

SUBCOMMITTEE #3: Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson



February 1st, 2011

1:00 PM

Room 4203
(John L. Burton Hearing Room)

(Diane Van Maren)

Item

Department

Vote Only Calendar

4265 Department of Public Health
4260 Department of Health Care Services
4440 Department of Mental Health

Issues for Discussion

4265 Office of AIDS, Department of Public Health
• AIDS Drug Assistance Program

4440 Department of Mental Health
• Proposal on Proposition 63 and Realignment
• Community Mental Health
• State Hospitals
• Other Programs and Administration

4265 Department of Public Health
• Every Woman Counts Program
• Women Infant and Children's Supplemental Food (WIC) Program
• Other Federal Grant Programs

PLEASE NOTE:

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

Vote Only Calendar:

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

1. Genetic Disease Testing Program

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

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

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

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

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

2. Federal Affordable Care Act: Pregnant and Parenting Teens

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

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

DPH states the purposes of these funds are to:

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

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

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

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

3. Lupus Surveillance in California

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

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

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

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

4. Federal Affordable Care Act: Tobacco Cessation

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

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

5. Sodium Reduction in Communities

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

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

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

6. Federal ARRA: Communities Putting Prevention to Work

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

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

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

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

7. Implementation of AB 2300 regarding Genetic Counseling Licensure

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

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

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

8. Federal Affordable Care Act: Personal Responsibility Education Program

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

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

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

9. Accountability Payment System-- Contract

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

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

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

Vote Only Calendar:

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

1. Family Health Programs—Three Programs

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

- *Genetically Handicapped Persons Program (GHPP).* Total expenditures of \$92 million (\$87.8 million General Fund, \$4 million Rebate Fund, and \$197,000 Enrollment Fees) are proposed for 2011-12. This reflects technical fiscal adjustments and caseload only.
- *California Children’s Services Program (CCS).* Total expenditures of \$298.1 million (\$140.5 million General Fund and \$157.7 million federal funds) are proposed for 2011-12. This reflects technical fiscal adjustments and caseload only.
- *Child Health & Disability Prevention (CHDP) Program.* Total expenditures of \$2.5 million (\$2.5 million General Fund, and \$8,000 Children’s Lead Poisoning Prevention Funds) are proposed for 2011-12. This reflects technical fiscal adjustments and caseload only.

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

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

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

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

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

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

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

Background: The Child Health & Disability Prevention Program (CHDP).

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

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

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

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

Vote Only Calendar:

C. Department of Mental Health

1. Legal Resources Request

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

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

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

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

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

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

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

Issues for Discussion:

A. Office of AIDS, Department of Public Health

AIDS Drug Assistance Program: Two Issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Current caseload is about 174 cases.

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

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

- Pre-Existing Condition Insurance Program (PCIP). As discussed in Subcommittee on January 26th, California received federal approval and an allocation of \$761 million (federal funds) to operate a high risk health insurance pool. PCIP offers health coverage to *medically uninsurable* individuals 18 years or older who live in California. It is available for people who did not have health coverage in the 6-months prior to applying. PCIP uses a preferred provider network that has contracted health providers in all 58 counties statewide. Monthly premium costs are based on the applicant's age and the region where the applicant lives. PCIP is to provide health care coverage for eligible individuals through December 31, 2013,
- Low-Income Health Program. Under the recently approved 1115 Medicaid Waiver, administered by the Department of Health Care Services, Counties can access additional federal funds to provide for health care to low-income individuals who previously were not eligible for Medi-Cal. These projects are commencing and it is reasonable to assume some ADAP expenditures will shift to this program on the natural.

Background: ADAP Rebate Fund. Drug rebates constitute a significant part of the annual ADAP budget. This special fund captures all drug rebates associated with ADAP, including *both* mandatory (required by federal Medicaid law) and *voluntary* supplemental rebates (additional rebates negotiated with 14 drug manufacturers through ADAP Taskforce).

Generally, for every dollar of ADAP drug expenditure, the program obtains 46 cents in rebates. This 46 percent level is based on an average of rebate collections (both “mandatory” and “supplemental” rebates).

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

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

Background—ADAP is Cost-Beneficial to the State. Without ADAP assistance to obtain HIV/AIDS drugs, individuals would be forced to: (1) postpone treatment until disabled and Medi-Cal eligible, or (2) spend down their assets to qualify, increasing expenditures under Medi-Cal. According to the Administration, 50 percent of Medi-Cal costs are borne by the State, whereas only 30 percent of ADAP costs are borne by the state. Studies consistently show that early intervention and treatment adherence with HIV/AIDS-related drugs prolongs life, minimizes related consequences of more serious illnesses, reduces more costly treatments, and increases an HIV-infected person’s health and productivity.

Subcommittee Staff Comment and Recommendation. The following actions are recommended:

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

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

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

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

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

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

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

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

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

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

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

Table: Administration’s Cost-Sharing Methodology

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

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

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

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

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

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

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

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

Individuals are eligible for ADAP if they:

- Reside in California;
- Are HIV-infected;
- Are 18 years of age or older;
- Have an adjusted federal income that *does not exceed* \$50,000;
- Have a valid prescription from a licensed CA physician; and
- Lack private insurance that covers the medications or do not qualify for no-cost Medi-Cal.

The ADAP is the *payer of last resort*. Individuals who have private health insurance, are eligible for Medi-Cal, or are eligible for Medicare, must access these services *first*, before the ADAP will provide services. The following chart provides a summary of estimated ADAP client enrollment.

ADAP Clients by Coverage Group (2011-12)

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

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

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

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

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

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

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

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

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

B. Department of Mental Health: Community Mental Health

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

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

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

- (1) Mental Health Managed Care (\$183.6 million);
- (2) Early and Periodic Screening, Testing and Treatment Program (\$579 million); and
- (3) AB 3632—mental health services to special education students (\$98.6 million).

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

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

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

Key aspects of this proposal are discussed below.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Most of the Act's funding is to be expended by County Mental Health for mental health services consistent with their approved local plans (3-year plans with annual updates) *and* the required five components as contained in the Act. The following is a brief description of the five components:

- **Community Services and Supports.** This component represents the programs and services identified by each County Mental Health Department through its stakeholder process to serve unserved and underserved populations, with an emphasis on eliminating disparity in access and improving mental health outcomes for racial/ethnic populations and other unserved and underserved populations.

- **Prevention and Early Intervention.** This component supports the design of programs to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for unserved and underserved populations.
- **Innovation.** The goal of this component is to develop and implement promising practices designed to increase access to services by underserved groups, increase the quality of services, improve outcomes, and to promote interagency collaboration.
- **Workforce Education and Training.** The component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness.
- **Capital Facilities and Technological Needs.** This component addresses the capital infrastructure needed to support implementation of the Community Services and Supports, and Prevention and Early Intervention programs. It includes funding to improve or replace existing technology systems and for capital projects to meet program infrastructure needs.

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

Background: Mental Health Managed Care (Adults) and Existing Waiver.

California provides “specialty” mental health services under a comprehensive federal Waiver that includes outpatient specialty mental health services, such as clinic outpatient services, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services.

County Mental Health Plans are the responsible entity that ensures services are provided and Medi-Cal clients *must* obtain their specialty mental health services through the County. County Mental Health Plans contract with local providers to provide services.

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

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

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

Background: Early and Periodic Screening, Testing & Treatment (Children). Most children receive Medi-Cal services through EPSDT. Specifically, EPSDT is a federally mandated program that requires States to provide Medicaid (Medi-Cal) recipients under age 21 any health or mental health services that is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified by an assessment, including services not otherwise included in a State's plan. Examples of mental health services include a family therapy, crisis intervention, medication monitoring, and behavioral management modeling.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Department of Mental Health: State Hospitals

Background and Description of State Hospital Patient Population. The DMH directly administers the operation of five State Hospitals—Atascadero, Coalinga, Metropolitan, Napa and Patton--, and two acute psychiatric programs at the California Medical Facility in Vacaville and the Salinas Valley State Prison.

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

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

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

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

Judicially committed patients are treated *solely* using state General Fund support. The majority of the General Fund support for these judicially committed patients is appropriated through the Department of Mental Health (DMH), along with some reimbursement from the CDCR, primarily for services provided at the two acute psychiatric programs.

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

The DMH uses a protocol for establishing priorities for penal code placements. This priority is used because there are not enough secure beds at the State Hospitals to accommodate all patients. This is a complex issue and clearly crosses over to the correctional system administered by the CDCR. The DMH protocol is as follows:

1. Sexually Violent Predators have the utmost priority due to the considerable public safety threat they pose.
2. Mentally Disordered Offenders have the next priority. These patients are former CDCR inmates who have completed their sentence but have been determined to be too violent to parole directly into the community without mental health treatment.
3. *Coleman v. Schwarzenegger* patients must be accepted by the DMH for treatment as required by the federal court. *Generally* under this arrangement, the DMH must have State Hospital beds available for these CDCR patients as required by the

Special Master, J. Michael Keating Jr. If a DMH bed is not available the inmate remains with the CDCR and receives treatment by the CDCR.

4. Not Guilty by Reason of Insanity is the next priority.
5. Incompetent to Stand Trial is the last priority. It should be noted that there are about 250 to 300 individuals who are incompetent to stand trial who are presently residing in County jails due to the shortage of beds within the State Hospital system.

Background—Deficiencies at State Hospitals Lead to US DOJ Consent Judgment Regarding CRIPA. In July 2002, the U.S. DOJ completed an on-site review of conditions at Metropolitan State Hospital. Recommendations for improvements at Metropolitan in the areas of patient assessment, treatment, and medication were then provided to the DMH. Since this time, the U.S. DOJ identified similar conditions at Napa, Patton, and Atascadero (Coalinga was not involved). The Administration and US DOJ finally reached a Consent Judgment for an “Enhanced Plan” of operations on May 2, 2006.

The Consent Judgment also appointed a Court Monitor to review implementation of the Enhanced Plan and to ensure compliance. Failure to comply with the Enhanced Plan would result in legal proceedings against the DMH and possible Receivership.

Under the Consent Judgment, the DMH has until *November 2011* to fully comply with the “Enhanced Plan” to improve patient treatment and hospital conditions. At this time the Court Monitor will depart and the DMH is to assume full responsibility for compliance.

The Enhanced Plan provides a timeline for the Administration to address the CRIPA deficiencies and included agreements related to treatment planning, patient assessments, patient discharge planning, patient discipline, and documentation requirements. It also addresses issues regarding quality improvement, incident management and safety hazards in the facilities.

Expenditures for State Hospitals—Ever Increasing. Expenditures for the State Hospital system have increased exponentially in the past several years from \$775.1 million (\$624.4 million General Fund) in 2004 to over \$1.220 billion (\$1.140 billion General Fund) for 2010-11. *This represents an increase of about \$516 million in General Fund support, or an 83 percent General Fund increase in only six-years.*

The DMH contends these increased expenditures are attributable to: **(1)** compliance with implementation of a settlement agreement with the federal government regarding the Civil Rights for Institutionalized Persons Act (CRIPA); **(2)** employee compensation adjustments required by the Coleman Court; **(4)** increasing penal code-related commitments; **(4)** continued activation of Coalinga State Hospital; and **(5)** expansion of Salinas Valley Psychiatric Program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. Update on Hospital Security at State Hospitals

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

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

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

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

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

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

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

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

3. Capital Outlay for the State Hospitals

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

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

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

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

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

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

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

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

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

D. Department of Mental Health: Sex Offender Evaluations

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

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

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

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

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

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

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

As such DMH states that more referrals will occur.

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

- *Screening.* The DMH screens referred cases to determine whether they meet legal criteria pertaining to SVPs to warrant clinical evaluation. Those not referred for an evaluation remain with the CDCR until their parole date.
- *Evaluations.* Two evaluators (Psychiatrists and/or Psychologists), who are under contract with the DMH, are assigned to evaluate each sex offender while they are

still held in state prison. Based on a review of the sex offender records, and an interview with the inmate, the evaluators submit reports to the DMH on whether or not the inmate meets the criteria for an SVP. If two evaluators have a difference of opinion, two additional evaluators are assigned to evaluate the inmate.

Offenders, who are found to meet the criteria for an SVP, as specified in law, are referred to District Attorneys (DAs). The DAs, then determine whether to pursue their commitment by the courts to treatment in a State Hospital as an SVP.

If a petition for a commitment is filed, the clinical evaluators are called as witnesses at court hearings. Cases that have a petition filed, but that do *not* go to trial in a timely fashion may require updates of the original evaluations at the DA's request.

The amount of time it takes to complete the commitment process may vary from several weeks to more than a year depending on the availability of a court venue and the DA's scheduling of cases. While these court proceedings are pending, offenders who have not completed their prison sentences continue to be held in prison. *However*, if an offender's prison sentence has been completed, he or she may be held either in county custody or in a State Hospital.

Background—Sexually Violent Predator Act. Enacted in 1995 (AB 888, Rogan), this act created a new civil commitment for "Sexually Violent Predators" (SVPs). The DMH is responsible for the implementation and administration of the SVP Program. This program is impacted by change which has occurred in the form of amended statutes, court decisions, changes in the methods of risk prediction and increased expectations for contract evaluators to be better prepared to conduct evaluations and provide court testimony.

Background—SB 1128 (Alquist), Statutes of 2006. This legislation made changes in law to generally increase criminal penalties for sex offences and strengthen state oversight of sex offenders. For example, it requires that SVPs be committed by the court to a State Hospital for an undetermined period of time rather than the renewable two-year commitment provided under previous law.

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

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

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

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

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

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

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

E. Department of Public Health: Various Programs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The requested 20 positions are as follows:

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

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

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

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

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

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

4. Maternal, Infant and Early Childhood Home Visiting Program

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

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

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

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

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

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

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

Federal guidelines require services that:

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

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

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

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

5. Performance Management and Public Health Infrastructure

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

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

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

The requested 15 positions are as follows:

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

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

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

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

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

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