SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

May 24, 2012

Upon Adjournment of Appropriations Committee

Room 112

Agenda – Part 2

(Michelle Baass)

PLEASE NOTE:

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

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

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VOTE ONLY CALENDAR

A. 4440 Department of Mental Health

1. Community Treatment Facilities

Budget Issue. The Administration proposes to eliminate $750,000 General Fund that is paid as a supplemental rate to Community Treatment Facilities (CTFs). The Administration argues that since this is not a statewide program, counties can use local funds to fund these CTFs at their discretion. (There are no federal funds for CTFs.)

There are two active CTFs in California:

- Starview Children and Family Services in Los Angeles County (40 beds)
- Vista Del Mar Child and Family Services in Los Angeles County (21 beds)

The San Francisco Community Alternatives Program in San Francisco County is in the process of closing and is performing assessments on all of its clients in order to refer each one to other programs and services in the area.

The $750,000 General Fund supplemental rate was based on three CTFs being operational in the state.

This issue was discussed at the April 12, 2012 Subcommittee #3 hearing.

Subcommittee Staff Recommendation—Approve. It is recommended to approve this proposal. Given the state's fiscal situation and since there are only two facilities in the state, counties can use realignment funds to fund placement at these facilities.

2. Reappropriation Metropolitan New Main Kitchen Project

Governor's Request. A Spring Finance Letter proposes reappropriation authority to complete the New Main Kitchen project at Metropolitan State Hospital.

Background. The New Main Kitchen Project started in 2004 and is complete, with one exception - a required fire water line is needed to be built to satisfy State Fire Marshall requirements. The water system's velocity and pressure required to pass the State Fire Marshal requirements to bring the Central Kitchen online were not met. The fire water line is currently being built; however, it has had the following challenges:

1. Unforeseen site conditions in the fire water line trench with existing utilities and soil conditions requiring new fill material meeting project requirements;
2. A contractor that is unfamiliar with state projects; and,
3. Issues in obtaining the required approvals on deferred submittals from the appropriate state entities.

These issues are being resolved and the project will be completed by the end of the year; however, there will be a lapse in project authority. This reappropriation provides an extension of existing authority so that the fire water line can be completed and any claims can be paid using the remaining funds available for this project.

Staff Comment and Recommendation—Approve. It is recommended to approve this item.

B. 0977 California Health Facilities Financing Authority

1. Funding for Competitive Grant Program for New Methods of Health Care Delivery

Issue. The California Health Facilities Financing Authority (CHFFA) Fund has over $6.5 million available in its reserve that could be used to fund a competitive grant program for one or more projects to demonstrate new or enhanced methods of delivery health care services to improve access and health outcomes for vulnerable populations or communities, or both that are effective at enhancing health outcomes and improving access to quality health care and preventive services. Those funds not awarded as a competitive grant would revert back to the fund balance on January 1, 2020.

Background. CHFFA was established in 1979 to be the state's vehicle for providing financial assistance to public and nonprofit health care providers through loans funded by the issuance of tax-exempt bonds. CHFFA also administers the Healthcare Expansion Loan Program II (HELP II), which provides direct loans to small and rural health facilities, and several grant programs that have provided funding for community clinics and 13 of the state's children's hospitals.

By borrowing through CHFFA, health facilities can likely obtain lower interest rates than they would through conventional bonds. Generally, nonprofit, licensed health facilities in California, including adult day health centers, community clinics, skilled nursing facilities, developmentally disabled centers, hospitals, and drug and alcohol rehabilitation centers are eligible for CHFFA financing.

Fees paid by CHFFA borrowers are deposited into the CHFFA Fund. These fees are competitively set and take into account the fees charged by competing lenders.

Subcommittee Staff Comment and Recommendation. It is recommended to create a competitive grant program using up to $6.5 million from the CHFFA Fund reserve. Given the reductions in services and funding for California's underserved and vulnerable populations in the past few years, this available fund balance provides an opportunity to fund innovative and cost-effective ways of delivering high quality care to vulnerable populations.

C. 4260 Department of Health Care Services

1. Eliminate Sunset Date for Specialty Provider Contracting

Budget Issue. AB 1183 (Statutes of 2008) amended Welfare and Institutions Code 14105.3 and allowed DHCS to enter into contracts with providers who distribute and provide care for specialty drugs and services. This provision allows DHCS to restrict payment of specialty drugs and services to a limited number of providers. The legislation included an annual reporting requirement following the first two years and a sunset provision of July 1, 2013.

Subcommittee Staff Comment and Recommendation—Reject. It is recommended to reject this proposed trailer bill language as there are no budget implications and there is time for the department to do policy legislation on this topic.

2. Adjustments to Gross Premium Tax (DOF Issue 134)

Budget Issue. The May Revision proposes a technical adjustment to the amount of Gross Premium Tax revenue available for the Medi-Cal program. The May Revision estimates a decrease of $26.6 million will be available.

Subcommittee Staff Comment and Recommendation—Approve. This is technical adjustment based on updated estimates.

3. Technical Changes to Implement AB 396 – Medi-Cal Juvenile State Inmate Program

Budget Issue. In the May Revision, the Administration proposes technical clean-up trailer bill language that is necessary to make changes to the provision of AB 396 (Mitchell, Statues of 2011).

Background. Prior to AB 396, county juvenile detainees were not eligible for Medi-Cal because they were juvenile inmates who, pursuant to Welfare and Institutions Code Section 14011.10, must be suspended and may not receive Medi-Cal benefits during the pendency of their suspension. As such, the counties were responsible to provide and pay for the medical services received by the county juvenile detainees whether the services were provided on or off the detention facilities.

AB 396 changed this by requiring that Medi-Cal eligibility not be denied to a county juvenile inmate who is an inpatient in a medical institution because of their status as an inmate of a public institution. AB 396 authorizes DHCS to develop a process for the counties to receive any available federal financial participation for acute inpatient hospital services and inpatient

psychiatric services provided to Medi-Cal eligible juvenile inmates admitted as inpatients into a medical institution off the grounds of the detention facilities.

Subcommittee Staff Comment and Recommendation—Reject. It is recommended to reject the Administration's technical clean-up language regarding AB 396.

ISSUES FOR DISCUSSION

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

A. 4440 Department of Mental Health, Community Mental Health

Background on Community Mental Health

California has a decentralized public mental health system with most direct services provided through the county mental health system. In 2011-12, major changes to the state's oversight and responsibility for these programs were initiated. (These changes are described in detail below.) Prior to 2011-12, the Department of Mental Health (DMH) was the lead state agency responsible for administering state and federal statutes pertaining to mental health treatment programs.

County Mental Health Plans. Counties (i.e., County Mental Health Plans) have the primary funding and programmatic responsibility for the majority of local mental health programs.

Specifically counties are responsible for: (1) all mental health treatment services provided to low-income, uninsured individuals with severe mental illness, within the resources made available, (2) the Medi-Cal Specialty Mental Health Managed Care Program, (3) the Early Periodic Screening Diagnosis and Testing (EPSDT) Program for children and adolescents, (4) mental health treatment services for individuals enrolled in other programs, including special education, CalWORKs, and Healthy Families, and (5) programs associated with the Mental Health Services Act of 2004 (known as Proposition 63).

Specialty Mental Health Services Managed Care. California provides "specialty" mental health services under a comprehensive Waiver that includes outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. These specialty mental health services are "carved out" of the Medi-Cal Program administered by the Department of Health Care Services (DHCS), which provides physical health care.

County Mental Health Plans are the responsible entity that ensures that specialty mental health services are provided. Medi-Cal enrollees *must* obtain their specialty mental health services through the County.

Medi-Cal enrollees may also receive certain limited mental health services, such as pharmacy benefits, through the Fee-For-Service system.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. EPSDT is a federally mandated program that requires the state to provide Medi-Cal beneficiaries under age 21 with any physical and mental health services that are deemed medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions, including services not otherwise included in the state's Medicaid plan. Counties are responsible for a 10 percent share of cost for the growth in EPSDT.

2011 Realignment and Mental Health Services. The 2011-12 budget realigned many public safety and health and human services and intended for the future realignment of Medi-Cal Specialty Mental Health and EPSDT in 2012-13. These programs were not realigned in 2011-12 because AB 100 (Statutes of 2011, budget trailer bill legislation) amended the Mental Health Services Act (MHSA) to allocate, on a one-time basis, $861 million in MHSA funds to counties to support EPSDT and Medi-Cal Specialty Mental Health managed care, and mental health services provided to special education students

Historically, County Mental Health Plans were funded with 1991 Realignment funds, General Fund, and federal funds and EPSDT was funded by the General Fund and federal funds with the counties paying a 10-percent share of cost above a specified baseline.

Administrative Transfer from DMH to Department of Health Care Services. AB 102 (Statutes of 2011) continued the process to restructure the state's mental health system. AB 102 transfers from DMH to the Department of Health Care Services (DHCS), effective July 1, 2012, the state administrative functions for the operation of Medi-Cal Specialty Mental Health Managed Care, the EPSDT Program, and applicable functions related to federal Medicaid requirements.

It required DHCS, in collaboration with DMH and the California Health and Human Services Agency (Agency), to create a state administrative and programmatic transition plan, in consultation with stakeholders that included specified components to guide the transfer of Medi-Cal Specialty Mental Health managed care and the EPSDT Program to DHCS.

AB 102's legislative intent is that the transfer occur in an efficient and effective manner, with no unintended interruptions in service delivery to clients and families, and that the transfer accomplish improved access to culturally appropriate community-based mental health services; effectively integrate the financing of services to more effectively provide services; improve state accountabilities and outcomes; and provide focused, high-level leadership for behavioral health services within the state administrative structure.

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

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

AB 100 also made changes to MHSA administration, including reducing the percentage amount available from MHSA revenues for state administration from 5 percent to 3.5 percent, requiring monthly distributions from the MHSA Fund, having the "state" (instead of DMH) administer the MHSA Fund, and having the Mental Health Services Oversight and

Accountability Committee provide technical assistance to counties. AB 100 was point-in-time legislation that was developed with the intention of coming back to define a process to restructure the state's mental health system.

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

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

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

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

1. Realignment - Medi-Cal Specialty Mental Health and EPSDT

Budget Issue. The May Revision includes trailer bill language on the 2011 Realignment Superstructure and updated estimates for Medi-Cal Specialty Mental Health and EPSDT. Additionally, in April, the Administration released trailer bill language to implement the realignment of Medi-Cal Specialty Mental Health services and EPSDT.

Realignment Superstructure. In the May Revision, the Administration is proposing trailer bill language to create a permanent structure for 2011 Realignment. The funding structure is designed to provide local entities with a known, reliable, and stable funding source for these programs. Within each Subaccount, counties would have the flexibility to meet their highest priorities, and will be able to use their funds to draw down the maximum amount of federal funding for these programs. In those programs in which there are federal requirements, such as eligibility and statewideness, counties would be responsible for meeting those requirements.

The realignment superstructure would establish the following two accounts in the County Local Revenue Fund: (1) Support Services Account and (2) Law Enforcement Services Account.

The **Support Services Account** will contain two Subaccounts:
- **Protective Services Subaccount** will contain funding for Foster Care; Child Welfare Services; Adoptions; Adoptions Assistance Program; Child Abuse Prevention, Intervention, and Treatment; and Adult Protective Services.
- **Behavioral Health Subaccount** will contain funding for Drug Medi-Cal; Drug Courts; Perinatal Drug Services; Non-Drug Medi-Cal Services; Mental Health Managed Care (Medi-Cal Specialty Mental Health); and Early and Periodic Screening, Diagnosis, and Treatment.

The **Law Enforcement Services Account** will contain five subaccounts:
- Trial Court Security Subaccount.
- Law Enforcement Services Subaccount.
- Community Corrections Subaccount.
- District Attorney/Public Defender Subaccount.
- Juvenile Justice Subaccount, containing both the Youthful Offender Block Grant and Juvenile Reentry Fund.

In addition, local realignment funding for the 1991 Mental Health Responsibilities would be allocated to the Mental Health Account (separate from the two subaccounts listed above).

Growth. The Governor proposes to allocate program growth on roughly a proportional basis first among the Accounts and then among the Subaccounts. Within each Subaccount, federally required programs would receive priority funding if warranted by caseload and costs.

The following components (related to mental health) are addressed in the realignment superstructure:

- ***County Share of EPSDT.*** The proposed trailer bill language continues counties' existing 10 percent match on EPSDT growth and clarifies that the match shall come from a funding source other than the Local Revenue Fund.

- ***Reallocation.*** In addition, the proposed language includes reallocation provisions similar to those in the 1991 realignment between the Protective Services Subaccount and the Behavioral Health Subaccount (the reallocation may not exceed 10 percent of the amount deposited in the subaccount with the lowest balance) and clarifies the reallocation is for one fiscal year and not a permanent funding source. This reallocation must be heard at a regularly scheduled County Board of Supervisors hearing and the documentation of this reallocation must be submitted to the State Controller (who would be required to provide this information to the Legislature upon request).

Program Base Funding. The base for each of the programs included in 2011 Realignment will ultimately become a "rolling base," meaning the previous year's allocation level plus growth will equal the new base for the following year.

The table below identifies the proposed "2011 Realignment" funding for mental health services.

Table: 2011 Realignment Funding – Local Revenue Fund (LRF) (dollars in millions)

	2011-12		**2012-13**	
	2011 Budget Act	Proposed	January Estimate	May Revision Estimate
Medi-Cal Specialty Mental Health	-	-	$188.8	$196.7
EPSDT	-	-	$544.0	$584.2
1991 Mental Health Responsibilities	$1,083.6	$1,083.6	$1,164.4	$1,120.6

Medi-Cal Specialty Mental Health. The May Revision proposes $398 million ($196.7 million Local Revenue Fund and $201 million federal funds) for Medi-Cal Specialty Mental Health.

The $7.9 million increase in Local Revenue Fund from the January budget estimate, noted in the table above, for Medi-Cal Specialty Mental Health (i.e., the mental health managed care program) reflects an increase in psychiatric inpatient services and includes an increase for Solano County that pertains to a previous pilot project.

EPSDT Estimate. The May Revision proposes $1.568 billion for EPSDT ($584.2 Local Revenue Fund, $882.9 million federal funds, and $99.7 million county funds). The May Revision includes the following adjustments to the Local Revenue Fund for EPSDT:

1. **Claims.** An increase of about $7.3 million LRF ($14.5 million total funds) based on an increase of approved claims for the forecast period.
2. **Healthy Families Program Transition to Medi-Cal.** Full year costs for the transition of Healthy Families Program children to Medi-Cal. The January estimate included $6.1 million LRF ($17.6 million total funds) for partial year implementation and the May Revision includes $17.3 million LRF ($49.3 million total funds).
3. ***Katie A.* Settlement.** Full year costs for the implementation of the *Katie A.* settlement. The January estimate included $5.3 million LRF ($10.6 million total funds) for partial year implementation and the May Revision includes $26.7 million LRF ($53.5 million total funds).

Realignment of Medi-Cal Specialty Mental Health and EPSDT. In April, the Administration released trailer bill language to implement the realignment of Medi-Cal Specialty Mental Health services and EPSDT. With this language, fiscal responsibility for Medi-Cal Specialty Mental Health and EPSDT would shift to the counties. However, given that these programs receive federal Medicaid funds, the Department of Health Care Services would maintain a role in the oversight of these programs.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold these items (i.e., the realignment superstructure trailer bill language, the mental health realignment trailer bill language, and the estimates for EPSDT and Medi-Cal Specialty Mental Health) open as discussions continue regarding realignment.

Realignment Superstructure. Concerns have been raised regarding the requirement that counties continue to provide the 10 percent match to any new growth in the cost of EPSDT and require that counties funding for this come from a source other than funds in each county's Local Revenue Fund allocation.

Program Baseline Funding. At the April 12, 2012 Subcommittee hearing on this topic, concerns were expressed that the level of funding for EPSDT was not sufficient and that the Administration did not account for full-year implementation of the Healthy Families Program Transition to Medi-Cal and the *Katie A.* lawsuit. The Administration has addressed these concerns.

Realignment of Medi-Cal Specialty Mental Health and EPSDT. Concerns have been raised that there are inconsistencies regarding state rule-making authority between the trailer bill language proposals to implement the 2011 Realignment for mental health services, alcohol and drug programs, and social services programs.

Additionally, counties highlight that the trailer bill language for mental health services realignment does not require the Department of Health Care Services to consult with counties prior to submitting federal waivers or state plan amendments. Under Realignment 2011, counties are responsible for 100 percent of the share of cost for federal programs and as such find that they should be at the table when policy and/or fiscal changes to these programs are proposed.

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

1. Please provide an brief overview of the realignment superstructure and the proposal to realign EPSDT and Medi-Cal Specialty Mental Health.
2. Please provide an overview of the May Revision EPSDT and Medi-Cal Specialty Mental Health estimates and how they compare to the January budget.

2. Transfer of State Administration of Medi-Cal Specialty Mental Health

Budget Issue. The Administration proposes trailer bill language to proceed with statutory changes necessary to transfer the administrative functions for Medi-Cal Specialty Mental Health managed care plan services and EPSDT from DMH to DHCS.

Background. AB 102 (Statutes of 2011) transferred the administration of the Medi-Cal Specialty Mental Health Services Program from DMH to DHCS, effective July 1, 2012. The intent of the transfer is to:

- Improve access to culturally appropriate community-based mental health services, including a focus on client recovery, social rehabilitation services, and peer support;
- Effectively integrate the financing of services, including the receipt of federal funds, to more effectively provide services;
- Improve state accountabilities and outcomes;
- Provide focused, high-level leadership for behavioral health services within the state administrative structure.

Effective September 1, 2011, 118.5 DMH Medi-Cal positions were transferred to DHCS.

AB 102 required DHCS, in collaboration with DMH and the California Health and Human Services Agency (Agency), to create a state administrative and programmatic transition plan, in consultation with stakeholders that included specified components to guide the transfer of Medi-Cal Specialty Mental Health managed care and the EPSDT Program to DHCS.

DHCS was required to provide the transition plan to all fiscal committees and applicable policy committees of the Legislature by October 1, 2011. AB 102 required the state administrative transfer to conform to the state administrative transition plan provided to the Legislature. Finally, AB 102 also authorized the transition plan to also be updated by the Governor and provided to the Legislature upon its completion, but no later than May 15, 2012.

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

- That DHCS improve business practices (examples include maximizing the claiming of federal funds; improving the claims reimbursement system, streamlining the cost reporting and settlement processes; eliminating redundancies in the provider certification process; facilitating same day billing for mental and physical health care services; integrating audits; integrating information technology systems; and, reducing processing times);
- That DHCS assure access and improve services (examples include adopting community-based best practices, such as peer support and maximizing the use of social rehabilitation services; increasing the use of telepsychiatry; focusing on prevention and early intervention; ensuring state staff are knowledgeable about mental health services; assuring children's mental health policy expertise; assuring providers can continue to

serve clients during and after the transfer; continuing progress in assuring cultural competence of services; addressing racial, ethnic, and cultural disparities in access to care and outcomes; reducing discrimination and stigma experienced by clients; eliminating disparity in access to services; integrating services; facilitating coordination with non-Medi-Cal mental health services; incentivizing the use of community settings; and assuring accountability in the mental health system and, of its providers and administrators);

- That DHCS ensure stakeholder participation (examples include providing regularly scheduled venues for regular stakeholder engagement; consulting with stakeholders on program changes, efficiencies, regulations, State Plan Amendments, and waiver amendments; engaging stakeholders in ongoing quality improvement, including county representation in assessment of legal issues and court decisions that require county implementation; facilitating stakeholder participation by funding travel to meetings; and, clearly identifying individuals that serve as state contacts for programs and services).

Subcommittee Staff and Recommendation—Hold Open. It is recommended to hold this item open as it is related to the Realignment issue above.

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

1. Please provide an overview of this proposal and the planning process that occurred in the summer and fall of last year.

3. Transfer of Non Medi-Cal Community Mental Health Programs

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

The reorganization of behavioral health began in 2011-12, as discussed above. The Administration intends that this proposal completes these efforts by transferring the remaining mental health programs to various state departments that perform related or similar functions. The Administration believes the consolidation of mental health, substance use disorder, and physical health at DHCS will provide for a continuum of care for consumers in preparation for health care reform in 2014.

Department of Health Care Services. The majority of existing community mental health programs and functions are proposed to be transferred to a new Division of Mental Health and Substance Use Disorders Services within DHCS. In addition to the transfer of these programs, the Administration proposes to create a new Deputy Director, Mental Health and Substance Use Disorder Services, who would lead this new division. The new Deputy Director would be a Governor's Appointee and would require Senate confirmation. The following functions would be transferred to DHCS:

- **Oversight of Certain MHSA Components.** DHCS would be responsible for the collection of data relating to certain Mental Health Service Act (MHSA) programs (Full Service Partnerships). In addition, DHCS would be responsible for MHSA state-level issue resolution which is a process by which consumers and stakeholders have a mechanism to resolve issues related to MHSA. And finally, DHCS would be responsible for MHSA Statewide Prevention and Early Intervention Projects (Suicide Prevention, Student Mental Health Initiative, and Stigma and Discrimination Reduction Programs).

- **Certification of Mental Health Programs at Facilities.** DHCS would assume responsibilities for the certification of mental health treatment programs at Skilled Nursing Facilities with Special Treatment Programs, Community Residential Treatment Systems (also known as Social Rehabilitation Programs), and Community Treatment Facilities.

- **Oversight of Federal Grants.** In addition, DHCS would be responsible for the oversight and administration of federal mental health funds including the Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grant and the Projects for Assistance in Transition from Homelessness (PATH). The SAMHSA block grant can be used to establish or expand an organized community-based system of care for providing non-Medi-Cal mental health services to children with serious emotional disturbances and adults with serious mental illness. The state administers this block grant and allocates the funds each year to 58 local county mental health agencies. The county mental health departments and contracted providers deliver a broad array of treatment and support

services that include over 150 individual programs supported by the block grant. PATH funds community-based outreach, mental health and substance abuse services, case management, and limited housing services for people experiencing serious mental illness who are experiencing homelessness or are at risk of becoming homeless.

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

Department of Public Health (DPH) - Office of Multicultural Services and Disaster Services. As discussed later in the agenda, the Administration proposes to transfer the Office of Multicultural Services (OMS) to DPH's new Office of Health Equity. Additionally, the $60 million in MHSA funds for the California Reducing Disparities Project (CRDP) would be transferred to DPH (with $15 million being appropriated each year for four years as a state administrative item). This appropriation to DPH is discussed later in the agenda under the Department of Public Health.

The CRDP is a project under the Prevention and Early Intervention component of the Mental Health Services Act. The initiative is focused on five populations: African Americans; Asian/Pacific Islanders; Latinos; Lesbian, Gay, Bi-sexual, Transgender, Questioning; and Native Americans. The project will develop population-specific reports that will form the basis of a statewide comprehensive strategic plan to identify new approaches to reduce disparities.

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

The DPH is the designated lead state agency for public health emergency preparedness and response.

Department of Social Services (DSS) – Licensing of MHRCs and PHFs. The Administration proposes to transfer DMH's facility licensing and quality improvement efforts to the Department of Social Services (DSS). DMH currently licenses mental health rehabilitation centers (MHRCs) and psychiatric health facilities (PHFs). The Administration finds that these facilities are similar to other residential facilities that are licensed by DSS.

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

The Legislature's intent with creating MHRCs was to create innovative programs that were alternatives to hospital care.

Psychiatric Health Facilities (PHFs). PHFs offer acute inpatient psychiatric treatment to individuals with major mental disorders in a nonhospital setting. PHFs mainly provide acute psychiatric treatment services to individuals subject to involuntary commitment under the Lanterman-Petris-Short Act. There are 25 PHFs in California with 432 beds. These facilities are locked facilities. PHFs employ a multidisciplinary model (consistent with its enabling legislation) which called for an innovative approach to acute psychiatric care.

PHFs were conceptualized and designed to be an alternative to acute psychiatric hospitals which are traditionally based on a medical model.

Approval of Involuntary Hold Facilities. Additionally, the Administration proposes to transfer DMH's roles and responsibilities related to Lanterman-Petris-Short Act involuntary holds (pursuant to Welfare and Institutions Code Section 5150) to DSS. These responsibilities include the approval of facilities designated by counties for 72-hour treatment.

Department of Education – Early Mental Health Initiative. The proposal transfers the Early Mental Health Initiative (EMHI) program to the Department of Education. The EMHI is a school-based program funded with Proposition 98 funds. The Senate Budget Subcommittee #1 will discussed this proposed transfer at its April 26 hearing.

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to adopt placeholder trailer bill language to reorganize the non-Medi-Cal community mental health programs to reflect agreement with agreement with the Administration on licensing and certification, technical changes regarding the elimination of DMH, and transfering programs to DHCS and DPH.

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

1. Please provide a summary of this proposal.

2. How has the Administration reached out to stakeholders to solicit feedback on this reorganization?

4. Proposition 63 – Mental Health Services Act

Budget Issue. In addition to the reorganization of non-Medi-Cal community mental health, the Administration's proposed trailer bill language makes changes to the Mental Health Services Act (MHSA), including:

- Changes approval of the MHSA innovation programs from the Mental Health Services Oversight and Accountability Commission (MHS OAC) to the county board of supervisors.
- Removes MHS OAC's authority to issue guidelines for MHSA innovation programs.
- Requires each county mental health program to prepare and submit a three-year plan adopted by its county board of supervisors to MHS OAC.
- Eliminates performance contracts between the state and counties.

Background. AB 100 (Statutes of 2011) made several changes to the Mental Health Services Act (MHSA). These changes include:

- Deleted the requirement that the Department of Mental Health (DMH) and the Mental Health Services Oversight and Accountability Commission (MHSOAC) annually review and approve county plans and updates.
- Deleted the requirement that a county annually update the 3-year plan but still required that there be updates.
- The "state," instead of DMH, would administer the Mental Health Services Fund (MHSF).
- Starting July 1, 2012, the State Controller shall distribute, on a monthly basis, to counties all unexpended and unreserved funds on deposit in the MHSF as of the last day of the prior month.
- Reduced the administrative funds for state departments from 5 percent to 3.5 percent.

AB 100 also contained language specifying that it was the Legislature's intent to ensure continued state oversight and accountability of the MHSA and that in eliminating state approval of county mental health programs, the Legislature expects the state to establish a more effective means of ensuring that county performance complies with the MHSA.

AB 100 Workgroup. Because several changes made by AB 100 needed clarification before they could be implemented, a workgroup was convened in an effort to try to develop consensus recommendations. This workgroup included representatives from DMH; the California Mental Health Planning Council; MHSOAC; the California Mental Health Directors; the National Alliance on Mental Illness; the California Network of Mental Health Clients; the Mental Health Association, California; and United Advocates for Children and Families.

Recommendations from the AB 100 workgroup include, but are not limited to:

- Implement the MHSA state level issue resolution process as a mechanism to assure county level compliance with the MHSA values.
- Charge MHSOAC with MHSA performance outcome evaluation.
- Continue MHSA programs through a performance contract.

Performance Contracts. Performance contracts were developed during the 1991 realignment as a way to ensure county accountability. These contracts provide for county assurance and reports and provide a mechanism to address noncompliance.

Senate Bill 1136 (Steinberg). Senator Steinberg has introduced SB 1136 to address issues regarding the restructuring of the public mental health system at both the local and State levels. Specifically, SB 1136 serves to address the changes occurring in the public mental health system as they pertain to the Mental Health Services Act. Key aspects of SB 1136 are discussed below.

Innovative Programs. SB 1136 clarifies the content of projects by reflecting guidelines adopted by the MHS OAC. The author finds that articulating these requirements in statute provides for transparency and accountability for all involved, including local constituencies, the counties and the State.

Prevention & Early Intervention (PEI) Programs. It provides for the Department of Health Care Services, in coordination with counties, to establish PEI Programs, and requires any revisions to these programs to be consistent with MHS OAC guidelines. These changes would assist in facilitating a stronger partnership at both the State and local levels.

Integrated Three-Year Plans and Updates. SB 1136 modifies the Integrated Plan approval process to ensure community participation, provide for Board of Supervisor approval, and oversight by the MHS OAC. It streamlines the expenditure of funds to ensure dollars are directed to needed services and supports. It requires both the Mental Health Director and County Auditor Controller to certify compliance with key cornerstones of the Act, including stakeholder participation, and non-supplantation requirements.

Mental Health Services Oversight Commission. This bill illuminates the ongoing role of the MHS OAC by:

- Continuing their oversight of the Innovative Programs and PEI projects;
- Requiring counties to provide their Integrated three-year plans and annual updates to the MHS OAC;
- Adding the MHS OAC as a joint partner in the establishment of performance outcomes and in the design of an evaluation plan;
- Continuing their authority to refer critical issues related to performance of a county mental health program to the DHCS; and
- Including the MHS OAC in the DHCS regulatory process by requiring coordination in these endeavors.

Expands Role of the California Mental Health Directors Association (CMHDA). This bill recognizes the integral role of counties in the implementation and success of the Mental Health Services Act and actively engages the CMHDA in key decisions including the establishment of performance measures, design of a comprehensive joint plan, the methodology used for revenue allocations to the counties, and provisions of technical assistance.

Provides for Local Accountability. This bill provides for local accountability through the following key changes:

- Provides authority to Board of Supervisors to approve Integrated three-year plans and annual updates;
- Clarifies that Integrated three-year plans and annual updates are to follow designated local stakeholder processes; and
- Requires certification of compliance with key cornerstones of the Act.

Workforce Development and Five Year Plan. This bill identifies that the next five-year plan is due April 1, 2014 and designates the Office of Statewide Health Planning and Development (OSHPD) to lead this effort. It recognizes the role of the California Mental Health Planning Council in this endeavor and links the county needs assessment to this process.

Deputy Director Position. SB 1136 also requires the Governor or Director of Health Care Services to appoint a Deputy Director of Mental Health and Substance Use Disorder and requires this new position to be subject to Senate Rules confirmation. Funding for this position is in the Governor's proposed Budget for 2012-13.

Section 18 of Proposition 63. The changes proposed in SB 1136 are clarifying procedures and terms within the meaning of Section 18 of Proposition 63. Legislative Counsel has keyed SB 1136 as a majority vote measure to reflect their concurrence.

Mental Health Services Act Background. Approved by voters on November 2, 2004, Proposition 63, the Mental Health Services Act (MHSA), applies a 1 percent tax on personal income in excess of $1 million. About $1 billion in revenues is generated annually. These annual revenues are devoted to reducing the long-term adverse impact of untreated mental illness by expanding mental health services and supports and monitoring progress towards statewide goals of serving children, transition age youth, adults, older adults and families with mental health needs.

The Mental Health Services Act addresses a broad continuum of prevention, early intervention and treatment service needs through systems of care and provides funding for necessary infrastructure.

California's community-based public mental health system is undergoing significant evolution due to transformative changes resulting from the Mental Health Services Act, pending implementation of 2011 Realignment of Medi-Cal Specialty Mental Health Services, and the restructuring of State administration which commenced through the enactment of AB 100, Statutes of 2011 and AB 102, Statutes of 2011.

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to reject the Administration's trailer bill language regarding MHSA. The Administration's proposed trailer bill language did not address the issues that need clarification as a result of AB 100 (since AB 100 was point in-time legislation necessary for last year's budget).

Instead it is recommended to adopt SB 1136's language as placeholder trailer bill language for implementing changes to the MHSA. This language has been vetted through a health policy committee and has had the involvement of stakeholders.

Add DHCS Positions for MHSA Activities. In order to maintain the integrity of Proposition 63 as intended by the voters, the State needs to oversee revenues and allocations made to the counties, and to ensure that these funds are expended for the purposes of the Mental Health Services Act.

To provide this oversight, it is recommended to provide the following 13 positions to the DHCS and $250,000 for technical assistance, for total expenditures of $1.650 million (Mental Health Services Act Funds). It should be noted that Subcommittee staff requested and received technical assistance for discerning the necessity of these positions and their classifications.

Outcome and Evaluation Functions (Four positions). The DHCS, Mental Health Services Oversight and Accountability Commission (MHS OAC), as well as the Mental Health Planning Council and the CA Mental Health Directors Association are to work collaboratively in establishing performance outcomes for all MHSA services programs and components.

Core functions that are currently unfunded or underfunded include:

(1) Design evaluation plan elements; evaluation goals; data to be used, collection of data, and timelines for data collection and evaluation partners;
(2) Data analysis;
(3) Reporting of data; and
(4) Working with interested partners.

The positions include: one Health Program Specialist I; two Associate Governmental Program Analysts; and one Research Analyst II.

Performance Contract (Four positions). The DHCS needs to address county perform through the performance contracting process established in Proposition 63. The DMH had not been performing this function in a comprehensive manner. Performance contracting for Proposition 63 coupled with the Medi-Cal Program realignment, will enable the DHCS to more comprehensive monitor and measure the public community mental health system.

The positions include: one Staff Services Manager I; one Associate Governmental Program Analyst; one Health Program Auditor III; and one Office Technician.

Methodology and Track and Review County MHSA Reports (Three positions). Core functions to be addressed here include:

(1) Obtaining and analyzing data for the methodology, including population data, rating factors, CPI data and other aspects;
(2) Coordinating with the State Controller's Office as to the distribution methodology;

(3) Maintain data and records documenting changes in population, service provisions, county expenditures, level of need and other methodology criteria;
(4) Analyzing county MHSA Reports on revenues and expenditures;
(5) Verify county attestations and communicate with counties; and
(6) Disseminating information.

The positions include: two Health Program Auditor IIIs and one Health Program Specialist I.

Regulations. Regulations will continue to be necessary and it is recommended to provide one Senior Staff Counsel and one Legal Analyst for this purpose.

Consultant Funds. It is further recommended to provide $250,000 (MHSA Funds) for the DHCS to utilize for the purpose of providing technical assistance with stakeholder groups during this transition, development of outcome measures and performance metrics, improvement of data sources to strength data validity and reliability and related aspects.

MHSA State Administrative Cap. State administrative expenses related to MHSA would still be under administrative cap of 3.5 percent (as discussed earlier, this cap was reduced from 5 percent to 3.5 percent under AB 100). The MHSA 3.5 percent administrative cap reserve would be $7.8 million, which would be allocated to the counties if unexpended.

Additionally, it should be noted that as will be discussed below, $15 million for the California Reducing Disparities Project is proposed to be budgeted under the state administrative cap for the Department of Public Health; thereby, increasing MHSA local assistance expenditures by $15 million. In total, the counties are getting $22.8 million from within the state's administrative cap.

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

1. Please provide an overview of the Administration's language regarding MHSA.

5. Patients' Rights Office

Budget Issue. Included in the Administration's trailer bill language for the reorganization of non-Medi-Cal community mental health is the proposal to have the Department of Health Care Services be responsible for the contract with a nonprofit entity for independent advocacy services for individuals in licensed health and community care facilities and to have the new Department of State Hospitals be responsible for the contract with a nonprofit entity for independent advocacy services for individuals in state hospitals.

Currently, the Department of Mental Health is the single state entity responsible for contracting out these services for both individuals in licensed health and community care facilities and individuals in state hospitals.

Background. The Patients' Rights Advocates (PRA) in the state hospitals are employees of Disability Rights California. The California Office of Patients' Rights is contracted by the Department of Mental Health to ensure that the treatment and legal rights of people receiving mental health treatment are maintained. Disability Rights California is a nonprofit agency that provides legal and other advocacy assistance to people with disabilities.

Under the contract with California's Department of Mental Health, Disability Rights California operates the California Office of Patients' Rights (C.O.P.R.) to provide support to Patients' Rights Advocates in the counties and employs a Patients' Rights Advocate at each State Hospital to directly advocate for the rights of people with psychiatric disabilities.

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to modify the Administration's trailer bill language regarding the Patients' Rights Office to allow the Department of Health Care Services and the Department of State Hospitals the ability to jointly contract with a nonprofit entity. Rather than requiring both state departments to enter into a contract.

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

1. Please provide a summary of trailer bill language regarding the Patients' Rights Office.

6. Elimination of Remaining Department of Mental Health Statutes

Budget Issue. The Administration proposes trailer bill language to eliminate statute referencing the Department of Mental Health (DMH) (i.e., the programs and statute remaining that is not proposed to be moved to another department).

These changes include, but are not limited, the elimination of statute referencing the:

- **Early Intervention Mental Health Program** - DMH does not implement this program and it is not proposed to be moved to another department.

- **Suicide Prevention Programs** – DMH created an Office of Suicide Prevention under an Executive Order and is funded through Mental Health Services Act funds.

- **Administration of State Institutions – Families of Persons with Serious Mental Disorders -** DMH indicates that this program has never been implemented. (It was intended to provide a self-help program for families who have family members in mental facilities at a statewide level.)

- **Primary Intervention Program –** The Early Mental Health Initiative program is proposed to be eliminated in the budget.

Subcommittee Staff Comment and Recommendation – Modify. It is recommended to adopt placeholder trailer bill language to eliminate statues that are no longer valid, such as statute referencing a report completed in 2001 regarding the Department of Youth Authority and the use of psychotropic medication; however, it recommended to not eliminate statute referencing programs created by the Legislature and the intention in which these programs were created.

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

1. Please provide an overview of this proposal.

B. 4140 Office of Statewide Health Planning and Development

1. Mental Health Services Act Workforce Education and Training Fund

Budget Issue. In the May Revision, the Administration is requesting a technical adjustment to the Governor's Budget as it relates to implementing the transfer of the Mental Health Services Act (MHSA) Workforce Education and Training (WET) program from the Department of Mental Health (DMH) to the Office of Statewide Health Planning and Development (OSHPD).

A one-time budget year appropriation of $15.0 million is required to support the WET program appropriated to OSHPD in accordance with AB 100. The following budget bill language is proposed to provide OSHPD with the authority to expend these funds:

Provisional Language for 4140-101-3085

X. The funds appropriated in this item are for the purposes of the Workforce, Education and Training (WET) programs established pursuant to Welfare and Institutions Code Sections 5820, 5821, and 5822. It is the intent of the Legislature that a total of $6,000,000 in WET funds be appropriated for purposes of Welfare and Institutions Code Sections 5820, 5821, and 5822 in a manner subject to the requirements set forth in Welfare and Institutions Code Sections 5820(a), 5820(e), and 5848 (a). It is further the intent of the Legislature that $9,000,000 be appropriated, for implementation of the Regional Partnerships component of the WET programs in equal amounts over a three year period beginning in 2014-15. The funds appropriated in this item are available for expenditure without regard to fiscal year.

Background. The Governor's January budget proposes to eliminate the Department of Mental Health. As part of this reorganization, coordination of the WET program is proposed to move to OSHPD. DMH recently conducted an audit of the Mental Health Services Act (MHSA) WET funds and found that $444.5 million of MHSA revenues were available for the WET program. Of this amount, $15 million has not been appropriated and must be set-aside in the MHSF for WET programs.

Subcommittee Staff Comment and Recommendation—Approve. This proposal is consistent with the MHSA and ensures that unexpended funds for the WET program are available in out years for this purpose.

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

1. Please provide an overview of this proposal.

C. 4265 Department of Public Health

1. Mental Health Services Act – California Reducing Disparities Project (DOF Issues 551 and 552)

Budget Issue. In the May Revision, the Administration requests an augmentation of $15 million from the Mental Health Services Fund (MHSF) per year for four years ($60 million total) for DPH to support the California Reducing Disparities Project (CRDP). These funds are to be augmented though the 3.5 percent state administrative cap of the MHSF and a new appropriation whereby funds may be spent without regard to fiscal year until the balance of funds are fully expended.

Background. The Governor's January budget proposes to eliminate the Department of Mental Health. As part of this reorganization, coordination of the CRDP is proposed to move to DPH. The CRDP is a project under the Prevention and Early Intervention component of the Mental Health Services Act. The initiative is focused on five populations: African Americans; Asian/Pacific Islanders; Latinos; Lesbian, Gay, Bi-sexual, Transgender, Questioning; and Native Americans. The project will develop population-specific reports that will form the basis of a statewide comprehensive strategic plan to identify new approaches to reduce disparities.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve the augmentation for CRDP and adopt the revised budget bill language:

Item 4265-001-3085 (DPH state support, Mental Health Services Act Fund)

Provisions:
1. It is the intent of the Legislature that a total of $60,000,000 for the California Reducing Disparities Project which seeks to improve timely access to mental health services for unserved and underserved populations in California by bringing forward community-defined solutions and recommendations developed by diverse workgroups comprised of community representatives shall be available over the course of four years beginning in fiscal year 2012-13. Contracts with entities representing focused populations to develop strategic planning workgroups are presently in effect to identify population-focused, culturally competent recommendations for reducing disparities in mental health services and to improve outcomes by identifying community-defined, strength-based solutions and strategies to eliminate barriers in the mental health service system. Results from these strategic planning workgroups are to be used to effectuate changes in the mental health system to reduce and mitigate multi-ethnic, sexual orientation, and cultural disparities.

Of the amount appropriated in this item, $15,000,000 is to fund the California Reducing Disparities Project beginning in 2012-13, and shall be available without regard to fiscal years.

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

1. Please provide an overview of this proposal.

2. Office of Health Equity

Budget Issue. The Administration proposes to create a new Office of Health Equity (OHE) at the Department of Public Health. This office would take a more comprehensive and integrative approach to address the issues of health disparity and promote healthy communities.

The OHE would be created by consolidating the following entities:

- Office of Multicultural Health (OMH) at DPH
- Office of Women's Health (OWH) at the Department of Health Care Services (DHCS)
- Office of Multicultural Services (OMS) at the Department of Mental Health (DMH)
- Health in All Policies Task Force (HiAP) at DPH
- Healthy Places Team at (HPT) DPH

Concerns were raised by various stakeholders at the April 12, 2012 Subcommittee #3 hearing on this proposal that the proposed trailer bill language was vague and provided no metrics to hold this new office accountable for improving health equities. Additionally, stakeholders were concerned that with the elimination of the existing offices, there would be a loss of focus on women's issues, for example.

Since the April 12, 2012 hearing, Legislative staff and stakeholders have worked together to strengthen the administration's proposal.

Subcommittee Staff Comment and Recommendation—Modify. It is recommended to adopt the revised placeholder trailer bill language to create a new Office of Health Equity.

This placeholder trailer bill language describes the duties of the office as:

(1) Conducting policy analysis and developing strategic policies and plans on specific issues affecting vulnerable communities and vulnerable places to increase access to services and supports, quality of care, and positive health and mental health outcomes for the communities described in subdivision (b) and decrease health and mental health disparities and inequities. The policies and plans should also include strategies to address social and environmental inequities and improve health and mental health.

(2) Establishing a comprehensive, cross-sectoral strategic plan to eliminate health and mental health disparities and inequities. The strategies and recommendations developed shall take into account the needs of the communities described in subdivisions (b) of this chapter and other defining characteristics to ensure strategies are developed throughout the state to eliminate health and mental health disparities and inequities. This plan should be developed in collaboration with the Health in All Policies Taskforce. This plan shall establish goals and benchmarks for specific strategies in order to measure and track disparities and the effectiveness of these strategies. This plan shall be updated periodically, but not less than every three years, to keep abreast of data trends, best practices, promising practices, and to more effectively focus and direct necessary resources to mitigate and eliminate disparities and inequities. The Office of Health Equity shall seek input from the public on the plan through an inclusive public stakeholder process.

(3) Working with state agencies and departments to consider health impacts of policies. The Office of Health Equity shall mirror and support the work of the Health in All Policies Taskforce and Strategic Growth Council in working with state agencies and departments to consider health in appropriate and relevant aspects of public policy development. The Office of Health Equity shall work collaboratively with the Health in All Policies Taskforce and Strategic Growth Council to assist state agencies and departments in developing policies, systems, and environmental change strategies that have population health impacts in the following ways:

(i) Develop intervention programs with universal and targeted approaches to address health and mental health inequities and disparities.

(ii) Prioritize building cross-sectoral partnerships within and across departments and agencies to changes policies and practices to advance health equity.

(iii) Provide a forum to identify and address the complexities of health and mental health inequities and disparities and the need for multiple, inter-related, and multi-sectoral strategies.

(iv) Provide technical assistance to state and local agencies and departments on building organizational capacity, staff training, and facilitating communication to implement strategies to reduce health and mental health disparities.

(v) Highlight and share evidence-based, evidence-informed, and community based promising practices on reducing health and mental health disparities and inequities.

(vi) Work with local public health departments, county mental health or behavioral health departments, local social services, and mental health agencies and other local agencies that address key health determinants including but not limited to housing, transportation, planning, education, parks, and economic development. The Office of Health Equity will seek to link local efforts with statewide efforts.

(4) Consulting with community based organizations and local governments agencies to ensure community perspectives and input are included in policies and any strategic plans, recommendations, and implementation activities.

(5) Assisting in coordinating projects funded by the state that pertain to increasing the health and mental health status of the communities described in subdivision (b).

(6) Identifying future service needs, trends, and unnecessary duplication of services, and providing information to impacted departments and state agencies.

(7) Providing consultation and technical assistance to state departments and other state and local agencies charged with providing or purchasing state-funded health and mental health care, in their respective missions to identify, analyze and report disparities and to identify strategies to address health and mental health disparities.

(8) Providing information and assistance to state and local departments in coordinating projects within and across state departments that improve the effectiveness of public health and mental health services to the communities described in subdivision (b) and that address community environments to promote health.

(9) Communicating and disseminating information within the department and with other state departments to assist in developing strategies to improve the health and mental health status of persons in communities described in subdivision (b) and to share strategies that address the social and environmental determinants of health.

(10) Encouraging innovative responses by public and private entities that are attempting to improve the health and mental health status of communities described in subdivision (b).

(11) Seeking additional resources, including in-kind assistance, federal funding, and foundation support.

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

1. Please provide an overview of this proposal.

2. What efforts has the department undertaken since the April hearing to reach out to stakeholders and solicit feedback? What were some key stakeholder concerns and how would you plan to address them?

3. April Letter – Special Fund Efficiency – Drinking Water Certification Program

Budget Issue. Through a Spring Finance Letter, DPH requested to eliminate the Residential Water Treatment Device Certification Program (and a reduction of $382,000 from the Water Device Certification Special Account). Currently, water devices require third party approval in addition to State certification. That approval is provided by an independent testing organization that has been accredited by American National Standards Institute (ANSI) or by the federal government.

California is only one of six states nationally that require water device products to have State certifications. According to DPH, eliminating California certification will have minimal impact on public health, as products will still require third party approval before being offered for sale in California.

Background. When a manufacturer claims that a drinking water treatment device will reduce contaminants or makes other health related performance claims, the device must be certified by DPH. The funding for the program is provided by fees collected from manufacturers for certifying water treatment devices. When a manufacturer desires certification for a new product, DPH assesses a fee of $1,400 to review the test data, determination compliance with California laws and regulations, and issue the certificate, which is good for five years. The manufacturer must then pay an annual renewal fee of $400 to continue to have the device listed in the DPH directory and on the DPH website. After five years, the product must be recertified (new test data submitted) and the fee is $1,400 for the recertification. The fee to revise the certification for a product that has been modified after initial certification is $300. Currently, there are approximately 300 certified devices.

Subcommittee Staff Comment and Recommendation—Reject. On May 10, 2012, this Subcommittee approved this proposal. However, concerns have been raised that removing the state's role in certifying these water devices could impact public health. It is important for the state to approve technologies for specific contamination types and review how the technology is being used in California. Leaving the approval in the hands of a third-party entity, does not ensure that state's public health is the primary focus of the certification. Consequently, it is recommended to reject this proposal.

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

1. Please provide an overview of this proposal.

2. How could the elimination of this program impact public health?

D. 4260 Department of Health Care Services

1. Cash Flow Loan for the County Medical Services Program

Budget Issue. The May Revision proposes trailer bill language that would permit the Director of Finance to approve no more than $100 million General Fund in cash flow loans in fiscal years 2012-13 and 2013-14 for County Medical Services Program (CMSP) Governing Board expenditures associated with a Low Income Health Program (LIHP) operated by the CMSP Governing Board. Any cash flow loans made would be considered short term and would not constitute General Fund expenditures. The loans and their repayment would not affect the General Fund reserve. Interest on this loan would be charged at the Pooled Money Investment Account rate.

The CMSP Governing Board elected to administer a LIHP; however, due to the fiscal challenges its member counties currently face, it requires a loan to bridge the time between when it will be required to pay out its first claims and when federal funds will begin to flow back to the program. This proposal would allow the CMSP Governing Board, upon approval from the Director of Finance, access to a cash flow loan of no more than $100 million over two fiscal years, 2012-13 and 2013-14, in order to ensure the Board's ability to maintain a financially solvent LIHP.

Background. The CMSP provides health care coverage to low-income adults who are ineligible for Medi-Cal in 34 counties, and, effective July 1, 2012, 35 counties. The CMSP Governing Board was established in 1995 and has overall program and fiscal responsibility for the program.

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

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

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this placeholder trailer bill language. This would ensure that CMSP is able to administer a LIHP.

It should be noted that Senator Wolk's SB 1517 is similar to the proposed trailer bill language and authorizes a $30 million loan to CMSP to cover its LIHP startup costs.

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

1. Please provide an overview of this proposal.

2. Children Services Program/Medical Therapy Program Financial Test

Budget Issue. The DHCS proposes trailer bill language to apply financial eligibility requirements to qualify for the California Children's Services (CCS) Medical Therapy Program (MTP). These financial eligibility requirements would be:

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

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

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

Background. The CCS MTP provides physical therapy, occupational therapy, and medical therapy conference services to children who meet specific medical criteria. These services are provided in an outpatient clinic setting known as the Medical Therapy Unit (MTU) that is located on a public school site. Currently, 24,433 CCS children are served by 125 school based MTUs operated by county CCS programs. Therapists at these sites are employed by the county.

Of these children, 14,273 have an Individual Education Program (IEP) under the provisions of the federal Individuals with Disabilities Education Act (IDEA). By federal law, schools are required to provide all therapy services included in a child's IEP, including "medical" therapy. However, it is generally understood that medical therapy services provided at an MTU and included in a child's IEP are paid for by CCS (state and county funds) and educational therapy services not provided at the MTU are funded by the schools.

Subcommittee Staff Comment and Recommendation—Reject. It is recommended to reject the Administration's proposal to add a financial eligibility test for CCS/MTP.

Instead it is recommended to use available federal special education funds to cover the costs of providing services to children with IEPs who receive therapy (that is included in the IEP) at an MTU. A conservative estimate of these costs is $24.6 million ($12.2 million General Fund and $12.4 million county funds). This reflects that 5,352 children would now be covered using special education funds with annual cost per child at an MTU of $4,595. This estimate is based on 75 percent (or 10,705) of the 14,273 children with an IEP receiving therapy at an MTU that is included in their IEP and of these children, 50 percent (or 5,352) of therapy is included in the IEP and covered under federal special education law.

Additionally, it is recommended to adopt placeholder trailer bill language to implement this alternative and budget bill language allowing the Department of Finance to adjust this estimate with notification to the Joint Legislative Budget Committee based on additional information

provided by the MTUs. DHCS is currently working with the MTUs to collect additional data, to get a better understanding of the number of children this may impact.

The subcommittee staff recommendation would require schools to pay for all therapies included in a child's IEP, including medical, (as required by federal law) and to provide schools with this additional special education funding to cover the increased cost. Under this scenario, the state would continue to require MTUs to provide medically necessary therapies, but placeholder language would specify that medically necessary therapies included in an IEP would not be the financial responsibility of the CCS, but would be funded by the schools.

Conforming action would be made on the education items.

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

1. Please provide a summary of the Subcommittee staff recommendation.

3. Value Based Purchasing

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

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

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

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

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

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

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

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation. It is recommended to do the following:

- Reject the Administration's proposed trailer bill language. The proposed Value-Based Purchasing process is outside the current regulatory framework which has established safeguards to ensure stakeholder participation and disclosure of departmental actions.
- Approve the $30 million in General Fund savings as a result of Medi-Cal no longer paying for services directly related to potentially preventable hospital admissions. Changes to statute or regulations are not necessary to implement these savings.

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

1. Please provide an overview of this proposal.

4. Eliminate Sunset Date for Nursing Home Quality Assurance Fee

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

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

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

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

Subcommittee Staff Comment and Recommendation. It is recommended to:

- Reject the Administration's trailer bill language to eliminate the sunset date for the nursing home quality assurance fee.
- Adopt placeholder trailer bill language that extends the nursing home quality assurance fee sunset date for two years (until July 31, 2015) and creates a special fund to deposit the QAF revenues.

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

1. Please provide a brief summary of this proposal.

5. Nursing Home Rate Reduction (DOF Issue 130)

Budget Issue. In the May Revision, the Administration proposes various rate reductions to skilled nursing facilities (SNFs) and subacute care units that generate $70.9 million in General Fund savings. These proposals are to:

1. Rescind a rate increase in 2012-13 that is up to the difference between 2.4 percent and the rate increase provided in 2011-12 for a savings of $33 million General Fund.

2. Delay the implementation of the Quality and Accountability Supplemental Payment System (QASP) until April 2014 and the redirect the 1 percent set-aside for QASP to the General Fund. This would result in $23.3 million in General Fund savings.

3. Recognize $13.2 million additional General Fund savings as a result of additional revenue from the quality assurance fee.

Included as part of these savings is keeping the savings from capping the professional liability insurance (PLI) at the 75th percentile in the General Fund instead of transferring it to the Skilled Nursing Quality and Accountability Special Fund ($8.5 million total funds, $4.25 million General Fund).

Background. AB 1629 (Statutes of 2004) changed the methodology for calculating reimbursement rates for freestanding SNFs and subacute units of those freestanding SNFs and allowed DHCS to assess a Quality Assurance Fee (QAF) to provide a revenue stream to fund the higher payments to SNFs under the new reimbursement methodology.

ABX1 19 (Statutes of 2011) mandated the following changes:

- Provided a rate increase of no more than 2.4 percent in 2012-13 rate year (resulting from the difference between the 2.4 percent increase and the actual rate increase from the 2011-12 rate year);
- Terminated the 10 percent reductions, as required by AB 97 (Statutes of 2011), on August 1, 2012, for AB 1629 SNFs;
- Held harmless facilities from rates that are less than their rate that was on file as of May 31, 2011;
- Provided a one-time supplemental payment in the 2012-13 rate year that is equivalent to the 10 percent reduction applied from June 1, 2011, to July 31, 2012, for Medi-Cal fee-for-service SNFs;
- Delayed until rate year 2012-13 the set-aside to the Quality and Accountability Supplemental Payment System (QASP) of 1 percent of the AB 1629 facilities reimbursement rate; and
- Delayed implementation of the QASP for one year.

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

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

1. Please provide an overview of this proposal including its interactions with ABX1 19.

6. Public Hospitals and Low Income Health Programs

Issue. State statute allows Low Income Health Programs (LIHPs) to be reimbursed under a capitated model. It also requires an LIHP to agree to a capitated rate with DHCS during a given demonstration year. That rate may then be implemented retroactively back to the first day of the demonstration year if it is agreed upon during the same demonstration year.

Public hospital systems are prepared to evolve their Low Income Health Programs from fee-for-service to risk-based programs to using capitated rates, but there is concern that federal approval of the proposed rates and subsequent agreement between LIHP and DHCS will not be finalized before June 30, 2012, the end of the current demonstration year. This would mean that these LIHPs would lose the ability to go capitated during the current demonstration year resulting in a loss of significant federal reimbursement.

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

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

Subcommittee Staff Comment and Recommendation. It is recommended to adopt technical trailer bill language to preserve the state's option under the existing 1115 Medi-Cal Waiver with the federal government to utilize a capitation rate under the LIHP. It is necessary to take this action before June 30, 2012. The technical trailer bill language is below:

1. Amend Section 15911 (e) as follows:

Section 15911 (e).

Notwithstanding Section 15910.3 and subdivision (d) of this section, if the participating entity cannot reach an agreement with the department as to the appropriate rate to be paid under Section 15910.3, at the option of the participating entity, the LIHP shall be reimbursed on a cost basis in accordance with the methodology applied to Health Care Coverage Initiative programs established under Part 3.5 (commencing with Section 15900), including interim quarterly payments. If the participating entity and the department reach an agreement as to the appropriate rate, the rate shall be applied no earlier than the first day of the LIHP year in which the parties agree to the rate, except that for the LIHP year ending June 30, 2012, the rate may apply as early as July 1, 2011 without regard to the date of the agreement between the participating entity and the department.

2. Add Legislative Intent Language as follows:

The department, in consultation with a number of the Low-Income Health Programs (LIHPs), has proposed LIHP capitation rates for federal approval. However, federal approval of the proposed rates may not be received and implemented through contract amendments before June 30, 2012. This statutory amendment would allow the federally approved capitation rates to apply to the LIHP year (July 1, 2011 through June 30, 2012), even if federal approval and the necessary contract amendments are not finalized until after June 30, 2012. Therefore, it is the Legislature's intent in amending Section 15911(e) to allow the LIHP capitation rates to apply for FY 2011-2012, even if final agreements on the capitation rates are delayed while awaiting federal approval and are not finalized until after June 30, 2012.

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

1. Please provide a summary of this issue and proposed technical trailer bill language.

7. Hospital Quality Assurance Fee Background & Technical Adjustment (DOF Issue 123)

Budget Issue. The May Revision reflects a decrease of $85 million General Fund to reflect the shift of $85 million in hospital quality assurance fee collection from the current year to the budget year. This is a result of not yet receiving federal CMS approval of the fee.

The May Revision estimates that the Hospital Quality Assurance Fee will bring in $2.9 billion in revenue and will be used to draw down $2.3 billion in federal funds in 2012-13. Of this $537 million would be for children's health care coverage.

Background. AB 1383 (Jones, Statues of 2009) authorized the implementation of a quality assurance fee (QAF) on applicable general acute care hospitals during April 2009 through December 2010. The fee was deposited into the Hospital Quality Assurance Revenue Fund (HQARF) created by AB 188 (Jones, Statutes of 2009). This fund is used to provide supplemental payments to private and nondesignated public hospitals (NDPHs), grants to designated public hospitals (DPHs), and increased payments to managed health care and mental health plans. The fund is also used to pay for health care coverage for children and for staff and related administrative expenses required to implement the QAF program.

AB 1653 (Jones, Statutes of 2010) and SB 208 (Steinberg, Statutes of 2010) revised the Medi-Cal hospital provider fee and supplemental payments enacted by AB 1383. AB 1653 altered the methodology, timing, and frequency of supplemental payments, increased capitation payments, and increased payments to mental health plans. AB 1653 also allowed the State to retain up to $420 million from the portion of the QAF fund set aside for direct grants to DPHs for the State's use while the bill is in effect. In exchange, a portion of federal flexibility funding was allocated to the DPHs and was identical to the amount of the sum retained by the State from the QAF fund. The Department claimed these federal funds upon receipt of the necessary expenditure reports and certifications from the public hospitals, and distributed those funds in conformity with the Hospital QAF payment schedule. SB 208 compressed the timeframe for collection of the QAF and distribution of supplemental payments, allowed accumulation of fees in the HQARF in order to make managed care payments, and altered the priority of payments.

SB 90 (Steinberg, Statutes of 2011) extended the QAF program established by AB 1383, for the period of January 2011 through June 2011. The extension provided for supplemental payments to private hospitals, increased payments to managed health care, and mental health plans if enough fees were collected to warrant payments. It also provided funding for health care coverage for children and for staff and related administrative expenses.

SB 335 (Hernandez, Statutes of 2011) creates a new QAF program for the period July 2011 through December 2013. This 30 month program was modeled on the original QAF program and two quarter extension. This program provides for supplemental payments to private hospitals, grants to DPHs and NDPHs, increased payments to managed health care, and mental health plans if enough fees are collected to warrant payments. It also provided funding for health care coverage for children and for staff and related administrative expenses.

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

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

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

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

DHCS is working with CMS on approval for this QAF.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve this technical adjustment.

1. Please provide a brief overview of the hospital quality assurance fee.

2. What is the status of federal approval of the current hospital quality assurance fee?

8. Hospital Quality Assurance Fee Positions

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

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

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

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

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

Subcommittee Staff Comment and Recommendation–Approve. This issue was heard at the March 22, 2012 Subcommittee #3 hearing and was held open to get further updates from DHCS on the status of CMS's approval of the fee. DHCS is still working with CMS on approval of this fee. It is recommended to approve this item to implement SB 335.

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

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

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

9. May Revision – Hospital Solutions Summary and Background

The May Revision includes several hospital payment savings proposals. The Medi-Cal program currently spends about $15 billion ($3.4 billion General Fund) on hospitals. The chart below (provided by DHCS) summarizes these proposals (which are discussed later).

Table: Hospital Solutions Summary of Governor's May Revision Proposal (in millions)

	General Fund			Net Hospital Impact		
	FY12-13	**FY13-14**	**Total**	**FY12-13**	**FY13-14**	**Total**
Non-Designated Public Hospitals (46)						
Eliminate Current In-Patient (IP) Fee-For-Services (FFS) Methodology	$ (76.42)	$(76.42)	$(152.84)	$(152.84)	$(152.84)	$(305.69)
Eliminate Current NDPH Supplemental Pool	(1.90)	(1.90)	(3.80)	(3.80)	(3.80)	(7.60)
Eliminate AB113 Inter-Governmental Transfer Supplemental Payment	3.32	3.32	6.64	(31.68)	(31.68)	(63.36)
Convert to IP FFS CPE	-	-	-	100.00	100.00	200.00
New Safety Net Care Pool (SNCP) Uncompensated Care (FFP only)	-	-	-	30.00	40.00	70.00
New Delivery System Reform Incentive Pool (DSRIP) (Only FFP shown here, funded by IGT)	-	-	-	30.00	60.00	90.00
NDPH Subtotal	$(75.00)	$(75.00)	$(150.00)	$(28.32)	$11.68	$(16.64)
Designated Public Hospitals (21)						
Health Care Coverage Initiative (HCCI) Rollover	$(100.00)	$(9.00)	$(109.00)	$(100.00)	$(9.00)	$(109.00)
Fee-funded Direct Grants	-	(21.50)	(21.50)	-	(21.50)	(21.50)
Fee-funded managed care (through increased children's coverage amount)	-	(20.00)	(20.00)	-	(40.00)	(40.00)
DPH Subtotal	$(100.00)	$(50.50)	$(150.50)	$(100.00)	$(70.50)	$(170.50)
Private Hospitals (~300)						
Increase children's coverage (decreased managed care for private hospitals)	$(150.00)	$(75.00)	$(225.00)	$(300.00)	$(150.00)	$(450.00)
Diagnosis-Related Group (DRG) Savings*	-	$(75.00)	$(75.00)	-	$(150.00)	$(150.00)
Private Subtotal	$(150.00)	$(150.00)	$(300.00)	$(300.00)	$(300.00)	$(600.00)
Total Hospital Solutions	***$ (325.00)***	***$(275.50)***	***$(600.50)***	***$(428.32)***	***$(358.82)***	***$(787.14)***

*Assumes DRG implementation date is July 1 2013.

10. Non-Designated Public Hospitals – Change Reimbursement Methodology (DOF Issue 131)

Budget Issue. The May Revision proposes to change the reimbursement methodology of non-designated public hospitals (NDPH). Currently, NDPHs receive either the California Medical Assistance Commission (CMAC) negotiated per diem rates or cost-based reimbursement for inpatient Medi-Cal fee-for-service (FFS). These reimbursements are paid with 50 percent General Fund and 50 percent federal funds. With the proposed change in methodology, NDPHs would be funded for their inpatient Medi-Cal FFS in the same manner as Designated Public Hospitals in that they would use their certified public expenditures (CPEs) to draw down federal funds. This would result in $75 million General Fund savings (as General Fund would no longer be used to reimburse NDPHs).

In addition, qualified NDPHs receive supplemental reimbursements from the NDPH Supplemental Fund, which is funded with 50 percent General Fund and 50 percent federal funds. This supplemental reimbursement would no longer be available, resulting in a General Fund savings of $1.9 million.

Finally, NDPHs would no longer be eligible for the supplemental payments authorized by AB 113 (Statutes of 2011), which are funded by intergovernmental transfers and federal funds.

Table: May Revision Impact on Non-Designated Public Hospitals (in millions)

	General Fund			Net Hospital Impact		
	FY12-13	**FY13-14**	**Total**	**FY12-13**	**FY13-14**	**Total**
Non-Designated Public Hospitals (46)						
Eliminate Current In-Patient (IP) Fee-For-Services (FFS) Methodology	$ (76.42)	$(76.42)	$(152.84)	$(152.84)	$(152.84)	$(305.69)
Eliminate Current NDPH Supplemental Pool	(1.90)	(1.90)	(3.80)	(3.80)	(3.80)	(7.60)
Eliminate AB113 Inter-Governmental Transfer Supplemental Payment	3.32	3.32	6.64	(31.68)	(31.68)	(63.36)
Convert to IP FFS CPE	-	-	-	100.00	100.00	200.00
New Safety Net Care Pool (SNCP) Uncompensated Care (FFP only)	-	-	-	30.00	40.00	70.00
New Delivery System Reform Incentive Pool (DSRIP) (Only FFP shown here, funded by IGT)	-	-	-	30.00	60.00	90.00
NDPH Subtotal	$(75.00)	$(75.00)	$(150.00)	$(28.32)	$11.68	$(16.64)

Under this proposal, DHCS would seek a waiver amendment to increase Safety Net Care Pool (SNCP) and Delivery System Reform Incentive Pool (DSRIP) funding available to California. The additional funds would be made available to NDPHs to offset their uncompensated care costs and to support their efforts to enhance the quality of care and the health of the patients and families they serve. NDPHs are currently not eligible for these funds.

Because they would no longer be funded with General Fund, NDPHs would be exempt from the Diagnosis-Related Group (DRG) payment methodology for inpatient services that will replace the current inpatient reimbursement methodology effective July 1, 2013.

Background. NDPHs are publicly owned and operated facilities, the majority of which are operated by health care districts. There are approximately 46 NDPHs. Approximately 16 of the NDPHs are designated as Critical Access Hospitals (CAHs) under Medicare. To be designated a CAH, a hospital must be located in a rural area; provide 24-hour emergency services; have an average length of stay for its patients of 96 hours or less; be located more than 35 miles (or more than 15 miles in areas with mountainous terrain) from the nearest hospital; and have no more than 25 beds.

Safety Net Care Pool (SNCP). Under the current Medi-Cal 1115 Waiver, the Safety Net Care Pool Uncompensated Care (SNCP) pool includes $7.1 billion over five years (from October 1, 2010 – October 31, 2015) to be used to reimburse Public Hospitals for uncompensated care costs. Additionally, the state will be able to access up to $400 million (and receive a federal match) annually for the state designated programs.

Delivery System Reform Incentive Pool (DSRIP). The current Medi-Cal 1115 Waiver includes the opportunity for Public Hospitals to receive up to $3.3 billion over five years (from October 1, 2010 – October 31, 2015) through the Delivery System Reform Incentive Pool (DSRIP). This pool is a subset of the Safety Net Care Pool. The DSRIP is intended to support California's Public Hospitals' efforts in enhancing the quality of care and the health of the patients and families they serve. Individual Public Hospital systems will submit proposals for state and federal approval that are focused on improving the experience of care, improving the health of populations, and reducing per capita costs of health care.

Subcommittee Staff Commend and Recommendation—Hold Open. It is recommended to hold this item open as discussions continue on this topic.

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

1. Please provide an overview of all the proposed changes to Non-Designated Public Hospitals.

11. Designated Public Hospitals – Unexpended Public Hospital Waiver Funds (DOF Issue 132)

Budget Issue. The May Revision proposes to allow the state to retain 50 percent of the federal funding attributable to the Health Care Coverage Initiative (HCCI) rollover that would have gone to Designated Public Hospitals (DPHs). There is a total of $218 million in rollover.

With this proposal, Designated Public Hospitals (DPHs) would voluntarily utilize their certified public expenditures (CPE) to claim the additional Safety Net Care Pool Uncompensated Care (SNCP) and allow the state obtain 50 percent of this federal funding. This proposal relies on DPHs spending their CPEs to draw down federal funds, of which the state is proposing to take 50 percent.

In addition, this proposal requires that, to the extent necessary for the State to achieve its designated General Fund savings of $400 million for SNCP, DPHs would allow the State to utilize their excess CPE.

This proposal would result in $100 million in General Fund savings in 2012-13.

Table: May Revision Impact on Designated Public Hospitals (in millions)

	General Fund			Net Hospital Impact		
	FY12-13	FY13-14	Total	FY12-13	FY13-14	Total
Designated Public Hospitals (21)						
Health Care Coverage Initiative (HCCI) Rollover	$(100.00)	$(9.00)	$(109.00)	$(100.00)	$(9.00)	$(109.00)
Fee-funded Direct Grants	-	(21.50)	(21.50)	-	(21.50)	(21.50)
Fee-funded managed care (through increased children's coverage amount)	-	(20.00)	(20.00)	-	(40.00)	(40.00)
DPH Subtotal	$(100.00)	$(50.50)	$(150.50)	$(100.00)	$(70.50)	$(170.50)

Background. The Bridge to Reform (BTR) Medi-Cal 1115 Waiver includes federal funding available to counties for the Health Care Coverage Initiative (HCCI) component of the Low Income Health Program (LIHP) to provide coverage to uninsured individuals between 133 percent and 200 percent of the federal poverty limit.

Under the Bridge to Reform (BTR) Medi-Cal Waiver, $360 million in total funding is available annually, through December 2013, for counties to establish HCCI coverage programs under their Low Income Health Programs (LIHPs), for individuals between 133 percent and 200 percent of the federal poverty limit. Based on the current LIHP contracts, significant HCCI funding will remain unclaimed; therefore, in 2011 DHCS submitted a Waiver amendment to CMS to rollover unclaimed HCCI funding into the SNCP Uncompensated Care component.

Additionally, as discussed in the item above, under the current Medi-Cal 1115 Waiver, the state has access up to $400 million (and receive a federal match) annually for state designated programs. This proposal would allow the state to use Designated Public Hospital's CPEs for claim federal funding for SNCP.

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

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

1. Please provide an overview of this proposal.

12. Redirect Hospital Fee Revenue (DOF Issue 133)

Budget Issue. The May Revision proposes to make changes to hospital fee revenue allocations for a total of $150 million General Fund savings in 2012-13. These changes include:

- Redirecting $150 million in hospital fee revenue in 2012-13 to the General Fund. This revenue was intended to fund supplemental payments to private hospitals by managed care plans.
- Redirecting $95 million in fee revenue in 2013-14 to the General Fund. Under current law, this funding would be provided to managed care plans ($75 million would have supported supplemental payments to private hospitals and $20 million for supplemental payments to designated public hospitals).
- Eliminating direct grants to designated public hospitals in 2013-14 ($21.5 million) and would instead use the funds for children's health coverage under Medi-Cal.

Table: May Revision Impact on Private and Designated Public Hospitals (in millions)

	General Fund			Net Hospital Impact		
	FY12-13	**FY13-14**	**Total**	**FY12-13**	**FY13-14**	**Total**
Designated Public Hospitals (21)						
Health Care Coverage Initiative (HCCI) Rollover	$(100.00)	$(9.00)	$(109.00)	$(100.00)	$(9.00)	$(109.00)
Fee-funded Direct Grants	-	(21.50)	(21.50)	-	(21.50)	(21.50)
Fee-funded managed care (through increased children's coverage amount)	-	(20.00)	(20.00)	-	(40.00)	(40.00)
DPH Subtotal	$(100.00)	$(50.50)	$(150.50)	$(100.00)	$(70.50)	$(170.50)
Private Hospitals (~300)						
Increase children's coverage (decreased managed care for private hospitals)	$(150.00)	$(75.00)	$(225.00)	$(300.00)	$(150.00)	$(450.00)
Diagnosis-Related Group (DRG) Savings*	-	$(75.00)	$(75.00)	-	$(150.00)	$(150.00)
Private Subtotal	$(150.00)	$(150.00)	$(300.00)	$(300.00)	$(300.00)	$(600.00)

Background. DHCS implemented California's first hospital provider fee and supplemental payment program for the period of April 1, 2009, through December 31, 2010. That program resulted in fee collections of $3 billion, and hospital payments of $5.7 billion. Fee revenue of $560 million was retained by the state to pay for health care coverage for children. The program was initially extended for the additional six month period of January 1 through June 30, 2011. The six month program resulted in fee collection of $1 billion, hospital payments of

$1.9 billion, and $210 million in General Fund offsets to pay for health care coverage for children.

SB 335 (the most recent hospital fee legislation) extended the fee program through December 31, 2013, and is projected to generate approximately $7.1 billion in fees from hospitals during the program period. Approximately $6.1 billion will be used to draw down an equal amount in additional federal funds in order to increase Medi-Cal payments to private hospitals and managed care plans. About $920 million will be retained to offset General Fund costs to pay for health care coverage for children. SB 335 set up various hospital payments, including supplemental fee-for-service payments made directly to private hospitals, increased payments to managed health care plans for the purposes of providing supplemental payments to private and designated public hospitals, direct grants to designated and non-designated public hospitals, and funding for children's health care coverage.

According to DHCS, hospital services represent the largest expenditure within the Medi-Cal program. These changes will enable the State to ensure continued support for children's health care coverage, while still providing for significant supplemental payments to hospitals under the fee program. With the proposed changes, about 81 percent of hospital fee revenue would be used to fund increased payments to hospitals and about 19 percent would be retained for General Fund savings. Fee revenue is projected to be $2.8 billion for 2012-13 and supplemental reimbursement to hospitals would total $4.6 billion with matching federal funds.

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

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

1. Please provide an overview of this proposal.