated from managed care plans shall also be reported on the board's Web site. In addition, the board shall periodically survey those families assisted by plans to determine if the plans are meeting the requirements of this section, and if families are being given ample information about the choice of health, dental, or vision plans available to them.
(k) Nothing in this section shall be seen as mitigating a participating health, dental, or vision plan's responsibility to comply with all federal and state laws, including, but not limited to, Section 1320a-7b of Title 42 of the United States Code.
~~(l) Paragraph (2) of subdivision (a) shall become inoperative on January 1, 2006~~.

2. Healthy Families—Changing Single Point of Entry—Conform to Prior Action

Issue: In the April 4th Subcommittee hearing, **the Subcommittee *rejected* the Administration's proposal to *change* the existing Single Point of Entry process** by, among other things, using a contractor to conduct certain eligibility determination processing in lieu of using County Welfare Department personnel. **As such, the appropriation for the DHS related items was amended at that time.**

However, the Administration had an error in their January budget for the MRMIB's budget related to their proposal. Specifically, they had noted that the HFP budget did not reflect an increase of $1.9 million (total funds) that would be needed for them to implement their proposed change. Since the dollars were not in the Administration's budget at that time, no action on them could be taken.

The May Revision now contains an appropriation of $1.9 million (total funds). Since the HFP is presented to the Subcommittee as an estimate package, it is recommend to take action to reject this funding to conform with the Subcommittee's prior action so that it is absolutely clear on what needs to be adjusted.

Subcommittee Staff Recommendation: It is recommended **to reject the $1.9 million (total funds) in the HFP budget for their proposal to change the Single Point of Entry process in order to conform to a prior Subcommittee action.**

3. County Health Initiative Matching Fund (CHIM) Program--Technical

Issue: The May Revision proposes to adjust the January budget for CHIM by $1 million ($350,000 County Health Initiative Matching Fund and $650,000 federal S-CHIP Funds) for total expenditures of $4.663 million ($1.632 million County Health Initiative Matching Funds) for 2005-06.

The MRMIB states that the May Revision reflects updated funding estimates submitted by the four pilot counties (Alameda, San Francisco, San Mateo, and Santa Clara), as well as the projected expenditures for one of the Phase II counties (Santa Cruz).

Subcommittee Staff Recommendation: It is recommended to **adopt** the May Revision as proposed. No issues have been raised. This program was discussed in our April 25 hearing.

Background—County Health Initiative Matching Fund (CHIM) Program: AB 495, Statutes of 2001, allow county governments and public entities to provide local matching funds to draw down federal S-CHIP funds for their Healthy Kids Programs (i.e., children 250 to 300 percent of poverty who are citizens). The State Plan Amendment approved by the federal CMS provided for four pilot counties (i.e., Alameda, San Francisco, San Mateo, and Santa Clara) with a phase-in of additional counties (i.e., Santa Cruz and Tulare) in 2005-06.

B. Item 4440 — Department of Mental Health *(Vote Only)*

1. Healthy Families Program Adjustments—*Supplemental Mental Health Services*

Governor's May Revision: The May Revision **proposes a *net* reduction of $2.5 million (Reimbursements from the MRMIB) to primarily reflect technical caseload adjustments to the HFP supplemental mental health services**. This adjustment is due to updated paid claims data and county administration adjustments. Total program expenditures are now estimated to be $14.9 million (total funds—federal reimbursement from the MRMIB and county realignment funds).

Background: The Healthy Families Program provides health care coverage and dental and vision services to children between the ages of birth to 19 years with family incomes at or below 250 percent of poverty (with income deductions) who are not eligible for no-cost Medi-Cal. Monthly premiums, based on family income and size, must be paid to continue enrollment in the program. California receives an annual federal allotment of federal Title XXI funds (Social Security Act) for the program for which the state must provide a 34 percent General Fund match, except for supplement mental health services in which County realignment funds are used as the match. With respect to legal immigrant children, the state provides 100% General Fund financing.

The enabling Healthy Families Program statute linked the insurance plan benefits with a supplemental program to refer children who have been diagnosed as being seriously emotionally disturbed (SED). The supplemental services provided to Healthy Families children who are SED can be billed by County Mental Health Departments to the state for a federal Title XXI match. Counties pay the non-federal share from their County Realignment funds (Mental Health Subaccount) to the extent resources are available.

Subcommittee Staff Comment and Recommendation: It is recommended to **adopt** the May Revision as proposed. No issues have been raised.

2. Conforming Action on Early Mental Health Program (Prop 98)

Issue and Subcommittee Staff Recommendation: The Governor's January budget proposed to reduce this program by $5 million (Proposition 98 General Fund) leaving only $5 million available for grants to schools to provide assistance to children in K to Third Grade.

In their May Revision hearing, the Senate Subcommittee #1 on Education designated an augmentation of $5 million (Proposition 98 Funds) for this program. Therefore, it is recommended for to increase Item 4440-102-0001 (Department of Mental Health) by this $5 million amount and eliminate the Governor's reduction. This will enable a new round of grants to be started and will continue the program.

Background—What is the Program: Under the Early Mental Health Initiative, the state awards grants (for up to three-years) to Local Education Agencies (LEAs) to implement early mental health intervention and prevention programs for students in Kindergarten through Third Grade. Schools that receive grants must also provide at least a 50 percent match to the funding provided by the DMH. Schools use the funds to employ child aides who work with students to enhance the student's social and emotional development.

Students in the program are generally experiencing mild to moderate school adjustment difficulties. Students must have parental permission to participate in the program. In addition, all Early Mental Health Initiative programs are required to contract with a local mental health agency for referral of students whose needs exceed the service level provided in this program.

The Early Mental Health Initiative is an effective school-based program. **It serves children experiencing school adjustment issues who are *not* otherwise eligible for special education assistance or county mental health services because the student's condition is usually not severe enough to meet the eligibility criteria in these other programs (such as the Children's System of Care Program or EPSDT services).**

3. Lease Revenue Bond Payment Adjustments—DMH Portion

Issue: The May Revision proposes to make an adjustment to the DMH budget for the purpose of allocating the set-aside contained in Budget Control Section 4.30 related to Lease Revenue Debt Service which was in the January budget. Specifically, the DMH budget is proposed to receive $27.034 million, including $88,000 in Reimbursements, for this purpose.

This is a technical adjustment to the budget to schedule these funds as needed in departments. The DMH amount reflects payment for construction of Coalinga State Hospital and some capital improvement projects at other hospitals.

Subcommittee Staff Recommendation: It is recommended **to adopt the May Revision as proposed.**

4. Energy Efficiency Bond Program Repayment

Issue: The May Revision proposes a reduction of $475,000 (General Fund) in the State Hospital Item to reflect utility savings generated from energy efficiency projects at Metropolitan State Hospital and repayment to the General Fund for these projects.

AB 156, Statutes of 204 provided $3.7 million (General Fund) to repay loans from the Pooled Money Investment Account that provided interim funding for these projects. Repayment to the General Fund, plus five percent interest, will occur over a ten-year period through the utility savings generated by the projects.

Subcommittee Staff Recommendation: It is recommended **to adopt the May Revision as proposed.** No issues have been raised.

5. Six-Month Extension for Emergency Mental Health Managed Care Regulations

Issue: As has been discussed in past years, the DMH is behind in completing their "regular" regulations for the Mental Health Managed Care Program. **Therefore, the May Revision is seeking a 6-month extension of emergency regulation authority, from January 1, 2005 to June 30, 2006.**

Subcommittee Staff Recommendation: It **is recommended to adopt the May Revision trailer bill language which provides the DMH with a six-month extension of emergency regulation authority until they complete their "regular" regulations.**

It should be noted that the DMH has been making progress on completing this regulation package. However, completion of the package is also contingent upon the completion of work by other entities, such as the Department of Health Services (serving in the "sole Medicaid state agency" role.). The DMH has made a commitment to have this as a priority to complete and maintains that the June 30, 2006 deadline will indeed be meet.

6. Adjustments for the San Mateo Field Test—Medicare Part D

Issue: The May Revision proposes a decrease of $672,000 (General Fund) to the DMH to adjust the funding levels provided for pharmacy expenditures in the San Mateo Field Test Project. This reduction is the result of implementing the federal Medicare Part D drug benefit as of January 1, 2006. With implementation of the federal Medicare Part D drug benefit, dual eligibles will lose Medi-Cal coverage for some medications currently covered by the San Mateo Pharmacy field test.

The DMH is proposing to reduce state funding for San Mateo pharmacy services by 10 percent. This reflects a half-year (January 1, 2006 to June 30, 2006) amount. If San Mateo wants to provide alternative coverage for individuals that may need assistance, they can choose to do that using County Realignment funds.

Subcommittee Staff Recommendation: It **is recommended to adopt the May Revision as proposed.** No issues have been raised.

Additional Background—What is the San Mateo Field Test Project? The San Mateo County Mental Health Department has been operating as the mental health plan under a federal Waiver agreement and state statute as a "field test" project since 1995. San Mateo is the only county that has responsibility for the management of some financial risk through a case rate system and the management of pharmacy and related laboratory services, in addition to being responsible for psychiatric inpatient hospital services and outpatient specialty mental health services.

The field test is intended to test managed care concepts which may be used as the state progresses towards the complete consolidation of specialty mental health services and eventually, a capitated or other full-risk model. As the San Mateo Field Test Project has matured and evolved, additional components have been added and adjusted.

7. Forensic Conditional Release Program (CONREP) Funding Adjustments

Issue: The May Revision proposes total expenditures of $15.4 million (General Fund) for a net decrease of $436,000 (General Fund) for CONREP. This reduction is primarily due to a reduction in caseload and is purely technical.

According to the DMH, this estimate will provide for outpatient treatment and supervision for a caseload of 730 patients (average cost of $21,091 per patient).

The balance of the funding supports contracts for (1) toxicology services with ancillary service providers, (2) pharmacy services for patients on Clozaril medication, (3) an answering service to meet statutory requirements, (4) statutorily required hearings, and (5) assessment services.

The budget consists of three key components, including (1) hospital liaison visits, (2) patient services, (3) funding for SVPs. The hospital liaison visits are done to assess outpatient readiness of State Hospital patients who are either Not Guilty by Reason of Insanity (NGI) or are a Mentally Disordered Offender (MDO).

In August 2003, the first SVP was placed into CONREP. The program as developed by the DMH includes sex offender treatment, dynamic risk assessments, psychiatric medications, and various monitoring tools (such as polygraphs, substance abuse screenings, and GPS monitoring), as well as supervision. The DMH is responsible for program, medical and living costs for the patient. The DMH contracts with Liberty Healthcare for SVP CONREP services in all 58 counties.

Background—Description of CONREP: Existing statute provides for the Conditional Release Program (CONREP). Specifically, it mandates for the DMH to be responsible for the community treatment and supervision of judicially committed patients, including Not Guilty by Reason of Insanity (NGI), Mentally Disordered Sex Offenders (MDOs), and Sexually Violent Predators.

CONREP, in operation since 1986, provides outpatient services to patients in the community and hospital liaison visits to patients continuing their inpatient treatment at State Hospitals who may eventually be admitted into CONREP.

CONREP services are provided throughout the state and are either county-operated *or* private/non-profit operated under contract to the DMH. The goal of CONREP is to ensure greater public protection in California communities via a system of mental health assessment, treatment, and supervision to persons placed on outpatient status.

Subcommittee Staff Recommendation: It is recommended **to adopt the May Revision as proposed.**

C. Item 4260 — Department of Health Services *(Vote Only)*

1. Child Health Disability Prevention (CHDP) Program

Issue: The **May Revision proposes total expenditures of $2.6** ($2.5 million General Fund and $102,000 Childhood Lead Poisoning Prevention Funds) for the program. This reflects a *net* increase of $727,000 (increase of $925,000 General Fund). The program will provide about 48,600 health screens for children. This reflects an increase of 8,800 screens over the January proposal. **The May Revision also contains an increase of $4,000 to add the fasting blood sugar and cholesterol screening as part of the CHDP health assessments when indicated.**

Subcommittee Staff Recommendation: It is recommended to **adopt the May Revision** as proposed.

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

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

The benefit package provided under the *CHDP-only* program is limited to providing a physical examination, nutritional assessment, vision and dental assessments, hearing assessment, laboratory tests and immunizations. Local health jurisdictions work directly with CHDP providers (private and public) to conduct planning, education and outreach activities, as well as to monitor client referrals and ensure treatment follow-up. With respect to funding, services for

2. Genetically Handicapped Persons Program (GHPP)—Cash/Accrual Change and Caseload Adjustment

Issue: The May Revision proposes a decrease of $22 million (General Fund) which is primarily due to the Administration's proposal to shift the GHPP from an accrual to cash accounting system, as was done with the Medi-Cal Program. Total program expenditures are estimated to be $33.5 million (General Fund) for the GHPP.

The accounting shift saves a total of $15.6 million General Fund in 2005-06. In addition, there is a minor caseload reduction and related technical adjustments. No policy changes are proposed other than the accounting shift.

Subcommittee Staff Recommendation: It is recommended to **adopt** the May Revision as proposed. No issues have been raised.

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

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

3. California Children's Services (CCS) Program

Issue: The Governor's May Revision proposes a *net* increase of $3.5 million (decrease of $1.9 million General Fund, increase of $5.4 million federal S-CHIP Title XXI funds, and a decrease of $55,000 in enrollment fees for total expenditures of $180.8 million (total funds).

This May Revision reflects minor caseload and technical adjustments. No policy changes are proposed. The increase in federal funds is primarily due to the availability of S-CHIP funds for AIM-born infants who need CCS services. This reflects existing state policy and statute.

Subcommittee Staff Recommendation: It is recommended to **adopt** the May Revision as proposed. No issues have been raised.

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

The CCS is the oldest managed health care program in the state and the only one focused specifically on children with special health care needs. It depends on a network of specialty physicians, therapists and hospitals to provide this medical care. By law, CCS services are provided as a separate and distinct medical treatment (i.e., carved-out service). CCS was included in the State-Local Realignment of 1991 and 1992. As such, counties utilize a portion of their County Realignment Funds for this program.

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

4. Fiscal Appropriations for Funding of Nurse-to-Patient Ratio

Issue & Prior Subcommittee Action: In the Subcommittee's April 4th hearing, the Subcommittee adopted place holder language to address concerns regarding the Administration's review for compliance regarding the nurse-to-patient ratio. In addition, concerns were expressed regarding "truth in budgeting" with respect to how the Medi-Cal Program Estimate package presented the issue. **It is in response to this discussion that the following Subcommittee staff recommendation is proposed**.

Subcommittee Staff Recommendation: It is recommended to **adopt** the following pieces of trailer bill language and Budget Bill Language as proposed by Subcommittee staff:

(1) Uncodified Trailer Bill Language for Compliance Comparison

The Department of Health Services shall provide the Legislature by no later than July 1, 2006 with a comprehensive review of nurse staffing levels that is a statistically valid sample of hospitals that are urban and rural, public and private, proprietary and non-profit, geographically-balanced, and small and large. At a minimum, this analysis shall include a comparison to the 2001 baseline staffing study, including the extent to which hospitals have increased registered nurse and licensed vocational nurse staffing.

(2) Uncodified Trailer Bill Language for CMAC Information

On an annual basis the Department of Health Services and the California Medical Assistance Commission shall provide fiscal information to the Joint Legislative Audit Committee and the Joint Legislative Budget Committee on the funds provided to the contract hospitals participating in the Medi-Cal Program, and the health plans participating in the Medi-Cal Managed Care Program for implementation of the nurse-to-patient ratios.

(3) Budget Bill Language for "Truth in Budgeting" (Item 4260-101-0001)

It is the intent of the Legislature that funding appropriated to the Department of Health Services for the Medi-Cal Program shall be expended for purposes that are consistent with the assumptions and estimates as defined in Section 14100.5.

Any change in the assumptions and estimates for the Medi-Cal Program, as defined in Section 14100.5, that results in an expenditure that is inconsistent with the purposes for which the Legislature appropriated the funding shall not be authorized by the Director of the Department of Finance any sooner

5. Expenditure of Federal Bioterrorism Funds—State Support & Local Funds

Issue: ***First,*** the Governor's January budget requested to extend 94.8 positions for two-years (to June 30, 2007) to continue existing efforts relating to bioterrorism preparedness and response as directed under federal grant agreements with the federal Centers for Disease Control and Prevention (CDC) and the federal Health Resources and Services Administration (HRSA). The DHS requests an appropriation of $8.2 million (federal funds) to continue these 94.8 positions in 2005-06.

Presently the DHS has a total of 104.8 positions of which 10 are permanent and 94.8 are limited-term and expire as of June 30, 2005. Of the 94.8 limited-term positions, 76 positions are associated with functions related to the CDC grant and 18.8 positions pertain to the HRSA grant. The remaining 10 permanent positions all pertain to the CDC grant.

The tables below summarize the request to extend (two-years) the 94.8 positions. As noted in the background discussion below, the existing CDC grant has seven "focus" areas and the HRSA grant has four "benchmark" measurements. The requested positions are therefore listed by these areas.

I. CDC Grant and Focus (76 positions)	Positions		Positions
A. Preparedness Planning & Readiness		**D. Laboratory Capacity--Chemical**	
Health Prog Mgr II/III	2	Research Scientist Supervisor IV	1
Environmental Sci IV	1	Research Scientist II/III	2
Medical Officer III	1	Staff Services Analyst	1
Pharmaceutical Consultant	1		7 total
Health Prog Specialist	1	**E. Health Alert Network**	
Staff Services Manager	1	Sr Information System Supvsr	1
Sr Accounting Officer	1	Information System Analysts	1
Associate Gov Analyst	4	Associate Info System Analysts	2
Office Technician	1		**4 total**
	15 total		
B. Surveillance & Epidemiology		**F. Health Risks & Health Info**	
Medical Officers II/III	3	Health Education Consultant III	1
Research Scientists II/III/ IV	12	Research Analyst II	1
Sr Information Systems Analysts	3	Staff Services Analyst	1
Associate Gov Analyst	2		**3 total**
Sr Sanitary Engineer	2		
Office Technician	1		
	23 total		
C. Laboratory Capacity--Biologic		**G. Education & Training**	
Microbiologist Specialists	3	Medical Officer III	2
Microbiologist I/II	11	Nurse Consultant III	1
Research Scientist IV	2	Associate Systems Analyst	1
Associate Gov Analyst	1	Associate Gov Analyst	1
Office Technician	1	Office Technician	1
	18 total		**6 total**

HRSA Grant Positions (18.8 total)	Positions		Positions
Priority Area 1—Program Direction		**Priority Area 3—Laboratory Connectivity**	
Staff Services Manager I	1	Health Program Specialist I	1
Health Program Specialist I	1.5		**1 total**
Research Analyst II	0.5	**Priority Area 4—Laboratory Data Standard**	
Associate Governmental Prog Analyst	2	Medical Officer III	2
Office Technician	1	Research Scientist III/IV	3
	6 total	Associate Governmental Prog	1
Priority Area 2—Regional Surge Capacity			**6 total**
Nurse Consultant II	1		
Associate Info Systems Analyst	1		
Health Program Specialist II	1.7		
Word Processing Technician	1		
Office Technician	1		
	5.7 total		

Second, the five-year bioterrorism grant provided by the Centers for Disease Control (CDC) used to fund 86 of the positions (i.e., 76 limited-term and 10 permanent) will expire on August 30, 2005 and a new multi-year grant will begin. The CDC has yet to finalize specifics on the requirements for the new federal grant funding cycle and it is unclear at this time when this guidance will be forthcoming to the states. As such, it is unclear as to whether all of the requested positions can be funded under the new cycle or whether the CDC will be changing its focus for states.

The table below summarizes the total funds received by the DHS to-date for both the CDC and HRSA grants.

Summary of DHS Funding (as of 12/30/04)	CDC Grant	HRSA Grant	TOTALS
1. Total Federal Funds Received (From 8/31/99 to 8/30/05)	**$195,152,000**	**$87,511,000**	**$282,663,000**
2. State Operations Total Amount	**$60,894,000**	**$35,017,000**	**$95,911,000**
Expenditures	$34,012,000	$12,550,000	$46,562,000
Encumbrances	$12,590,000	$8,403,000	$20,993,000
Remaining Balance	($14,292,000) 23.5 %	($14,064,000) 40.2%	($28,356,000) 29.6%
3. Local Assistance Total Amount	**$134,258,000**	**$52,494,000**	**$186,752,000**
Expenditures	$83,451,000	$3,272,000	$86,723,000
Encumbrances	$47,405,000	$42,532,000	$89,937,000
Remaining Balance	($3,402,000) 2.5%	($6,690,000) 12.7%	($10,092,000) 5.4%
4. Total Summary for the Grants	**$195,152,000**	**$87,511,000**	**$282,663,000**
Expenditures	$117,463,000	$15,822,000	$133,285,000
Encumbrances	$59,995,000	$50,935,000	$110,930,000
Remaining Balance (Not obligated)	($17,694,000) 9.1%	($20,754,000) 23.7%	($38,448,000) 13.6%

Third, the Legislative Analyst's Office (LAO) contends that the Administration overall, including the DHS, Office of Homeland Security (OHS), and others, lacks a unified strategic approach to homeland security, and that only 31 percent of the state's overall

Existing State Statute: Existing statute provides a framework for the DHS to contract with, and allocate to, Local Health Jurisdictions for expenditure of bioterrorism funds (local assistance). Among other things, existing statute (1) requires the DHS to develop a plan with representatives of local governments for submittal to the federal government for receipt of the grant funds, (2) requires the DHS to develop a streamlined process for continuation of bioterrorism preparedness funding that will address any new federal requirements and will assure continuity of local plan activities, (3) enables the DHS to contract with public or private entities to meet the federally-approved bioterrorism plan and these contracts shall be exempt from the State Contract Act, and (4) enables the DHS to allocate these funds to Local Health Jurisdictions generally on a per capita basis.

Prior Subcommittee Hearing: In the March 14th hearing, the Subcommittee **(1)** adopted Budget Bill Language to require the DHS to provide the Bureau of State Audits with information for auditing purposes, **(2)** adopted placeholder trailer bill language to require the DHS to provide the Legislature with an accounting of their expenditures (proposed language is contained below), and **(3)** left the issue of the positions opening pending receipt of further guidance from the federal CDC regarding this year's grant cycle.

Senate Subcommittee #5 Action: In addition, **Senate Subcommittee #5 adopted language**, similar to language suggested by the LAO, regarding the Office of Homeland Security and the Department of Health Services. This language is as follows:

> ***Proposed Budget Bill Language for development of a statewide strategic plan:***
> The Office of Homeland Security, in collaboration with the Department of Health Services, shall report to the Chairperson of the Joint Legislative Budget Committee, and the chairperson of the budget and policy committees of each house of the Legislature on or before January 10, 2006, a statewide strategic plan for the use of federal homeland security and bioterrorism funds by all departments and local jurisdictions. The plan shall include the state's goals and objectives for improving the state's level of preparedness for a terrorism event, which 1) is based on an assessment of the state's level of preparedness and 2) reflects a coordination of preparedness activities at the state and local level. It is not the intent of the Legislature to require the Office of Homeland Security or the Department of Health Services to disclose or include sensitive or classified information in the strategic plan.
>
> ***Proposed Trailer Bill Language for an annual expenditure report:***
> **Section x.** The Office of Homeland Security, in collaboration with the Department of Health Services, shall annually report to the Chairperson of the Joint Legislative Budget Committee, and the chairperson of the budget committees of each house of the Legislature on or before January 10, its expenditures of federal homeland security and bioterrorism funds. This report shall include: 1) descriptions of the grant expenditures and coordination activities at the state and local level that have occurred over the past year; 2) how those activities met the state's strategic goals and objectives; 3) the funding amounts

> awarded to local jurisdictions and specific departments; 4) the funding levels by grant and grant year that have been expended, encumbered, and unencumbered; 5) any challenges that the departments or local jurisdictions encountered that hindered the expenditure of these funds; and 6) the areas of focus for the upcoming year. It is not the intent of the Legislature to require the Office of Homeland Security or the Department of Health Services to disclose or include sensitive or classified information in the strategic plan.

Assembly Subcommittee #1 Action: In addition, the Assembly Subcommittee #1 adopted trailer bill language to require audits of the local expenditures every three years. This trailer bill language is as follows:

> "It is the intent of the Legislature that the department shall audit the cost reports every three years commencing January 2007 to determine compliance with federal requirements and consistency with local health jurisdiction budgets, contingent upon the availability of federal funds for this activity and contingent upon the continuation of federal funds for bioterrorism preparedness.

Subcommittee Staff Recommendation: It is recommended to **(1)** retain the Budget Bill Language adopted in the March 14th hearing regarding the Bureau of State Audits,**(2)** rescind placeholder trailer bill language from the prior Subcommittee action for expenditure reporting since the Subcommittee #5 action provides similar language that has already been negotiated, **(3)** conform to the Senate Subcommittee #5 action by adopting the same Budget Bill Language for Item 4260-111-0001 (DHS item) and the same trailer bill language, **(4)** approve the Administration's request to continue the 94.8 positions using federal funds, **(5)** adopt the Assembly's trailer bill language regarding an audit every three years as shown above, and **(6)** adopt the following trailer bill language to require the coordination of DHS bioterrorism activities with the CA Office of Border Health (as shown below).

In addition, it is also recommended to add trailer bill language as follows in order to ensure that bioterrorism activities are coordinated with the California Office of Binational Border Health. This proposed language is as follows:

> "The Department of Health Services shall coordinate their federal bioterrorism activities as applicable with the California Office of Binational Border Health, as the single point of coordination on border health activities. These activities shall include at a minimum the following: (1) surveillance for the spread of infectious disease, (2) monitoring for environmental health safety issues related to food safety and air and water quality, and (3) responding to any potential bioterrorism threat."

These proposed actions would (1) provide the Administration with their requested funding and positions; (2) conform to both the Senate and Assembly actions as noted above; and (3) reintegrate the importance of coordination of bioterrorism activities along the border between California and Mexico.

6. AIDS Drug Assistance Program (ADAP)—May Revision Adjustment

Issue: The Governor's May Revision proposes total expenditures of $268.3 million ($91.1 million General Fund, $100.9 million federal Ryan White Care Act Funds, and $76.3 million in ADAP Drug Rebates) for ADAP.

This reflects a *net* increase of $4.7 million (increase of $4.7 million ADAP Drug Rebates, a decrease of $79,000 General Fund and an increase of $79,000 federal Ryan White Care Act Funds). This proposed adjustment is the result of (1) steadily increasing drug prices, and (2) increased access to those drugs by ADAP clients. This estimate is based on actual data expenditures through March 2005.

It should be noted that ADAP affects demand for Medi-Cal services. Without ADAP assistance to obtain HIV/AIDS drugs, infected individuals would be forced to (1) postpone treatment until disabled and Medi-Cal eligible, or (2) spend down their assets to quality, increasing expenditures under Medi-Cal. Fifty percent of Medi-Cal costs are borne by the state as compared to about 28 percent of ADAP costs.

Subcommittee Staff Recommendation: It is recommended to **adopt** the May Revision as proposed. It should be noted that though the Office of AIDS has done well in securing drug rebate funds, the state should not become too reliant on this resource as a stable funding agent. Some of the rebate contracts will be expiring within a few months. As such, it is recommended to adopt the May Revision which maintains a reasonable funding mix.

7. Administration's Proposed Trailer Bill Legislation—CalWORKS & Medi-Cal

Issues: The Governor's May Revision proposes to reduce CalWORKS by changing the "maximum aid payments" (MAP) for CalWORKS recipients commencing as of July 1, 2005. Any change to this calculation would affect the Section 1931 (b) families program income eligibility threshold in the Medi-Cal Program.

As such, the Administration's proposes trailer bill language to maintain the existing Medi-Cal income standard for Section 1931 (b) families at its current level (i.e., not less than the income standard that was in effect on January 1, 2004.

In addition, the May Revision contains an increase of $1.560 million ($780,000 General Fund) for County Administration processing in order to shift CalWORKs individuals in Medi-Cal from CalWORKS-linked to "Medi-Cal" only.

Subcommittee Recommendation: It is recommended to **reject** the Administration's language and funding request because it is not necessary (i.e., conforming action). The Subcommittee rejected the CalWORKS MAP reduction and as such, does not need to make any changes to the Medi-Cal Program. **Therefore, a reduction of $1.560 million ($780,000 General Fund) is also recommended.**

8. Botulism Treatment and Prevention Program and "BabyBIG"

Issue: The Assembly Subcommittee adopted placeholder trailer bill language to reimburse hospitals for BabyBIG which is used to treat Infant Botulism poisoning.

The proposed language is as follows. In discussions with the DOF and DHS, no concerns were raised regarding the language. As such, it is recommended to conform to the Assembly language.

Add Section 14085.6 (g) (4) to Welfare and Institutions Code as follows:

> Be able to demonstrate a purpose for additional funding under the selective provider contracting program including proposals relating to emergency services and other health care services, including infrequent, yet high-cost services such as anti-AB human antitoxin treatment for infant botulism (HBIG - human botulinum immune globulin, commonly referred to as "Baby-BIG"), that are made available, or will be made available, to Medi-Cal beneficiaries.

The above language directs the California Medical Assistance Commission to specifically consider the costs of BabyBIG in its reimbursement rate contract negotiation with hospitals.

Each dose of BabyBIG costs $45,300 to purchase. California averages about forty cases per year. Currently there is no specific reimbursement mechanism to reimburse the hospitals that provide the medical care to young children stricken with the potentially lethal disease. The proposed language would remedy this.

Subcommittee Staff Recommendation: It is recommended to **conform** to the Assembly and adopt the trailer bill language.

Background on the Program: The purpose of the Infant Botulism Treatment and Prevention Program is to provide and improve the treatment of infant botulism, and to prevent infant botulism and related diseases.

The program became permanently effective in May 1997 when its multi-year clinical trial of the Orphan Drug human Botulism Immune Globulin (BIG) demonstrated its apparent safety and efficacy as the first specific treatment for infant botulism. BIG was officially licensed by the U.S. Food and Drug Administration on October 23, 2003 for the treatment of infant botulism types A and B under the proprietary name of BabyBIG.

State statute established the program (H&SC Sect. 123700-123709) as a fee-supported, special fund activity that is required to (1) produce and distribute BabyBIG® statewide and nationwide, (2) provide diagnostic and consultative medical services for infant botulism, (3) investigate all cases of infant botulism in California, (4) develop and implement prevention and control measures for infant botulism, and (5) carry out applied research into improving the prevention and treatment of infant botulism and related illnesses.

BabyBIG® represents the "standard-of-care" for all patients hospitalized with infant botulism. The high national profile of the program is also a consequence of its interactions with the U.S. Food and Drug Administration (FDA), the U.S. Centers for Disease Control and Prevention (CDC), the Massachusetts Public Health Biologic Laboratories, all California local Health Departments and approximately 200 major university, children's, and community hospitals statewide and nationwide.

Through the development phase the program was funded by loans from the State's General Fund. The loan from the General Fund is approximately $3.5 million and is to be repaid from the fees charged providers. At the current rate of utilization it will take three to four years to repay the loan.

9. California Rx Program Funding—January Budget & May Revision

Issue: The Governor's January budget proposed an increase of $3.9 million (General Fund) to fund 18.5 positions to establish a state pharmacy assistance program for certain low-income individuals who do not have a public or private prescription drug benefit.

In addition, the May Revision proposes an increase of $7.8 million (General Fund) for **total proposed expenditures of $11.7 million** (General Fund). Of the total $11.7 million, (1) $5.7 million was for various administrative support functions, including the 18.5 positions and (2) $6.4 million was for local assistance.

Policy legislation to implement the proposed Cal Rx Program has stalled in the Senate Health Committee. Further, in her Perspectives and Issues document (pages 244 to 261), the Legislative Analyst's Office raised considerable policy and fiscal issues with the Governor's January proposal. There are also several potential ballot initiatives regarding implementation of subsidized pharmacy programs. In addition, as discussed further below, the federal Medicare Part D Program which is pending implementation as of January 1, 2006, potentially complicates how a Cal Rx Program would operate.

Subcommittee Staff Recommendation: It is recommend to **reject** the $3.9 million (General Fund) in the budget **and** the $7.8 million (General Fund) proposed in the May Revision.

In its present form, the Cal Rx Program needs considerable work to proceed through both houses of the Legislature. Therefore the timelines of the budget process are ill suited for development of this new program.

10. Consumer Price Index Adjustment--Nuclear Planning Assessment Special Account

Issue: The May Revision proposes an increase of $16,000 (Nuclear Planning Assessment Special Account) as required by Section 8610.5 of the Government Code which provides for a consumer price index adjustment. These funds are used to support the existing Nuclear Power Preparedness Program.

Legislation mandating the Nuclear Power Preparedness Program has been continuous since 1979, enacted as Government Code Section 8610.5, the Radiation Protection Act. The program is funded by the utilities through a special assessment fund managed through the State Controller.

While State OES has absolute coordination authority during emergency response, **the Department of Health Services (DHS) is assigned the technical lead responsibility during ingestion pathway and recovery phases of an emergency.** The goal during ingestion pathway response is preventing contaminated water, food and food animals from reaching the consumer. The goal during recovery is restoring areas to pre-accident conditions.

Background: In California, there are two operating nuclear power plant sites: Diablo Canyon in San Luis Obispo County has two active units and San Onofre Nuclear Generating Station (SONGS) in San Diego County has two active units. A third unit at SONGS is in a "safe storage" mode (fuel has been removed and stored). The operating life of the active units is expected to extend well into the 21st century.

Under state law, counties have the authority and responsibility to protect the lives and property of their citizens. The state supports their emergency response activities involved in nuclear power plant planning.

Subcommittee Staff Recommendation: It is recommended to **adopt** the May Revision as proposed. No issues have been raised.

11. Genetic Disease Testing Program Fund—Repay General Fund Loan

Issues: The May Revision proposes to add a provision to the Budget Bill to require the Genetic Disease Testing Fund **to fully repay outstanding General Fund loans that were provided in the Budget Acts of 2002 and 2003 by June 30, 2006** (i.e., add Item 4260-402).

These two Budget Acts authorized a total of $10.3 million in General Fund loans to the Genetic Disease Testing Fund to be paid back by June 30, 2008 and June 30, 2009, respectively. As of July 1, 2005, outstanding General Fund loans to the Genetic Disease Testing Fund will total $7.2 million. **The DOF states that due to favorable revenue collections and increased collection rates, the Genetic Disease Testing Fund will have sufficient resources to repay the loans on an accelerated schedule.**

The proposed language for this purpose is as follows:

"4260-402—Nothwithstanding Provision 1 of Item 4260-011-0001, Budget Acts of 2002 and 2003, the $10.3 million loan authorized to the Genetic Disease Testing Fund shall be fully repaid to the General Fund by June 30, 2006. This loan shall be repaid with interest calculated at the rate earned by the Pooled Money Investment Account at the time of the transfer."

Subcommittee Staff Recommendation: It is recommended to **adopt** the May Revision as proposed.

12. Genetic Disease Testing Program—May Revision Caseload Adjustments

Issue: The DHS is requesting an increase of $1.5 million (Genetic Disease Testing Fund) due to caseload increases in the Newborn Screening Program and the Prenatal Screening Program. The DHS states that these additional costs are due to an increase in the number of tests performed.

According to the DHS, there has been a utilization increase of 47,160 tests over the current budget base and as such, a total increase of about $1.5 million (Genetic Disease Testing Fund)is needed. This is shown in the table below:

	New Born Program	**Prenatal Program**
Baseline Tests	530,889	374,884
2005-06 revised estimate	560,631	392,302
Total Additional Tests (47,160)	29,742	17,418
Cost per Test	$39.82	$17.27
Total ($1.5 million)	$1,184,326	$300,809

Subcommittee Staff Recommendation: No issues have been raised. It is recommended to **adopt** the May Revision as proposed.

Background on the Program: Genetic and congenital disorders are a serious health problem and a major cause of disability and death. The DHS operates two public health medical screening programs—the Newborn Screening Program and the Prenatal Screening Program. By legislative mandate, these screening tests may only be provided under these two programs. **Fees deposited in the Genetic Disease Testing Fund support both programs.**

The Newborn Screening Program screens over 500,00 newborns a year (99 percent) in 325 maternity hospitals. Laboratory services are provided under contract with eight private laboratories. Follow-up activities are secured by contract with other private institutions. A blood specimen is collected on special filter paper forms from each newborn at the hospital of birth and mailed to a designated regional laboratory. Identifying information and results of laboratory analysis are electronically provided to the DHS. Any positive tests or unsatisfactory specimens are noted and electronically transmitted to one of seven regional Newborn Screening Program test follow-up centers that track the case until evidence of a proper referral and treatment is received.

State law requires all medical practitioners to inform pregnant patients between 15 and 20 weeks of gestation of the availability of prenatal screening for serious birth defects. This is a voluntary screening. This blood test, the Expanded AFP (triple marker testing)—provides pregnant women with a risk assessment for major birth defects, including neural tube defects, abdominal wall defects, and chromosomal defects.

13. Lease Revenue Debt Service—Allocation of Set-Aside in Control Section 4.30 & Richmond Laboratory Project

Issue: The May Revision proposes to make a series of adjustments to the DHS budget for the purpose of allocating the set-aside contained in Budget Control Section 4.30 related to Lease Revenue Debt Service. In addition, it proposes a series of adjustments to reflect a reduction in base rental payments, fees, and insurance costs due to an updated debt service payment schedule for the Richmond Laboratory lease revenue project.

Specifically, the DHS budget is proposed to be increased by $1.809 as follows to reflect the set-aside for the Control Section 4.30:

- Item 4260-003-0001 be increased by $1.250 million
- Item 4260-003-0044 be increased by $60,000
- Item 4260-003-0080 be increased by $37,000
- Item 4260-003-0098 be increased by $14,000
- Item 4260-003-0203 be increased by $440,000
- Item 4260-003-0890 be increased by $8,000

The DHS budget also needs to be decreased by $2.7 million as follows for the Richmond Laboratory lease revenue project technical adjustments:

- Item 4260-003-0001 be decreased by $1.842 million
- Item 4260-003-0044 be decreased by $88,000
- Item 4260-003-0080 be decreased by $54,000
- Item 4260-003-0098 be decreased by $21,000
- Item 4260-003-0179 be decreased by $1,000
- Item 4260-003-0203 be decreased by $648,000
- Item 4260-003-0890 be decreased by $12,000

Subcommittee Staff Recommendation: No issues have been raised. It is recommended to **adopt** the May Revision as proposed.

14. Technical Adjustment to the CA Nutrition Network

Issue: The May Revision **proposes an increase in reimbursements of $372,000 (Reimbursements from the DSS which are federal funds) to the California Nutrition Network Program. This increase is proposed for the purpose of aligning available resources as included in the Department of Social Services (DSS) budget.**

The California Nutrition Network is a social marketing campaign that promotes health eating and physical activity among food stamp and other income households. The services provided through interagency agreements includes: (1) staff support for statewide public and private partnerships, planning and administration, including resource development, (2) research and evaluation, (3) media and supermarket interventions, (4) community interventions funded through over 190 local assistance contracts with a variety of local governments and community based organizations, (5) special projects of statewide significance to promote system and environmental change, (6) outreach and education services to improve access to the Food Stamp Program, and many more.

Subcommittee Staff Recommendation: This was a technical error in the Governor's January budget and the May Revision is proposing an adjustment for this purpose. Therefore it is recommended **to adopt the May Revision as proposed.**

15. Delta Dental Enrollment Staff for Provider Enrollment Functions

Issue: The May Revision requests **an increase of $997,000 ($281,000 General Fund) to fund an additional 7 Delta Dental provider enrollment positions. The DHS has existing authority to contract with Delta for this purpose.**

The DHS states that there is a backlog for the processing of dental provider applications in the Medi-Cal Program and these resources are needed for this purpose. This issue parallels the problems discussed previously by the Subcommittee regarding Medi-Cal Provider enrollment. This aspect of the problem is in the dental area (i.e., Denti-Cal).

Subcommittee Staff Recommendation: No issues have been raised. It is recommended to **adopt** the May Revision as proposed.

D. Item 0530 — CHHS Agency *(Vote Only)*

1. Request for Staff for Medicare Part D Coordination

Issue: The May Revision **requests an increase of $100,000 (General Fund) to fund a Career Executive Assignment (CEA I)** (two-year limited-term) position to provide oversight and coordination concerning the implementation of Medicare Part D implementation.

Subcommittee Recommendation: It is recommended **to reject the May Revision.** This is recommended for several reasons.

First, the administration is seeking staff resources in certain "operating" departments—Department of Aging (4 positions), Department of Developmental Services (4 positions at headquarters and 11.5 positions at the Developmental Centers), and Department of Mental Health (one at headquarters and 9 at the State Hospitals). Providing some additional resources in the operating departments makes sense.

Second, in the Budget Act of 2004, an increase of $1.8 million (General Fund) and 14 new positions were provided to the CHHS Agency. This action more than doubled the size of the agency in one-year.

Third, based on information obtained from the Agency as of April 20, 2005, there is an existing CEA position which is currently vacant. Therefore, this vacant position could be used for this purpose.

E. Item 1760 Department of General Services *(Vote Only)*

Issue: The Administration requests that Item 1760-001-0666 be increased by $429,000 to fund increased security costs for the State Capitol building.

Staff Recommendation: It is recommended to adopt the proposal.

II. ITEMS FOR DISCUSSION *(Shown by Department)*

A. Item 4280--Managed Risk Medical Insurance Board

(Also See DHS for Proposition 99 Items)

1. Healthy Families Program Estimate—Adjustments for May Revision

Issue: The May Revision proposes a series of technical adjustments for the Healthy Families Program (HFP). Total program expenditures are now estimated to be $959.4 million ($347.4 million General Fund, $601 million federal S-CHIP funds and $9.8 million in Reimbursements).

The May Revision reflects the following key adjustments:

- Increase of $47.9 million ($16.5 million General Fund) to fund an increased caseload of 78,117 children by June 30, 2006. It is estimated that the HFP will serve 867,418 children in 2005-06.
- Increase of $14.148 million ($5.106 million General Fund) to reflect an average 2.9 percent rate increase provided to the HFP participating plans. This pending rate increase was discussed before the Subcommittee in a prior hearing.

Background—Overall on the HFP (See Hand Out): The Healthy Families Program (HFP) provides health, dental and vision coverage through managed care arrangements to uninsured children (through age 18) in families with incomes up to 250 percent of the federal poverty level, who are not eligible for Medi-Cal but meet citizenship or immigration requirements.

The benefit package is modeled after that offered to state employees. Eligibility is conducted on an annual basis.

In addition, infants born to mothers enrolled in the Access for Infants and Mothers (AIM) Program (200 percent of poverty to 300 percent of poverty) are immediately enrolled into the Healthy Families Program and can remain under the HFP until *at least* the age of two. If these AIM to HFP two-year olds have families that exceed the 250 percent income level, then they would no longer be eligible to remain in the HFP. Families pay a monthly premium and copayments as applicable. The amount paid varies according to a family's income and the health plan selected. Families that select a health plan designated as a "community provider plan" receive a $3 discount per child on their monthly premiums.

Subcommittee Staff Recommendation: It is recommended **to adopt the May Revision as proposed.** No issues have been raised.

Questions:

1. MRMIB, Please provide a brief summary of the key aspects of the May Revision adjustments.

2. Administration's Proposed Language to Carve-Out CCS Program Kids in the Transfer of AIM Program Infants to the HFP

Issue: The May Revision **proposes trailer bill language that would provide explicit retroactive (up to 12-months) authority for authorization of services provided under the California Children Services (CCS) Program for infants born to mothers enrolled in the Access for Infants and Mothers (AIM) Program** who after June 30, 2004 elect to enroll their infants in the Healthy Families Program (i.e., AIM-linked infants in the HFP).

The MRMIB states that this legislation is necessary for the implementation of the AIM to HFP transfer enacted in the Budget Act of 2003, and accompanying trailer bill language.

The Administration states that the authority would be limited to services provided to treat the CCS eligible medical conditions of AIM-linked infants by CCS-approved providers. **This language would also provide that, for cases approved on a retroactive basis, the DHS may reimburse providers for CCS treatment costs of AIM-linked infants for services rendered prior to the time the infant becomes known to CCS. This will ensure that families of these infants are not required to pay for these specific services.**

The Administration's proposed trailer bill language is as follows:

Add Section 123929 to the Health and Safety Code:

"(a) Except as otherwise provided in this section and Welfare and Institutions Code section 14133.05, California Children's Services Program services provided pursuant to this Article require prior authorization by the department or its designee. Such prior authorization is contingent on determination by the department or its designee that:

- The child receiving such services is confirmed to be medically eligible for the CCS Program;
- The provider of such services is approved in accordance with the standards of the CCS Program; and
- The services authorized are medically necessary to treat the child's CCS eligible medical condition.

(b) Effective July 1, **2004**, the department or is designee may approve a request for a treatment authorization that is otherwise in conformance with Subdivision (a) for services for a child participating in the Healthy Families Program pursuant to the provisions of Section 12693.70(a)(6)(A)(ii) of the Insurance Code, received by the department or its designee after the requested treatment has been provided to the child.

(c) Effective July 1, **2004**, if a provider of services who meets the requirements of subdivision (a)(2) incurs costs for services described in subdivision (a)(3) to treat a child described in subdivision (b) who is subsequently determined to be medically eligible for the California Children's Services Program as determined by the department or its designee, the department

may reimburse the provider for such costs. Reimbursement under this section shall conform to the provisions of Section 14105.18 of the Welfare and Institutions Code.

Subcommittee Staff Recommendation: The language has been reviewed and discussed with some constituency groups. The proposed language is consist with the intent of the actions taken in the Budget Act of 2003. The language would help ensure that children with special medical needs receive appropriate CCS-level care when necessary. No issues have been raised. **Therefore, it is recommended to adopt the trailer bill language.**

Questions:

1. MRMIB and DHS, Please explain why this language is needed.
2. MRMIB and DHS, Does this language assist in drawing down federal S-CHIP funds?
3. MRMIB and DHS, Please explain why the language is retroactive to July 1, 2004.

B. Item 4260 Department of Health Services (*Discussion Items*)

MEDI-CAL PROGRAM ISSUES

1. Medi-Cal Baseline Estimate Package

Issue: The entire Medi-Cal Estimate is recalculated at the May Revision. As such, the Estimate package needs to technically be adopted as a baseline and then individual issues are adjusted as needed (as discussed in the issues noted in the Agenda, below).

The Medi-Cal Program local assistance expenditures for 2005-06 are estimated to be $29.4 billion ($12.962 billion General Fund), excluding special funds provided to hospitals. This reflects a *net* decrease of $39.4 million (increase of $16.1 million General Fund), based on the Governor's May Revision proposed policy changes. This is shown in the table below.

Summary Totals of Governor's May Revision for Medi-Cal Program

Component of the Medi-Cal Program	May Revision 2005-06	Change from Governor's January
Medical Care Services	$27,258 billion ($12,184 billion GF)	-$99.3 million (-$6.9 million GF)
County Administration	$1,875 billion ($682 million GF)	$67.3 million ($27.6 million)
Fiscal Intermediary	$320 million ($96.5 million GF)	-$7.4 million (-$4.6 million GF)
TOTAL	$29,452 billion ($12,962 billion GF)	-$39.4 million ($16.1 million GF)

Of the proposed $29.4 billion**, (1)** $27.258 billion is for Medical Care Services, **(2)** $1.875 billion is for County Administration and related items, and **(3)** $320 million is for the Fiscal Intermediary services, including EDS processing, Delta Dental processing and Maximus processing (as the health care options contractor for Medi-Cal Managed Care).

In addition to these expenditures, a total of $5.127 billion (all special funds and federal funds) is provided to fund payments for Disproportionate Share Hospitals, voluntary governmental transfers for supplemental hospital funding and capital debt projects for hospitals.

The DHS notes that the Medi-Cal Estimate does **not** reflect any adjustments related to the Administration's proposed Hospital Waiver. (The Hospital Waiver will be discussed later in this Agenda.)

The average monthly caseload for 2005-06 is projected to be 6.734 Medi-Cal enrollees which represents a decrease of 74,900 people, or 1.1 percent from the January budget.

Subcommittee Staff Recommendation for Baseline Adjustments: The Governor's May Revision contains the following key baseline adjustments in which the Subcommittee staff has raised no issues:

A. Two Plan Model Managed Care Expenditures (Existing Program): The May Revision proposes expenditures of $2.982 billion ($1.499 billion General Fund) for Medi-Cal enrollees who are receiving medically necessary services from one of the Two Plan Models. Each designated county has two competing managed care plans. These counties include Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. No issues have been raised regarding this item.

B. Geographic Managed Care (Existing Program): The May Revision proposes expenditures of $419.3 million ($210.6 million General Fund) for Medi-Cal enrollees who are receiving medically necessary services from a Geographic Managed Care Plan (plans located in Sacramento County and San Diego County). No issues have been raised regarding this item.

C. Quality Improvement Fee for Managed Care Plans: The May Revision proposes expenditures of $315.7 million (total funds) for implementation of this proposal by July 1, 2005. This fee was approved through the Budget Act of 2004 and was also discussed in our April 4th hearing. The federal CMS approval was finally granted as of March 10, 2005.The May Revision assumes the following:

- Six percent fee paid by plans — $198.8 million revenues
- Rate increase to be paid to plans — $315.7 million ($157.8 million GF)
  - Net increase to plans — $116.9 million
  - Net savings to the GF — $40.9 million

No issues have been raised regarding this item.

D. Long-Term Care Rate Adjustment: The May Revision proposes an increase of $59.9 million ($29.9 million General Fund) for a rate adjustment to Nursing Homes (Level A), Intermediate Care Facilities-Developmentally Disabled (ICF-DD) and related facilities, Managed Care (including PACE, COHS and others), Distinct-Part Nursing Facilities (DP-NFs), Rural Swing Beds, and Pediatric Subacute. This rate adjustment is effective as of August 1, 2005. This rate adjustment is in keeping with California's existing State Plan and rate methodology for these facilities.

The break out by facility category is as follows (figures are not adjusted for the lag factor as contained in the budget):

ICF-DD	8.96 percent increase	$3.4 million (total funds)
ICF-DD/H	3.94 percent	$8.7 million
ICF-DD/N	less than 1	$391,000

NF-Level A	5.98 percent	$600,000
Distinct Part/NF Level B	11.71 percent	$31.7 million
Rural Swing Beds	11.71 percent	$300,000
Subacute	5.08 percent	$12.8 million
Pediatric Subacute	5.97 percent	$3.4 million
Managed Care		$4.6 million

It should be noted that this rate adjustment reflects a two-year cost-of-living adjustment because the rates were frozen for one year (2003-04) as directed in the Budget Act of 2003.

(One facility type—Adult Day Health Care Centers (ADHCs) should also have received a rate adjustment but the Administration is proposing to freeze it. This issue is discussed under the ADHC issue below in this Agenda.)

E. Technical Request from DOF: The DOF has requested inclusion of $200,000 GF due to the need to correct for a technical error.

Questions:

1. DHS, Please provide a *brief* summary of the baseline adjustments for Medi-Cal.

2. Technical Adjustments to Medi-Cal Baseline--*Prior* Subcommittee Actions

Issue: In prior Subcommittee hearings, the Subcommittee has made adjustments to the Medi-Cal Program. The fiscal adjustments for these prior actions have changed because Medi-Cal enrollment, utilization and assumptions have changed at the May Revision due to updated data. Therefore, technical adjustments to these actions must be done.

The prior actions and their adjustments are as noted below. This action does not include any new proposals, just adjustments to prior actions.

Subcommittee Staff Recommendation: It is recommended to adopt the revised fiscal estimates for these actions in order to appropriately reflect the Subcommittee's prior actions.

A. S-CHIP Funding for Prenatal Care: The Subcommittee agreed to authorize the Administration to submit a State Plan Amendment to the federal CMS in order to draw down a 65 percent federal match. Trailer bill legislation was adopted for this purpose (no change to this prior action). The Medi-Cal May Revision slightly adjusts the savings level to reflect minor technical adjustments. **The savings level is now $191.728 million (General Fund).**

B. Rejected Administration's $1,000 Dental Cap: In the May 2nd hearing, the Subcommittee adopted a $1,800 dental cap with specified exemptions and no retroactivity. As such, there will be no savings for this action in the budget year.

The Administration's proposal assumes a savings level of $38.2 million ($19.1 million General Fund) at the May Revision (not including the increased cost for individuals with developmental disabilities which is addressed under the DDS item—See Vote Only). **As such, this savings level is rejected**. **The amount proposed for Delta Dental costs for preparation of establishing the dental cap needs to be maintained at a cost of $2 million ($500,000 General Fund).**

***C. Rejected Medi-Cal Premiums*:** In the April 4th hearing, the Subcommittee rejected the Administration's proposal to require certain Medi-Cal enrollees to pay premiums. The May Revision contains expenditures of $12.9 million ($6.5 million General Fund) for County Administration for the processing of premium payments. **These increased costs need to be deleted due to the rejection of the premium requirements.**

D. Rejected Changes to Single Point of Entry: In a prior hearing, the Subcommittee rejected the Administration's proposal to change the existing Single Point of Entry process by using a Contractor to perform certain functions presently done by County Welfare Departments. Therefore, the proposed net savings of $3.364 million ($2.159 million General Fund) needs to be deleted.

E. County Performance Monitoring Contractor Cost: In a prior Subcommittee hearing, the Administration's proposal to use a contractor to

monitor the counties performance was rejected **for savings of $600,000 ($300,000 General Fund).** Other performance measure actions were adopted at that time and are being maintained (relates to trailer bill language and state positions).

F. Disease Management Program: In a prior Subcommittee hearing, the Subcommittee reduced this program due to delays in implementation. The May Revision has also reflected the delay in implementation and a technical adjustment. **Therefore, it is recommended to conform to the Administration's expenditure amount of $2.250 million ($1.125 million General Fund) which is about $1.750 million (total funds) less than January.**

3. Administration's Proposal on Medi-Cal Drugs and Medicare Part D Interaction—*ISSUES "A" to "D"*

Overall Background: The Medicare Modernization Act (MAA) makes significant changes to the federal Medicare Program and as such, affects the state's Medicaid (Medi-Cal) Program. Part D of the MAA is the new outpatient prescription drug benefit that will be implemented as of January 1, 2006. As of this date, Medicare will begin to pay for outpatient prescription drugs through "Prescription Drug Plans (PDPs) or Medicare Advantage plans. Enrollment into these plans will include "dual eligibles"—individuals enrolled in both Medi-Cal and Medicare.

There are about 1.1 million Medi-Cal/Medicare enrollees (dual eligibles) in California. According to the DHS, about 137,000 of these individuals are enrolled in Medi-Cal Managed Care and 937,000 are enrolled in "fee-for-service" Medi-Cal.

According to the California Health Policy Forum, dual eligibles typically have incomes of less than $10,000 a year. Dual eligibles tend to be in poor health due to chronic illnesses and conditions such as diabetes, heart disease, dementia or a serious mental illness.

Medicare will contract with private plans to provide outpatient prescription drugs. The federal CMS has deemed California its own region for purposes of creating "Prescription Drug Plans (PDPs) competition (since California has the largest number of people in Medicare).

The Governor's May Revision continues to assume that Medicare will be responsible for all drug coverage for dual eligibles effective January 1, 2006, and no Medi-Cal drug benefit will be available to any Medi-Cal enrollee participating in Medicare, **except** for limited circumstances as discussed below.

The Governor's May Revision also includes a new outreach component and requests for increased state staff to address Part D issues. These issues will be discuss individually as shown below unless otherwise directed by the Chair.

Table 1: Governor's May Revision for Medi-Cal Due to Part D Drug Shift

Description of Component	2005-06 (Half Year) (General Fund)
1. Reduced Drug Costs in Medi-Cal: This savings level assumes elimination of dual eligible drug benefits, currently being paid by the Medi-Cal Program, beginning January 1, 2006. The federal Part D Program is to now provide most drugs. This savings level assumes that dual eligibles are about 56.85 percent of Medi-Cal's pharmacy expenditures. The DHS estimates that the federal Part D Program will cover 94.11 percent of the dual eligibles expenditures. The remaining 5.89 percent of costs are discussed below.	-$759.6 million (savings)
2. Loss of Drug Rebate: It is anticipated that the shift from Medi-Cal drug coverage to the Medicare Part D coverage could weaken the DHS' ability to successfully negotiate supplemental rebates with drug manufacturers, potentially increasing program costs by tens of millions. No affect is anticipated for 2005-06, but losses will occur in 2006-07.	N/A
3. "Clawback": Federal law requires states to make a "state contribution" payment to help finance Part D dual eligibles. The May Revise has adjusted this "clawback" downward by about $135 million from the January budget which reflected a $646 million figure.	$511 million (expenditure)
4. Medi-Cal Coverage for Drugs Not Covered by Part D: The May Revision proposes to have Medi-Cal continue to pay for Medi-Cal drug coverage for those categories of drugs excluded by Part D. These categories of drugs include weight loss drugs, barbiturates, benzodiazepines, over-the-counter drugs, cough and cold medications, and various medical supplies.	$46.8 million (expenditure)
5. DHS Adjustment for Medi-Cal Managed Care: The Part D requirement will result in lower Managed Care capitation payments for Managed Care plans for the drug services that will be covered under Part D. This savings was not recognized in the January budget.	$57.6 million (savings)
Proposed Net Impact for Budget Year	$259.5 million (savings)

The DHS has also provided a projected estimate for 2006-07 (full-year of implementation). This estimate is shown in the table below.

Table 2-DHS Projected Estimate for 2006-07 for Drug Shift

Description of Component	2006-07 (General Fund)
1. Reduced Drug Costs in Medi-Cal	-$1.830 billion (savings)
2. Loss of Drug Rebate	$539.7 million (expenditure)
3. "Clawback"	$1.291 billion (expenditure)
4. DHS Adjustment for Medi-Cal Managed Care	-$115.2 million (savings)
5. Medi-Cal Coverage for Drugs Not Covered by Part D	$112.8 million (expenditure)
Projected Net Impact for 2006-07 (budget + one year)	**$1.9 million (savings)**

ISSUE "A"—Shift of Drugs from Medi-Cal to Medicare Part D

Issue: The May Revision assumes implementation of the federal Part D Program by January 1, 2006 as directed by the MAA. **As shown in the table below, there are three key components to the baseline program—(1)** the shift of 94.11 percent of the dual eligibles drug expenditures to the federal Part D Program, **(2)** the loss of future drug rebate funds from this shift, and **(3)** the state's contribution to the federal government.

2005-06 (January 1, 2006, **Half-Year**)

1. Reduced Drug Costs in Medi-Cal: This savings level assumes elimination of dual eligible drug benefits, currently being paid by the Medi-Cal Program, beginning January 1, 2006. The federal Part D Program is to now provide most drugs. This savings level assumes that dual eligibles are about 56.85 percent of Medi-Cal's pharmacy expenditures. The DHS estimates that the federal Part D Program will cover 94.11 percent of the dual eligibles expenditures. The remaining 5.89 percent of costs are discussed below.	-$759.6 million (savings)
2. Loss of Drug Rebate: It is anticipated that the shift from Medi-Cal drug coverage to the Medicare Part D coverage could weaken the DHS' ability to successfully negotiate supplemental rebates with drug manufacturers, potentially increasing program costs by tens of millions. No affect is anticipated for 2005-06, but losses will occur in 2006-07.	N/A
3. "Clawback": Federal law requires states to make a "state contribution" payment to help finance Part D dual eligibles. The May Revise has adjusted this "clawback" downward by about $135 million from the January budget which reflected a $646 million figure.	$511 million (expenditure)

The DHS has approached the federal CMS to readjust the "clawback" formula to include rebates paid in 2004 for the 2003 year. This adjustment would reduce the state's clawback that is to be paid to the federal government. To-date the DHS has been unsuccessful in this effort.

It should also be noted that no additional county administration funding for eligibility processing has been provided by the DHS.

The DHS is also proposing trailer bill language as follows:

Add Section 14001.11 as follows:

"14001.11 (a) The department shall implement the federal requirements described in Section 1398u-5 of Title 42 of the United States Code.

(b) **In each of the several counties of the state, the eligibility and enrollment functions required** under Section 1396u-5(a)(2) and (3) of Title 42 of the United States Code, which may include, but are not limited to, determining eligibility and offering enrollment for premium and cost sharing subsidies made available under and in accordance with Section 1395w-114 of Title 42 of the United States Code, **shall be a county function and responsibility, subject to the direction, authority, and regulations of the department.**

(c) **Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all county letters, provider bulletin, or similar instructions.**

Thereafter, the department ***may*** adopt regulations in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of the Government Code.

(d) The department shall seek approval of any amendment to the state plan necessary to implement this section as required by Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.). Nothwithstanding any other law and only when all necessary federal approvals have been obtained, this section with the exception of the Phased-Down State Contribution as described in 42 U.S.C. Section 1396u-5(c)(1)(A)-(C), shall be implemented only to the extent federal financial participation is available."

Subcommittee Staff Recommendation: It is **recommended to (1)** approve these fiscal three components of the DHS proposal, **(2)** modify the DHS language to require the DHS to include counties and appropriate stakeholders in the development of the all-county letters or other forms of instruction that are sent out, and **(3)** modify the DHS language to require them to work with the counties to develop an estimate of cost for this eligibility processing which is to be presented in the Governor's 2006-07 budget submittal to the Legislature.

Questions:

1. DHS, Please provide a brief summary of the components as noted in the table.
2. DHS, Has the federal CMS taken into consideration any of California's previous cost containment in this area or related concerns with the high amount of the state's clawback?

ISSUE "B"—Medi-Cal Managed Care Plan Capitation Savings Due to Federal Part D Drug Benefit

Issue: The Governor's May Revision reduces by $115.2 million ($57.6 million General Fund) the capitation rate paid to certain Medi-Cal Managed Care plans. The DHS states that since the federal Part D Program will be providing drug coverage for dual eligibiles, an adjustment in the capitation rate paid by the state to plans for dual eligibles (i.e., aged, blind, disabled and long-term care) enrolled in Medi-Cal Managed Care is warranted. Therefore, the proposed adjustments reflect the enrollment level of dual eligibles in each plan.

The DHS is proposing the following adjustments (January 1, 2006 to June 30, 2006):

Medi-Cal Managed Care Plan	Total Funds	General Fund Savings
County Organized Health System	$93.3 million	$46.7 million
Two Plan/GMC Model/Other	$21.9 million	$10.9 million
Total *Savings* (half-year)	$115.2 million	$57.6 million savings

Subcommittee Recommendation: It is **recommended to adopt the May Revision as proposed.** At this point in time, there appears to be no other better estimate.

Questions:

1. DHS, Please describe how these savings were calculated.
2. DHS, Will a revised methodology be used for next year when more information regarding the federal Part D Program is known?

ISSUE "C"—Medi-Cal Coverage for Drugs Not Covered by Part D, & Advocacy Concerns with Continuity of Care Issues

Issue: The May Revision **proposes an increase of $93.6 million ($46.8 million General Fund) to continue to pay for Medi-Cal drug coverage for those categories excluded from the federal Part D Program.**

This is a change from the Governor's January budget which proposed to not cover any drugs for the dual eligibles that the federal Part D would not pay for. Clearly there are concerns from all involved about ensuring that gaps in the federal Part D Program are filled in—at least to some degree.

Specifically, the categories which are excluded from the federal Part D coverage that the DHS is going to cover include the following. The DHS estimated expenditures assume a January 1, 2006 implementation which corresponds to the federal program (half year).

Drug Category	Total Fund Amount
Barbiturates/Benzodiazepines	$9.241 million
Over-the-Counter, Cough & Cold	$44.3 million
Weight Loss Drugs	$ 180,000
Biologicals	$5.2 million
Potassium Chloride	$2.3 million
Part B Medi-Cal (Drugs covered by under Part B Medicare& Medical)	$17 million
Medical Supplies (incontinence/intravenous and other)	$23 million
Total Amount	$101.2 million
Total Budget	**$93.6 million**
(adjusted for cash and payment lag factor)	**($46.8 million GF)**

According to the DHS, these categories comprise 6.31 percent of the dual eligibles expenditures based on 2003 data and information provided by the federal CMS. **However, the DHS states that Part D coverage and Medi-Cal coverage may change as additional information becomes available.** In fact, the DHS will not know what the new Prescription Drug Plans (PDPs) will be offering until after the Budget Act for 2005 is completed.

The Administration is also proposing the following trailer bill language:

Add Section 14133.23 to Welfare and Institutions Code:

(a) It is the intent of the Legislature to comply with the Medicare Modernization Act, which provides federal drug benefits to Medicare beneficiaries. To the extent that federal financial participation is not available, **the Legislature intends to eliminate the provision of drug benefits under this chapter to full-benefit dual eligible beneficiaries** who are eligible for drug benefits under Part D of Title XVII of the Social Security Act (42 USC Section 1395 w-101 et

seq.) or under an MA-PD plan under Part C of Title XVIII of the Social Security Act (42 USC 1395w-21 et seq.).

(b) (1) Notwithstanding any other provision of law, commencing January 1, 2006, ***only*** **drug benefits for which federal financial participation is available shall be provided under this chapter to a full-benefit dual eligible beneficiary.**

(2) As a benefit under this chapter, **the department, subject to the approval of the Department of Finance and only to the extent that federal financial participation is available**, **<u>may</u> elect to provide a drug or drugs in a class of drugs not covered** under Part D of Title XVIII of the Social Security Act (42 USC 139w-101 et seq) or under an MA-PD pan under Part C of Title XVIII of the Social Security Act (42 USC 1395w-21 et seq.) to full-benefit dual eligible beneficiaries.

(3) As a benefit under this chapter, and only to the extent that federal financial participation is available, the department shall provide a drug or drugs to full-benefit dual eligible beneficiaries who are otherwise eligible to receive such a drug or drugs due to their entitlement under Title 42 US Code, Chapter 7, Subchapter XVIII, Part A or their enrollment under Title 42 US Code, Chapter 7, Subchapter XVIII, Part B.

(4) **Except as provided under paragraph (3), nothing in this section shall be interpreted to require the department to provide any drug or drugs not covered under Part D of Title XVIII of the Social Security Act (42 USC 1395w-101 et seq.) or under an MA-PD plan under Part C of Title XVIII of the Social Security Act (42 USC Section 1395w-21 et seq) if federal financial participation is not available.**

(c) The **department shall seek approval of any amendments** to the state plan necessary to implement this section as required by Title XIX of the Social Security Act (42 USC 1396 et seq).

(d) **Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret or make specific this section by means of all county letters, provider bulletins, or similar instructions**. Thereafter, the department may adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(e) For the purposes of this section, a “full-benefit dual eligible beneficiary” means an individual who:

(1) Is eligible or would be eligible for coverage for the month for covered Part D drugs under a prescription drug plan under Part D of Title XVIII of the Social Security Act (42 USC Section 1395w-101 et seq.) or under an MA-PD plan under Part C of Title XVIII of the Social Security Act (42 USC Section 1395w-21 et seq.) and

(2) Nothwithstanding any other provision of this section, is determined eligible for full scope services, including drug benefits, for which federal financial participation is available.

(f) Subdivisions (a) and (b) of this section shall become operative on January 1, 2006.

The Governor's May Revision does *not* address any of the following concerns with the new federal Part D Drug Program:

- *Transition Period (from Medi-Cal to new PPD):* The DHS has also approached the federal CMS to grant a 3 to 6 month or so transition period to maintain continuity of care. (This would require a federal regulation change.) However, the federal CMS is not interested in providing any longer transition period as yet.

- *Cost Sharing:* Under the Part D Program, dual eligibles will have to pay new co-payments of $1 to $5 to get each prescription. The Governor's May Revision does not provide any assistance. In addition, dual eligibles may have to pay additional monthly premiums for drug coverage if they need to enroll in a prescription drug plan above the benchmark plan (i.e., low-cost plan) in order to obtain access to their particular existing drugs (such as certain anti-psychotics and HIV/AIDS drugs

Constituency Group Concerns—Transition Period, Wrap Around, Premiums, and Cost Sharing: Various constituency groups have raised concerns regarding the transition period, wrap-around coverage, new premiums and new cost sharing arrangements for dual eligibles who must now enroll in a Prescription Drug Plan (PDP).

Transition coverage is being requested in order to mitigate potential lapses in coverage as the dual eligibles go from Medi-Cal to the new Prescription Drug Plan (PDP). Specifically, the following three transition aspects are raised:

- *Continuity of Care:* There should be continued drug coverage by Medi-Cal and/or the new Prescription Drug Plan (PDP) for those drugs currently taken by the dual eligible in order to prevent disruptions of coverage and to allow for an appropriate transition to new drug formularies and appeal processes.
- *Access to Emergency Drug Supplies:* There should be access to "emergency" drug coverage for those dual eligibles who may need them during and after the transition period. Access to emergency drug coverage should be provided by the DHS and/or new Prescription Drug Plan (PDP). Medicare does not require drugs to be covered pending an appeal as does the Medi-Cal Program. Therefore a disabled person or frail, elderly individual might need some medication while pursuing the appeal.
- *Use "Troubleshooting" Mechanisms:* The DHS and federal government need to fund and authorize beneficiary assistance and troubleshooting systems that enable beneficiaries and their representatives to resolve eligibility and enrollment problems in a timely and effective manner.

"Wrap-around" coverage pertains to those drugs that are covered under the federal Part D Program but are not covered by a particular Prescription Drug Plan (PDP). If wrap-around is not provided, constituency groups note that the dual eligibles will have to pay the full cost of needed non-formulary drugs if they are unsuccessful in appealing for coverage of the drug through their Prescription Drug Plan (PDP).

Subcommittee Recommendation: The following actions are recommended:

- **(1)** Approve the increase of $93. 6 million (total funds) in order to provide drugs to dual enrollees for those categories of drugs excluded from the federal Part D Program;
- **(2)** Reject the Administration's proposal trailer bill language
- **(3)** Adopt placeholder trailer bill language to implement the federal Part D Program by January 1, 2006;
- **(4)** Adopt placeholder trailer bill language to provide drugs to dual enrollees for those categories of drugs excluded from the federal Part D Program as long as federal funds are available for this purpose;
- **(5)** Adopt placeholder trailer bill language for the DHS to develop a process for providing emergency drug coverage for **a dual eligible for up to 60-days during the first year of implementation of the federal Part D program**. The intent is to have the DHS develop a process in fall 2005 and to notify the Joint Legislative Budget Committee as to its content and potential cost. The cost could then be presented in the Governor's January budget (revised 2005-06 and 2006-07). This timeframe will also enable the DHS to have a better idea as to whom is warded the PDP contracts and what drugs are to be offered and more of how the program is to operate.

  Such a plan would provide for a transition during the first year. Again, the intent would be for emergency coverage—such as for antipsychotics, HIV/AIDS drugs, anti-seizure or other specified classes of drugs or conditions. This is such an unknown and important transition

Questions:

1. DHS, Please provide a brief summary of the proposal.
2. DHS, What drug categories will not be covered?
3. DHS, When may the state know more about implementation of the federal program as far as providing transition coverage?

ISSUE "D"—Federal Part D Program Interaction with the ADAP

Issue: California's Aids Drug Assistance Program (ADAP) also interacts with the implementation of the federal Part D Drug Program.

ADAP works with other third party payers to (1) make sure that ADAP is the payer of last resort, and (2) ensure that access to treatment and drugs are maintained for the ADAP eligible population in order to maintain health of HIV positive people.

Currently, the ADAP has paid share of cost payments for HIV positive Medi-Cal enrollees who could not afford to pay them. This is because it was cost-beneficial for the state to do so. **Beginning January 1, 2006, the ADAP will no longer cover share-of-cost for this population. This is because these individuals will not be eligible for the federal Part D Drug Program.**

Constituency Concern: The Subcommittee is in receipt of propose trailer bill language to provide for a cross-walk between the state's ADAP and the new federal Medicare Part D Program. This proposed language is as follows:

> "The department subsidizes the cost of these drugs for persons who do not have private health coverage, are not eligible for Medi-Cal, or cannot afford to purchase the drug privately. The subsidy program is funded through state and federal sources. The department may also subsidize certain cost-sharing requirements for persons with existing non-ADAP drug coverage by paying for prescription drugs included on the ADAP formulary in up to but not excluding the amount of that cost-sharing obligation. This cost-sharing may only be applied when the ADAP payment is allowed by the other payer. **This cost-sharing may only be applied when the ADAP payment is allowed to be the other payer."**

The intent of this language is to enable the ADAP Program to pay for the copays associated with the new federal Part D Program, as is presently done in the existing ADAP Program. This language is not intended to go outside the structure of the existing ADAP parameters.

Background—How Does AIDS Drug Assistance Program Serve Clients? ADAP is a subsidy program for low and moderate income persons (individual income cannot exceed $50,000) with HIV/AIDS who have no health care coverage for prescription drugs and are *not* eligible for the Medi-Cal Program. On average, ADAP clients access the program an average of 7.4 months per year.

ADAP is cost-beneficial to the state. Without ADAP assistance to obtain HIV/AIDS drugs, infected individuals would be forced to (1) postpone treatment until disabled and Medi-Cal eligible or (2) spend down their assets to qualify for Medi-Cal. About 50 percent of Medi-Cal costs are borne by the state, as compared to only 28 percent of ADAP costs.

Under the program eligible individuals receive drug therapies through participating local pharmacies under subcontract with the statewide contractor**.** The state provides reimbursement for drug therapies listed on the ADAP formulary (about 153 drugs currently). The formulary includes anti-retrovirals, opportunistic infection drugs, hypolipidemics, anti-depressants, vaccines, analgesics, and oral generic antibiotics.

Since the AIDS virus can quickly mutate in response to a single drug, medical protocol now calls for Highly Active Antiretroviral Treatment (HAART) which minimally includes three different anti-viral drugs. Studies consistently demonstrate that early intervention, minimizes more serious illness, reduces more costly treatments and

Subcommittee Recommendation: It is **recommended to adopt the above language as "placeholder" language and to meet with the DHS prior to Conference Committee to technically work out any issues regarding how the language would be made operational.**

Questions:

1. DHS, From a technical assistance basis, please comment on the language.

4. Proposed Elimination of Medicare HMO Premiums Due to Federal Part D

Issue: The May Revision proposes **to eliminate paying the monthly premium for 40,000 existing individuals (dual eligibles) who are presently enrolled in Medicare HMOs. This would occur as of January 1, 2006, when the federal Part D Drug Program is implemented.**

Beginning January 1, 2001, the Medi-Cal Program began paying a monthly premium to certain HMOs that have enrolled Medi-Cal/Medicare dual eligibles. Premium payments are made to ensure that individuals will remain enrolled and that Medi-Cal will avoid paying the pharmacy costs for these individuals. **However, because of the Part D Program, the May Revision assumes that the last premium payment for these individuals will be December 2005.**

As such, it is very likely that these 40,000 individuals will leave managed care and re-enroll into Medi-Cal Fee-for-Service.

Subcommittee Staff Recommendation: If desired, the Subcommittee could continue to fund the premium payment for the remainder of the 2005-06 fiscal year (from January 1, 2006 to June 30, 2006) in order to provide for a transition period for these individuals**. If this is desired, an increase of $13.1 million ($6.5 million General Fund) would be needed. This would provide for coverage for an additional 7 months, through to June 30, 2006.**

Questions:

1. DHS, Please explain the May Revision proposal.
2. DHS, How are people going to be notified and what are the potential consequences?

5. Administration's Proposal on Medicare Part D—Outreach & Administrative Function Changes in Medi-Cal

Issue: The Governor's May Revision proposes several changes within the Medi-Cal Program related to outreach activities and administrative function changes due to the pending implementation of the federal Part D Program. These outreach and administrative adjustments within the Medi-Cal Program are as follows:

- ***A. Enrollee Outreach:*** The Administration is proposing an increase of $2.2 million ($1.1 million General Fund) in Medi-Cal to print and mail flyers to dual eligibles. The DHS states that the DMH and DDS will design the flyers specifically geared to the special needs of the consumers that they serve. The DHS is doing the printing and mailing since the names and address of the Medi-Cal/Medicare dual eligibles is confidential. It is assumed that 6 mailings will go out within the 2005-06 fiscal year.

- ***B. Provider Relations:*** The Administration is proposing an increase of $1.7 million ($463,000 General Fund) to support provider relations activities at the Fiscal Intermediary (i.e., EDS). The DHS states that additional EDS staffing is needed to provide training and offer telephone assistance and clarifications on claims processing changes. Further, there will be costs for provider notification and education activities, such as provider bulletins, notices and internet messaging actions.

- ***C. Adjudicated Claims Lines Reductions:*** The DHS states that savings of $3.1 million ($1.5 million General Fund) will be recognized due to less claims processing due to the shift in drug coverage.

- ***D. Treatment Authorization Request (TAR) Reductions:*** The DHS assumes savings of $5 million ($1.2 million General Fund) from the reduced processing of TARs related to drug coverage.

- ***Eligibility Systems Changes:*** The DHS proposes an increase of $2 million ($204,000 General Fund) to enter into a contract for eligibility system changes, phase-down validation, production of federal Part D required data files, and related functions. The DHS states that Medi-Cal processing must be modified to ensure proper identification, tracking and reporting of the recipient population to be covered by the federal Part D Program. System modifications will need to be made to several systems including the Medi-Cal Eligibility Data System (MEDS), Fiscal Intermediary Access to Medi-Cal Eligibility (FAME), claims data file and to generate new reports. The federal CMS will require the DHS to submit a monthly file of dual eligibles for verification processing. An enhanced federal matching rate of 90 percent will be obtained for these changes.

Questions:

1. DHS, Please provide a brief summary of these proposed changes.

Subcommittee Staff Recommendation: It is recommended to approve these changes as proposed.

6. Adult Day Health Care Program—*Several Issues*

Issues: The Governor's May Revision proposes several changes to the Adult Day Health Care (ADHC) Program. Each of these is outlined below.

As discussed in the Subcommittee's May 9th hearing, recent conversations with the federal CMS have clarified that California must eventually submit a federal Waiver (not a State Plan Amendment) in order to maintain our Adult Day Health Care Program. This conclusion was just recently solidified with the federal CMS even though conversations have been ongoing about this program since 2003.

The DHS states that implementation of an ADHC Waiver by Spring of 2007 is anticipated. However, this timeline is probably optimistic. Transitioning to a Waiver Program will require considerable fore thought particularly given federal requirements pertaining to cost-neutrality, eligibility, service structure and relates aspects.
Any ADHC Waiver will also require state statutory change as well as federal CMS approval. Policy bills are currently moving regarding the state statutory change. Clearly, it is unknown how long it may take the federal CMS to review and approve an ADHC Waiver.

The Governor's May Revision proposes the following adjustments:

- ***Moratorium:*** The May Revision proposes savings of $45.7 million ($22.9 million General Fund) to the ADHC by continuing the "moratorium" implemented through the Budget Act of 2004 and accompanying trailer bill language. This proposed savings level assumes that no changes are made to existing statute. Further, it is assumed that any moratorium will remain in place until a federal Waiver is approved to change the program.

- ***Rate Freeze and Trailer Bill Language:*** This is a new proposal intended to replace the "rate redesign" proposal made in the Governor's January budget. Since the rate redesign proposal cannot commence due to the need to obtain a federal Waiver first, a rate freeze is being proposed.

  The proposed rate freeze assumes an implementation date of June 30, 2005, and *"cost avoids"* $21.9 million ($11 million General Fund). The January rate redesign proposal would have saved $11.3 million ($5.7 million General Fund). The rate freeze would be in effect until the federal CMS established an effect date for a Waiver or set forth a new reimbursement rate methodology for ADHCs.

  Under existing statute, the ADHCs would receive a 5.8 percent rate increase effective as of August 1, 2003 that equates to $21.9 million (total funds).

  The average monthly cost per participant in an ADHC is $717.82. Currently Medi-Cal reimburses ADHCs at a "bundled rate"—a single rate which is paid per recipient, per day (minimum of a four-hour stay required). This rate is set at 90 percent of the state's reimbursement rate for Nursing Facility—Level A.

This rate structure was the **outcome of a legal settlement agreement** done in 1993. Therefore, the Administration is also proposing trailer bill legislation to negate those aspects of the settlement agreement that pertain to the rate being linked to Level A nursing facilities.

This rate includes payment for all required ADHC services as specified in Title 22, California Code of Regulations. This list of required services includes, among other, physical therapy, occupational therapy, speech therapy and recipient transportation to and from the ADHC facility.

- ***Request for DHS State Staff:*** The DHS has submitted a Finance Letter which requests an increase of $48,000 ($24,000 General Fund) to hire an Associate Governmental Program Analyst position beginning January 1, 2006 and ending January 1, 2008. The purpose of this position would be to assist in the restructuring of the ADHC Program.

Any federal Waiver proposal by the DHS would require state statutory change prior to implementation. The Administration is sponsoring policy legislation—AB 1258 (Daucher)—on this issue and it is proceeding through that process.

In addition, SB 642 (Chesbro) is also proceeding through the policy committee process and it would, among other things, make statutory changes to enable the DHS to obtain a federal Waiver for the ADHC Program as well.

Prior Subcommittee Hearing and Constituency Request for Changes to the Moratorium: In the May 9th hearing, the Subcommittee discuss proposed changes to the existing moratorium as presented by the CA Association of Adult Day Services. This proposal language would do the following:

- Address a specific need in the San Francisco area regarding the Laguna Honda nursing facility and a need to utilize community-based resources;
- Allow ADHC provider expansion in Imperial County due to the number of low-income seniors residing in the county;
- Address a specific need in Napa County, as noted (see page 2 of hand out);
- Address a specific need in Humboldt County, as noted; and
- Enable 25 older adults with developmental disabilities to be phased-in for services as noted.

Based on technical assistance provided by the DHS, enactment of the proposed language as outlined above would increase ADHC expenditures by $376,000 ($188,000 General Fund) for 2005-06. Estimated 2006-07 expenditures would be $1 million ($500,000 General Fund).

Background Over All—Existing Program: Adult Day Health Care (ADHC) is a community-based day program which provides nursing, physical therapy, occupational therapy, speech therapy, meals transportation, social services, personal care, activities and supervision designed for low-income elders and younger disabled adults who are *at risk* for being placed in a nursing home. There are about 300 ADHC facilities in the state that are certified in the Medi-Cal Program.

ADHC has been a successful model for elderly individuals for they can obtain many services in one location. The general concept behind providing ADHC services is that they delay or defer individuals from going into nursing homes or other more costly forms of care and therefore, it saves Medi-Cal money**.** Compared to the monthly Medi-Cal cost of a nursing home at about $3,400 per month, ADHC can cost as much as three to four times less. Currently, there are about 43,000 Medi-Cal recipients who receive ADHC services in any given month.

Typically, each ADHC has the capacity to serve between 40 and 100 clients per day. According to the LAO, about 56 percent of the total number of ADHCs are located in Los Angeles County.

Subcommittee Recommendation: One of the purposes of implementing the "moratorium" was to freeze the program in place until a federal Waiver or State Plan Amendment could be crafted and put into place. The moratorium was meant to be a temporary measure. The trailer bill language proposed by CAADS is a very modest lessening of the moratorium.

The rate freeze and accompanying trailer bill language are questionable due to the legal settlement in effect since 1993. If the Administration thinks the legal settlement should be re-crafted, then discussions with the plaintiffs could occur to seek other remedies rather than a unilateral proposal. Therefore, it is recommended to reject the trailer bill language.

The overall recommendation is to **(1)** adopt placeholder trailer bill language to modify the moratorium as noted in the agenda, **(2)** increase by $376,000 ($188,000 General Fund) for the change in the moratorium, **(3)** reject the proposed trailer bill language to negate the 1993 settlement agreement regarding rates in ADHCs, **(4)** increase by $21.9 million ($11 million General Fund) to reflect the existing required rate increase (effective as of July 1, 2005), and **(5)** approve the Finance Letter for the DHS position.

Questions:

1. DHS, Please provide a brief description of the May Revision proposal.

7. Federal Funds for Local Trauma Centers

Issue: The Budget Act of 2003 and accompanying trailer bill language authorized Los Angeles and Alameda counties to transfer funds to the Medi-Cal Program to be matched with federal funds through Medi-Cal. The funds for this transfer come from counties taxes as adopted by local voters.

The DHS is to use these funds to offset the costs of care at local trauma care centers throughout the two counties. Payments are expected to begin September 1, 2005 and are to be retroactive to July 1, 2003. The DHS states that they did not obtain approval of a State Plan Amendment until March 31, 2005. As such, the Trauma Care Centers have not been able to receive payments as yet.

The total federal share available is as follows:

• 2003-04 retroactive payment	$7.2 million
• 2004-05	$10.7 million
• 2005-06	$11.2 million
Total Amount	$29.1 million (federal funds)

The Governor's May Revision reflects **yet another implementation date change** from January 1, 2005 to September 1, 2005. Will the revised date be met?.

Subcommittee Staff Recommendation: It is recommended to adopt the May Revision but the DHS needs to assure that the funds will begin to flow as of September 1, 2005.

Questions:

1. DHS, Please provide a status update regarding the pending federal CMS approval?
2. DHS, Please describe how these funds will be allocated to the trauma care centers.

8. Medi-Cal Drug Budget—Implementation of "Protect State Rebates"

Issue: Through the **Budget Act of 2002, and accompanying trailer bill legislation, the DHS proposed savings of $14 million ($7 million General Fund) related to protecting the state's supplemental rebate program**.

Specifically, this issue pertains to how the federal government views some of our rebates in the context of the overall drug manufacturer law. Federal Medicaid drug rebate law requires drug manufacturers to pay state rebates based on a percentage of their average manufacturer's price or the difference between their "best price" and their average manufacturer price. Payments are made to the states each quarter based on the manufacturers' calculation of the AMP for each drug product they sell. Federal law allows manufacturers to recalculate the AMPs on a retroactive basis that affects payments made to states for past quarters. **This has resulted in states, including California, having to pay back or give manufactures a credit towards future rebate payments.**

The DHS noted that since Medi-Cal also collects state supplemental rebates (i.e., rebates based on contractual agreements that are in addition to the federally mandated rebates), and since these supplemental rebates are often based on the manufacturer's AMP, California is affected by retroactive changes in the manufacturers AMP. **As such, this has resulted in the loss of millions of dollars in rebates (both federal and state).**

Governor's May Revision: The Governor's May Revision lists the "protect state rebates" as part of its overall drug budget reduction within the Medi-Cal estimate package but it **does not reflect any savings for 2005-06.** Instead, it says that the issue is pending federal CMS approval of a State Plan Amendment.

Subcommittee staff has obtained updated information from the DHS. Apparently, the federal CMS is not now going to require submittal of a State Plan Amendment but instead, the DHS must submit a revised drug rebate contract for federal CMS approval. This document should be sent to the federal CMS by May 2005.

Subcommittee Recommendation: It is recommended to reduce the Medi-Cal drug budget by $3.5 million (General Fund) by assuming completion and approval by the federal CMS of California's request which has been pending now for three years with the DHS. The DHS notes that once CMS approval is obtained, they will need to redo some of the contracts on drug rebates. **Therefore, the proposed savings of $3.5 million (General Fund) reflects only a half-year potential.**

Questions:

1. DHS, What is the status of getting the needed information to the federal CMS?

9. Administration's Trailer Bill Language for Three Medi-Cal Benefits

Issue: The Governor's May Revision proposes three pieces of trailer bill legislation and budget adjustments as follows:

- ***Speech-Generating Devices Rate Increase:*** An increase of $100,000 ($50,000 General Fund) is requested to reflect a rate increase for speech-generating devices. This proposed increase would **settle litigation issues** by providing adequate access to the product. The DHS is also requesting trailer bill language to enable these devices to be paid the lesser of either 100 percent of the Medicare cost, or a contract price as specified.

- ***Therapeutic Diabetic Shoes and Inserts:*** The Administration proposes trailer bill legislation to add therapeutic diabetic shoes and inserts as a Medi-Cal benefit. The Administration assumes that the cost of adding this benefit would be offset by the savings that would occur in other areas of the program.

- ***Portable X-Ray Transportation Rate Increase:*** The Administration proposes trailer bill legislation to increase the rates paid for portable x-ray transportation to 100 percent of the Medicare rate. The Administration assumes that the cost of providing this benefit would be offset by the savings that would occur in other areas of the program.

Subcommittee Staff Recommendation: It is recommended to approve the proposed trailer bill legislation and budget adjustments as proposed. Clearly these changes are needed to improve access to these services.

Questions:

1. DHS, Please provide a brief summary of each of these proposals.
2. DHS, After these changes are made will appropriate access to these services be available statewide?

10. Stanislaus –Two Plan Model Contract (Existing Program)

Issue: Stanislaus County is a Two-Plan Model Medi-Cal Managed Care county. (This means that the DHS is supposed to contract with two managed care plans in the county. **One plan is supposed to be a "local initiative" and the other plan is a commercial plan** (i.e., non-government operated). Children and families are enrolled on a mandatory basis in one of the managed care plans, whereas aged, blind and disabled individuals are enrolled on a voluntary basis or can access fee-for-service Medi-Cal.

In Stanislaus County, fee-for-service was restored as an option beginning in 1999 because the commercial plan—Omni—terminated its contract. As such, Medi-Cal enrollees had the choice of enrolling into the Local Initiative or using Medi-Cal fee-for-service.

In the Spring of 2003, the DHS released a "Request for Proposal" to obtain a new contractor. HealthNet was awarded the contract to operate the commercial plan and is expected to begin operations as of August 2005.

The Governor's May Revision proposes an increase of $3.9 million ($1.9 million General Fund) in 2005-06 to account for the conversion. This is an estimate since the rates for the new commercial plan (HealthNet) are not yet available. Projected capitation has been calculated using the rates paid to the Local Initiative in Stanislaus. Rates are therefore assumed to be 95 percent of fee-for-service.

It should be noted that one large hospital within the county has refused to contract with HealthNet. Therefore, the DHS is proceeding to carve-out a five zip code area around the hospital that will continue to be fee-for-service and use Blue Cross. The rest of the county will use the Two Plan Model (Local Initiative and HealthNet).

Subcommittee Recommendation: Subcommittee staff has raised no issues with the proposed budget adjustment since it is primarily due to a payment lag factor associated with Medi-Cal making cash/accrual accounting adjustments. However, discussion of the conversion and how it was done is important given the Administration's proposed expansion of Medi-Cal Managed Care.

Questions:

1. DHS, Please briefly describe why it has taken from 1999 to 2005 for a second plan to be obtained for Stanislaus County.

11. Managed Care Intergovernmental Transfer for Rate Increase--CalOPTIMA & San Mateo COHS's

Issue: The University of California system and San Mateo County are both transferring funds to the state (DHS) for the purpose of providing capitation rate increases. Specifically, these proposed Intergovernmental Transfers (IGTs) are as follows:

- University of California system for CalOPTIMA $7.5 million
- San Mateo County for their COHS $4 million

- Total Transfer Amount = $11.5 million

This $11.5 million amount is used to draw down the federal match of $11.5 million. As such, $15 million will be provided to CalOPTIMA (Orange County) and $8 million will be used by the Health Plan of San Mateo for capitation rate increases.

Subcommittee Staff Recommendation: It is recommended to approve as proposed.

Questions:

1. DHS, Please briefly summarize the May Revision proposal and why this IGT would meet federal CMS approval?

12. DHS Provided Three Percent Rate Increase for CalOptima

Issue: The Governor's **May Revision proposes an increase of $18.4 million ($9.2 million General Fund) to provide CalOptima (Orange County) with a three percent rate increase effective as of October 1, 2005.**

The DHS states that this rate increase is needed because CalOptima is experiencing severe financial difficulties. **The DHS states that this rate increase is needed to avoid the plan's insolvency which has been projected by the plan to occur as early as 2007-08.**

The DHS states that CalOptima is experiencing financial difficulties as reported in their quarterly financial statements. Losses have occurred in eight of the last nine quarters and the plan continues to deplete financial reserves. The last three quarter losses have resulted in an average loss margin of 3.5 percent (negative profit rate). The DHS states that at this loss rate, the plan's operations are unsustainable. CalOptima has reported to the DHS that its equity position will fall below the required regulatory tangible net equity level in 2006-07. **It should be noted that CalOptima also received a three percent rate increase last year in the Budget Act of 2005.**

Background on Capitation Rates: Capitation rates for CalOptima are negotiated between the plan and the California Medical Assistance Commission (CMAC). The DHS state's that due to the state's fiscal problems over the last four years, CalOptima's negotiated capitation rates have significantly lagged behind inflationary trends in the health care industry. Adding to this situation is that the current CalOptima's rates are well below the fee-for-service equivalent costs.

Medi-Cal Managed Care Rate Structure: Questions regarding the existing Medi-Cal Managed Care rate structure have been evolving for several years. As noted by the LAO in past Analyses, the existing methodology is outdated.

Though the DHS did change its methodology in 2003 in order to meet federal law requirements to be actuarially based, amongst other things, the DHS does not use encounter data to make rate determinations.

The "base cost" is the part of the rate that relates to experience from the past. Generally, to calculate the base cost, an attempt is made to find a group of individuals that will be similar to the group for which the rates are being set. Claims tapes for four COHS's is used for determining the Two Plan Model rates. Various adjustment factors are applied to the base costs, such as for age/sex population mix, enrollee's duration of Medi-Cal enrollment, trend factors for hospital inpatient and outpatient services, trend factors for pharmacy, and other factors. In addition, changes made through the state budget process are also to be factored in as part of the process.

Currently there are contract provisions that provide for an administrative remedy and an appeals process when disputes are raised by the plans regarding contract issues. These provisions are included in the Two Plan Model, Geographic Managed Care and the COHS contracts. Specifically, there is (1) an initial "notice of dispute"

process, (2) an administrative appeals process, and (3) a Writ of Mandate process which is filed with the Superior Court to protest the Administrative Appeal decision. Within the last two-years, 15 plans have filed some form of Administrative Appeal regarding rates. Four cases have been taken to Superior Court.

The DHS notes that they have recently awarded a contract to Mercer which begins May 1, 2005. Expenditures in the current year for this contract are expected to be $300,000 (total funds) and $1 million for 2005-06.

Subcommittee Staff Recommendation: It is **recommended to (1)** adopt the May Revision as proposed to provide the needed rate adjustment to CalOptima, and **(2)** adopt Budget Bill Language to require the DHS to provide the Legislature with the results from the Mercer rate analysis. **The following Budget Bill Language is proposed (Item 4260-001-0001):**

> "The Department shall provide to the fiscal and policy committees of the Legislature the quantitative analyses and key data results obtained from the rate study being conducted by an independent contractor. This information shall be provided on a flow basis, when applicable and by no later than March 1, 2006. No proprietary or confidential information is being requested by this language."

Questions:

1. DHS, Please specifically describe how this rate increase was determined and why it is needed.
2. DHS, How does the DHS monitor for plan fiscal solvency issues and the appropriateness of Medi-Cal Managed Care rates?

13. Alameda Alliance for Health—Issue of Fiscal Solvency

Issue: The Alameda Alliance for Health is the Local Initiative in the Two Plan Model in Alameda County. Based on recent enrollment figures, there are 78,000 Medi-Cal enrollees in this plan.

Alameda is experiencing fiscal solvency issues, similarly to CalOptima. **As such, the Subcommittee is in receipt of trailer bill language as follows:**

> "A supplemental rate increase for Medi-Cal services of 5 percent shall be provided to the Alameda Alliance for Health for fiscal years 2005-06 through 2008-09.
>
> The Alliance shall provide a corrective action plan to the Department of Health Services that illustrates that, with the rate increase, the Alameda Alliance for Health is positioned to maintain solvency for the period of the rate increase and beyond.
>
> The department shall conduct periodic audits during the period of the rate increase to ensure compliance with the corrective action plan and to ensure that solvency is maintained."

Over the past five years, as with most counties, the safety net services in Alameda have been severely threatened due to the cost of providing services to the uninsured and the inadequacy of Medi-Cal reimbursement rates. As such, the Alameda Alliance for Health has depleted its reserves. **The Alameda Alliance is working with the Department of Managed Health Care on a corrective action plan for fiscal solvency. However, even with changes in order to avoid falling below the tangible net equity requirements in the first quarter of 2006, the Alameda Alliance must receive a rate increase of five percent.**

Over the past decade and a half, Alameda County has enacted several organizational reforms aimed at improving the access and cost effectiveness of its system. It consolidated the administration of its two acute hospitals, closing one emergency room and reducing its medical surgical beds. It has invested heavily in new outpatient facilities, both county and community based organization operated, and targeted both discretionary Tobacco Master Settlement Funds and newly enacted sales tax revenue to expand serve and access. Services expansions included innovative partnerships with school districts and private hospitals.

Despite these commitments and gains, the system is threatened by inadequate reimbursement rates and a dwindling provider base willing and able to address populations of special need.

Subcommittee Staff Recommendation: It is **recommended to (1)** appropriate $6.1 million ($3 million General Fund) to provide for the rate increase in 2005-06, ***and* (2)** adopt the above trailer bill language as shown.

14. DHS Hospital Waiver Update

Issue: The Subcommittee has discussed numerous times the many evolving components of the pending federal Waiver regarding hospital financing.

Grave concern has been expressed regarding the magnitude of the issue and how it affects California's overall health care system, particularly the safety net hospitals. The late timing of the negotiations with the federal CMS and lately federal OMB has also been disconcerting (our existing Waiver expires as of June 30, 2005). The state's health care system is at significant risk.

Questions:

1. DHS, Please provide an update on the status of the federal Waiver overall.
2. DHS, Please provide an update on each component piece of the funding.
3. DHS, Please provide an update on the policy changes regarding any coverage product, requested federal changes to California's Medi-Cal Program and related matters.
4. DHS, What are the next steps?

15. Administration's Proposal to Expand Medi-Cal Managed Care— *ISSUES "A" to "B"*

Issue and Prior Subcommittee Hearings: As discussed in several Subcommittee hearings, the Administration is proposing an aggressive expansion of the Medi-Cal Managed Care Program. This expansion would be achieved through a phased-in process **over a twelve to eighteen month period** commencing in January 2007. It is anticipated that **816,000 *additional* Medi-Cal enrollees would be added during this period.** Of this amount, 554,000 are aged, blind, and disabled.

The proposed expansion assumes the following **key components**:

- ***Mandatory enrollment of aged, blind and disabled individuals:*** This enrollment would need to be implemented in the 12 Two-Plan Model counties (two plans in each county), the two GMC counties and the 13 new counties. Voluntary enrollment is the present option in use (i.e., one chooses to enroll). There are about 290,000 aged, blind and disabled individuals who are enrolled presently, or less than 10 percent of the total 3 million Medi-Cal Managed Care enrollees. **The proposed mandatory enrollment would add about 554,00 aged, blind and disabled individuals, or about twice the number of individuals presently enrolled.** About 74 percent of these individuals are in the SSI/SSP Aid to the Disabled category.

- ***Expansion to 13 New Counties:*** The Administration would expand Medi-Cal Managed Care to 13 additional counties, including El Dorado, Imperial, Kings, Lake, Madera, Marin, Mendocino, Merced, San Benito, San Luis Obispo, Sonoma, Placer and Ventura. Enrollment would include families, children and the mandatory enrollment of aged, blind and disabled individuals.

  The Administration assumed the following Managed Care model configurations for these new counties:

  - Include El Dorado and Placer counties in the existing Sacramento GMC;
  - Include Imperial County in the existing San Diego GMC;
  - Convert Fresno County (now a Two Plan) to a GMC and include Madera, Merced, and potentially Kings counties;
  - Expand existing COHS to include the counties of Marin, Mendocino, San Benito, San Luis Obispo, Sonoma, Ventura and possibly Lake. For example, San Luis Obispo County could merge with the existing Santa Barbara COHS.

  The Administration assumes that all of these counties are up and operational (ready for enrollment) by no later than April 2008.

  It should be noted that federal law currently restricts California from having more than the five COHS which are presently in operation (i.e., five COHS's in eight counties). As such, if Ventura or another individual county wants to become a COHS, then a federal law change is required. Further, federal law also mandates

that not more than 14 percent of all Medi-Cal enrollees can participate in the COHS model.

ISSUE "A"—Policies on Expansion and Mandatory Enrollment

Issue and Prior Subcommittee Hearings: As discussed in several prior Subcommittee hearings, the Administration proposal would require (1) state statutory changes, (2) approval of a federal Waiver, and (3) adoption of state regulations (though the Administration may choose not to use the regulation process for some or all program components).

Subcommittee Recommendation: Based on discussions from several Subcommittee hearings, the following actions are recommended:

- ***1. Reject Administration's Trailer Bill Language:*** This language proposed a mandatory enrollment of aged, blind and disabled individuals and provide complete carte blanch authority to the Director of the DHS to do any type of sole source contracting for services, and to seek any type of federal Waivers for this purpose. The proposed language completely lacked any involvement of the Legislature and did not contain any language regarding improvements to the core Medi-Cal Managed Care Program.

- ***2. Allow Existing County Organized Health Care Systems to Expand to New Counties:*** Some of the 13 new counties may be interested in merging into an existing COHS. For example, Marin maybe interested in joining the Partnership Health Plan COHS. It should be noted that the DHS will need to submit a Waiver revision to the federal CMS for changes to be made to the COHS model.

  It should also be noted that a federal law change would be needed for any county wanting to be its own COHS since federal law limits California to a total of five COHS's, which we presently have in operation.

  By the nature of the model, COHS's require the mandatory enrollment of aged, blind and disabled individuals. Therefore, counties that choose to become part of an existing COHS would have mandatory enrollment and would also need to meet the following conditions regarding the CCS Program and plan readiness.

- ***3. Allow Expansion for Managed Care Using Existing Program Enrollment Method***: For those counties (of the 13 counties) that choose to (1) join an existing GMC model, (2) establish their own GMC model, or (3) establish a Local Initiative to commence with implementation of a Two-Plan Model, they may proceed with operating under the existing arrangements—i.e., mandatory enrollment of children and families, and voluntary enrollment of aged, blind and disabled.

- ***4. Carve Out of California Children's Services (CCS) Program:*** Existing statute "carves-out" the CCS Program from Medi-Cal Managed Care until September 1, 2008, except for certain County Organized Health Systems (COHS). With the proposed expansion recommendation, it is recommended to adopt the following trailer bill language as placeholder to enable COHS to expand, as noted, but to also retain the integrity of the CCS Program. The proposed placeholder language is as follows:

  "When a managed care contractor authorized to provide CCS covered services pursuant to subdivision (a) of Welfare and Institutions Code Section 14094.3 proposes to expand to other counties, the contractor shall demonstrate how it will maintain and comply with California Children's Services Program (CCS) standards including, but not limited to: referral of newborns to the appropriate neonatal intensive care level, referral of children requiring pediatric intensive care to CCS-approved pediatric intensive care units, and referral of children with CCS eligible conditions to CCS approved inpatient facilities.

  The managed care contractor shall demonstrate how it will comply with CCS program medical eligibility regulations. Questions about interpretation of the state CCS medical eligibility regulations, or disagreements between the county CCS program and the managed care contractor regarding interpretation of those regulations, shall be resolved by the local CCS program consulting in writing with the appropriate CCS regional office or state CCS staff. The response shall be communicated in writing to the managed care contractor.

  The managed care contractor shall demonstrate how it will ensure the timely referral of children with special health care needs to CCS paneled providers who are board certified in both pediatrics and in the appropriate pediatric subspecialty.

  The managed care contractor shall demonstrate how it will report expenditures and savings separately for CCS covered services and CCS eligible children.

  All children who are enrolled with a managed care contractor who are seeking CCS program benefits shall retain all rights to appeals and fair hearings of denials of medical eligibility or of service authorizations. Information regarding the number, nature, and disposition of appeals and fair hearings shall be part of an annual report to the Legislature on managed care contractor compliance with CCS standards, regulations, and procedures. This report shall be made available to the public.

  The state, in consultation with stakeholder groups, shall develop unique pediatric plan performance standards and measurements, including, but not limited to the health outcomes of children with special health care needs."

- ***5. "Plan Readiness":*** In a March document, the DHS describes how they intend to determine a "plans readiness" for becoming operational to provide services to Medi-Cal enrollees. As such, it is recommended to adopt placeholder legislation that corresponds with the DHS document (codify key components and intents).

- ***6.Adopt Placeholder Trailer Bill Language—Reporting to Legislature:*** It is also recommended to adopt placeholder trailer bill legislation to require the DHS to do the following:

  - Provide the Legislature with a quarterly update, beginning January 10, 2006, on core activities to improve the Medi-Cal Managed Care Program and to

expand to the 13 counties. This update shall include key milestones and objectives of progress regarding changes to the existing program, submittal of State Plan Amendments to the federal CMS, submittal of any Waiver documents and related key functions related to the expansion effort.

Questions:

1. DHS, Any comment regarding the proposal?

ISSUE "B"—Administration's Request for Staff & Contract Funds

Issue: The DHS is requesting a total **increase of $7.6 million** ($3.3 million General Fund and $4.3 million federal funds) to **(1)** hire **47.5 new state staff as of July 1, 2005**, **(2)** provide $1 million for external contracts, and **(3)** provide $1.9 million for "interdepartmental" contracts.

This request for resources assumed the mandatory enrollment of aged, blind and disabled individuals.

The table below provides a summary of where the 47.5 requested positions would be located and also displays the 2006-07 anticipated future request for next year. This proposed staffing level by the Administration assumes legislative approval of their entire managed care proposal—13 new counties, mandatory enrollment in all counties of aged, blind and disabled individuals, **and** implementation of the Alternative Long-Term Care Integration Program (not, just the newly scaled down three Pilots).

Table 1: **Summary of Administration's Staffing Proposal**

DHS Divisions & CMAC	New Positions for 2005-06 **(Budget Year)**	New Positions for 2006-07 **(Next Year)**	Total Positions
Medi-Cal Managed Care	22.0	14	36
Payment Systems	8.5	0	8.5
Long-Term Care	8.0	0	8
Administration	5.0	3.0	8
Legal Services	4.0	0	4
CA Medical Assist. Commission	0	3	3
Totals	**47.5 Requested**	20.0 Future	67.5

The following discussion outlines the position request by each area.

Medi-Cal Managed Care Division (22 positions, or 40 percent of the budget request):
The DHS states that existing staffing levels have been significantly depleted over the last 18 months to 24 months as a result of the budget deficit, resulting positions cuts, and the extended hiring freeze instituted by the Governor, which has resulted in about a 30 percent reduction of staff within the DHS Medi-Cal Managed Care Division. As such, they are requesting 22 new positions.

Table 2—Medi-Cal Managed Care Division Request *(22.0 positions)*

Type of Positions Requested	Description of DHS Stated Need	Number of Positions
Staff Services Manager II	Coordinate activities for the expansion	1.0
Staff Services Manager I	Oversee contract development and operational issues	2.0
Associate Gov Prog Analysts	Provide additional contract management for new contracts in the expansion counties.	8.0
Associate Management Auditor	Conduct ongoing financial monitoring of contracted health plans in the new counties and work with actuary staff in development of experienced-based rates for both the expansion areas *and* aged/blind/disabled	2.0
Office Technician	Perform duties due to expansion	1.0
Nurse Consultant III	Develop new policies and procedures relative to clinical standards, policies, and quality measures for quality of care	1.0
Medical Consultant II	Support special needs services	1.0
Nurse Evaluator II	Develop medical monitoring protocols and tools for expansion population.	2.0
Research Program Spec II	Support rate methodology and encounter data research	1.0
Research Program Spec I	Support rate methodology and encounter data research	1.0
Actuary Positions	Make actuarial valuations and verify capitation rates	2.0
Total for the Division		**22.0**

Payment Systems (8.5 positions):

Table 3—DHS Payment Systems Division *(Two Areas)*

Type of Positions Requested	Description of DHS Stated Need	Number of Positions
A. Health Care Options	Conduct materials development, system modification and contract amendments with Health Care options contractor (Maximus)	**6.0 total**
Staff Info Systems Analyst		2.0
Associate Gov Prog Analysts		2.0
Research Program Specialist I		1.0
Office Technician		1.0
B. Fiscal Intermediary & Provider Relations	Oversee written communications, training materials and serve as DHS resource for provider activities (billing questions and claims processing)	**2.5 total**
Office Technician		0.5
Total for the Division		**8.5 total**

Long-Term Care (8 positions):

Table 4—DHS Long-Term Care Division

Type of Positions Requested	Description of DHS Stated Need	Number of Positions
Staff Services Manager II	To coordinate and provide liaison with other programs and state departments.	1.0
Staff Services Manager I	To supervise 6 staff and to develop ALTCI policies.	1.0
Associate Gov Prog Analysts	To provide ALTCI policy development and oversight.	4.0
Nurse Evaluator II	To provide review and evaluation of current clinical outcome measures and clinical practice guidelines.	1.0
Office Technician	To provide administrative support	1.0
Total for the Division		**8.0**

Administration Division (5 positions):

Type of Positions Requested	Description of DHS Stated Need	Number of Positions
Personnel Specialist	Process workload with the requested positions	0.5
Associate Gov Prog Analyst	Perform contract management	1.0
Research Program Specialist II	Develop and maintain complex data projects for the Fiscal Forecasting Branch	1.5
Account Technician	Process additional workload	1.0
Office Assistant	Support to the contract processing activities	1.0

Legal Services (4 positions):

Type of Positions Requested	Description of DHS Stated Need	Number of Positions
Staff Counsel III	To perform contracting work and drafting procurement documents related to managed care expansion.	1.0
Staff Counsel I	To perform contracting work and drafting procurement documents related to managed care expansion.	1.0
Staff Services Manager I	For the Office of Regulations, though the trailer bill language assumes little if any regulations.	1.0
Associate Gov Prog Analyst	For the Office of Regulations, though the trailer bill language assumes little if any regulations.	1.0

Contract Funding Request: The DHS is also seeking about $3 million (total funds) in additional contract funds for 2005-06. These contract funds would be used as follows:

- ***Health Care Options Contract ($300,000 for 2005-06)***: Maximus is the Medi-Cal Managed Care "enrollment broker" who (1) presents the plan choices to the pending managed care enrollee, and (2) defaults enrollees to plans as needed if a choice is not made. The DHS states that costs are calculated based on enrollment. The projected costs for 2005-06 are $300,000 (total funds) for them to (1) develop new enrollment materials, (2) revise existing enrollment materials, and (3) begin system change work for the development of new informing materials specific to the aged, blind and disabled populations. Expenditures for the out-years would increase.

- ***Fiscal Intermediary (Electronic Data Systems Contract) (total funds not specified by the DHS):*** The DHS states that changes would need to be made to the "adjudicated claim line" process as well as other aspects.

- ***External Quality Review Organization ($312,000 total funds):*** The EQRO is an accrediting body that is an expert in the scientific review of the quality of health care provided to Medi-Cal enrollees in a state's managed care program. It activities are required by federal law. It is unclear however what specifically would be done with these funds.

- ***Translation Services—University of California System ($190,000 total funds):*** The DHS presently has a consultant services contract with the UC to translate written Medi-Cal Managed Care informing materials for Medi-Cal enrollees. This would include expenditures for both the proposed geographic expansion as well as the proposed mandatory enrollment of aged, blind and disabled.

- ***Independent Assessment of Waivers ($210,000 total funds):*** These funds would be needed only if the Legislature grants the DHS authority to seek a federal Waiver for the mandatory enrollment of aged, blind and disabled individuals. Further, it is unclear as to why funds would be needed in 2005-06 when the DHS assertive schedule shows that enrollment would not commence until at least January 1, 2007.

- ***Information Technology Contract ($1.215 million total funds)***: This proposed expenditure of $1.215 million ($304,000 General Fund) would be for "systems changes" to (1) develop of programming specifications, (2) coordination of the Health Care Options vendor (Maximus), (3) development of materials for training new counties about the Medi-Cal Eligibility Determination System related data, (4) development of changes to plan tables, (5) assessment of HIPAA related changes, (6) assessment of changes to paid claims data, (7) coding of system changes, (8) testing of system changes, and (9) coordination of external testing with counties.

- ***Outreach to Aged, Blind and Disabled ($500,000 total funds):*** The DHS states that these funds are needed if mandatory enrollment of aged, blind and disabled individuals is done.

- ***Long-Term Care Diversion Assessment Tool ($500,000 total funds):*** It is the intent of the state to have the ALTCI plans work with a contractor on the development and implementation of a uniform Long-Term Care Diversion and Assessment Protocol for seniors and adults with disabilities. This protocol would be used to determine functional needs and preferences and to ensure that seniors and adults with disabilities receive care that supports maximum community integration and self-direction. **This contract is part of the proposed Acute Long-Term Care Integration Projects.**

Legislative Analyst Office Comment and Recommendation: The LAO notes that once the Legislature has decided what aspects of the Administration's proposed Medi-Cal Managed Care proposal it wants to proceed with, then it can decide what necessary DHS staff components and contract amounts are necessary.

For example, if the Legislature wants to proceed with expansion of the existing Managed Care Program (i.e., children and families, and voluntary enrollment of aged, blind and disabled) into new geographic areas, then less DHS resources would be necessary in 2005-06.

However, at a minimum, the LAO would recommend deleting at least 5.5 of the requested DHS 47.5 positions for savings of $469,000 (General Fund), and to make four of the positions two-year limited-term appointments.

Questions:

1. DHS, Please present your request for staff resources and for contract funding.
2. DHS, Are all of the identified contract funds necessary in the budget year?

17. Long-Term Care Integration Assistance *(Pre-Cursor to ALTCI)*

Issue: The Legislature authorized planning grants commencing in 1998 to facilitate the integration of long-term care services as a result of state and local interest in creating a more efficient delivery system for seniors. The first grants were allocated by the DHS in 1999. A total of $2.6 million (General Fund) has been awarded to 16 counties between 1999 and 2004. Both San Diego and Contra Costa counties have sustained ongoing planning efforts and were the first entities to receive "implementation" grant awards (total of $897,500) in 2004-05 to precede with various integration activities.

The May Revision continues to provide $898,000 (General Fund) for these integration purposes. However, it is unclear on how these funds are to be allocated by the DHS given the newly proposed ALTCI Projects (as discussed below).

In addition, the DHS is seeking an increase of $236,000 ($118,000 General Fund) to continue 3 limited-term positions that expire as of June 30, 2005. The DHS is asking to extend these positions for one more year (to June 30, 2006).

Subcommittee Staff Recommendation: **First,** after discussion with the CHHS Agency, the following Budget Bill Language is recommended to be added to Item 4260-101-0001 to direct the allocation of the $898,000 to the Acute Long-Term Care Integration Projects.

> "Of the amount appropriated in this Item, $898,000 shall be directed from the long term care integration pilot project set forth in Article 4.3 (commencing with Section 14139), of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, and made available to the director for use by local entities implementing Acute and Long Term Care Integration Projects and shall be available only for reimbursable start-up costs approved by the director of the Department of Health Services."

Second, it is recommended to approve continuation of the three positions for one more year.

Questions:

1. DHS, Please provide a brief explanation of the request.

18. Acute & Long-Term Care Integration Projects (Three Only)—*Revised Language*

Issue: The Subcommittee has discussed this issue in several hearings. The Administration has revised their proposal for developing Acute and Long-Term Care Integration Projects. Under their revised language, it is clarified that three projects would be created in three county areas--Contra Costa, Orange and San Diego.

However, the Subcommittee is still waiting receipt of a second revision that was promised by the Administration and is late. The Administration notes that revised draft language (#2) is still pending delivery. It is a work in progress overall.

The Subcommittee has also received considerable comment from a variety of constituents and stakeholders. This information has been very constructive and clearly, further discussions are necessary.

Subcommittee Staff Recommendation: It is **recommended to adopt placeholder trailer bill language for implementation of the three proposed Acute Long Term Care Projects with the intent to continued discussions over the next few weeks**. For purposes of sending the language to Conference Committee it is recommended to (1) adopt placeholder language regarding the development of rates, and (2) adopt placeholder language regarding the use of public authorities for personal care services.

Questions:

1. DHS, When will revised language (#2) be available for review?
2. Public Comment—key issues and ideas.

19. Administration's Trailer Bill Language for LA County Outpatient Clinics

Issue: The Administration is proposing trailer bill language that would permanently establish in state statute the cost-based reimbursement methodology presently provided in Los Angeles County for Los Angeles County owned or operated hospital clinics and community care clinics that participated in the Los Angeles County Waiver (set to expire as of June 30, 2005).

The federal Waiver for Los Angeles (second period from 2000 to June 30, 2005) enabled **LA-County outpatient hospitals (except emergency rooms) and clinics the opportunity to attain Federally Qualified Health Center (FQHC) designation and thereby, enhance their Medi-Cal reimbursement rate (the rate was would now be "cost-based").**

According to the DHS, federal CMS rules have changed and they will not now designate hospitals as FQHC. There are **presently 33** LA County owned and operated community care clinics that have not achieved FQHC status. These 33 clinics fall under the categories of outpatient departments of various hospitals, comprehensive health centers, Juvenile Court health centers, and other various health centers.

Therefore when the LA County Waiver expires as of June 30, 2005, the enhanced FQHC rate these 33 clinics are receiving will no longer be applicable without a state statutory change. The DHS notes that if the cost-based reimbursement is not continued, the DHS will need to revert these clinics back to a blended local code rate and over the long-term, this will further destabilize the LA County health care system.

Approval of the Administration's proposed trailer bill will enable the DHS to submit a State Plan Amendment to the federal CMS to allow cost-based reimbursement to a strictly defined category of outpatient hospitals and clinics.

The Administration's proposed trailer bill language is as follows:

Add Section 14105.24 to Welfare and Institutions Code:

(a) Clinics and hospital outpatient departments, except for emergency rooms, owned or operated by LA County that participated in the CA Section 1115 Medicaid Demonstration Project for Los Angeles County and received 100 percent cost-based reimbursement pursuant to the Special Terms and Conditions of that Waiver shall continue to be reimbursed under a cost-based methodology on and after July 1, 2005.

(b) Reimbursement to hospitals and clinics described in subdivision (a) shall be at 100 percent of reasonable and allowable costs for Medi-Cal services rendered to Medi-Cal beneficiaries. Reasonable and allowable costs shall be determined in accordance with applicable cost-based reimbursement provisions of the following regulations and publications:

(1) The Medicare reimbursement methodology as specified at Sections 405.2460 through 405.2470 of Title 42 of the Code of Federal Regulations (together with applicable definitions in Subpart X of Part 405 of title 42 of the Code of Federal Regulations to the extent those definitions are applied by the department in connection with payments to FQHCs in California).

(2) Cost reimbursement principles outlined in Part 413 of Title 42 of the Code of Federal Regulations. In the event of a conflict between the provisions of Part 405 and Part 413, the provisions of Part 405 shall govern.
(3) "Cost Principles for State, Local, and Indian Tribe Governments" (OMB Circular A-87)
(4) "Rural Health and FQHC Manual" (CMS Publication 27).
(5) Subdivision (e) of Section 14087.325 of the Welfare and Institutions Code, and any implementing regulations.

(c) The methodology for reimbursement adopted by the state to comply with Section 1396a (aa) of Title 42 of the US code shall not be applicable to clinics that are paid pursuant to this section.

(d) This section shall become operative on the effective date established by the federal CMS for an amendment to the CA Medi-Cal State Plan that approves the cost-based reimbursement methodology for the clinics described in subdivision (b).

(e) Notwithstanding subdivision (a) of Section 14105 of the Welfare and Institutions Code and the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement and administer the cost-based rates of reimbursement described in this section by means of provider bulletins or manuals, or similar instructions.

Subcommittee Staff Recommendation: It is recommended to approve the proposed trailer bill legislation.

Questions:

1. DHS, Please present the May Revision proposal.

20. Third Party Liability—Request for State Staff and Estimated Savings

Issue: The DHS is requesting a total increase of $5.850 million ($1.741 million General Fund), including an adjustment in the May Revision, to fund positions to increase and expand the functions of the Third Party Liability Program which is operated by the DHS to "cost avoid" and recoup payment for Medi-Cal services as allowed under both state and federal law. The table below is a summary of the DHS request and the LAO recommendation. (Please note the table does not display the federal fund match due to space constraints, but there is one.)

Summary Table #1—Governor's Request and LAO Recommendation

Proposal Component	DHS Positions	DHS General Fund	LAO Positions	LAO General Fund
1. Enhanced Estate Recovery & ACM				
Senior Tax Representative Supervisor	2	$46,122		
Program Technician	2	28,252		
Tax Compliance Representative	5	93,247		
Program Technician II	6	91,139		
Staff Information System Analyst	1	25,491	1	25,491
Associate Information System Analyst	3	71,163	3	71,163
SUBTOTAL	**19.0**	**$355,414**	**4.0**	**$96,654**
2. Statutory Changes to Increase Asset Recovery Collections				
Program Technician II—**May revise deleted**	~~**4**~~	~~$60,759~~		
Staff Counsel I—**May revise (delete 2)**	~~3~~ 1	~~157,442~~ 52,480		
Staff Counsel III	1	68,608		
Associate Governmental Prog Analyst	1	44,371		
SUBTOTAL	~~**9.0**~~ **3.0**	~~**$331,180**~~ **$165,180**	**0**	**0**
3. Recover Expenses from Managed Care Enrollees				
Senior Tax Representative Supervisor	1	$23721		
Senior Tax Representative Specialist	1	23,721		
Program Technician	1	14,126		
Tax Compliance Representative	5	96,545	4	77,236
Program Technician II	4	60,759	2	30,380
SUBTOTAL	**12.0**	**$218,872**	**6.0**	**$107,616**
4. Increase Other Health Identification				
Supervising Program Technician I	1	$15,604	1	$15,604
Program Technician	14	197,766	14	197,766
SUBTOTAL	**15.0**	**$213,370**	**15**	**$213,370**
5. Increase HIPP Enrollment				
Supervising Program Technician II	1	$16,438		
Program Technician II	5	75,949		
Program Technician	3	42,379		
SUBTOTAL	**9.0**	**$134,766**	**0**	**0**
6. Increase Recoveries from Private Health Insurance Center Billings				
Senior Tax Compliance Rep, Supervisor	1	$23,061	1	$23,061
Tax Compliance Representative	6	111,896	6	111,896
SUBTOTAL	**7.0**	**$134,957**	**7.0**	**$134,957**

Proposal Component (Page 2)	DHS Positions	DHS General Fund	LAO Positions	LAO General Fund
7. Fiscal Management Resources				
Accounting Administrator	1	$49,609		
Accounting Officer	1	39,933	1	39,933
Accounting Analyst	1	37,299	1	37,299
Accounting Technician	2	60,759	1	30,380
Associate Accounting Analyst	3	138,367	2	92,245
SUBTOTAL	**8.0**	**$325,967**	**5.0**	**$199,857**
8. Personnel Management Branch				
Associate Personnel Analyst	1.5	$45,464	1.0	$30,279
SUBTOTAL		**$45,464**		**$30,279**
9. Automation—Health Coverage Identification (One-Time cost)	**N/A**	**$146,650**	**N/A**	**$146,650**
TOTAL General Fund Amount	**~~80.5~~**	**~~$1.907 million~~**	**38.0**	**$929,000**
May Revision Adjusted	**74.5**	**$1.741 million**		
TOTAL Federal Fund Amount		$4.397 million		$1.941 million
TOTAL ALL FUNDS		$6.3 million		$2.870 million

Summary Table #2—Estimated Savings in 2005-06 from Above Positions (DHS and LAO)

Proposed Activity (Corresponds to activity and number from above)	DHS General Fund Savings	LAO General Fund Savings	Difference General Fund
1. Enhanced Estate Recovery & ACM	none in 2005-06	N/A	N/A
2. Statutory Changes to Increase Asset Recovery Collections *(May Revise adjusted)*	$1.7 million	0	$1.7 million (less savings)
3. Recover Expenses from Managed Care Enrollees	$718,500	$718,500	--
4. Increase Other Health Identification	$4.1 million	$4.1 million	--
5. Increase HIPP Enrollment	$583,000	--	$583,000 (less savings)
6. Increase Recoveries from Private Health Insurance Center Billings	$1.450 million	$1.450 million	--
9. Automation—Health Coverage Identification	$19.452 million	$19.452 million	--
Total Estimated Savings	**$28 million**	**$25.704 million**	**$2.283 million (less savings)**

The DHS proposes to augment staff in the **Third Party Liability Recoveries area by establishing a revised total of 74.5 positions (31 are two-year limited-term appointments) as noted above.** The DHS contends that the increased revenue and cost savings generated by the proposed enhancements creates a high return on investment.

There are a number of federal and state laws that pertain to third party recovery. Federal law requires states to seek reimbursement from estates of certain deceased Medi-Cal enrollees and to ensure that Medicaid (Medi-Cal) is the payer of last resort for those medical expenses caused by third party torts. Federal law also requires states to utilize third party information, within 60-days of receipt, to establish the existence of a liable third party before a claim for payment is filed. Information exchange (data matches) with private health insurance carriers is authorized in state law.

The DHS has authority to recover from liable private insurance carriers any payments made by Medi-Cal when the private carrier is determined to have primary payment responsibility.

There is also a state mandate to pay private health insurance premiums for eligible Medi-Cal enrollees when it is cost effective to do so. In addition the provisions for payment of Medicare Part A and Part B premiums on behalf of eligible Medi-Cal enrollees are also part of the state's agreement with the federal CMS for the state's Medi-Cal Program.

Legislative Analyst's Office Recommendation: The LAO is recommending **(1)** approval of 38 of the revised 74.5 positions for an increase of $1.941 million ($929,383 General Fund) in state support, and **(2)** adoption of a revised local assistance savings figure of $25.7 million (General Fund)

Subcommittee Staff Recommendation: Subcommittee staff concurs with the LAO recommendation.

Questions:

1. DHS, Please provide a brief summary of each of the component areas and explain each of the requests for resources.
2. LAO, Please explain your recommendation.

21. Medi-Cal Drug Rebate Accounting and Information System (RAIS)

Issue: The May Revision proposes an increase of $1.830 million ($457,000 General Fund) to fund a "refresh" of Medi-Cal's Rebate accounting and Information System (RAIS). The DHS states that a "refresh" is necessary for the system given its age and the importance the system provides in supporting the invoicing of over $1 billion in Medi-Cal drug rebates.

According to the DOF, prior to expenditures of funds for this project, the DHS shall provide a business-based justification of the need as well as a cost analysis for the project. The DHS states that expenditure of these funds will require DOF approval.

The DHS contends that the RAIS "production platform"—the system used to develop and test needed ongoing modifications to the RAIS production system—is near the end of its useful life period and is in need of equipment refresh.

The DHS states that memory storage is reaching its maximum capacity while hardware components are starting to fail due to age of the equipment. The Fiscal Intermediary contractor—EDS—is being directed to evaluate all production equipment used for the drug rebate program and determine which components need to be replaced within the 2005-06 fiscal year.

Background: The RAIS supports annual invoicing of over $1 billion in rebates on drugs and blood factors provided by Medi-Cal. The RAIS "production system" was implemented in 2001 and has collected over $4 billion in drug rebates. RAIS is used for invoicing drug rebates and tracking payment collections. This system was developed and is maintained by Unisys under a subcontract with EDS.

Subcommittee Staff Recommendation: It is **recommended to adopt the May Revision.**

Questions:

1. DHS, Please provide a brief summary of the request and an idea as to its timeline for completion.

22. CA Medi-Cal Management Information System—Two Issues

Issue: The DHS is requesting two changes in the May Revision for this project. **First, they are seeking to convert 5 limited-term positions (expire as of June 30, 2005) to permanent status effective July 1, 2005.**

These positions are used to maintain the Medi-Cal claims processing contract to ensure the integrity of the California Management Information System. **The May Revision proposes an increase of $490,000 ($193,000 General Fund) for this purpose. The positions are:** (1) three Associate Governmental Program Analysts, (2) one Associate Information Systems Analyst, and (3) one Nurse Consultant**. The DHS states that these five positions work as a team and that all are necessary.**

The CA Medi-Cal Management Information System (CA-MMIS) is operated by the state's Fiscal Intermediary—EDS, Inc. This contract is one of the largest ($188 million in 2004-05) and most complex contracts in state government with millions of lines of computer program coding and hundreds of computer programs required to operate the system. According to the DHS, these five requested positions have contributed to the timely implementation of new programs, helped reduce the incidence of significant system errors, installed changes to identify program fraud, and approved system changes resulting in millions of dollars in program savings.

DHS contends the positions are necessary to (1) avoid costly monetary losses resulting from the inability to perform contract management and oversight; (2) manage the design, development and installation of system changes to effectuate state budgetary proposals; (3) ensure that necessary medical services are accurately paid in a timely manner; and (4) ensure that provider claims for services are processed according to Medi-Cal policies.

Second, the DHS is requesting an increase of $500,000 ($250,000) to assess the CA-MMIS to help guide the DHS in planning the future direction of the CA-MMIS system.

The DHS states that they intend to contract for this assessment using the California Multiple Award Schedule (CMAS) contractor list from which to select a contractor.

Background—CA-MMIS: The CA-MMIS is the claims processing system used for Medi-Cal. The DHS states that over 20 years of changes to this system to incorporate technological advances as well as to address new business and legislative requirements has contributed to a system that is extremely complex.

Subcommittee Staff Recommendation: It is recommended to **(1)** approve the request to provide an increase of $490,000 ($193,000 General Fund) to permanently establish the five positions, **(2)** approve the request to provide $500,000 ($250,000 General Fund) for the assessment, and **(3)** adopt Budget Bill Language to require the DHS to provide the assessment information to the Joint Legislative Budget Committee. This proposed language is as follows:

> "Upon completion of the CA-MMIS assessment, the Department of Health Services shall provide a copy of the assessment to the Joint Legislative Budget Committee."

Questions:

1. DHS, Please provide a brief summary as to why the positions are needed.

C. Item 4260 Department of Health Services *(Others for Prop 99)*

PUBLIC HEALTH ISSUES

1. Proposition 99-Funded Programs for the Budget Year-- *Issues "A" to "D"*

(See Hand Outs—multiple charts)

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

Various programs, administered under several different state departments, are funded using revenues deposited in the specified accounts. The accounts that pertain to health care are as follows:

- *Hospital Services Account:* This account receives **35 percent** of the annual Proposition 99 revenues. Revenues from this account must be used to supplement and not supplant indigent healthcare services provided in hospital settings.
- *Physician Services Account:* This account receives **10 percent** of the annual Proposition 99 revenues. Revenues from this account must be used to supplement and not supplant indigent healthcare services provided by physicians.
- *Unallocated Account:* This account receives **25 percent** of the annual Proposition 99 revenues. Revenues from this account must be used to supplement and not supplant indigent healthcare services provided by physicians.
- *Research Account:* This account receives **5 percent** of the annual Proposition 99 revenues. Revenues from this account must be used to supplement and not supplant research activities associated with anti-tobacco efforts. This account also receives funding from Proposition 10—the California Children and Families First Act of 1998.
- *Health Education Account:* This account receives **20 percent** of the annual Proposition 99 revenues. Revenues from this account are used for various anti-tobacco education efforts. This account also receives funding from Proposition 10—the California Children and Families First Act of 1998.

Overall Governor's May Revision: The May Revision projects **increased Proposition 99 revenues** due to an increase in the revenue estimate for other tobacco products (like chewing tobacco). Total revenues are estimated to be $321 million for 2005-06.

The May Revision has changed considerably, partially in response to actions taken by this Subcommittee. **Key aspects of the Governor's May Revision proposal and its interaction with prior Subcommittee actions is outlined below:**

- *Fourth-Fifths Vote for Federal Funds:* Conforms to the Subcommittee's action to adopt legislation to amend Proposition 99 to authorize the state to use these funds to draw down federal matching funds (for example, federal S-CHIP funds, Medicaid funds or potentially, hospital Waiver funds). Only the three "indigent health care" accounts—Physician, Hospital Services, and Unallocated Accounts would be affected by this proposal.

- *Access for Infants and Mothers (AIM) Funding:* As noted in the May 9th Subcommittee hearing, agreement with the Administration has been reached regarding legislation to enable California to draw down federal funds for perinatal/pregnancy care for women provided in both the AIM Program and the Prenatal Care Services to Undocumented Women Program.

  With respect to the non-federal match for AIM, the Administration had proposed in January to use General Fund support for this purpose. **However in the May Revision, the Governor has now elected to shift to the use of Proposition 99 Funds in lieu of using General Fund support.** Use of Proposition 99 Funds is now being proposed because of the four-fifths vote legislation. **Using Proposition 99 Funds saves $27.4 million in General Fund support.**

- *Use of Managed Risk Medical Insurance Program Reserve:* As discussed in our May 9th hearing, there is $20 million in reserve in the MRMIP Fund due to the recovery of prior-year overpayments to certain health plans. The Governor's January budget had not recognized this revenue source. In his May Revision, the MRMIP retains these funds and then receives only $20 million as part of the Proposition 99 revenue transfer to them. As such, MRMIP receives their $40 million (i.e., keep reserve and receive $20 million) as historically provided. Further, this action then allows for $20 million in Proposition 99 revenues to be used in other programs.

  In the May 9th Subcommittee hearing, the Subcommittee appropriated $18 million of the $20 million in excess MRMIP reserve and used these funds to **(1)** provide $3 million to the Steven M Thompson Medically Underserved Account to address physician loans and providing services in medically underserved areas, **(2)** provide $2 million on a one-time basis to the Rural Demonstration Program in the HFP, and **(4)** backfill $13.2 million in General Fund support on a one-time basis in the CCS Program.

- *Deletes Use for Legal Immigrants in Medi-Cal and Directs to Orthopedic Hospital Settlement Funding:* The Governor's January budget had proposed using a portion of Proposition 99 funds to back fill for General Fund support in the Legal Immigrant Program within Medi-Cal. **Concerns were raised by the Subcommittee regarding this January proposed fund shift in earlier hearings. As such, the May Revision proposes to use Proposition 99 funds to backfill for a portion of General Fund support in the Orthopedic Hospital Settlement.** (This is a settlement agreement that provided for rate adjustments for hospital outpatient services. No issues remain on the settlement, the state just funds the expenditures for it. In addition, we receive a federal Medicaid match.) The May Revision recognizes the concerns that had been expressed.

- *Numerous Program Adjustments, Including New Programs:* The May Revision proposes numerous caseload and funding adjustments for programs historically funded by Proposition 99 Funds. **In addition, the May Revision proposes new funding of $4 million (Proposition 99 Funds) on a one-time basis for certain Asthma-related activities**.

- *Deletes All Proposition 99 Funding for the State Hospitals:* The May Revision deletes $20.5 million in Proposition 99 Funding that had been provided for the State Hospitals within the Department of Mental Health in the January budget.

Issue "A"—Access for Infants & Mothers Funding—*Several Issues*

Issue: The **May Revision proposes to use Proposition 99 Funds in lieu of General Fund support, as had been proposed in the Governor's January budget, for the AIM Program. This fund shift will save $27.4 million (General Fund). The proposed above Proposition 99 Fund adjustments reflect an increase of $3.3 million for caseload and then the shift from General Fund to Proposition 99 Funds.** A minor adjustment is also proposed for a federally required consumer survey (AIM and HFP).

These funds will be used as a federal match to draw down an enhanced federal S-CHIP match of 65 percent. This is now being proposed due to the four-fifths vote proposal which will enable Proposition 99 Funds to be used as a federal match (only for the three indigent health care-related accounts).

The availability of federal funds is due to federal CMS regulatory changes as was discussed in the Subcommittee's April 4th and May 9th hearings. Trailer bill language regarding this aspect of the issue has been agreed to by the Subcommittee, Administration and other involved parties.

Specifically, the May Revision proposes total expenditures of $115.7 million ($50.7 million Perinatal Insurance Fund—receives transfers from Proposition 99 accounts--, $1.1 million General Fund, and $63.9 million federal S-CHIP funds) to provide pregnancy, delivery, postpartum care and other comprehensive health care services to 10,581 women, 8,421 first-year infants and 75,288 second-year infants.

The May Revision provides a total of $44.6 million in Proposition 99 Funds for AIM that are transferred to the Perinatal Insurance Fund for expenditure. The Proposition 99 Funds are as follows:

- Provides $34.4 million from the Hospital Services Account;
- Provides $10 million from the Physicians Services Account; and
- $175,000 for a consumer survey for the AIM/HFP programs (the survey is required by federal law).

The proposed above Proposition 99 Fund adjustments reflect an increase of $3.3 million for caseload and then the shift from General Fund to Proposition 99 Funds.

In addition, the May Revision proposes an increase of $6.4 million ($2.2 million General Fund and $4.1 million federal S-CHIP funds) to reflect an average 7.2 percent rate increase for pregnant women, and an average 1.6 percent rate increase for infants up to one year of age, and an average 3.9 percent rate increase for infants from one year to two years of age. This is based on recently completed contract negotiations with the MRMIB and the participating Health Plans. This issue had been

referenced in a prior Subcommittee hearing but dollar amounts were not at that time available.

Background—AIM Program: The Access for Infants and Mothers (AIM) Program provides health insurance coverage to women during pregnancy and up to 60 days postpartum, and covers their infants up to two years of age. Eligibility is limited to families with incomes from 200 to 300 percent of the poverty level. Subscribers pay premiums equal to 2 percent of the family's annual income plus $100 for the infant's second year of coverage.

Subcommittee Staff Recommendation: It is **recommended to adopt the May Revision appropriation amounts for AIM as proposed by the Administration**. No issues have been raised.

The Subcommittee's actions regarding trailer bill language adopted in prior hearings remain in tact (i.e., language regarding S-CHIP and receipt of federal funding, and the four-fifth's vote language change to Proposition 99 to allow for a federal match).

Questions:

1. MRMIB, Please provide a brief summary of the budget proposal.

Issue "B"—Managed Risk Medical Insurance Program (MRMIP) & All Related Interactions with Prior Subcommittee Actions

Issue: The May Revision proposes to require the Managed Risk Medical Insurance Board to fund the MRMIP Program at its capped appropriation amount of $40 million by **(1)** using the existing $20 million in MRMIP reserve funds, *and* **(2)** obtaining only a $20 million transfer from Proposition 99 Funds. Normally there would have been a $40 million transfer to this MRMIP from Proposition 99 Fund accounts. No other changes to the program are proposed.

This proposed May Revision action requires technical trailer bill language, which adjusts existing statute, for the $20 million transfer (in lieu of the standard $40 million transfer). This language is as follows:

> "Notwithstanding Section 12739 of the Insurance Code, on a one-time basis for the 2005-06 budget year, upon order of the Director of Finance, the State Controller shall reduce the amounts to be deposited in the Major Risk Medical Insurance Fund as follows: $3,107,000 reduction from the Hospital Services Account in the Cigarette and Tobacco Products Surtax Fund; $5,893,000 reduction from the Physician Services Account in the Cigarette and Tobacco Products Surtax Fund; and $1,000,000 reduction from the Unallocated Account in the Cigarette and Tobacco Products Surtax Fund."

Prior Subcommittee Hearing: In the May 9th hearing, the Subcommittee adopted the following actions (all actions are Proposition 99 Funds):

- Appropriated **$18.2 million** of the $20 reserve in the MRMIP available from the adjustments to health plans from past years **and allocated these funds as follows**;
  - **$3 million** (one-time only) to the **Steven M. Thompson Medically Underserved Account** to address physician loans and providing services in medically underserved areas.
  - $2 million (one-time only) to **the Rural Demonstration Projects in the Healthy Families Program.**
  - **$13.2 million (one-time) to backfill for General Fund support in the California Children Services Program (CCS.** Budget Bill Language was also done to clarify the intent of this action.

Subcommittee Staff Recommendation (See Table, below): **It is recommended to:**

(1) Adopt the May Revision for the MRMIP, including the trailer bill language;

(2) Retain the $3 million transfer for the Steven M. Thompson Medically Underserved Account by appropriating $2 million from the Physicians Services Account and $1 million from the Unallocated Account of Proposition 99;

(3) Reduce by $2 million (Physicians Services Account) in the California Healthcare for Indigent Persons Program (CHIPP);

(4) Reduce by $1 million (Unallocated Account) the new proposal for Asthma activities.

(4) Reduce by $1 million (Unallocated Account) the Media Campaign;

(5) Provide $1 million (Unallocated Account) for the Rural Demonstration Projects, in lieu of the $2 million (Proposition 99 Funds) prior Subcommittee action and increase by $1.9 million (federal S-CHIP funds) to recognize the match to these funds; and

This information is shown in the Table below.

Program (Proposition 99 Funds)	Governor's Budget	Governor's May Revision	Governor's Change	Staff Recommended Adjustment to May Revision
CHIP Program	$45,252,000	$68,236,000	$22,984,000	-$2,000,000 ($66,236,000)
Media Campaign	$15,695,000	$1,000,000 (Unallocated Acct)	$16,695,000	-$1,000,000 ($15,695,000)
Asthma	N/A	$4,000,000	$4,000,000	-$1,000,000 ($3,000,000)
Subtotal Adjustment			N/A	**-4,000,000**
Steven M. Thompson				+$3,000,000
Rural Demonstration	$1,047,000	$1,047,000	no change	+$1,000,000 ($2,047,000)
Subtotal Adjustment			N/A	**+4,000,000**

Background on Steven M. Thompson Program: The Steven M. Thompson Physician Corps Loan Repayment Program, operated by the Medical Board of California, is used to repay student loans for physicians and surgeons practicing in medically underserved communities.

Existing law creates the Medically Underserved Account for the purposes of the program. The fund consists of private donations and transfers from the Contingent Fund of the Medical Board which is supported by fees. The total amount of the transfers from the Contingent Fund to the Medically Underserved Account is $3.450 million ($1.150 million annually for three consecutive years which began in 2003). As such, the last transfer occurs in 2005-06.

Background—Description of the Rural Demonstration Projects in the HFP: The Rural Demonstration Projects within the Healthy Families Program (HFP) have been operational since the inception of the HFP. These projects have used different strategies, contingent on the rural area's needs, for addressing barriers faced by residents of rural areas in receiving health care. Examples have included (1) purchasing dental equipment; (2) improving patient tracking systems; (3) extending clinic hours during certain seasons; (4) establishing telemedicine capabilities; and (5) improving coordination with local drug and alcohol providers.

Background on CHIP Program: The May Revision proposed an increase of $22.9 million from the January budget for the California Healthcare for Indigent Persons

Program. Specifically, the proposed appropriation went from $45.3 million to a proposed $68.2 million. Funds in this program assist in funding uncompensated medical care needs.

Background on the New Asthma Activities: The **Administration proposes to use $4** million in new one-time only Unallocated Account Funds to conduct surveillance of asthma prevalence, hospitalizations, mortality, and risk factors, to refine the most appropriate prevention strategies. The DHS will also conduct the Childhood Asthma Initiative addressing asthma in children aged 0 to 5 years, and the California Asthma Among the School Aged program addressing asthma in children aged 5 to 18 years. The programs will fund asthma community health worker services in 20-35 community health centers statewide, and provide asthma training and materials will be provided.

It should be noted that these funds are being used as a replacement for foundation funding and funds provided by the California Families First Commission (Proposition 10 Funding). It should also be noted that based on the Administration's May Revision proposal, about $754,000 of "unrestricted reserve" funds are available for expenditure in the Health Education Account. If necessary, the Administration could choose to use a portion of these funds to support Asthma education material development as it pertains.

Background Media Campaign: The Governor's budget proposed $15.7 million (Health Education Account Funds) for the annual media campaign regarding anti-smoking messages. His May Revision augments by $1 million from the Unallocated Account which is historically used to fund indigent health care programs. Among other things, the augmentation would be used to (1) provide $200,000 to contract for improvements to the DHS online tobacco information system, (2) $200,000 to contract for the design and implementation of an updated evaluation method for the DHS staff to use for the "local competitive grants" (This is a separate program that will receive $18.4 million in funds), (3) and increase anti-smoking messages.

Issue "C"—Emergency Physicians Use of Proposition 99 Funds

Issue: For the past five years, the Legislature has been appropriating ***about*** **$25 million** (Proposition 99 Funds) annually to reimburse emergency and on-call physicians for the costs of providing care to uninsured, indigent patients requiring emergency medical care. **The Governor's May Revision continues this appropriation level.**

It has come to the attention of interested parties and Subcommittee staff that since a 4/5ths vote to allow Proposition 99 Funds to be matched with federal funds is being pursed by both the Subcommittee and now the Administration, these funds should be used within the Medi-Cal Program to obtain a federal match. **This option is shown in the Subcommittee staff recommendation below.**

Prior Subcommittee Action: In the May 9th hearing, the Subcommittee took the following actions:

- Appropriated $24.8 million (Proposition 99 Funds) as proposed by the Administration;
- Deleted the Administration's Budget Bill Language (unnecessary due to trailer language);
- Adopted trailer bill language that more specifically states how emergency physicians would be reimbursed using these funds;

Subcommittee Staff Recommendation: It is **recommended to rescind the prior Subcommittee action and to instead (1)** appropriate the $24.8 million (Proposition 99 Funds) under the Medi-Cal Program, local assistance item, **(2)** increase federal funds by $24.8 million to reflect the matching rate, and **(3)** adopt trailer bill legislation to provide for a **Medi-Cal rate increase of 62 percent for emergency physicians who provide services in an emergency room or trauma care facility.**

The rate increase percentage assumes that a total o $79.1 million ($24.8 million Proposition 99 Funds and a federal match) would be available. Based on DHS data as provided to the Subcommittee as a technical assistance request, six of the HCPCS procedure codes account for the bulk of the expenditure for services in an emergency room setting

According to technical assistance provided by the DHS, a standard State Plan Amendment would be needed for final approval but this should be straightforward.

Questions:

1. DHS, Please provide technical assistance comments, if necessary regarding the recommendation.

Issue "D"—Other May Revision Adjustments *(See Hand Out)*

Issue: The May Revision for Proposition 99 Funded-Programs also makes a number of other adjustments as follows:

- ***Deletes Use for Legal Immigrants in Medi-Cal and Directs to Orthopedic Hospital Settlement Funding:*** The Governor's January budget had proposed using a portion of Proposition 99 funds to back fill for General Fund support in the Legal Immigrant Program within Medi-Cal. Concerns were raised by the Subcommittee regarding this January proposed fund shift in earlier hearings. As such, the May Revision proposes to use Proposition 99 funds to backfill for a portion of General Fund support in the Orthopedic Hospital Settlement**.** (This is a settlement agreement that provided for rate adjustments for hospital outpatient services. No issues remain on the settlement, the state just funds the expenditures for it. In addition, we receive a federal Medicaid match.) The May Revision also backfills with General Fund support in the Legal Immigrant Program in Medi-Cal. (This adjustment is in the Medi-Cal local assistance baseline).

- ***Breast Cancer Early Detection Program (Every Woman Counts):*** An increase of $1.139 million to support increased case load.

- ***Competitive Action Grants:*** An increase of $3.6 million is provided for the Tobacco Control Section's Competitive Grant Program. This program funds a variety of local, regional, statewide and pilot projects that seek to educate people about the dangers of tobacco use.

- ***Evaluation for Competitive Action Grants:*** Increases by $400,000 to allow the DHS to evaluate the competitive grant programs and projects.

Subcommittee Staff Recommendation: It is recommended to adopt the May Revision for these items and the remaining base amounts. No issues have been raised.

Questions:

1. DHS, Please provide a brief summary.

2. West Nile Virus

Issue: The May Revision proposes an increase of $12 million (General Fund) and two pieces of Budget Bill Language, which among other things, allows for exemptions from the competitive bid process.

The DHS proposes to do the following with the $12 million General Fund augmentation:

- **$2 million** to purchase mosquito control products and application equipment needed throughout the state.

  Specifically, $1.7 million of this $2 million amount will be for the purchase of mosquito control products and application equipment, $140,000 is for administrative oversight through contract services, and $120,000 is for auditing local agencies.
- **$3 million** for emergency mosquito control response in West Nile "hot spots". These funds will be distributed to "high risk" counties and potentially under-funded agencies from the southern region of the state;
- **$2 million** to the Northern Sacramento Valley, especially the Butte Sink area (i.e., Butte, Colusa, Glenn, and Sutter counties);
- **$1.5 million** to the Northern San Joaquin Valley;
- **$2 million** to the Southern San Joaquin Valley; and
- **$1.5 million** to the Sacramento Delta region.

According to the DHS, the $10 million in local assistance would be provided through allocation agreements to supplement resources for existing mosquito control programs and for expansion to surrounding areas.

The DHS is also seeking approval of the following two pieces of Budget Bill Language:

Provision x for the $2 million (Item 4260-001-0001):

"In response to the public health implications of the West Nile Virus, and in order to expedite the implementation of mosquito control efforts funded by no more than $2 million appropriated in this item, the department shall be exempt form competitive bidding, and shall be exempt from the requirements of Part (commencing with Section 10100) of Division 2 of the Public Contract Code for purposes of making and receiving and/or entering into contracts and interagency agreements."

Provision x for the $10 million (Item 4260-111-0001):

"(a) Of the amount appropriated in this item, the department shall at the discretion of the Director allocate $10 million to local mosquito and vector control agencies or other governmental entities, or contract with other entities to supplement resources for existing local mosquito control programs or to provide mosquito control efforts to currently unserved areas across the state in response to the threat of West Nile Virus transmission.

(b) In response to the public health implications of the West Nile Virus, and in order to expedite the implementation of mosquito control efforts funded by no more than $10 million dollars appropriated in this item, the department may make and receive grants, and enter into contracts and interagency agreements, shall be exempt from competitive bidding, and shall be exempt from the requirements of Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code."

Background—Current Efforts: According to the DHS, **about $70 million is budgeted by local mosquito control districts**. In a recent survey by the DHS, local mosquito control agencies reported that expenditures (dollars per parcel) for mosquito control agencies increased 16.1 percent from 2003 to 2005 resulting in elimination of emergency mosquito treatment funding reserves in many districts.

In addition, the Legislature appropriated $977,000 (General Fund) to the DHS to support West Nile Virus activities. These funds allow for (1) expanded surveillance activities to enhance detection, (2) improved laboratory diagnostic methods and capabilities, and (4) enhanced efforts to educate the general public, affected industries, medical and veterinary health communities and others.

Subcommittee Staff Recommendation: It is recommended **to approve as proposed in the May Revision.**

Questions:

1. DHS, Please provide a brief summary of the request, including how quickly the funds will be provided to the local entities.

3. Proposal to Use Federal Bioterrorism Funds for Capital Outlay

Issue: The May Revision proposes an increase of $1.266 million (federal Bioterrorism Funds) for preliminary plans, working drawings and construction of an Emergency Operations Center within the Emergency Preparedness Office of the DHS.

According to the DHS, the existing Emergency Operations Center operated by the DHS is presently located in inadequate space per federal guidelines and needs to be relocated to space adequate to allow the DHS to managed public health emergencies that occur within California. The proposed new Emergency Operations Center would be located within the Sacramento East End Project.

The DHS states that the federal Centers for Disease Control recently reported numerous deficiencies with the existing Emergency Operations Center including insufficient number of computer terminals, no redundant power supply or communication ability, and an inability to ensure 24-hour-a-day coverage.

The DHS states that during a disaster, an additional 40 specialists could be working at the Emergency Operations Center. They contend that the typical Emergency Operations Center allows for easy managerial observation of emergency workers, planning areas, conference areas, redundant communications capabilities, and backup electrical power.

The proposed Emergency Operations Center would occupy a redesigned area of the third floor of Building 173 at the East End Project. Enhancements would include modular furniture removal, and redesign with some new components to be purchased, management and planning rooms, communications, logistics, supply storage room creased from an existing conference room, and a breakout room for small teams created from a quite room.

Renovations include new walls, glazing and blinds, new and relocated doors and hardware, blackout window shades, new and relocated lighting, mechanical, electrical outlets, telecommunication/data outlets and audio/visual infrastructure. All electrical including the lighting and HVAC for this space will be put on emergency generator power. New low height antennas and satellite dishes will allow for a fully functional Emergency Operations Center.

The space adjacent to the Emergency Operations Center will have three new quite rooms, seven new offices and a new copy room. Renovations are needed on all of this as well.

Subcommittee Staff Recommendation: It is suggested to take this issue to Conference in order to obtain more information regarding whether all of this proposed work can be completed using the proposed $1.266 million. It is highly usually to receive a request for Capital Outlay in the May Revision.

Capital Outlay letters are customarily provided to the Legislature by May 1st in order to provide for an appropriate review period. In addition, confirmation needs to be received from the federal CDC that federal bioterrorism funds can be used for this purpose.

Questions:

1. DHS, Have you officially received written confirmation that the federal bioterrorism funds can be used for construction purposes?
2. DHS, Will the proposed $1.266 million fully fund the entire project as proposed?
3. DHS are any other costs likely to be incurred from this project, such as moving costs or other support items? If so, how much?

4. Administration's Proposal on Mitigating Obesity—"Better State of Health" (See Hand Outs)

Issue: The budget proposes **an increase of $ 6 million (General Fund)** for an obesity prevention program. Of this amount, $3 million is for state support including two new positions and consultant contacts, and $3 million is for local assistance.

The Administration is also proposing trailer bill legislation to create the program and to award contracts. The language contains a two-year sunset clause.

Summary Table of Administration's Proposal

DHS Component	DHS Positions	General Fund Expenditure
DHS Coordinating Office	**1**	$ 371,000
Training & Technical Assistance		500,000
Surveillance, Evaluation & Research		500,000
Public Relations		150,000
Operating Expenses		76,000
Subtotal		($1,597,000)
Enhance Medi-Cal Services		1,408,000
Community Action Grants	**1**	3,029,000
TOTALS	**2**	**$6,034,000**

Under the proposal, **a "coordinating office"** would be created and would report directly to the State Public Health Officer. This new office would serve as the lead entity within the DHS to facilitate all public health obesity prevention initiatives. **It is estimated that $371,000 would be expended for this coordinating office**.

Of the proposed $6 million total, about $2.8 million would be used for various consultant contracts as follows:

- $150,000 for public relations;
- $500,000 for clearinghouse information and training;
- $500,000 for surveillance, applied research and evaluation activities;
- $150,000 for DHS work place wellness; and
- $1.4 million for quality improvement techniques in up to six participating health plans in Medi-Cal. The techniques would include promotion of breastfeeding, increased screening to promote healthy eating, and treatment and referral for overweight and at-risk for overweight children. The project would be implemented in up to six collaboratives made up of hospitals, clinics, and other medical service providers that serve significant numbers of Medi-Cal beneficiaries

The $3 million proposed for local assistance would be allocated to 15 new **and existing** "community action projects". The intent of these projects would be to address both nutrition and physical activity issues in local communities and serve as role models for the state.

***Background on Existing Programs (See Hand Outs)*: Currently, DHS spends about $1.2 billion annually** from federal and private sources for a variety of programs that are intended to promote good nutrition and increased physical activity as a means to improve public health. Approximately 75 percent of the funding is for the Women, Infants, and Children (WIC) Program. WIC provides nutritional education, breastfeeding information and of course, nutritional food to low-income families.

Numerous programs reside within the DHS that address issues regarding nutrition, the promotion of physical activity and healthy eating behaviors, and reach activities, such as the following (selected examples):

- **$895 million (federal funds) in WIC**. This amount is used to provide nutritious foods to a specific population as a short-term intervention and adjunct to on-going health care. Foods are selected to meet enhanced dietary needs.

- **$212.6 million (federal funds) in WIC.** This amount is to provide education to pregnant women and parents to support healthy pregnancy outcomes, successful breastfeeding, and promoting active lifestyles for children.

- **$3.3 million (federal funds) in WIC Farmer's Market.** This amount provides fresh fruits and vegetables to WIC participants.

- **$90 million (federal funds) for the CA Nutrition Network for Healthy, Active Families (Network).** The Network is funded primarily by federal funds awarded by the USDA. The six key strategic result areas that the Network employs to secure large-scale behavior change among low-income families are as follows:
    - Provide statewide leadership, build infrastructure and mobilize resources for large-scale social marketing campaigns to promote healthy eating, physical activity, and food security to help prevent serious chronic diseases such as cancer, diabetes, heart disease and obesity;
    - Conduct media and retail promotions;
    - Conduct surveys, research and evaluation;
    - Develop and empower lower-income communities;
    - Conduct special programs for children; and
    - Stimulate and enable changes in policies, systems, and environments to make healthy eating and physical activity easiest choices for lower-income families.

- **$1.7 million for CA Project LEAN** (federal funds) to increase access to healthy foods and physical activity.

- **$1.3 million for CA Center for Physical Activity** to increase physical activity level to reduce chronic disease.

- **$275,000 for the CA Obesity Prevention Initiative** to reduce the burden of obesity and to support obesity prevention. They are to also do strategic planning on obesity in California.

- **$284,000 (Title V Funds)** to provide assistance to local maternal and child health programs to improve nutrition within the maternal and child health population.

Legislative Analyst's Office Comment & Recommendation: The LAO raises a number of concerns with the proposal, including the overlap with many existing activities. **Given the multitude of programs, projects and activities at the state level, the LAO urges the Administration to complete an assessment of the nutrition programs that are currently functioning before additional General Fund resources for new obesity prevention efforts are committed.**

The LAO recommends approving only $180,000 (General Fund) of the $6 million to fund a Medical Officer position. This position would be used to direct the department's coordinating activities. The remaining amount—about $5.9 million—would be deleted from the request.

Subcommittee Staff Recommendation: Subcommittee staff concurs with the LAO analysis to provide $180,000 to fund the Medical Officer position to conduct coordinating functions or redesign activities regarding the state's nutritional programs. **This action would conform to the Assembly.**

In addition, it is recommended to adopt Budget Bill Language as follows (4260-001-0001):

"The DHS shall develop a comprehensive strategic plan that would assess California's current programs and efforts in obesity prevention, identify core gaps or concerns, identify best practices and make recommendations for improvement. This strategic plan shall be provided to the Legislature when completed, but by no later than June 30, 2006."

Finally, due to the state's fiscal crisis, question arises as to why the Administration's obesity-related health care concerns cannot be addressed through other means. For example, The California Endowment (TCE) is presently investing $26 million for a variety of efforts, including $9 million to five communities over a four-year period to combat childhood obesity. Further, there are other non-General Fund resources that could be made available, such as funds from the Families First Commission (Proposition 10). In addition, several foundations are approving projects in this area.

Questions:

1. DHS, Please provide an overview of your proposal.
2. DHS, How does this new proposal interact with the $1.2 billion in existing program resources in this area and how is it different?

D. Item 4440 Department of Mental Health (*Discussion Items*)

Community Mental Health Issues

1. Mental Health Managed Care—May Revision Adjustments

Issues: The May Revision proposes a net reduction of $974,000 (General Fund) to the Mental Health Managed Care Program. This net reduction reflects the following adjustments:

- Decrease of $1.047 million for a change in the number of Medi-Cal eligibles.
- Increase of $9,000 to reflect a one-percent adjustment for inpatient growth.
- Reduction of $3,000 for a decrease in the number of eligibles in the Breast and Cervical Cancer Treatment Program who obtain mental health assistance.
- Increase of $67,000 to reflect changes in the appeals and state fair hearing processes. The federal CMS, as a condition of approving California's Waiver renewal for Mental Health Managed Care, required some modifications to this process. Effective under the Waiver renewal, enrollees must exhaust the problem resolution process before going to a state fair hearing. The DMH states that this change will result in costs related to training, informing materials, revised notices of action and regulations.

California received federal CMS approval of the state's Waiver renewal as of April 26, 2005, only one day shy of its expiration date of April 27th (after one extension).

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

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

The Waiver promotes plan improvement in three significant areas—access, quality and cost-effectiveness/neutrality. The DMH is responsible for monitoring and oversight activities of the County MHPs to ensure quality of care and to comply with federal and state requirements.

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

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

The state's allocation is contingent upon appropriation through the annual Budget Act.

Subcommittee Staff Comment and Recommendation: It is **recommended to adopt the** May Revision. No issues have been raised with the estimate.

Questions:

1. DMH, Please provide a brief summary of the May Revision, including the requested federal CMS change to the state's fair hearing process.

2. Federal CMS Requirement Regarding "Informing Materials"

Issue: The May Revision proposes a special one-time only increase of $19.3 million ($9.6 million General Fund) imposed by the federal CMS on California as a condition of approving California's Waiver for Mental Health Managed Care.

The proposed expenditures include the costs of printing and mailing to 3.5 million households of existing Medi-Cal enrollees, as well as tens of thousands of new enrollees in the program, 60-page brochures on mental health program benefits and extensive lists of providers of mental health services. For example, the DMH proposes to mail every Medi-Cal household in Los Angeles County a 976-page list of providers as well as the 60-page brochure.

On March 11, 2005, the federal CMS, DMH and DHS (sole Medicaid state agency role) participated in a conference call to discuss the Waiver renewal request. During this conference call, the federal CMS indicated that they intended to deny California's request for a waiver of the provision of federal law that requires state's to meet certain "informing" requirements.

As a result of this denial, the DMH must comply with the federal requirement to provide a one-time distribution of informing materials to all Medi-Cal enrollees in each county and a one-time distribution of informing materials and provider lists to all current mental health clients. The DMH had originally requested to comply with this federal requirement by providing informing materials and provider lists to enrollees when they first access services through the County Mental Health Plan, *and* on request of the enrollee at any time. However, the federal CMS did not find this to be acceptable.

The DMH therefore contends that the denial of California's request by the federal CMS results in the proposed expenditures.

Legislative Analyst's Office Recommendation: The LAO recommends to reduce the request by $4.4 million ($2.2 million General Fund) by having the DMH mail out three or more regional versions of the provider directory within Los Angeles County, instead of one single 976-page directory as proposed. This action would reduce printing and mailing costs of complying with federal rules.

In addition, the LAO recommends adopting Budget Bill Language directing the DMH to expend no funding for these purposes until October 1, 2005, in order to provide the state with additional time to seek relief from the federal CMS for these excessive federal mandates. The proposed Budget Bill Language is as follows:

> "None of the funds appropriated in this item for compliance with federal Medicaid managed care notification requirements shall be expended before October 1, 2005. It is the intent of the Legislature that, in the interim, the state shall seek assistance from the California congressional delegation, the new national commission to reduce Medicaid Program costs, or other appropriate parties to modify these requirements to reduce their cost to the state and to the federal government. In the event that the federal notification requirements are modified, the Director of Finance may revert, at his discretion, any part or all of the appropriation provided in this item for compliance with the requirements."

Subcommittee Staff Recommendation: The DMH, LAO and Subcommittee staff believes that the federal CMS is being very unreasonable with respect to these requirements. The requirements are excessive and will likely be of no use to the Medi-Cal enrollee. Further for those individuals who will also be enrolling into the Medicare Part D program, any huge mailing could lead to further confusion. However, until California can make the federal CMS bend towards being practical, the requirement must be addressed or the federal CMS could rescind their approval of California's Waiver.

It is therefore recommended to adopt the LAO recommendation to **(1)** reduce by $4.4 million ($2.2 million General Fund), and **(2)** adopt Budget Bill Language as proposed.

Questions:

1. DMH, Please explain the requested augmentation and any rationale behind the federal CMS demands.
2. DMH, Please comment on the LAO recommendation.

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

Issue: The May Revision proposes two adjustments for the EPSDT Program. **First,** the Administration is requesting an increase of $139.4 million ($67.7 million General Fund) to pay County Mental Health Plans for the final settlement of fiscal year 2002-03 cost reports under the program. **Second**, a decrease of $117.9 million ($55.7 million General Fund) is proposed for 2005-06. Both of these proposed changes are based on updated projections for EPSDT children's mental health services program costs.

Legislative Analyst's Office Recommendation: The LAO is recommending a technical adjustment to reduce the May Revision request by a total of $11.8 million (Reimbursements which are **$4.996 million in state General Fund**) to account for anticipated savings on program costs from new auditing activities that will commence in the current fiscal year (2004-05). This adjustment is the total amount across the two-year period (i.e., reduction of $1.665 million General Fund in 2004-05 and a reduction of $3.331 million in 2005-06)

The DMH's January budget had reflected savings in 2005-06 from these audits but it appears that this adjustment was inadvertently left out of the May Revision calculation.

Subcommittee Staff Recommendation: It is recommended to adopt the LAO recommendation to reduce by $11.842 million ($4.996 million General Fund), pending any further technical change by the DMH.

Questions:

1. DMH, Please provide a brief summary of the EPSDT proposal.
2. DMH, Do you concur with the LAO adjustment to account for the savings from auditing claims?

4. Mental Health Services Provided to Special Education Students ("AB 3632")

Issues: The May Revision proposes changes to the Governor's January proposal regarding this program. Based on these recent changes, the following key aspects to the program should be noted:

- ***Education:*** Continues **$100 million in funding** for mental health services. Of this amount, $69 million (federal IDEA funds) is set-aside for County Offices of Education to contract with counties for service provision.

  The remaining $31 million (Proposition 98/General Fund) is provided directly to Local Education Agency.

- ***Department of Mental Health and State Controller:*** Provides **$90 million** (General Fund) to reimbursement County Mental Health for a portion of the costs claimed for the mandates for fiscal years 2002-03, 2003-04 and 2004-05. Specifically, $72 million is to reimburse auditable claims for the "Services to Handicapped Students Program, and $18 million is for reimbursement of auditable claims for the Seriously Emotionally Disturbed Pupils Program.

- ***Repeals Statute:*** Administration is proposing trailer bill language to repeal the relevant sections of Government Code that create the state mandates on the Counties. The proposed language would also amend SB 1895 (Burton) to ensure that special education pupils continue to have access to mental health services (according to the Administration anyway). LEAs would be allowed to contract with Counties to provide services.

  The DOF states that there is no proposal to remove the two County mandates from the schedule of programs listed in the DMH Item (4440-295-0001) or to remove the suspension language from that item until such time as the mandates are repealed.

Recent Background on the Program—No Mandate Funding and SB 1985: *Prior* to the Budget Act of 2002, County MHPs were primarily reimbursed for their AB 3632 mental health services provided to special education students through the Commission on State Mandates. However a moratorium was placed on mandate reimbursements for local government beginning in 2002. This moratorium was continued in the Budget Act of 2003. But $69 million in federal IDEA funds was appropriated to schools in the Budget Act of 2003. These funds were then to be allocated to County MHPs for their services. However, the County MHPs note that about $120 million was actually expended on AB 3632 services for this year. SB 1895 (Burton), as discussed below, clarified the funding stream interactions for the 2004-05 fiscal year.

Among other things, SB 1895 (Burton), Statutes of 2004 does the following:

- Requires LEAs, prior to the referral of a pupil to County MHPs, to follow procedures regarding an Individualized Education Plan (IEP), as defined in

current law. It also directs the LEAs to request the participation of County MHPs in this process.

- Reconfirms that County MHPs are eligible for reimbursement from the state for all allowable costs for specified mental health services provided to special education students.
- Requires that $31 million (Proposition 98/General Fund) appropriated in the Budget Act of 2004 be distributed on the basis of provided services that are consistent with the federal IDEA. The intent is that the provision of upfront, more preventive services would over time lower the costs to counties for the mandate.
- Requires that the $69 million provided in the Budget Act of 2004 allocated to County Offices of Education be used to support mental health services by County MHPs for special education children. (This offsets General Fund mandate costs.)
- Specifies that a County MHP does not have fiscal or legal responsibility for any costs it incurs prior to the approval of an IEP, except for costs associated with conducting a mental health assessment.

Background—Mental Health Services to Special Education Pupils: Federal law (PL 94-142 of 1975-- the Education for All Handicapped Children Act—and the later Individuals with Disabilities Education Act (IDEA) mandates states to provide services to children enrolled in special education, including all related services as required to benefit from a free and appropriate education. Related services include mental health services, occupational and physical therapy and residential placement.

In California, County MHPs are responsible for providing mental health services to students when required in the pupil's Individualized Education Program (IEP). This is because AB 3632 (W. Brown), Statutes of 1984, shifted responsibility for providing these services from School Districts and transferred them to the counties. This was done because School Districts were not appropriately providing the services.
These services are an entitlement and children can receive services irrespective of their parent's income-level. In addition, County MHPs cannot charge families for these services because the children are entitled to a free and appropriate public education under federal law.

What Mental Health Services Are Mandated: Services to be provided, including initiation of service, duration and frequency of service, are included on the student's IEP and must be provided as indicated. Services can only be discontinued on the recommendation of the County MHP *and* the approval of the IEP team, or by parental decision. Among other things, mental health services include assessments, and all or a combination of individual therapy, family therapy, group therapy, day treatment, medication monitoring and prescribing, case management, and residential treatment.

Subcommittee Staff Recommendation: It is recommended to **(1) reject** the Administration's trailer bill language to repeal sections of Government Code that create the mandate on the counties and modifies SB 1895 (Burton), Statutes of 2004, **(2)** reject the Administration's proposed Budget Bill Language to use funds for past mandate claims, **(3)** appropriate $90 million (General Fund)—the same amount as contained in the May Revision--, *and* **(4)** adopt Budget Bill Language as stated below.

> Proposed Budget Bill Language (Item 4440-105-0001):
>
> 1. The $90 million (General Fund) appropriated in this Item shall be used to reimburse local government agencies for costs claimed for 2004-05 and 2005-06 for Services to Handicapped Students (Chapter 1747, Statutes of 1984) and Serious Emotionally Disturbed Pupils (Chapter 654, Statutes of 1996) state-mandated local programs. Reimbursement for claims shall only be made for claims that are still subject to audit by the State Controller.
>
> 2. It is the intent of the Legislature for these funds, as well as those appropriated within the State Department of Education for services to students enrolled in special education and requiring mental health assistance in order to benefit from the education services provided, to be fully expended to address needs in the 2004-05 and 2005-06 fiscal years.

SB 1895 was only enacted last year and needs to be given sometime to work. Proposition 63 Funds, which really will not begin to flow until later this year and next, can be used to assist in mitigating children needing the more intensive treatment therapies that are often needed for AB 3632-eligible children. The primary issue is to ensure that children receive timely and appropriate mental health treatment assistance. County Mental Health Plans and their contractors do this best. This is why the program was transferred in the first place in 1984.

Utilizing the budget funds in this manner will provide a total of about $145 million for 2004-05 and for 2005-06. This should equate to about full funding at this point in time.

5. Governor's Initiative on Chronic Homelessness—Proposition 63

Issue: The May Revision proposes an increase of $2.3 million *one-time only* Proposition 63 Funds—state support-- for rent subsidies and to establish collaboratives at local level to assist counties in developing projects to promote stable housing for homeless persons. Of the $2.3 million amount, $2 million is for the subsides and $400,000 is for the local collaboratives. (It should be noted that $100,000 in Proposition 63 Funds has been used in the current-year for beginning this project.)

Budget Bill Language is also proposed. This language would provide for a two-year expenditure period.

Overall, the Governor's Initiative on Chronic Homelessness consists of five core components across several departments as follows:

- $40 million (Proposition 46 Bond Funds) for housing construction for individuals with mental illness (Housing and Community Development Department). These funds will be leveraged to attract private investor capital and locality funding.
- $10 million for capital for community-based organizations (CA Housing Finance Agency).
- **$2.4 million (Proposition 63 Funds) for rent subsidies and local collaborations (Department of Mental Health)**.
- $250,000 (General Fund) to create an interagency council on homelessness to improve coordination among state departments (Business, Transportation and Housing Agency and others).
- **$750,000 (General Fund) for predevelopment loans to fund upfront housing project costs. These are the types of costs that are not eligible for bond expenditures** (Housing and Community Development Department—HCDD).

Legislative Analyst's Office Recommendation: In an effort to offset General Fund support, the **LAO is recommending to appropriate $750,000 in Proposition 63 Funds for the predevelopment loans to fund upfront housing project costs.** The $750,000 in Proposition 63 Funds would be from the state's portion of funding. Therefore, the Budget Bill Language proposed by the Administration would be modified as follows:

"Of the funds appropriated in this item, ~~$2,400,000~~ **$3,150,000** is one-time funding for rent subsides, **predevelopment costs for housing for the mentally ill**, and collaborative efforts to promote stable housing for homeless persons. These funds will be used for the Governor's Initiative to End Chronic Homelessness. These funds are available for expenditure in 2005-06 and 2006-07."

Subcommittee Staff Recommendation: It is **recommended to adopt the LAO** recommendation to **(1)** appropriate $3.150 million, and **(2)** adopt the Budget Bill Language as crafted.

Questions:

1. DMH, Please provide a brief summary of the May Revision proposal.

D. Item 4440 Department of Mental Health (*Continued Discussion Items*)

STATE HOSPITAL ISSUES

Overall Background—Summary of State Hospital Patients & Funding: The department directly administers the operation of five State Hospitals—Atascadero, Metropolitan, Napa, Patton, and Coalinga (to be activated). In addition, the DMH administers acute psychiatric programs at the California Medical Facility in Vacaville, and the Salinas Valley State Prison.

Patients admitted to the State Hospitals are generally either (1) civilly committed, or (2) judicially committed. As structured through the State-Local Realignment statutes of 1991/92, County Mental Health Plans (County MHPs) contract with the state to purchase beds. County MHPs reimburse the state for these beds using County Realignment Funds (Mental Health Subaccount). Judicially committed patients are treated solely using state General Fund support.

1. State Hospital Adjustments for May Revision

Issues: The May Revision proposes several adjustments for the State Hospitals for a *net* increase of $47.8 million (increase of $128.6 million General Fund). Total expenditures for the State Hospitals are now estimated to be $888.6 million ($802.1 million General Fund) for 2005-06.

The key adjustments include the following:

- **$20.5 million reduction in Proposition 99 Funds and a corresponding increase of $20.5 million in General Fund support to backfill the loss.** (This was referenced in the Proposition 99 Fund discussion under the DHS Item.)
- **$9.2 million (General Fund) increase due to the Administration's rescission of their Sexually Violent Predator (SVP) "pre-commitment" proposal**. The identified savings came by shifting "pre-commitment" SVPs to the counties. This proposal had been rejected by the Legislature in past years. The Administration noted during a prior Subcommittee hearing that they would be reversing course on this.
- **$10.1 million (General Fund) to reflect an increase of 188 judicially committed penal code patients and 128.6 permanent staff to address level-of-care and non-level-of care staffing licensing requirements.** This patient estimate is based on a regression analysis of recent data.
- **$61 million (General Fund) which was shifted from the CA Department of Corrections (CDC) to the DMH budget via a Spring Finance Letter.** This shift which was approved by the Subcommittee in our May 2nd hearing reflects the amount that the CDC already reimburses the DMH for in providing services to certain inmates. (This is just a more effective way to budget the cost.)

- **$733,000 (General Fund) increase to reflect recruitment and retention pay differentials at Coalinga State Hospital and Salinas Valley Psychiatric Program.** This funding is consistent with the plan submitted by the Department of Corrections in response to a recent order in the ongoing Coleman case. (The Coleman case pertains to an ongoing oversight of the provision of mental health services within the Department of Corrections by the courts.)

Summary of Overall Caseload: The DMH May Revision caseload assumes a budget-year population of **5,741 patients for 2005-06** (as of June 30, 2006). Of this total caseload, only 555 patients are committed by County Mental Health Plans. The remaining 5,186 patients are penal-code related patients (698 are SVP patients).

Summary of Changes in Patient Population by Facility

Hospital Summary	January 2005-06 Population	May Revision 2005-06 Population	Difference Population
Atascadero	1,271	1,402	131
Coalinga	583	747	164
Metropolitan	745	745	0
Napa	1,120	1,120	0
Patton	1,376	1,369	-7
Vacaville	295	294	0
Salinas	64	64	0
TOTALS	**5,453**	**5,741**	**288**

Subcommittee Staff Recommendation: The May Revision reflects a significant increase in caseload due to judicially required commitments. It also reflects the technical adjustment due to the Proposition 99 Fund shift, the required recruitment and retention pay differentials at Coalinga State Hospital and related technical adjustments. **No issues have been raised. It is recommended to adopt the May Revision estimate package.**

2. Office of Patient Rights—Need for Assistance

Issue: The Subcommittee is in receipt of a request **to restore $120,000 (General Fund)** to the Office of Patient Rights within the DMH for the contract services that provide patient's rights advocacy services. The DMH has reduced this contract by 15 percent, or $120,000 (General Fund) as part of their unallocated reduction process.

Constituency concerns have been raised regarding this issue because of the ever increasing caseload at the State Hospitals, as noted above, and the complexity of the patient population (about 90 percent penal code, many with violent behaviors).

Under state and federal law, State Hospitals are required to have a compliant process which allows patients to file complaints that their rights have been violated, including conditions of their care. State law requires that the Patient Right's Contractor take action within two days to investigate each complaint.

The lack of having an adequate number of advocates at each State Hospital make it difficult to comply with these requirements and pose a risk that residents could challenge the DMH's failure to provide advocacy services which are compliant with state and federal law.

The Patient Right's Contractor assists in the licensing reviews and advises the DMH on the plans of corrections required by the Department of Health Services (DHS). The DHS has the authority to impose financial fines for patients' rights violations. Therefore, it is in the best interest of the DMH to want to have a fully operational Patient Right's contract.

The state is at risk here. The federal Department of Justice (DOJ) conducted two extensive reviews of Metropolitan State Hospital which have resulted in the state DMH having to make sweeping changes at Metropolitan regarding every aspect of the hospital operations, including significant changes in patient treatment. The federal DOJ is also slated for conducting a review of every one of California's State Hospitals over the next few years. Several of the issues identified in the DOJ report had previously been raised by the independent Patient's Rights contractor. Proactive involvement by the contractor, as well as responding to specific patient complaints, assists the DMH in developing policies and procedures which address deficiencies identified in the DOJ reports.

Subcommittee Staff Recommendation: It is recommended to increase by $120,000 (General Fund) to restore the DMH reduction to the Patient's Rights Contractor.

Questions:

1. DMH, Please provide a brief summary of the functions of the Patient's Rights Contractor. Are these services effective?
2. DMH, How does your funding level on this, with a patient population of 5,741 patients, compare with the DDS' and their Developmental Center population of 3,071 consumers?

3. Sexually Violent Predator (SVP) Evaluation and Court Testimony Estimate

Issue: The May Revision proposes a *net* reduction of $102,000 (General Fund) to the SVP evaluation and court testimony appropriation. The adjustments are shown in the table below.

This evaluation and court testimony estimate relates only to SVP evaluations performed by private contractors for initial, update, replacement and recommitment evaluations, as well as costs for evaluator court testimony.

The table below summarizes the proposed budget and component parts

SVP Program Evaluation & Court Estimate	2005-06 January	**2005-06 May Revise**	**Difference**
Initial Evaluations	**$1,264,000**	**$2,411,000**	**$1,147,000**
Initial Court Testimony	911,000	516,000	-395,000
Initial Evaluation Updates	394,000	487,000	93,000
Recommitment Evaluations	1,369,000	538,000	-831,000
Recommitment Testimony	436,000	243,000	-193,000
Recommitment Updates	319,000	400,000	81,000
Airfare Costs	141,000	138,000	-3,000
Consultation Costs	47,000	46,000	-1,000
Totals	**$4,881,000**	**$4,779,000**	**-$102,000**

The DMH states that this revised estimate is based on their historical data.

Legislative Analyst's Office Recommendation: The LAO contends that the May Revision has over budgeted for the "initial evaluations" component of this proposal by about $811,000 (General Fund). **As such, the LAO recommends an overall reduction of $913,000 (General Fund).** (This consists of the DMH reduction of $102,000 and the additional $811,000.)

The DMH projects that a larger amount of funding is needed for these evaluations based on trending of recent caseload data. However, the LAO thinks that due to some technical adjustments assumed by the DMH, the DMH estimate is in fact, too high.

Subcommittee Staff Recommendation: It is recommended to adopt the LAO recommendation **to reduce by a total of $913,000 (General Fund) to reflect less anticipated need and cost.**

4. Implementation of Medicare Part D—State Hospitals and DMH Staff

Issue: The May Revision is proposing three adjustments within the DMH area related to the implementation of the Medicare Part D Drug Program. Based on these adjustments, a net savings of about $500,000 would be obtained by the state. The proposed adjustments are as follows:

- **$69,000 (General Fund)** to fund an Associate Governmental Program Analyst (two-year limited-term) at DMH headquarters.
- **$806,000 ($500,000 General Fund**--$240,000 one-time only) and $306,000 County Realignment Funds) to support a total of nine positions (two-year limited-term) in the State Hospitals and to purchase computer hardware and software. These positions pertain to Accounting, Pharmacy, Health Records, and technical, analytical staff. Of this total amount, $25,000 is to purchase computer workstations and software, and $194,000 is for one-time only consultant services.
- Increased **revenue of $1.1 million (General Fund)** to the state due to generating additional Medicare revenue from the Pharmacy Drug Plans (PDPs) in the budget year.

Background on the State Hospitals and the Part D Program: The DMH estimates that 850 patients in the State Hospital are Medicare eligible but only 768 will choose to enroll in Part D. Of these, only 26 patients are currently dual eligible (Medi-Cal/Medicare). Those State Hospital patients eligible for Medicare, but who are not dual eligible or low-income, will pay premiums, deductibles and co-payments from their trust accounts or the State Hospital will pay these charges.

Once enrolled, the Pharmacy Drug Plan (PDP) will pay for the cost of drugs for the patient. If a particular drug is not on the PDP formulary, the State Hospital will have to pay for the non-formulary drug. It is estimated that 70 percent of the drugs used by State Hospital patients will be on the PDP formulary.

Each State Hospital will likely become a long-term care pharmacy under each PDP. Every PDP must offer to contract with a long-term care pharmacy willing to accept the PDP's terms and reimbursement rates. If a long-term care pharmacy does not contract with the PDP because its rates are too low, the patient would have to go to a local pharmacy under contract with the PDP. This is not a viable option for patients in the State Hospitals. **The State Hospitals would order drugs from their normal sources and account for drugs given to PDP enrollees.**

The number of PDPs in California will not be known until this fall. Depending on the region, there could be as many as 35 PDPs in California (based on a teleconference call with the federal CMS in March 2005).

Subcommittee Staff Recommendation: It is **recommended to adopt the May Revision as proposed.** There will be considerable work that will need to be done at the State Hospitals to address this complex, new federal program. No issues have been raised.

Questions:

1. DMH, Please provide an overview of how the Part D Program will operate in the State Hospital setting.
2. DMH, Please briefly explain your May Revision request.

5. Department's Proposed Trailer Language for SVP Treatment Restructuring *(See Hand Out)*

Issue: In his January budget, the Governor proposed total savings of $15.2 million General Fund from a series of changes that pertain to the commitment and treatment of Sexually Violent Predators (SVPs). As noted above, one of these proposals was rescinded (i.e., "pre-commitment"). Policy legislation is moving separately from the budget on issues related to extending SVP commitment periods (no budget year savings).

The only remaining issue related to budget year savings is a proposal to restructure the SVP Treatment Program. In the March 7th hearing, the Subcommittee discussed this issue, which proposes savings of $6 million (General Fund) in the budget year. However at that time, the Administration did not have their trailer bill language available so the issue was held "open".

Five months after the release of the January budget, the DMH has now provided proposed trailer bill language with the May Revision. The core components of this language are as follows:

- Effective January 1, 2006, the DMH would restructure the supervision and treatment services provided to SVP patients, including the establishment of a new secure SVP residential licensing category. The treatment would be less than that provided by a licensed health facility. Generally, the concept behind this restructuring is to use less nursing staff and clinical staff.
- Provides the DMH with complete authority in how they would choose to restructure the program.
- Provides the DMH with the authority to not following any other provision of law except those requirements related to fire and life safety.
- Provides that the DMH can place existing health facility beds at Coalinga State Hospital (to be operational as of September 1, 2005) is "suspense" for a period of up to six years.

Background—SVP Treatment Program: The existing Sex Offender Commitment Program designed for SPV patients is organized into five phases. The first four phases are inpatient treatment and the fifth phase is outpatient.

SVP patients entering the SVP Treatment Program enter as Phase 1 patients. Based on their willingness to participate in the treatment programs and their performance, patients "graduate" to the next phase until reaching outpatient status. As of January 2005, there are a total of 135 patients from 32 counties in phases 2,3,4 and 5 of treatment. The balance of the SVP population (424 patients or 76 percent) remain in Phase I as noted below.

Phase 1: Treatment Readiness (474 patients)
Phase 2: Skills Acquisition (107 patients)

Phase 3: Skills Application (19 patients)
Phase 4: Skills Transition (7 patients)
Phase 5: Community Outpatient Treatment (2 patients)

The statute provides that the SVP patient or the DMH Director may petition the court for conditional release (Phase 5) after the initial two-year commitment. Unlike the initial commitment or re-commitment process (jury trial), the process for a petition for conditional release requires only a court hearing before a judge, no jury trial.

Background—Designation of SVP: In 1995, the Legislature established a civil commitment process for offenders deemed by a court or jury to be a Sexually Violent Predator (SVP). The SPV law is designed to ensure that specified offenders receive intensive inpatient treatment, as well as outpatient treatment and supervision upon their release from state prison. To qualify as an SVP, an offender must have committed specified sexual acts (e.g., rape, sodomy and lewd or lascivious acts with a child) involving two or more victims and have a diagnosed mental disorder that makes the individual likely to engage in sexually violent predatory behavior in the future.

Background---Overview of the Process: All SVPs first serve their sentence in a CDC prison. Through an initial records review process, the CDC and Board of Prison Terms refer records of inmates suspected of meeting SVP criteria. The DMH orders evaluations to determine whether the offender potentially qualifies for a SVP commitment.

Any inmate meeting SVP criteria then receives a clinical evaluation to determine if a diagnosed mental disorder exists. Inmates meeting all the statutory SVP criteria are referred to District Attorneys for their action. For those cases which a DA decides to file a petition, a probable cause hearing is held before a judge to determine if the facts of the case warrant a full commitment trial. If a jury or judge finds that it is likely an individual would re-offend, then the individual is committed to the DMH State Hospital system for treatment and supervision. The statutory length of commitment is presently two years.

Subcommittee Staff Recommendation: It is **recommended to reject the proposed trailer bill language and to restore the $6 million (General Fund) that was identified as a savings.**

Subcommittee staff has been advised by the Senate Public Safety Committee that the proposed language would likely be declared unconstitutional. Defendants have successfully challenged how SVP programs are implemented, despite adequate provisions in statute requiring treatment.

Department of Finance

1. Department of Finance--Trailer Bill Language regarding Health & Human Services

Issue: The Subcommittee is in receipt of proposed trailer bill language received from the Department of Finance on May 19th.

The proposed language from the DOF is as follows:

Section 27 is added to the Welfare and Institutions Code to read:

27. (a). The Department of Health Services, Department of Alcohol and Drug Programs, Managed Risk Medical Insurance Board, Department of Developmental Services, Department of Mental Health, Department of Rehabilitation, and Department of Child Support Services shall annually submit by September 10 of each year and March 1 of the following year, to the Department of Finance for its approval, all assumptions underlying all estimates used to develop the departments' budgets.

(b) The Department of Finance shall approve, modify, or deny the assumptions underlying all estimates within 15 working days of their submission. If the Department of Finance does not modify, deny, or otherwise indicate that the assumptions are open for consideration pending further information submitted by the department by such date, the assumptions as presented by the submitting department shall be deemed to be accepted by the Department of Finance as of that date.

(c) Each department shall submit an estimate of expenditures for each of the categorical aid programs to the Department of Finance by November 1 of each year and April 20 of the following year. Each estimate shall contain a concise statement identifying applicable estimate components, such as caseload, unit cost, implementation date, whether it is a new or continuing premise, and other assumptions necessary to support the estimate. The submittal shall include a projection of the fiscal impact of each of the approved assumptions related to a regulatory, statutory, or policy change; a detailed explanation of any changes to the base estimate projections from the previous estimate; and a projection of the fiscal impact of such change to the base estimate.

(d) These departmental estimates, assumptions, and other supporting data as have been prepared shall be forwarded annually to the legislative fiscal committees not later than January 10 and May 15 if this information has not been released earlier by the Department of Finance. Each estimate shall identify those premises to which either of the following applies:
(1) Have been discontinued since the previous estimate was submitted.
(2) Have been placed in the basic cost line of the estimate package.

Subcommittee Staff Recommendation: It is recommended **to reject this language without prejudice to send it to Conference for several reasons.**

First, there is existing statute regarding the preparation of estimate packages and assumptions. Section 14100.5 of Welfare and Institutions Code addresses the Medi-Cal Program assumptions and estimates. Section 10614 of Welfare and Institutions Code addresses the Department of Social Services estimate package. Therefore, it is not clear how the DOF language affects this existing statute.

Second, the language has just been received and needs to be analyzed. There may be aspects of the language that the Legislature would like to change to address concerns with receiving more comprehensive descriptions of budgetary assumptions and estimates.

Questions:
1. DOF, Please present the proposed trailer bill language.
2. LAO, What are your initial thoughts? Do you have any initial suggestions?

Senate Budget and Fiscal Review—Wesley Chesbro, Chair

SUBCOMMITTEE NO. 3 Agenda
Health & Human Services

Chair, Senator Denise Ducheny

Senator George Runner
Senator Tom Torlakson

May 21, 2005
(Saturday)

10:00 AM

Room 4203

(Diane Van Maren)

Item	Department
4260	**Department of Health Services *(one issue only)***
4300	**Department of Developmental Services**

PLEASE NOTE:

(1) ALL previous actions taken by the Subcommittee remain, unless the Subcommittee otherwise modifies the proposal at this May Revision hearing.
(2) The "VOTE ONLY" CALENDAR may include the modification or denial of proposals, as well as acceptance of proposals. This will be noted in the Agenda as applicable.
(3) Only those issues in today's agenda are before the Subcommittee.
(4) Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.
(5) Testimony will be limited. Thank you.

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

A. Item 4260 Department of Health Services--*Discussion*

1. Requests for a Change to the Medi-Cal Pricing Updates

Issue: The Budget Act of 2004 implemented several changes to pharmacy reimbursement and the Medi-Cal Drug Contracting Program. One of these changes pertained to a change in the Average Wholesale Payment (AWP) made to pharmacies. (Pharmacy reimbursement consists of two components—a drug ingredient cost and a professional fee payment.)

As such, under existing law, the DHS is required to update allowable drug product prices *no less often than every 30 days*. These prices are used to pay pharmacists for the furnishing of prescription drugs to Medi-Cal enrollees. **This means that when a manufacturer increases its price, a pharmacy pays the new price for the drug, but continues to be paid at the old (lower) rate for 30 days.**

Therefore the Pharmacist Association is seeking a change in existing statute to require the DHS to update the drug product prices ***every seven days.***

Subcommittee Staff Recommendation: Based on technical assistance information obtained from the Department of Health Services, an increase of $4.5 million ($2.1 million General Fund) would be required if this 7-day notice change to existing statute was made. Specifically, this breaks out as follows:

- $580,000 ($145,000 General Fund) for the Fiscal Intermediary to perform the weekly (7-day) updates;
- $3.9 million ($1.964 million General Fund) for the increased cost in Medi-Cal services associated with the higher reimbursement payment to Pharmacists.

In addition, trailer bill language to effectuate the changes in the days would also be needed.

It should also be noted that SB 861 (Speier), as introduced, would change the days as noted. This legislation is presently on the Senate Suspense File for consideration next week.

B. Item 4300 Department of Developmental Services

ISSUES RECOMMENDED FOR "VOTE ONLY"

1. Conforming Action to Title XX Federal Block Grant with DSS Actions

Issue: The Governor's May Revision **provides a total of $56 million (Title XX Block Grant Funds) for expenditure in the DDS Item.** California has received Title XX Block Grant funds for social services since 1981. Each state has wide discretion in determining the range of services to be provided and how the funds are to be distributed. In California, these funds are administered by the Department of Social Services and are used for Temporary Assistance for Needy Families (TANF).

Typically, Title XX funds are only used in the DDS item when they are not needed for the TANF Program. In the DDS item, the Title XX Funds are used to backfill for General Fund support. When Title XX Funds are not available from the Department of Social Services, then the state uses General Fund support to backfill in the DDS item.

Subcommittee Staff Recommendation--Conforming: Due to Subcommittee actions taken in the Department of Social Services Item, there are no Title XX Funds to provide to the DDS. **Therefore, it is recommended to conform to prior actions by deleting the $56 million (Title XX Funds) in the DDS budget and increasing by $56 million General Fund support to offset the loss of the Title XX Funds.**

2. Guardianship/Conservatorship Filing Mandate

Issue: The Administration proposes to suspend this mandate for the 2005-06 fiscal year. The mandate was established in 1976 and requires the cost of investigations for limited Conservatorship hearings reimbursable to counties. Section Court Rule 810 guidelines subsequently defined the expenditures as allowable state court cost. The Department states the mandate needs to be suspended until such time as the mandate is repealed.

Subcommittee Staff Recommendation: It is recommended **to adopt** this Spring Finance Letter. No issues have been raised with this request.

3. Implementation of Medi-Cal Adult Dental Cap—*Conforming Action*

Issue: In a prior hearing, the Subcommittee adopted a higher capitation level for Medi-Cal Adult dental services than that proposed by the Governor. Specifically, the Subcommittee action was the following:

- Placeholder trailer bill language to implement a $1,800 cap over a one-year period using a calendar year and ***no* retroactivity**. An implementation date of January 1, 2006 is to be assumed. (The DHS date of August 1, 2005 was not realistic given the need to implement a tracking system and the practicality of using a calendar year such as done in the commercial marketplace.)
- Exclude the following involved procedures from the cap: (1) emergencies, dental services provided in long-term care facilities and related items as contained in the DHS proposal, (2) dentures, and (3) complex oral and maxillofacial surgeries. (This includes the following procedures codes 275, 277, 285, 289, 700 to 724, 900 to 916, and 974 to 985.)
- Provide a three-year sunset date of January 1, 2009, unless extended or a new program is implemented. In this manner the Legislature can revisit the issue and see if any adjustments for rates or services are warranted.

The May Revision for the DDS item provides an increase of $1.1 million (General Fund) to fund services to consumers who access services through the Regional Centers. However, this augmentation is *not necessary* since the Subcommittee approved a higher capitation level.

Subcommittee Staff Recommendation: **It is recommended to delete the $1.1 million (General Fund) amount in the May Revision estimate for the Regional Centers because it is unnecessary.** The Subcommittee adopted a higher capitation level ($1,800 cap) with the above noted exclusions.

4. Reappropriation for Agnews Related Community-Based Housing

Issue: The May Revision proposes to **reappropriate $11.1 million** (one-time only General Fund support) that was provided in through the Budget Act of 2004 the Legislature identified $11.1 million (one-time only General Fund support) to facilitate the initial development of community-based living options for the current residents of Agnews. The DDS notes that after consultation with the California Housing and Finance Agency and the Department of Housing and Community Development, the DDS approved the housing plan n May 11, 2005.

The expenditure plan has been submitted to the Joint Legislative Budget Committee (JLBC), chaired by Senator Chesbro. Funds cannot be expended until the DDS receives approval of the expenditure plan from the JLBC which is anticipated by the end of the 2004-05 fiscal year. Therefore, plan implementation will extend beyond this fiscal year, requiring reappropriation.

Additional Background: AB 2100, Statutes of 2004 (Steinberg and Richman), served as implementing legislation for the expenditure of the $11.1 million, as well as established the new "Family Home Teaching Model" to the list of residential living options. .

Through the use of the $11.1 million (one-time) and the passage of AB 2100, Statutes of 2004, the DDS proposes to authorize the Bay Area RCs to fund predevelopment costs (escrow deposit, environmental impact, various fees and related matters) to establish a permanent stock of housing for individuals with developmental disabilities transitioning from Agnews. The Bay Area RCs will contract with a local non-profit housing coalition to administer the fund. Housing will be developed using a lease/purchase/donate model facilitated by the Bay Area RCs and the local housing coalition.

Prior Subcommittee Hearing: This issue was discussed in our April 11th hearing and it was noted that it would be unlikely for all of the funds presently appropriated for the current-year to be fully expended.

Subcommittee Staff Recommendation: It is recommended **to adopt the May Revision, including the reappropriation language.**

5. Regional Center—Caseload and Funding Mix Adjustments--Current Year Estimate and Budget Year Estimate *(Technical Only—no Policy)*

Issue: The May Revision **for the *current year* (2004-05) reflects a decrease of $62.5 million ($69.6 million General Fund) compared to the January 2004-05 proposal.** This reflects a reduction of 1,900 in estimated community population and continued reduced expenditures due to the existing cost containment actions enacted primarily in the Budget Act of 2003.

The May Revision for 2005-06 also reflects certain technical adjustments as well. These are as follows:

- Adjust the Regional Center Operations area by increasing by a net of $189,000 (total funds) due to updated caseload data
- Adjust the Regional Center Purchase of Services area by reducing by a net $53.7 million (total funds) based on updated based, caseload, utilization, and expenditure data.
- Adjust the Regional Center budget to reflect a total increase of $144,000 and Reimbursements due to (1) an increase of $30,000 in federal funds for adding "environmental adaptation services" to the Home and Community-Based Waiver, and (2) an increase of $114,000 in federal funds for the Targeted Case Management Program.

Prior Subcommittee Hearing: In the April 11 hearing, the Subcommittee adopted an LAO adjustment which reflected a reduction due to estimated caseload being less.

Subcommittee Staff Recommendation: It is **recommended to (1)** adopt the Administration's May Revision for the current-year to reflect even a further reduction in expenditures than anticipated, *and* **(2)** adopt the Administration's technical adjustments for caseload, utilization and the receipt of federal funds and Reimbursements. No issues have been raised.

6. Governor's Continuation of Cost Containment—*May Revision*

Issue: The Governor's May Revision **proposes to continue prior year cost containment actions for a total savings of $94.7 million ($83.5 million General Fund) in 2005-06.** These savings would occur from the items listed below. These actions have all been in affect from at least the Budget Act of 2003. **This issue was discussed at length in our April 11th Subcommittee hearing.**

- *Delay in Assessment (Purchase of Services):* Through the Budget Act of 2002, trailer bill language was adopted to extend the amount of time allowed for the Regional Center's to conduct assessment of new consumers from 60 days to 120 days following the initial intake. **The Governor proposes to continue this extension through 2005-06 through trailer bill language. This is the same language as used in previous years**.

- *Family Cost Participation (RC operations and purchase of services)*: Through the Budget Act of 2004, trailer bill legislation was adopted to implement a Family Cost Participation Program by January 1, 2005. Under this program, families with incomes greater than 400 percent of poverty based on income and family size, that purchase Respite, Day Care, or Camp services must pay a parental co-payment. This program has been implemented by the DDS.
- *2004-05 Unallocated Reductions (RC operations and purchase of services):* An unallocated reduction of $6.4 million (General Fund) for RC Operations was adopted in the Budget Act of 2004, as well as a reduction of $7 million (General Fund) for the Purchase Of Services.
- *Day Program Rate Freeze:* Day Programs are community-based programs for individuals served by a Regional Center. Types of services available through a Day Program include: (1) developing and maintaining self-help and self-care skills, (2) developing the ability to interact with others, (3) developing self-advocacy and employment skills, (4) developing community integration skills such as accessing community services, and (5) improving behaviors through behavior management. The rate freeze means that provides who have a temporary payment rate in effect on or after June 30, 2003 cannot obtain a higher permanent rate. The Administration's proposed trailer bill language is the same as last year's, with a date extension to include 2005-06.
- *Contract Services Rate Freeze:* Some Regional Centers contract, through direct negotiations, with providers for certain services in lieu of the DDS setting an established rate. Continuation of the rate freeze would mean that Regional Centers cannot provide a rate greater than was in effect as of June 30, 2004. The Administration's proposed trailer bill language is the same as last year's, with a date extension to include 2005-06.
- *Community Care Facility (CCFs) Rate Freeze and Elimination of Pass Through:* The Budget Act of 2003 froze the CCF rates. Further, the SSI/SSP cost-of-living-

adjustment that is paid to CCFs by the federal government is being used to off-set General Fund expenditures for these services (off-set is $1.6 million General Fund for 2005-06).

- *Non-Community Placement Start-Up Suspension (RC purchase of services):* Under this proposal, a Regional Center may not expend any Purchase of Services funds for the startup of any new program unless the expenditure is necessary to protect the consumer's health or safety or because of other extraordinary circumstances, and the DDS has granted authorization for the expenditure. The Administration's proposed trailer bill language would continue this freeze through 2006-07, or one-year longer than all of the other proposals.
- *2003-04 Unallocated Reduction (RC Purchase Of Services):* An unallocated reduction of $10 million (General Fund) for RC Purchase of Services was enacted for this year and is continued in the base.
- *Revision of Eligibility:* The Budget Act of 2003 and accompanying trailer bill language prospectively implemented the use of the federal standard for "substantial disability" to existing state Lanterman Act eligibility criteria. This revision, effective July 1, 2003, requires a person to have deficits in at least three of the seven life domains (i.e., communication skills, learning, self-care, mobility, self-direction, capacity for independent living, and economic self-sufficiency.
- *Habilitation Services Rate Freeze:* The Habilitation Services Program consists of the (1) Work Activity Program (WEP), and (2) Supported Employment Program (SEP). The WAP services are primarily provided in a sheltered setting and are reimbursed on a per-consumer-day basis. SEP enables individuals to work in the community, in integrated settings with support services provided by community rehabilitation programs. The Administration's proposed trailer bill language would continue the rate freeze into 2005-06. (This issue is separate and apart from the Supported Employment Program "group size" adjustment which is discussed later in this agenda.)

Subcommittee Staff Recommendation: It is recommended to adopt the Governor's proposal regarding these items, *except* for one trailer bill language change. With respect to the "non-community placement start-up" issue, it is recommended to extend this proposal for 2005-06 only, and not include 2006-07 in the language. All other language associated with these existing actions would be approved (i.e., extending the dates for one-more year.)

ISSUES FOR DISCUSSION--DDS

A. State Support and Community-Based Services Issues

1. DDS Headquarters' Request—Quality Management System for HCB Waiver & Developmental Centers to Meet federal CMS Requirements

Issue: The May Revision **requests an increase of $1 million (General Fund)** ***(one-time only)*** to the DDS state support budget to provide additional resources for implementing new quality assurance requirements of the federal CMS. **Specifically, these funds are requested for a consultant to conduct a comprehensive, system-wide study for implementing integrated, yet distinct management programs in the state Developmental Centers and Regional Centers.**

These funds are in addition to the Governor's January budget increase of $522,000 ($290,000 General Fund) to fund 4 new positions and operating expenses to support the development of a statewide Quality Management System (QMS) consistent with federal CMS requirements. The need for these positions was discussed in the Subcommittee's April 11th hearing.

The May Revision funds would be used to have a consultant do the following key aspects:

- Review documentation of federal requirements and any related documents, including outcome areas to be reported;
- Review the department's interpretation and work to date on these federal requirements;
- Identify any areas that the department may want to expand beyond the federal requirements and provide justification for these expansions;
- Identify and consider how various factors affecting the Regional Centers and Developmental Centers, as applicable, may be examined within the Quality Management System. Potential factors include:
    - Current and proposed cost containment measures;
    - Population and caseload trends;
    - Purchase of service growth, access to services, and quality of care; and
    - Rate-setting methodologies where rates are currently negotiated by the Regional Center and service provider.
- Inventorying existing capacities, processes, procedures, and data collection and reporting efforts in Regional Centers, Developmental Centers, and headquarters;
- Determine whether all Developmental Centers should conform to one system or whether systems remain intact, adding only necessary components, such as a headquarters management information system for tracking selected performance measures;

- For Regional Centers, critically review products from the federal CMS to identify improvements or changes in direction from the current approach in the Bay Area Quality Management System.
- For Regional Centers, the consultant will also work to assist in the development of required elements to the Quality Assurance System, including: (1) service provider expectations, (2) identification and validation of performance indicators, (3) development and delivery of related training programs for consumers, Regional Center Staff, providers and other interested parties, (4) development of system wide strategies to utilize data to identify trends and prioritize quality improvement projects.
- For Developmental Centers, the consultant will also conduct a feasibility study report that will address the enterprise perspective for the Developmental Centers and develop a comprehensive, long-term plan for improvements.

The DDS notes the following timetable for this work:

- Develop scope of work and recruit qualified consultant through a unified request for proposal—January 2006.
- Contractor to conduct certain "phase-one" activities (some noted above) and complete development of an integrated long-range plan for implementation of Quality Management System.
- Make recommendations for development of processes for remediation and quality improvement—October 2006.
- Complete a Feasibility Study Report (FSR) for Developmental Centers—January 2007.
- Develop Regional Center and service provider performance expectations, identify key indicators, develop tools and processes for measurement and data collection, and develop training resources—January 2007.

Background—Importance of Federal Funding under the Waiver: California's Home and Community-Based Waiver for individuals with developmental disabilities living in the community **has grown substantially in the past four years** as noted below by the increase of consumers and the level of federal funds now obtained. **Without the Waiver, California would need to replace the federal fund support, noted below, with General Fund moneys.**

- 2000-01 27,000 people $295 million (federal)
- 2004-05 63,500 people $600 million (federal)
- 2005-06 70,000 people (capped) $635.1 million (federal)

The federal CMS has made it clear that California—as the largest Home and Community-Based Waiver in the nation—needs to commence with implementation of a comprehensive Quality Management System.

Background on Need for Quality Assurance Framework: **In May 2004, the federal CMS issued updated interim procedures for states to follow regarding a quality assurance "framework" whereby states with Home and Community-Based Waivers will need** to meet certain assurances.

The "framework" defines quality through the delineation of desired outcomes for consumers across seven broad domains and 35 sub-domains. **The seven domains include:** (1) consumer access; (2) consumer-centered service planning and delivery; (3) provider capacity and capabilities; (4) consumer safeguards; (5) consumer rights and responsibilities; (6) consumer outcomes and satisfaction; and (7) financial integrity and system performance.

The DDS believes that existing structures adequately support a number of the seven domains. **However, the domains of provider capacity and capabilities, participant safeguards, and system performance need significant enhancement to address federal CMS concerns.**

The "framework" identifies the functions that are necessary for achieving desired outcomes as follows:

- *Design:* Design quality assurance and improvement strategies into the Waiver at the initiation of the program;
- *Discovery:* Collect data and direct participant experiences in order to assess the ongoing implementation of the program, identifying strengths as well as opportunities for improvement;
- *Remedy:* Taking actions to remedy specific problems or concerns that arise;
- *Continuous Improvement:* Utilize data and quality management information to engage in actions that assure continuous improvement in the program, at the consumer, vendor and systems levels.

DDS further notes that the state's present system of quality assurance efforts rely heavily on the fragmented and varied quality assurance programs of the 21 RC's, the design of which was done in the 1990's. The federal CMS expects that states will move beyond current practice and take action to improve performance based upon information and

The state's Developmental Centers would also benefit from the proposed "framework". The department's "framework" for the Developmental Centers will be consistent with the DDS' overall design, including quality assurance and improvement strategies, data collection and analysis and continuous improvement. The DDS is including them in an effort to assure continued federal funding, minimize licensing and certification issues, and to improve consumer outcomes.

Subcommittee Staff Recommendation: It is recommended **to adopt the May Revision** to include the additional $1 million (General Fund) one-time only for specified consultant work regarding the development and implementation of a Quality Management System.

This is particularly warranted at this time given the changes and transitions which are occurring within the overall developmental services system. **Further, California's developmental services system is heavily reliant on the receipt of these federal funds and needs to ensure that appreciate quality measures are being met to ensue consumer quality of life and safety, as well as the continued receipt of federal funds.**

Questions

1. DDS, Please briefly describe the need for the funding contained in the May Revision.

2. DDS Headquarters' Request—Medicare Part D Resources Request

Issue: The May Revision proposes an increase of $1.2 million (General Fund) to assess the impact of the federal Part D Drug Program on health care systems and fiscal accounting and reporting systems. Specifically, the request would be used as follows:

- $224,000 (General Fund) for two limited-term positions—one Pharmacy Services Manager and one Senior Programmer Analyst;
- $775,000 (one-time) for an information technology consultant contract and software purchase. Of this amount, $505,000 would be used to contract for an upfront analysis and Feasibility Study Report (FSR) and $270,000 would be to purchase software.
- $200,000 to backfill for the loss of Medi-Cal reimbursements for administrative costs;

According to the DDS, implementation of the federal Part D Drug Program will create the following new workload:

- Data and infrastructure changes to billing and information technology systems;
- Additional Developmental Center consumer insurance billing, posting, and accounting management;
- Need for review and alteration of existing Developmental Center rates;
- Training of Regional Center case managers, consumers and families;
- Pharmacy formulary changes;
- Development of appeal and exception processes for denial of drugs;
- Possible changes in the drug delivery system for the Developmental Centers; and
- Numerous other requirements.

The initial implementation will include an analysis of workload requirements in each of the affected areas. **System changes as noted below will also be required:**

- Critical health information applications at the Developmental Centers, specifically the electronic record, the pharmacy system, and the admissions/transfers/discharges system;
- Cost Recovery System and CALSTARS infrastructures to meet state and federal cost data collection reporting, and billing requirements, and to account for patient liability and payments for drug charges that are no longer part of the Developmental Center room rates; and
- A new billing system to allow the DDS to invoice Prescription Drug Plans for drugs provided through the Developmental Center pharmacies.

The DDS estimates that about 42,200 individuals with developmental disabilities will be affected by the new federal Part D Drug Program. Of these individuals, about 40,000 consumers are living in the community and access services through the Regional Center system and about 2,200 consumers are living in a Developmental Center.

Subcommittee Staff Recommendation: It is recommended to **(1)** approve the $224,000 (General Fund) for two limited-term positions, ***and*** the $775,000 (one-time) for an information technology consultant contract and software purchase.

In addition, it is recommended to deny the request for the $200,000 (General Fund) due to the loss of Medicaid reimbursements for administrative costs. No justification has been provided for this request. In addition, the DDS needs to review its expenditures to see about any potential availability for obtaining some portion of federal funds for some of the proposed activities.

Questions:

1. DDS, Please describe how the federal Part D Drug Program is to operate in the DDS programs.
2. DDS, Please provide a brief description of the request.

B. Issues Regarding Services in the Community

Overall Background—May Revision: The May Revision reflects a net decrease of $30.1 million as shown in the table below. **This table summaries the Governor's overall adjustments for the Regional Centers, including adjustments to the Purchase of Services as well as to Operations.**

As noted in the Summary Table, the Governor's proposal increases Operations by a total of $17.1 million and *decreases* the funding for services provided to consumers through the Purchase of Services item.

The community population estimate has decreased by 2,865 individuals since January for a total anticipated caseload of 208,020 consumers accessing community-based services. According to the DDS, this revised estimate reflects actual data through January 2005.

Summary of Governor's May Revision

Component	January 2005-06 (thousands)	May 2005-06 (thousands)	Difference
Total Expenditures	**$2,953,700**	**$2,923,600**	**-$30.1 million**
Operations	461,700	479,400	**$17.1 million**
Purchase of Services	2,471,900	2,424,100	***-$47.8 million***
Early Start/ Other Agencies	20,100	20,100	
Fund Sources	$2,953,700	$2,923,600	-$30.1 million
Total General Fund	$1,946,600	$1,868,500	-$78.1 million
GF Match (for federal)	($735,600)	($783,500)	($47.9 million)
GF Other	($1,211,000)	($1,085,000)	(-$126 million)
Reimbursements	$952,100	$999,400	$47.3 million
Federal Funds	$52,900	53,600	$700
Program Development Fund	$2,000	$2,000	--
Disabilities Services Acct	$100	100	--

1. Governor's Proposed Reductions to the Purchase of Services-- *Additional*

Issue: As discussed in the **Subcommittee's April 11th hearing**, the Governor is proposing additional reductions to the Purchase of Services area ***in addition*** to the cost containment activities enacted from prior years.

Specifically, the Governor proposes substantial policy changes through trailer bill legislation to grant Regional Centers (RCs) broad authority for reducing Purchase of Services (POS) expenditures.

The May Revision reflects a reduction to services of $13.7 million ($10.3 million General Fund) in 2005-06, with total savings of at least $41 million ($30.8 million General Fund) annually once the phase-in has been completed.

It should be noted that the Legislature has rejected similar proposals for the past three years.

It is assumed that RCs would apply these new requirements at the time of an individual's program plan (IPP) development or scheduled review. An individual's IPP is to be reviewed no less than once every three years. As such, the budget assumes that one-third of the RC population (208,000 people) would have their plans reviewed each year. **The proposed cumulative savings from these new requirements are as follows**:

Fiscal Year and Cumulative Effect	Total Proposed POS Reductions Due to New Requirements	Proposed Savings in General Fund
2005-06 One-third of population is reviewed.	$13.7 million	$10.3 million
2006-07 Continue 2005-06 savings and review next one-third of population.	$27.4 million	$20.6 million
2007-08 Continue 2005-06 and 2006-07 savings and review next one-third of population.	$41 million	$30.8 million

To implement these standards, the Governor is also proposing an augmentation of $6.0 million (General Fund) to RC operations for implementation of the proposed POS requirements. This increased funding is to be used for (1) 50 new positions; (2) $296,000 for office rent; (3) $500,000 for increased administrative law hearings; (4) $146,000 for annual statements of POS; and various related operating expenditures.

The Governor's proposed POS requirements and their anticipated component savings are as follows:

- *1. Vendor Selection Based On Lowest Cost:* The cost of providing services by different vendors, if available, would be reviewed by an RC and the least costly

vendor who is able to meet the consumer's needs, as identified in the consumer's IPP, would be selected. This provision is assumed to save $24.3 million ($17.9 million General Fund) annually when fully implemented.

- *2. Statement of RC Services:* RCs would annually provide the consumer or their parent/guardian a statement of RC purchased services and supports. This statement would include the type, unit, and cost of the services and supports. This provision of the guidelines is intended to serve as a validation that the described services and supports are indeed being provided to the consumer by the designated vendor. This guideline is intended to save $6.2 million ($4.6 million General Fund) annually when fully implemented.

- *3. Directs RCs to Adhere to Existing Laws and Regulations In Purchasing Services:* RCs would be directed to establish internal processes to ensure that (1) their staff is following all laws and regulations when purchasing services and supports for consumers, and (2) other services, such as generic services provided by other agencies in the community, are pursued and used prior to authorizing the expenditure of RC funds for consumers. It is anticipated that $6.1 million ($4.5 million General Fund) in savings would be obtained annually when fully implemented.

- *4. Services to a Minor Child:* Under the Governor's proposal, legislation would be enacted to require RCs to take into account the family's responsibility for providing similar services to a minor child without disabilities when determining which services or supports would be purchased by the RC for the child. It is assumed that $2.6 million ($2.3 million General Fund) would be achieved annually when fully implemented.

- *5. RC Clinical Review:* RCs would be required to have a clinician review all requests for certain services and supports prior to the RC authorizing their purchase for the consumer. This review would pertain to certain supplemental program supports, assistive technology and environmental adaptations, behavioral services, specialized medical or dental services, and therapeutic services. The Administration assumes savings of $1 million ($750,000 General Fund) annually when fully implemented.

- *6. Use of Group Modality:* RCs would be directed to give preference for purchasing a service or support using a group modality, in lieu of an individual intervention, if a consumer's needs, as identified in their IPP, could be met using a group modality for the following services: Behavioral Services, Social and Recreation Activities, and Non-Medical Therapy Services. This provision is assumed to save $912,000 annually when fully implemented.

Background—Individualized Program Plan (IPP): The provision of services and supports to consumers is coordinated through the Individualized Program Plan (IPP). The IPP is prepared jointly by an interdisciplinary team consisting of the consumer, parent/guardian/conservator, persons who have important roles in evaluating or assisting the consumer, and representatives from the Regional Center and/or state Developmental

Center. Clinicians or others are to be involved in the IPP process when needed to complete the IPP.

Services included in the consumer's IPP are considered to be entitlements (court ruling).

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

Constituency Concerns: The Subcommittee is in receipt of numerous letters opposing the Governor's additional cost containment strategies. Of particular concern is: (1) the "assault" on the IPP process; (2) the belief that the proposals violate federal Medicaid "freedom of choice" protections provided under the Home and Community-Based Waiver, and (3) the belief that the state's quality assurance obligations under the Home and Community-Based Waiver would be violated.

Subcommittee Staff Recommendation: It is recommended **to reject the Governor's proposed additional cost containment proposals as noted above for several reasons.**

The Legislature has rejected similar proposals for the past three years. First and foremost is that the proposed trailer bill **language gives the Administration carte blanche authority in making programmatic decisions. The Legislature needs to maintain both the policy and fiscal integrity of the program.**

Several of the proposed measures would also likely violate the IPP process and lead to litigation.

2. Impact of the Medicare Part D on Regional Center Consumers

Issue: The May Revision reflects several adjustments for the Regional Centers regarding implementation of the federal Part D Drug Program. The DDS notes that about 39,240 individuals (out of 208,000 consumers) residing in the community will be affected by this new program. It is assumed (at this time), that 70 percent of the current costs covered under Medi-Cal will continue to be covered by both Medi-Cal and Medicare. Further, the remaining 30 percent will be appealed, of which the DDS assumes half would be successfully appealed. **The proposed total increase is $9.3 million (General Fund) which is split between the two areas below:**

- ***Cost of Drugs Not Covered by Federal Part D Program:*** An **increase of $4.4 million** (General Fund) is proposed to fund those medications no longer covered by Medi-Cal or Medicare.

- ***Contract for Enrollment Brokers (One-Time Only):*** An **increase of $4.9 million** (General Fund) is proposed for the Regional Centers to contract with enrollment brokers for assistance to consumers in enrollment and appeals and with physicians and clinical pharmacists for enhanced medication review and consultation. Specifically, these funds are to be used as follows:
    - $3.1 million for contracted enrollment brokers to facilitate enrolment of consumers into the federal Part D Drug Program;
    - $662,250 to enhance clinical staff;
    - $392,400 to assist clients in appeals related to medications not covered under the federal Part D Drug Program;
    - $525,000 for training sessions for RC staff, providers, families and clients during July through October 2005; and
    - $147,000 for clinical pharmacist reviews.

Background on Federal Part D Drug Program: Effective January 1, 2006, pursuant to the Medicare Prescription Drug Improvement and Modernization Act of 2003, Part D, coverage of prescription medications will shift from Medi-Cal to Medicare for individuals who are dually eligible.

Legislative Analyst's Office Recommendation: The **LAO recommends to (1)** approve the $4.4 million (General Fund) to continue to provide drugs to RC consumers as noted, and **(2)** adopt Budget Bill Language (below) regarding expenditure data for the costs of drugs purchased by the Regional Centers. The LAO recommends *withholding* on the $3.1 million (General Fund) for the enrollment contractors.

"The State Department of Developmental Services shall provide to the Legislature, by May 1, 2006, expenditure data for costs of drugs purchased by Regional Centers between January 1, 2006 and March 31, 2006, for the Regional Center consumers eligible for the Medicare Part D Drug Program."

Subcommittee Staff Recommendation: It is **recommended to (1)** approve the total May Revision increase of $9.3 million (General Fund) and **(2)** to adopt the LAO's proposed Budget Bill Language.

3. Supported Employment—Group Size Adjustment

Issue: In the Budget Act of 2004, the group size of Supported Employment Programs was increased from a group of three to a larger group of four. Based on data obtained from the DDS, this increase in the group size actually has restricted job growth.

Specifically, the DDS notes that in 2003-04 there were 273 new Supported Employment Groups but in 2004-05, there were only 74 new groups. Consumers participating in Supported Employment Groups spend their entire time in paid work.

Based on information obtained from the DDS and DOF, an increase of $1.4 million ($1.078 million General Fund) would be needed in the DDS item to change the group size back to the more "workable", smaller group. However, it should also be noted that the Department of Rehabilitation (DOR) operates a similar program. As such, though it is not statutorily required, the DOR item should be adjusted to maintain program and policy integrity across the services programs.

Subcommittee Staff Recommendation: It is recommended to do the following to return the Supported Employment Program "group size" back to a total of 3 individuals. As such, the following actions are needed:

- Increase the DDS Item (4300-101-0001) by $1.4 million ($1.078 million General Fund, and $322,000 Reimbursements);
- Increase the Department of Rehabilitation Item (5160-001-0001) by $2.154 million ($459,000 General Fund and $1.695 million federal funds);
- Adopt trailer bill legislation to change the group ratio back.

The change to existing statute is noted below:

Amend Section 4851 of Welfare and Institutions Code as follows:

(r) "Group services" means job coaching in a group supported employment placement at a job coach-to-consumer ratio of not less than one-to-~~four~~ **three** nor more than one-to-eight where services to a minimum of ~~four~~ **three** consumers are funded by the regional center or the Department of Rehabilitation. For consumers receiving group services, ongoing support services shall be limited to job coaching and shall be provided at the worksite.

Background: Supported employment provides opportunities for individuals with developmental disabilities to work in the community in integrated settings with support services provided by community rehabilitation programs. These services enable consumers t learn necessary job skills and maintain employment. **Supported Employment Programs provide services for individually employed consumers (individual placements), as well as consumers employed in group settings (Group Placements).**

Enrollment in Supported Employment Programs is impacted by employment opportunities within the community and the ability of consumers to obtain and maintain employment. Enrollment is affected by Regional Centers referring consumers for Supported Employment.

4. Self-Directed Services Delivery Model—Local Assistance and DDS Support *(See Hand Outs)*

Issue: The May Revision continues the Administration's proposal to proceed with a federal Waiver **to expand the existing Self-Directed Services Model**, **an alternative service model that enables participants to receive an individual budget allocation *if they so choose*, in lieu of having a Regional Center purchase services for the individual.** The DDS notes that a consumer enrolled into the Self-Directed Services Model could choose to return to the "traditional" service delivery system at any time.

The May Revision proposes (1) a net increase of $426,000 (decrease of $45,000 General Fund and an increase of $471,000 Reimbursements) to reflect technical adjustments on the original January assumptions, **and (2)** revised trailer bill language.

The Self-Directed Services expansion was discussed at length in the April 11th Subcommittee hearing. In addition, there have also been discussions in policy committee regarding Senator Chesbro's legislation on this topic—SB 481.

The Administration and various constituency groups have been convening meetings to craft workable trailer bill legislation. Though it is still a work in progress, considerable closure on several items has already occurred.

This budget proposal contains four components as follows: (1) trailer bill language which deletes the existing Pilot Program; (2) trailer bill language which proposes the new program framework; (3) a reduction of $300,000 (General Fund) in RC Purchase Of Services (POS) funds; and (4) an increase of $500,000 ($300,000 General Fund) to fund 5 positions at DDS Headquarters to implement and monitor the Waiver and the Self-Directed Services Model. Based on the DDS fiscal information provided, there would be no *net* General Fund impact in 2005-06.

Additional Background: As authorized through trailer legislation for the Budget Act of 2003, the DDS is proceeding with a federal "Independence Plus" Waiver to expand the existing Self-Directed Services Model. The Self-Directed Services Model is an alternative service model that enables participants to receive an individual budget allocation that will result in a 10 percent cost reduction in the *aggregate* to the state. Five percent of this savings would be set aside for participating consumers' unanticipated needs, and the remaining five percent is savings to the General Fund.

It should be noted that *all* services provided to individuals enrolled into this Waiver would be eligible for federal matching funds. As such increased federal reimbursements would be available because not all services for consumers on the Home and Community-Based Waiver are eligible for federal matching funds.

The Self-Directed Services Model would be available to all Regional Center consumers who meet Waiver eligibility requirements and are over the age of 3 years. Unlike the Regional Center's traditional service delivery model, this Waiver would provide an array of flexible, non-congregate services.

The DDS notes that self-determination offers consumers a person-centered planning process. Consumers would be able to arrange services in a manner that best suits their needs, and negotiate the service volume, cost and provider. For example, consumers could arrange part-day services rather than those that are offered for a full day.

A finite individual budget allocation would be used to purchase services. "Support brokerage" and financial management service entities would be available to assist consumers to arrange for needed services, as well as determine if prospective service providers meet the requisite qualifications.

Background on the Model: SB 1038 (Thompson), Statutes of 1998, created three "Self-Determination" Pilot Projects. These original pilot projects, including their respective Area Boards, were as follows: (1) Eastern Los Angeles Regional Center; (2) Tri-Counties Regional Center; and (3) Redwood Coast Regional Center. In addition to these, two more pilots were added at Kern Regional Center and San Diego Regional Center. Currently, about 145 consumers participate in these pilots.

Based on an independent evaluation done on these projects (Conroy, et al, March 2002), the evidence supports a positive conclusion: "Self determination is highly beneficial to, and extremely welcome to, participants and their families. The evidence also indicates that self-determination in inherently fiscally conservative." As such the evidence supports a policy move from pilot towards large-scale system efforts.

Subcommittee Staff Recommendation: It is **recommended to (1)** adopt the May Revision adjustments regarding the funding, **and (2)** adopt SB 481 (as amended) as the proposed trailer bill language.

It should be noted that the Assembly adopted the Administration's revised language. **As such, in order to send the language to Conference, it is recommended to adopt SB 481 (as amended). Thought the language of the two proposals is quite similar, a key difference is that SB 481 does not contain emergency regulation authority, whereas the Administration's language does contain this authority.**

It should be noted that no issues have been raised regarding the fiscal aspects of the proposal.

5. California Developmental Disabilities Information System (CADDIS)

Issue: The DDS **is requesting (1)** an increase of $2 million (General Fund) in order to make functional changes to CADDIS, ***and*** **(2)** Budget Bill Language to make expenditure of the funds contingent upon the approval of the Director of Finance.

The DDS recently submitted a Special Project Report on CADDIS which reflects functional changes to the application based on input from Regional Centers during and after "acceptance" training to add new programs to the computer system.

Based on this submittal, the Department of Finance has requested that the Health and Human Services Agency oversee an independent assessment of the status of the CADDIS project, prior to approval of the Special Project Report on CADDIS. As such, the $2 million is requested for this purpose. Among other things, this proposed assessment will consider whether CADDIS will meet the DDS and Regional Centers business practice requirements and objectives, including objectives related to federal programs.

Legislative Analyst's Office Recommendation: The LAO recommends to approve the $2 million May Revision request but to modify the proposed Budget Bill Language as follows:

(a) Of the funds appropriated in this Item, $3.730 million shall be available for information technology costs of the CADDIS. Of this amount, $2 million is set aside for the sole purpose of funding functional changes to CADDIS.

(b) Expenditure of the $2,000,000 for CADDIS functional changes shall be made no sooner than 30 days after notification in writing by the Department of Finance to the chairperson of the budget committee in each house of the Legislature and the Chairperson of the Joint Legislative Budget Committee of its approval ~~by the Director of Finance~~ of a revised Special Project Report approving these functional changes. The intent of the set-aside is to ensure that sufficient funding is available for the purpose in the event that the Director of Finance determines such changes are necessary for successful completion of the project and approve the Special Project Report. The Director of Finance's determination will be informed by the findings of an independent project review of CADDIS conducted by an independent contractor under the oversight of the California Health and Human Services Agency and the Department of Finance.

(c) The independent project review will be an assessment to determine if the current DACCIS design maps t and reflects the project objectives as represented in the original project Feasibility Study report and Request for Proposal. The assessment will consider whether CADDIS will meet DDS and Regional Center business practice requirements and objectives, including objectives related to federal programs. The assessment will examine project management, schedule, and status.

(d) Funding in this item for Regional Center operations also includes a set-aside of $467,000 General Fund and $92,000 in Reimbursements for Regional Centers to input federally required consumer attendance data into CADDIS upon its implementation. These funds shall not be expended until such time as CADDIS implementation occurs.

(e) On or before September 1, 2005, the Department of Finance shall report to the chairperson of the budget committee in each house of the Legislature and the Chairperson of the Joint Legislative Budget Committee of its strategy to resolve problems on the CADDIS project. The strategy shall include, but is not limited to, (1) identification of problems or issues on the project, and (2) actions, costs, and timeframes broken out by budget year and future years to correct those problems or issues. The Department of Finance shall include a copy of the independent project review with its report.

~~(e)~~ (f) Based on the findings of the independent project review, and no sooner than 30 days after notification in writing by the Department of Finance to the chairperson of the budget committee in each house of the Legislature and the Chairperson of the Joint Legislative Budget Committee , the Director of Finance may transfer management of the CADDIS project from the Department of Development Services to the California Health and Human Services Agency or another appropriate state agency, in order to promote successful completion of the project.

~~(f)~~ (g) Nothing in this provision is intended to nullify the approval and legislative notification provisions of Section 11.00 or Section 11.10 of this Act.

Subcommittee Staff Recommendation: It is recommended to approve the LAO recommendation to (1) appropriate the May Revision amount of $2 million and (2) modify the proposed Budget Bill Language as noted.

Background on CADDIS: The California Developmental Disabilities Information System (CADDIS) **is an integrated case management and fiscal accounting system that is being implemented by the Regional Centers (RCs) at the direction of the DDS.** CADDIS will replace the current Uniform Fiscal System (UFS) and the San Diego Information System (SANDIS) case management system, both developed and implemented over 20 years ago.

CADDIS is needed in order to obtain more accurate and necessary consumer data regarding needs and services, and in order to enhance the receipt of federal funds by meeting federal reporting requirements.

Initiated in July 2000, CADDIS has encountered several system delays. In the Budget Act of 2003, it was assumed that CADDIS would be operational by June 2004. This date was pushed back to December 2004 through the Budget Act of 2004. **Now the DDS contends that implementation will not occur until June 2006. CADDIS expenditures to date are shown in the table below:**

Fiscal Year	General Fund
2000-01	$707,000
2001-02	$5,306,000
2002-03	$401,000
2003-04	NA
2004-05	$6,439,000
2005-06	$3,730,000
Total Funding	**$16,583,000**

Questions:

1. DDS, Please provide an update on the CADDIS project and the timing of completion of the overall assessment

6. CADDIS Delay Affects Vendor Processing

Issue: The DDS proposes **an increase of $559,000 ($467,000 General Fund)** for **Regional Center Operations to hire 42 positions to manually process data necessary for billing contracted and other services to the Home and Community-Based Waiver, thereby accessing federal funds.**

The issue is that if CADDIS was operational, data could be electronically uploaded from vendors to the Regional Centers. However this clearly not occur until at least June 2006 (revised CADDIS implementation date).

Subcommittee Staff Recommendation: Unfortunately, there is no other alternative than to approve the May Revision as proposed.

Questions:

1. DDS, Please explain the May Revision request.

7. Proposed Augmentation for RC Operations

Issue: The May Revision updates the Governor's January proposal to significantly increase the funding for the Regional Center Operations budget. **Specifically, the May Revision proposes an increase of $20.2 million ($8.8 million General Fund and $11.4 million Reimbursements from the DHS of which 50 percent, or $5.7 million, is state General Fund).**

The Administration contends that this level of funding is needed to help Regional Centers maintain compliance with the federal Centers for Medicare and Medicaid Services (CMS) for the Home and Community-Based Services Waiver. **No trailer bill or Budget Bill Language is proposed as to how these funds will specifically be used, or exactly how the use of these funds will indeed ensure compliance with the Waiver requirements.**

As noted under the DDS support item in this agenda, the DDS is just beginning to craft a comprehensive Quality Management System as requested by the federal CMS. **As such, it is unknown at this time how the proposed funding will be incorporated into any performance measures for the RCs**.

It should also be noted that the current-year request for $10.6 million (General Fund) (half-year funding) for this proposal was submitted via the Section Letter process and was recommended for denial by the LAO.

Legislative Analyst's Office Recommendation: The LAO recommends to deny the entire request.

They note that a report due to the Legislature by January 10, 2005 that would provide information on key attributes of Regional Center Operations as it relates to the Home and Community-Based Waive is overdue. **Therefore, the LAO does not believe that the Legislature has sufficient information to act upon the request.**

Subcommittee Staff Recommendation: Subcommittee staff concurs with the LAO recommendation. Issues have been raised with the Administration regarding receipt of the report, as well as the lack of any controlling language regarding the potential receipt of the funds. Presently there are no accountabilities or performance measures. As such, the Regional Centers could use the funds for other purposes.

Questions:

1. DDS, Please provide a brief summary of the May Revision proposal.

C. Issues Regarding the State Developmental Centers

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

State operated facilities are entitled to payment for Intermediate Care Facility (ICF) services at actual allowable costs for services for individuals with developmental disabilities. Reimbursement levels for payment of services are based on rates developed by the DDS and approved by the DHS. Medi-Cal reimbursement is available for most DC services, except for nine residential units at Porterville DC (no longer eligible due to forensic-related issues). According to recent DDS data, the average cost per person residing at a DC is about $228,000 annually.

1. May Revision Adjustments for the Developmental Centers—*Various*

Issue: The May Revision reflects total expenditures of $708 million ($379.2 million General Fund) for the DCs or an increase of $9.4 million ($6.1 million General Fund) over the Governor's January budget. This increase is due to a series of proposed adjustments including the following:

- ***Population Adjustments:*** The May Revision reflects a reduction of $6.1 million ($3.6 million General Fund) from January due to a projected decrease in population of 55 residents (from 3,071 residents to 3,016 residents).
- ***Employee Compensation Adjustment:*** An increase of $2.1 million ($1.2 million General Fund) to capture employee compensation costs that were inadvertently overlooked during the Fall budget development process of the Administration's.
- ***Quality Management System Requirements:*** An increase of $664,000 ($369,000 General Fund) to fund 5 positions (two-year limited-term) to assist in evaluating the current systems for performance indicators for organizational, operational, and consumer outcomes, and regulatory compliance, and address improvements as appropriate.
- ***Worker's Compensation One-Time Settlement Funding:*** DDS is requesting $4.9 million ($2.8 million General Fund) to aggressively settle claims and reduce future liability for which there is no funding in the base budget and to include funding to compensate the State Compensation Insurance Fund (SCIF) staff to facilitate the settlement process.
- ***Medicare Part D Prescription Drug Benefits:*** An *overall* **increase of $1.2 million (General Fund)** to implement the provisions of the federal Part D Drug Program is proposed. Effective January 1, 2006, drug and pharmacy costs for dual eligible

Developmental Center consumers will shift from Medi-Cal to Medicare. All of this proposed increase is for administration purposes.

Specifically, of the total proposed increase, **$586,000 (total funds) is for 11.5 positions at the Developmental Centers, effective January 1, 2006**, including Accounting, Pharmacy, Program and Health Records positions. **In addition $578,000 (one-time) is for computer workstations billing software, and consultant services to review existing pharmacy and physician systems, and $40,000 in other operating expenses.**

About 2,200 dual eligible consumers, or 65 percent of the DC residents, will be enrolled for low-income subsidies, which will exempt them from co-pays, premiums, and annual benefit caps. These individuals will be required to enroll in Prescription Drug Plans (PDP) of their choice.

The DDS' Medicare Part D Drug Program proposal assumes that existing Developmental Center pharmacies will operate as long-term care pharmacies and contract with Prescription Drug Plans (PDPs) to provide drugs to consumers under the federal Part D Drug Program. The DDS notes that considerable work will need to be done in the Developmental Centers to implement the federal Part D Drug Program requirements as additional information is provided by the federal government.

Subcommittee Staff Recommendation: No issues have been raised regarding these adjustments. It is recommended to adopt the May Revision.

Questions:

1. DDS, Please provide a *brief* summary of each of the above component changes.
2. DDS, Please describe how the long-term care pharmacy function will operate in order to implement the federal Part D Drug Program.

2. Adjustments for Agnews Developmental Center Closure

Issue: The Subcommittee's April 11th hearing discussed in the detail the Governor's closure of the Agnews Developmental Center. The Governor's May Revision proposes the following technical adjustments to the proposed closure of Agnews Developmental Center:

- $3.5 million ($2.4 million General Fund) for Agnews state staff to work in the community to facilitate the transition of consumers from Agnews to other living arrangements. This funding level reflects a technical adjustment on the part of the Administration, as well as a later start date—October 1, 2005 instead of July 1, 2005. The DDS states that 50 state staff would be used, which is consistent with the closure plan. AB 1378 (Lieber) is an Administration sponsored bill that is proceeding through the policy process on this issue.

- $3.2 million ($1.7 million General Fund) to fund a new methodology to reasonably staff Agnews DC and provide personal services to support administrative and operational requirements as the Agnews DC population declines. Licensing standards dictate specific ratios of licensed staff to population as well as minimum licensed staffing levels. These resources are needed to ensure the appropriate level of non-level-of-care staffing at Agnews during the transition to closure.

Subcommittee Staff Recommendation: It is **recommended to approve these technical adjustments as proposed in the May Revision.**

Background—Agnews Closure: The Governor proposes to close Agnews Developmental Center, located in San Jose, by June 30, 2007, if the community is ready. The Governor's budget contains certain components of this closure Plan, while Administration sponsored policy legislation associated with other components of the Plan is proceeding through the Policy Committee process.

As justification for its policy, the Administration cites the need for the state to comply with the 1999 U.S. Supreme Court decision ("Olmstead"), in which the court ruled that keeping persons in institutions who could transition to a community setting constituted discrimination under the Americans with Disabilities Act. The Administration also cites as reasons to close Agnews the high capital improvement costs that would have to be incurred if the facility were left open, and the high cost of institutional care at Agnews as compared to community-based care. According to recent DDS data, the average cost per person residing at a DC is about $228,000 annually. In addition, due to the level of fixed costs at the DCs and the need to maintain minimum staffing levels, the cost per resident will continue to increase as the total resident population decreases.

It should be noted that the Agnews Developmental Center Plan closure is different than the two most recent closures of Developmental Centers—Stockton DC in 1996 and Camarillo DC in 1997—both of which resulted in the transfer of large numbers of individuals to other state-operated facilities. In contrast, the Agnews Plan relies on the development of an improved and expanded community service delivery system in the

Bay Area that will enable Agnew's residents to transition and remain in their home communities. The DDS proposes to achieve this by:

- Establishing a permanent stock of housing dedicated to serving individuals with developmental disabilities.
- Establishing new residential service models for the care of developmentally disabled adults.
- Utilizing Agnew's state employees on a transitional basis in community settings to augment and enhance services including health care, clinical services and quality assurance.
- Implementing a Quality Management System (QMS) that focuses on assuring that quality services and supports are available in the community.

The Plan provides for the development of new resources and innovative programs. Key components are as follows:

Family Teaching Home Model: AB 2100, Statutes of 2004, also added a new "Family Teaching Home" model to the list of residential living options. This new model is designed to support up to three adults with developmental disabilities by having a "teaching family" living next door (usually using a duplex). The teaching family manages the individuals' home and provides direct support when needed. Wrap-around services, such as work and day program supports, are also part of this model.

Bay Area Unified Community Placement Plan. The three Bay Area RCs (Golden Gate, San Andreas, and East Bay) have a unified plan for community placement whereby extensive individual assessment and person-centered planning is conducted. A regional approach (i.e., the greater Bay Area) is then taken for the planning and development of services and supports for individuals with developmental disabilities.

By taking a unified approach to housing, health services, quality assurance, and residential living options, resources can be used more efficiently and effectively, and more individuals can be transitioned to the community, when appropriate

Pilot Projects for Adults with Special Health Care Needs. Through policy legislation—SB 962 (Chesbro), as introduced-- the DDS is proposing to establish a new pilot residential project designed for individuals with special health care needs and intensive support needs. This pilot would be a joint venture with the Department of Social Services (DSS) and would serve up to 120 adults, with no more than five adults residing in each facility. This pilot would be limited to individuals currently residing at Agnews.

Use of State Employees to Facilitate Transition. Through policy legislation—AB 1378 (Lieber), as introduced--the DDS proposes to use up to 200 Agnew's employees to augment and enhance services provided in the community. These state employees would be used to provide direct care, resolve crises, train and provide technical assistance to new providers, and other functions. The employees would operate under special

contracts between the state and either an RC or service provider. These arrangements would continue through 2009.