

SUBCOMMITTEE #3: Health & Human Services

Chair, Senator Mark DeSaulnier

**Senator Elaine K. Alquist
Senator Bill Emmerson**



**March 15, 2012
9:30 a.m. or
Upon Adjournment of Session
Room 4203
(John L. Burton Hearing Room)**

Staff: Jennifer Troia

<u>Item</u>	<u>Department</u>
4170	Department of Aging
4260	Department of Health Care Services
5160	Department of Rehabilitation
5180	Department of Social Services

PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate File for dates and times of subsequent hearings. Issues will be discussed in the order noted in the Agenda unless otherwise directed by the Chair.

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VOTE-ONLY AGENDA

Department of Social Services

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

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

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

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

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

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

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

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

DISCUSSION AGENDA

Department of Aging (CDA)

Multi-Purpose Senior Services Program (MSSP)

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

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

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

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

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

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

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

Questions for the Administration & LAO:

- 1) How was the 2011-12 reduction to MSSP implemented? What efforts did the Administration undertake to achieve the savings operationally?
- 2) Please describe the existing relationships between managed care plans and MSSP sites.
- 3) How would the transition to receiving LTSS through managed care work for current MSSP clients and those currently awaiting services?

- 4) How is the Administration engaging MSSP sites and staff as the Coordinated Care Initiative is being developed and refined?
- 5) Looking toward 2015 and beyond, would MSSP continue to be budgeted as a separate LTSS program? Would CDA maintain its programmatic oversight role? Who would authorize MSSP services? How would federal funding potentially change?

Department of Rehabilitation (DOR)

Rehabilitation Appeals Board

Budget Issue: The Governor proposes to achieve savings and efficiencies from eliminating the Rehabilitation Appeals Board (RAB), which currently reviews appeals filed by applicants for or consumers of DOR services. The associated responsibilities would be transferred to impartial hearing officers (IHOs) through an interagency contract with the Office of State Hearings or another state entity. The Administration estimates that contracting with IHOs will cost approximately \$80,000 and DOR would continue to incur staffing costs of another \$95,000 for one staff position to coordinate case referrals. Thus, the total cost for this proposal would be \$175,000 per year (\$37,000 GF). By contrast, in 2010-11 the budget for RAB was \$205,000 (\$43,000 GF); but actual expenditures over the last five years averaged \$292,000. The Legislature rejected a similar proposal made by the Governor as part of the 2011-12 budget process.

Background: By law, the RAB consists of seven members appointed by the Governor, although at present one seat is vacant. Members serve a term of four years and are subject to Senate confirmation. A majority of board members must be individuals with disabilities who are independently self-supporting in businesses and professions within the community. Board members receive reimbursement for travel expenses and a per diem of \$100 for each day spent on their duties. The RAB hears appeals by applicants for DOR services who wish to contest a denial of eligibility and by existing DOR consumers who are not satisfied with the services being provided to them. The DOR provides vocational rehabilitation services to approximately 115,000 Californians with disabilities annually. In federal fiscal year 2011, approximately 11,000 consumers achieved employment outcomes. During that same period of time, 32 requests for appeal were resolved.

Rationale for Proposed Change: According to the Administration, the present RAB appeals process complies with federal law but has several significant drawbacks, including that hearings cannot always be scheduled within the statutory timeframes due to quorum requirements and that the RAB has consistently exceeded its budgeted operating costs. The Administration also indicates that IHOs with more legal and

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

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

Questions for DOR:

- 1) Please describe the appeal and decision-making processes, including due process protections, as they exist today and how they would differ under this proposal.
- 2) How would the Administration ensure the accessibility of the appeals process to consumers of the department's services?

Department of Social Services (DSS)

1. CalFresh

CalFresh Program Overview & Administration

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

A Snapshot:

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

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

CFAP budget includes \$68.5 million GF for food benefits in 2012-13.

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

Caseload Trends¹: The CalFresh caseload grew every year from 1988-89 through 1994-95 and then declined each year until 1999-2000. The caseload has risen each year since that time, including recent growth of around 30 percent in 2009-10 and 20 percent in 2010-11. The Governor’s budget assumes 16 percent growth in 2011-12 and 15 percent growth in 2012-13.

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

*Estimated

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Questions for the Administration & LAO:

- 1) To what do you attribute California's low CalFresh participation rate?
- 2) How can the state better ensure that more eligible low-income Californians receive federally funded food benefits?
- 3) Are there additional efficiencies that the state could achieve in order to increase participation while utilizing existing administration funding?

2. In-Home Supportive Services (IHSS)

IHSS Overview

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

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

Program Structure and Employment Model: County social workers determine eligibility for IHSS after conducting a standardized in-home assessment, and periodic reassessments, of an individual's ability to perform specified activities of daily living.

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

A Few Facts About IHSS:

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

IHSS providers live with the recipients.

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

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

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

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

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

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

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

Proposed Restrictions on Domestic & Related Services

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

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

According to the LAO, Washington State recently enacted a restriction on domestic and related services for individuals who lived with their IHSS providers. The state’s Supreme Court determined, however, that the policy violated federal requirements regarding the equal treatment of Medicaid beneficiaries.

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

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

Questions for the Administration & LAO:

- 1) Please briefly describe the proposal.
- 2) Under the proposed policy, would an IHSS recipient potentially be eligible for domestic and related services if his/her need was not being met in common for reasons other than a housemate's receipt of IHSS or physical or mental impairment (e.g., because the housemate is not available or not willing to assist)?
- 3) Does the presumption that domestic and related needs are met in common extend to areas of the house that are not shared (e.g., cleaning the recipient's bedroom and bathroom) or responsibilities that are not shared (e.g., laundering the recipient's sheets if s/he sleeps alone)?
- 4) What analysis has the Administration conducted to determine whether this reduction would comply with federal and state Medicaid and disability-related laws?
- 5) How does this proposal fit in with the Administration's Coordinated Care Initiative proposal, which relies on an increased investment in IHSS and other long-term care supports and services in order to reduce costs associated with hospitalizations and nursing home stays.

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

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

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

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

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

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

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

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

Questions for the Administration:

- 1) What are the findings of available research regarding the causes of patients’ non-adherence to medication prescriptions?
- 2) What research has been conducted on the effectiveness of medication dispensing machines in remedying the associated problems?
- 3) Please summarize your estimates of the likely costs or savings from implementing the pilot project as enacted.

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

SSI/SSP Grants

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

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

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

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

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

Questions for the Administration & LAO:

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

4. CalWORKs

Maximum Aid Payments in Exempt Cases

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

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

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

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

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

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Questions for the Administration & LAO:

- 1) What is the policy rationale for eliminating the exempt-MAP, which has historically been higher in recognition that some families include adults who are unable to work and make up for lost income because of a disability?
- 2) How are families expected to fare in light of such historically large grant reductions that would come on top of other recent grant reductions?
- 3) What are the anticipated human consequences of an increased number of the state's children living farther below the federal poverty line? What pressures on other state and local systems, such as Child Welfare Services, might result?

Cal-Learn Program

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

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

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

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

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Questions for the Administration & LAO:

- 1) What information is the Administration tracking in order to determine the impacts of suspending or eliminating funding for Cal-Learn?
- 2) Is the suspension or elimination of Cal-Learn funding likely to lead to fewer teen parents who are CalWORKs recipients graduating from high school or an equivalent program?