



## Senate Budget and Fiscal Review

# Subcommittee No. 3 2010 Agendas

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*California State Senate*  
SENATE BUDGET & FISCAL REVIEW  
**SUBCOMMITTEE No. 1**

**Agenda**

**March 8, 2004**  
**Upon Adjournment of Session – Room 113**

EDUCATION  
JACK SCOTT, CHAIR  
BOB MARGETT  
JOHN VASCONCELLOS

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# **SUBCOMMITTEE #3: Health & Human Services**

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**Chair, Senator Mark Leno**

**Senator Elaine K. Alquist  
Senator Roy Ashburn**



**April 22, 2010**

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

**Room 4203**

Committee Staff: Jennifer Troia

<b><u>Item</u></b>	<b><u>Department</u></b>
<b>4700</b>	<b>Department of Community Services and Development</b>
<b>5180</b>	<b>Department of Social Services</b>

*(See Table of Contents on page 2 for More Specific Listing of Issues.)*

**Please note: The Committee will discuss only the items contained in this agenda at this hearing.**

Please see the Senate File for dates and times of subsequent hearings. The Committee will discuss the issues in the order noted in the agenda, unless otherwise directed by the Chair.

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### 5180 Department of Social Services

#### **DSS Issue 1: Kinship-Guardianship Assistance Payment Program (Kin-GAP) / Subsidized Relative Guardianship Proposal**

**Budget Issue:** The 2009-10 budget for Kin-GAP includes a total of \$144.9 million (\$110.5 million GF). The Governor's budget for 2010-11 proposes trailer bill language (TBL) that allows the state, beginning October 1, 2010, to opt into newly available federal financial participation in the costs of a subsidized relative guardianship program that is similar to the state's existing Kin-GAP program. Under the Governor's proposal, the state would pay 60 percent of nonfederal costs, and the counties would pay 40 percent. This would be a change from the existing Kin-GAP, in which the state pays for roughly 80 percent of the program.

The Governor's budget estimated savings of \$1.3 million GF in 2010-11 from opting into the federally subsidized relative guardianship program. However, the Administration has since acknowledged that this estimate included an error and is still working on a revised estimate. Kin-GAP is currently part of the state's CalWORKs program; and its state and county expenditures count toward the MOE requirement imposed on the state as a condition of receiving federal Temporary Assistance to Needy Families (TANF) funds for the CalWORKs welfare-to-work program. As a result, the state's Kin-GAP expenditures are also eligible for American Recovery and Reinvestment Act (ARRA) Emergency Contingency Fund (ECF) resources. The Governor's budget had also assumed GF savings as a result of these ECF stimulus funds for Kin-GAP.

**Background on Kin-GAP:** Kin-GAP was implemented in 2000 to enhance family preservation and stability by placing foster children in long-term placements with relative caregivers. Under Kin-GAP, a dependent child who has been living with a relative for at least 12 months in foster care may receive a monthly grant if the relative assumes guardianship and the dependency case is dismissed. The grant is identical to the one the child received while in foster care. The average monthly Kin-GAP caseload is over 14,000 children.

**Federal Funding Streams:** Until the recent passage of the federal Fostering Connections to Success and Increasing Adoptions Act of 2008 (P.L. 110-351), there was no option for states to receive federal financial participation in subsidized guardianship programs under Title IV-E of the Social Security Act (which establishes requirements for much of federal child welfare support). Under those new provisions, the federal government would generally provide 50 percent of grant costs for children in subsidized guardianships who meet other eligibility requirements (generally around 70 percent of California's caseload). During the period of ARRA's enhanced Federal Medical Assistance Percentage (FMAP) (currently authorized through December 2010, but assumed in the Governor's budget to be extended through the state fiscal year), the

federal share would temporarily be higher at 56.2 percent. In order to draw down these IV-E funds for subsidized relative guardianships, California would have to make some statutory changes to its existing Kin-GAP program.

During the time that the TANF ECF is available under ARRA (currently authorized through December 2010, but the Governor's budget assumes extension through the state fiscal year), federal financial participation in the costs of various components of the CalWORKs program (including Kin-GAP as currently structured and financed) is available at the higher rate of 80 percent to offset costs that exceed the corresponding costs during FFY 2006–07.

**Estimated Savings When ECF Expires:** The LAO estimates that once a federally-supported guardianship program is fully implemented under Title IV-E—including the complete transition of all existing Kin-GAP cases into the new program—GF savings would likely be about \$48 million per year under the Governor's proposed 60/40 state/county sharing ratios. If existing 80/20 state/county sharing ratios were instead maintained, GF savings would likely be about \$35 million per year.

**Pending Legislation:** In addition to other changes to the child welfare system, AB 12 (Beall, Bass), which is currently pending in the Senate, proposes to make the required statutory changes to transform the Kin-GAP program into a federally-eligible subsidized relative guardianship program and to opt the state into Title IV-E funding for Kin-GAP upon a declaration by the Director of DSS that relevant TANF ECF funding is no longer available.

**Subcommittee Staff Comment & Recommendation:** Staff recommends holding this issue open pending an updated estimate from the Administration at May Revision.

**DSS Issue 2: Probation Access to Child Welfare Services/Case Management System (CWS/CMS)**

**Budget Issue:** DSS proposes, in a new estimate premise, \$1.2 million (\$552,000 GF) in expenditures for 560 probation officers to receive training on using the CWS/CMS system and for 385 of those probation officers to newly gain access to the system.

**Background on Probation-Supervised Foster Care:** Children can enter foster care through the involvement of county child welfare agencies or probation departments. In addition, youth with child welfare/dependency cases who are charged with delinquency offenses may be placed in probation-supervised foster care. Consistent with requirements for federal financial participation in the costs of foster care, probation officers provide case management services in foster care cases that are supervised by probation departments (e.g., prevention, placement, or family reunification services). These are the same services that must be provided by social workers in child welfare-supervised foster care cases.

There are currently 66,000 children in foster care statewide. Of those children, approximately 61,000 are under the supervision of county child welfare agencies and close to 5,000 are under the supervision of probation departments.

**Background on CWS/CMS:** CWS/CMS is an automated system that provides case management capabilities for child welfare services, including the ability to generate referrals, county documents, and case management and statistical reports. The total 2009-10 CWS/CMS project budget is \$83.3 million (\$38 million GF).

**Subcommittee Staff Comment & Recommendation:** Staff recommends approval of the proposed funding for training and access to CWS/CMS by probation officers who oversee the cases of children in foster care.

**DSS Issue 3: Unaccompanied Refugee Minor (URM) Program**

**Budget Issue:** The Governor's budget includes, in a budget change proposal, \$102,000 (all federal funds) for the establishment of one new, permanent position to support the URM program within DSS's Refugee Programs Bureau.

**Background:** The URM program is administered by the federal Office of Refugee Resettlement (ORR) to provide child welfare and foster care services to refugee, asylee, and trafficked children who have come to the United States without parents or a close relative to care for them. ORR provides funding to DSS to contract with voluntary resettlement agencies in California. This request for expanded state operations staffing for the program is the result of: 1) an anticipated quadrupling in the number of children served (from 29 children in 2008-09 to 111 children in 2010-11), 2) the inclusion of additional youth who have been granted Special Immigrant Juvenile Status (unknown number at this point) as a result of the recent federal Trafficking Victims Protection Reauthorization Act of 2008, and 3) corrective actions required by ORR as a result of its review of the Northern California URM program. These corrective actions are focused on the need for the state to better develop placement sites, monitoring, and data collection policies and procedures.

**Subcommittee Staff Comment & Recommendation:** Staff recommends approval of the proposed funding and position.

## Discussion Agenda

### **4700 Department of Community Services and Development (CSD)**

With a total budget of \$475.1 million (no GF) and 109 authorized staff positions in 2009-10, and a proposed budget of \$260.2 million (no GF) in 2010-11 (year-over-year reduction largely due to expiration of ARRA federal stimulus funding), CSD administers federal programs to help low-income families achieve and maintain self-sufficiency, meet their home energy needs, and reside in housing free from dangers of lead hazards. CSD works with a network of agencies statewide that provide services and programs directly in the community.

#### **CSD Issue 1: Weatherization Assistance Program (WAP) & American Recovery and Reinvestment Act (ARRA) Weatherization for Low-Income Persons Program**

**Budget Issue:** The 2009-10 budget for weatherization assistance programs administered by CSD includes \$98.5 million federal funds (\$17.6 million of which are for state operations with the remainder for local assistance). Of this total, \$14.6 million are WAP funds and \$83.9 million are one-time stimulus funds as part of ARRA. The Governor's proposed 2010-11 budget for weatherization assistance administered by CSD includes \$99.2 million federal funds (\$92.9 million of which are ARRA funds).

**WAP and ARRA Weatherization Programs:** The purpose of California's weatherization programs is to increase the energy efficiency of homes owned or occupied by eligible low-income citizens, reduce the amount they spend on energy, and improve their health and safety. Preference is given to low-income people who are particularly at risk, such as individuals who are elderly or who have disabilities and those who use a lot of energy. Typical weatherization measures may include weather-stripping, insulation, caulking, water heater blankets, refrigerator replacement, or heating/cooling system repair or replacement.

In July 2009, California received roughly half of the approximately \$186 million in ARRA funds awarded to the state for weatherization purposes. To gain access to the remaining funds, CSD must meet performance milestones issued by the federal Department of Energy (DOE).

**State Audit of ARRA Weatherization Funding:** The Bureau of State Audits (BSA) released a report in February 2010 regarding CSD's implementation of weatherization stimulus funds (available online at: <http://www.bsa.ca.gov/pdfs/reports/2009-119.2.pdf>). The audit raised concerns about significant delays in ARRA-funded weatherization efforts. In particular, the Audit found that even though the federal government distributed ARRA funds to CSD in July 2009, no California homes had been weatherized using those resources as of December 1, 2009. Among other

recommendations, BSA suggested that CSD ask DoE for extensions of key deadlines, as well as improve its cash management and sub-recipient monitoring practices.

**Updates and CSD Response to Audit:** CSD has stated that a great deal of the initial delays in service provision was due to delayed implementation guidance from the federal government. In addition, the federal government requires that weatherization service providers pay workers the prevailing wage rates for the area as specified by the federal Davis-Bacon Act. These requirements did not previously apply to CSD's weatherization contractors, and their implementation can be very complex (e.g. an individual provider may provide services using more than one funding stream and differing requirements may now apply).

CSD reports that those initial delays have been resolved, and that the Department is on track to meet its established performance metrics. In its initial response to the Auditor's report, the Department provided the summary of its goals copied below.

	2010				2011				2012
	Mar	Jun	Sep	Dec	Mar	Jun	Sep	Dec	Mar
Total Planned Units	3,912	5,054	6,179	5,635	4,965	5,215	5,068	4,338	2,784
% of Total Units	9%	12%	14%	13%	12%	12%	12%	10%	6%
Total Planned Units at Benchmark on Sep-2010			15,145		Total Planned Units for Grant				43,150
Percentage of overall unit projection			35%						

In an April 12, 2010 letter to the Auditor, CSD stated that as of March 31, 2010, the number of dwellings weatherized in the state totaled 2,934, with an additional 1,174 units in process and 1,864 scheduled. Additionally, the Department indicated that it has improved many of its monitoring practices.

CSD also reports that it has executed contracts that cover roughly 83 percent of total ARRA funding. The remaining nine contracts, covering approximately 17 percent of ARRA funds, are under negotiation or pending execution. Outstanding contracts include contracts with the Los Angeles Department of Water and Power (6.1 percent of total funds), Sacred Heart Community Service in Santa Clara County (2.7 percent), the City of Oakland and County of Alameda (2.5 percent), and the City and County of San Francisco (1.7 percent).

**Weatherization of Multi-Family Housing Units:** Effective February 24, 2010, DOE amended WAP eligibility rules that apply to multi-unit buildings. As a result, eligibility verification can be streamlined if a multi-unit building under a public housing program is included on a list published by DOE. DOE also provided guidance to states about meeting requirements that benefits of weatherization assistance in these units, including units where the tenants pay for energy through their rent, accrue primarily to low-income tenants. As a model, DOE cited the State of Washington's policy recognizing that preserved low-income housing, added comfort, and environmental health benefits as a result of weatherization upgrades can be considered direct benefits to tenants. Given

these new policies, the City of San Francisco, which is currently negotiating a contract with CSD to provide services directly, intends to focus its efforts on retrofitting non-profit-owned affordable rental housing.

**Subcommittee Staff Comment & Recommendation:** This is an informational and oversight-related item, and no action is required. However, staff does recommend that the Subcommittee continue to monitor CSD's progress in meeting its weatherization program performance milestones.

**Questions for CSD:**

- 1) Prior to ARRA, how many units did CSD contractors weatherize in a given year? With both WAP and ARRA funding in 2009-10 and 2010-11, how many units does CSD anticipate will be weatherized?
- 1) Please briefly summarize challenges the Department faced in getting ARRA funded projects up and running from July to December 2009, and the progress made to address those challenges.
- 2) What is the current status of the Department's progress toward meeting its goals for the number of units to be weatherized (including WAP and ARRA funds)? How does the Department plan to further ramp up to meet those goals going forward?
- 3) How is the Department working toward inclusion of multi-family affordable housing units in its weatherization efforts? What are the considerations involved in a potential expansion of this focus to cities beyond San Francisco?

**Questions for BSA:**

- 1) Please briefly describe your Audit of CSD's implementation of ARRA weatherization efforts and the process for your continued involvement.
- 2) Please summarize any continuing concerns you have regarding CSD's current oversight and implementation of ARRA weatherization funding.

**5180 Department of Social Services (DSS)**

See March 18, 2010 Agenda for Subcommittee #3 for DSS budget overview.

**DSS Issue 1: Community Care Licensing (CCL) Program Update**

**Budget Issue:** With a total budget of \$107.8 million (\$20.7 million GF) and more than 1,000 state operations staff (plus 87 county staff who perform licensing duties locally) in 2009-10, CCL oversees the licensure of approximately 83,000 facilities, and has the responsibility to protect the health and safety of the individuals served by those facilities. For the last several years, DSS has provided an update on the current status of CCL's workload and performance with respect to statutory requirements. The Department will provide that update again during this hearing.

**Background on CCL:** The facilities licensed by CCL include child care centers; family child care homes; foster family and group homes; adult residential facilities; and residential care facilities for the elderly. CCL does not license skilled nursing facilities (licensed by the Department of Health Care Services) or facilities that provide alcohol and other drug treatment. All individuals seeking to be licensed to operate, work in, or reside at a community care facility (approximately 197,000 in 2009-10) must first complete a criminal background check that is processed (and in some circumstances investigated) by CCL. CCL is also responsible for reviewing and responding to any reports of criminal activity that lead to an arrest subsequent to an initial background check. CCL also performs regular inspection visits to licensed facilities and responds to complaints regarding facilities (roughly 13,000 in 2009-10).

**Additional Background on Inspection Requirements:** DSS is required to conduct pre- and post-licensing inspections for new facilities (including when a previously licensed facility changes hands). In addition, the Department must conduct unannounced visits to licensed facilities under a statutorily required timeframe. Prior to 2003, these routine inspection visits were required annually for all facilities except family child care homes (which received at least triennial inspections). In 2003, a human services budget trailer bill (AB 1752, Chapter 225, Statutes of 2003) reduced the budget for CCL by \$5.6 million and reduced the frequency of these inspections. As a result, CCL must visit a small number of specified facilities and conduct random, comprehensive visits to at least 10 percent of the remaining facilities annually. Ultimately, the Department must visit all facilities at least once every five years. In addition, there is a "trigger" by which annually required inspections increase if citations increase by 10 percent from one year to the next. Finally, CCL is required to respond within 10 days to complaints and may conduct related onsite investigations.

After the 2003 changes, DSS fell significantly behind in meeting the new requirements. The trigger for increased annual inspections due to a higher number of complaints was pulled twice and then suspended. In 2006-07, DSS was given 29 limited-term staff specifically for the purpose of ensuring that the Department could visit each facility once

every five years. These positions were extended for an additional 18 months, covering part of 2008-09. With these staff, CCL reduced its inspection backlog from over 10,000 to less than 1,000 facilities. Currently, there are 449 due and overdue five year inspections.

**Current Performance of CCL Duties:** In 2009-10, CCL projects that it will conduct 82 percent of its required routine inspection visits within the required timeframe (declining from 97 percent in 2007-08 and 92 percent in 2008-09) and accrue a backlog of 40 overdue inspections each month (down from 236 per month in 2008-09). CCL also projects that it will conduct 93 percent of complaint-related visits on time within 10 days (declining from 96 percent in 2007-08 and 2008-09). Finally, CCL anticipates a declining total number of citations (down to 48,000 from 80,000 in 2007-08 and 66,000 in 2008-09) and of serious incident and citation follow-up visits (down to 19,000 from 23,500 in 2007-08 and 20,700 in 2008-09). The Department attributes these decreases in 2008-09 and 2009-10 at least in part to the impacts of furloughs and staffing cuts.

**Subcommittee Staff Comment & Recommendation:** This is an informational and oversight-related item, and no action is required.

**Questions for DSS:**

- 1) Please provide an overview of the funding and staffing for CCL in recent years and how the department has performed with respect to its criminal background check, routine inspection, and complaint investigation responsibilities.
- 2) What are the challenges CCL faces in meeting its statutory duties?

**DSS Issue 2: Proposal for CCL Inspection & Fee Changes**

**Budget Issue:** DSS proposes, in a Spring Finance Letter and corresponding Trailer Bill and Budget Bill Language (TBL and BBL), to overhaul, effective January 1, 2011, statutory licensing inspection requirements. The Administration also proposes to raise facility application and annual fees by 10 percent. The BBL would allow the Department of Finance to reduce the GF authority for CCL commensurate with the amount of additional fee revenue that CCL receives (anticipated to be \$1.4 million for six months of 2010-11 and \$2.8 million annually thereafter). DSS has indicated that the costs for automation changes associated with this proposal would be absorbed as part of its ongoing system maintenance costs.

**Background on CCL and on Existing Inspection Requirements:** See prior agenda item.

**Proposed Inspection Requirements:** The proposed TBL would require annual, unannounced inspections for all facilities, with the exception of biennial inspections for family child care homes. As a result, approximately 42,000 facilities would receive annual inspections and 41,000 would receive biennial inspections. These inspections would, however, use an assessment process that is less comprehensive than existing inspection protocols. The Department anticipates that the changes would reduce by roughly half the time required for an inspection (e.g. from four to two hours for a residential care facility for the elderly). The new protocols would include “zero tolerance” violations, like fire clearance or access to bodies of water, and “key indicators,” such as criminal record clearances for adult residents and medication storage requirements. Per DSS, the new protocols would vary by facility category, and details would be developed depending on common complaints and on the input of stakeholders relevant to each of the facility categories.

The proposed changes would also eliminate existing requirements for pre-licensing inspections when a facility is sold or transferred to a new owner, and eliminate requirements for all post-licensing inspections (inspections that must occur within 90 days of the facility’s acceptance of its first client for placement). DSS annually conducts approximately 1,800 pre-licensing visits where an existing, previously-licensed facility is changing ownership. The fiscal savings tied to the lack of a requirement for these visits is estimated at \$349,000 for 5.5 staff.

**Justification for Changes in Inspection Requirements:** According to DSS, existing law and fluctuations in resources for CCL are placing the health and safety of vulnerable children and adults in community care facilities at risk. More frequent inspections would allow for more opportunities to address health and safety concerns. DSS has also indicated that the current statutory trigger mechanism is not effective because it assumes that increased citations would indicate increased health and safety violations, without taking into account the reduction in citations that may result from reduced frequency of inspections.

**Background on Fees and Proposed Fee Changes:** The 2009-10 budget increased application and annual fees by 10 percent, which was the first increase since 2004-05. As a result, fees currently cover about 21 percent of the costs for the state's licensing and enforcement activities. The chart below compares recent and current annual and application fees to those proposed. In addition, CCL proposes a new \$100 fee for any facility in which a citation has been issued and a follow-up inspection is needed to verify compliance.

### Examples of Current and Proposed CCL Fees

Facility Type	Annual Fee			Application Fee		
	2008-09	2009-10	2010-11 Proposed	2008-09	2009-10	2010-11 Proposed
Family child care home (1-8 children)	\$60	\$66	\$73	\$60	\$66	\$73
Child care center (1-30 children)	200	220	242	400	440	484
Adult day facility (16-30 adults)	125	138	152	250	275	303
Residential facility (16-30 residents)	750	825	908	1,500	1,650	1,815
Foster family agency	1,250	1,375	1,513	2,500	2,750	3,025

**Subcommittee Staff Comments & Recommendation:** Staff recommends holding this issue open.

### Questions for DSS:

- 1) Please summarize this proposal, including the process the Department undertook when considering its options for how to meet licensing duties going forward. Please include a high-level description of how the proposal would change the duties and workload of CCL.
- 2) How did the Department calculate the costs associated with this proposal? How confident is the Department that the proposed inspection requirements are realistic given CCL and local licensing staff levels?
- 3) How has and will the Department engage with providers and stakeholders regarding these proposed changes?
- 4) How and when would front-line licensing staff receive training in the new inspection protocols? Would they continue to also receive training on and be expected to cite facilities for observed violations of regulations that are not included in those protocols?

**DSS Issue 3: Child Welfare Services (CWS) Performance and Program Improvement Update**

**Budget Issue:** The federal Administration for Children and Families (ACF) conducts reviews (called the Child & Family Services Review or CFSR) of California's child welfare system. In 2002, California passed two of the seven systemic factors and failed all seven of the outcome measures pertaining to child safety, well-being, and permanency (e.g., committed family relationships). As a result, the federal government assessed \$9.0 million (all GF) in initial penalties against the state (plus \$2 million in interest that accrued in 2008 and an additional penalty of \$1.7 million that year). The state successfully appealed all of those penalties, which the federal government has since rescinded.

ACF performed another CFSR in California and published the results in 2008 (summarized below). After this recent CFSR, DSS developed a draft Program Improvement Plan (PIP) to improve outcomes for children and families and hopefully avoid fiscal penalties. Under the worst case scenario, the federal penalty for these recent CFSR results could exceed \$107 million GF in 2011-12 or 2012-13.

**Background on CWS and California's Recent Performance:** The total 2009-10 budget for child welfare services and foster care is \$4.2 billion (\$1.1 billion GF). The CWS system includes emergency response to allegations of abuse and neglect, supports for family maintenance and reunification, and out-of-home foster care services for approximately 66,000 children. The chart below summarizes the state's most recent CFSR performance.

<b>Safety and Permanency Outcomes</b>	Substantial Conformity	% of Cases Substantially Achieved
Safety Outcome 1: Children are first and foremost, protected from abuse and neglect	NO	80.6
Safety Outcome 2: Children are safely maintained in their homes when possible and appropriate	NO	76.9
Permanency Outcome 1: Children have permanency and stability in their living situations	NO	41.0
Permanency Outcome 2: The continuity of family relationships and connections is preserved	NO	79.5
<b>Child and Family Well Being Outcomes</b>		
Well Being Outcome 1: Families have enhanced capacity to provide for children's needs	NO	58.5
Well Being Outcome 2: Children receive services to meet their educational needs	NO	88.0
Well Being Outcome 3: Children receive services to meet physical, mental health needs	NO	81.0

*(Continued on next page)*

<b>Systemic Factors</b>	<b>Substantial Conformity</b>	<b>Score<sup>1</sup></b>
Statewide Information System	YES	3
Case Review System	NO	2
Quality Assurance System	YES	3
Training	NO	2
Service Array	NO	2
Agency Responsiveness to the Community	YES	3
Foster and Adoptive Parent Licensing, Recruitment, and Retention	NO	2

<sup>1</sup>Scores are based on a scale from 1 to 4, where 1 signifies the lowest and 4 the highest compliance level.

According to ACF, challenges facing the state included high caseloads and turnover of social workers, an insufficient number of foster homes and lack of caregiver support and training, a lack of statewide implementation of innovative practices, and a lack of needed services (e.g., mental health and substance abuse treatment services).

**PIP and Targeted Funding:** The state's PIP was finalized in 2008 and included the goals of expanding or strengthening: 1) case planning strategies that involve youth and families, 2) more consistent efforts to support permanency across a child's time in foster care, 3) caregiver recruitment, training, and support, 4) flexibility in services and supports to meet children and families' needs, 5) staff and supervisor training, and 6) implementation of a statewide risk-assessment system. The 2009-10 budget includes \$22.2 million (\$12.7 million GF), and the Governor's proposed 2010-11 budget includes \$23.1 million (\$13.0 GF), in resources designated to support some of these PIP goals.

**Subcommittee Staff Comments and Recommendation:** This is an informational item, and no action is required.

### **Questions for DSS:**

1. What are the factors that lead to the state's poor performance on such critical measures related to the health, safety, and well-being of children who have been abused or neglected?
2. Please summarize the PIP process and the state's progress to date on meeting its goals. In particular, how has the Department implemented the PIP strategies for which the 2009-10 budget dedicated specific resources?
3. How confident is the Department that the state will meet its PIP goals and will improve on critical performance measures prior to the next federal review of our child welfare system?

**DSS Issue 4: Veto of CWS Funding in 2009-10**

**Budget Issue:** When he signed the amendments to the 2009-10 budget contained in ABx3 1 (Chapter 1, 3<sup>rd</sup> Extraordinary Session, Statutes of 2009) in July 2009, the Governor used a line-item veto to make an unallocated reduction of \$80.0 million GF to CWS and foster care programs. After the Administration allocated the vetoed funding across programs, the total cut to CWS was \$133.5 million, including \$53.5 million in federal fund losses corresponding to the GF reductions.

**The Legislature Had Rejected a Proposal for a Smaller Unallocated Cut to CWS:**

With its passage of ABx3 1, the Legislature rejected the Governor's prior proposal to reduce CWS funding by \$70.6 million GF (and a then unknown amount of additional, corresponding federal funds). During public hearings, members heard and expressed concerns that such a large reduction would too greatly hinder the state's ability to protect the health and safety of its most at-risk children.

The Legislature did, however, adopt other targeted reductions to the CWS system totaling roughly \$36.5 million GF (and in some cases, additional corresponding federal funds). In particular, the enacted budget for 2009-10 included: 1) \$26.6 million GF savings from a 10 percent reduction to the rates paid to group homes and foster family agencies; 2) \$4 million GF savings from a decrease to the maintenance and operations budget for the Child Welfare Services/Case Management (CWS/CMS) automated system; 3) \$5 million GF savings from a reduction to the Transitional Housing Program Plus, and 4) \$900,000 GF savings from reforms to the Adoption Assistance Program. An association of group home providers challenged the group home rate reduction via litigation and as a result, that particular reduction has been enjoined from taking effect.

**Implementation of the Veto Reductions:** According to DSS, the Department adopted guidelines for implementing the veto that focused on the preservation, to the extent possible, of the core CWS program (i.e. county child welfare workers), direct services provided to children and families, and federal funding and mandates. The resulting reductions are outlined on the next page. Of the total reduction, \$19.1 million GF was allocated to Alameda and Los Angeles counties, which are operating under a federal waiver and have greater discretion to determine their CWS expenditures during the period of that waiver.

A currently pending appeal to the California Supreme Court challenges the Governor's authority to increase mid-year reductions in appropriations made by the Legislature for some of these CWS, as well as other social services, reductions. A Court of Appeal decision previously approved the Executive authority at issue in that litigation.

*(continued on next page)*

**Major Reductions Included in CWS Veto Allocation**  
(Chart As Updated April 27, 2010)

	FY 09-10 Appropriation		CY \$80 M GF Veto	
	GF	Federal Funds	GF Reduction	Federal Fund Reduction
<b>CWS Programs Included in the CWS Allocation</b>				
Basic Costs	\$270,240	\$337,687	\$39,608	\$40,153
<b>Other Child Welfare Allocations</b>				
Extended Independent Living Program	\$15,166	\$0	\$1,945	\$0
Chafee Postsecondary Education and Training Vouchers	\$5,700	\$6,852	\$684	\$822
Emancipated Foster Youth Stipends	\$3,602	\$0	\$3,602	\$0
Dual Agency Supplement to the Rate	\$53	\$42	\$6	\$5
Foster Parent Training and Recruitment	\$1,327	\$1,092	\$159	\$131
Kinship/Foster Care Emergency Funds	\$917	\$505	\$110	\$61
Group Home Monthly Visits	\$6,818	\$3,752	\$0	\$0
Health Services for Children in Foster Care	\$4,680	\$0	\$562	\$0
Chafee Federal National Youth in Transition Database	\$512	\$311	\$61	\$37
Health Oversight and Coordination (PL 110-351)	\$1,998	\$0	\$240	\$0
CWS Program Improvement Fund	\$4,000		\$0	\$0
State Family Preservation	\$21,493	\$3,540	\$4,279	\$705
Transitional Housing Placement Program (THPP)	\$3,459	\$5,188	\$2,200	\$3,300
THP Plus - 52 counties	\$35,878	\$0	\$169	\$0
Supportive/Therapeutic Options Program	\$9,954	\$0	\$1,194	\$0
Recruitment and Retention of Social Workers	\$172	\$97	\$21	\$12
Substance Abuse/HIV Infant Program	\$2,399	\$1,594	\$288	\$191
Kinship Support Services	\$4,000	\$0	\$480	\$0
Tribal-State Title IV-E Agreements	\$118	\$126	\$10	\$11
Child Fatality and Near Fatality PQCRs	\$110	\$88	\$13	\$11
Total Child Welfare Training Program	\$8,564	\$14,763	\$2,826	\$4,872
Federal Child & Family Services Review	\$192	\$108	\$23	\$13
CWS/CMS Ongoing M&O	\$37,425	\$42,402	\$2,000	\$2,266
CWS/CMS WEB	\$3,340	\$3,813	\$401	\$458
<b>SUBTOTAL</b>			<b>\$21,274</b>	<b>\$12,893</b>
TOTAL Item 151			\$60,882	\$53,047
TOTAL Item 153 (IV-E Waiver Counties)			\$19,075	\$0
<b>Grand Total</b>		<b>\$133,004</b>	<b>\$79,957</b>	<b>\$53,047</b>

**Impacts of the Veto on the Health, Safety & Well-Being of Children:** It is too early to know all of the impacts of these reductions to the budget for CWS. Preliminary information reported by the counties indicates the loss statewide of more than 500 front-line social workers who investigate emergency reports of abuse and neglect, help families stay together or be reunited, and work to find children permanent homes so that they do not remain in foster care unnecessarily. The most recent analysis of social worker caseloads conducted by the LAO in 2007-08 estimated that in counties representing 98 percent of the foster care caseload, social worker caseloads already exceeded the minimum (not optimal) standards established by a study conducted in response to the requirements of SB 2030 (Chapter 785, Statutes of 1998). Social worker caseloads at the time were estimated to be less than 80 percent of the minimum standard in counties representing 48 percent of the caseload.

According to the counties, statewide performance data also indicates that reports of abuse and neglect are less likely to be timely investigated. Foster children are being moved between homes more frequently; and the percentage of children getting timely health examinations is steadily decreasing. In addition, an estimated 16,800 current and former foster youth statewide lost a total of \$3.6 million in stipends that would otherwise have been available in grants of \$50 to \$500 to assist with critical needs (e.g., a security deposit for an apartment or bus pass). In some counties, additional matching funds from community partners for these stipends were also lost.

**Subcommittee Staff Comment & Recommendation:** Given the gravity of health and safety risks to children who have been abused or neglected, staff recommends restoring vetoed funding that supported basic child welfare and social work services; services or benefits provided directly to children and families, such as transitional housing and stipends for emancipated youth; and other efforts that are particularly critical to their health, safety and well-being. Veto-related cuts most likely to be sustained in 2010-11 would thus include some administration, training, or automation costs (including, as appropriate, corresponding reductions to Title IV-E waiver counties' funding). To operationalize this prioritization, staff should be directed to work with DOF and DSS to finalize a list of which estimate premises and budget allocations would be impacted.

**Questions for DSS and DOF:**

- 1) How does the Administration reconcile the veto of \$133.5 million (\$80 million GF) for child welfare services with its 2009-10 requests for additional funding to support the state's Program Improvement Plan (PIP)? With the need underlying the PIP to improve the state's ability to meet foster children's basic health, safety, and well-being-related needs?
- 2) Please describe how the Department determined, after the budget was enacted, which CWS programs to reduce or eliminate as a result of the vetoed funding.
- 3) How is the Department tracking the impacts of the vetoes on the state's ability to protect at-risk children and to meet federal performance requirements?

**DSS Issue 5: Trailer Bill Language (TBL) for Implementation of Federal Fostering Connections to Success & Increasing Adoptions Act (FCSA) of 2008**

**Budget Issue:** DSS proposes, via TBL, to add specified costs of transporting a child to his or her school to those that are included in the definition of foster care maintenance payments, to amend statutes related to the placement of siblings in foster care, and to amend statutes governing adoption or foster care programs operated by Indian tribes. According to the Department, these changes are required for the state to conform to requirements of the federal FCSA (P.L. 110-351).

The 2009-10 budget includes \$8.7 million (\$2.2 million GF, for six months beginning in January 2010), and the Governor's 2010-11 budget includes \$17.4 million (\$4.5 million GF), for costs associated with education-related transportation.

**Background on Reimbursement for Transportation Costs:** Among a number of other significant reforms to child welfare and adoption assistance programs, the federal FCSA added "reasonable travel for the child to remain in the school in which the child is enrolled" at the time of foster care placement to the list of costs that must be included in a foster care maintenance payment made to caregivers or group home facilities. 42 U.S.C. 675(4)(A)). Previously existing state law enacted by AB 490 (Chapter 862, Statutes of 2003) gave foster children the right, if it is in their best interests, to remain in their schools of origin for the rest of the school year following their initial placement in out-of-home care or a subsequent move. AB 490 did not, however, specify who was responsible for providing or funding related transportation to a child's school of origin.

DSS estimates that 13,414 children in foster care whose placement is outside their school district of origin may be impacted by the relevant requirements of AB 490 and the FCSA. The Department assumes that their transportation covers an average of 20 miles roundtrip at a cost of \$.55 per mile.

AB 1933 (Brownley) is currently pending in the Assembly Appropriations Committee. Among other provisions, AB 1933 would make changes to the statutes created by AB 490 to extend the right of foster children to remain in their schools of origin beyond the existing timeframe of the remainder of one school year. The author states that this change is also necessary to conform to federal requirements under FCSA.

**Background on Sibling Placement Provisions:** Under provisions enacted by the FCSA, states are required to make reasonable efforts to place siblings together and to ensure their visitation or interaction if they are placed separately (as long as it is in their best interests). Current state law includes similar, but not identical, requirements, as well as other protections related to these sibling relationships.

**Background on Provisions Related to Negotiations with Tribes:** Under provisions enacted by the FCSA, Indian tribes and entities are authorized to enter into direct agreements with the federal government to operate foster care and adoption programs

for tribal children (as opposed to being required to first enter into an agreement with the state in which the tribal entity is located). Provisions of FCSEA also required states to negotiate in good faith with tribes that do wish to operate their own programs via agreements with the state. AB 770 (Chapter 124, Statutes of 2009) made conforming changes to state law. However, according to DSS, some further technical fixes are required to fully comply with federal law.

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

**Questions for DSS:**

- 1) The 2009-10 budget includes \$8.7 million (\$2.2 million GF) for six months of funding caregivers' costs of transporting foster children to their schools of origin from January to July of 2010. How has the Department implemented associated policies and allocated those resources to date? Are those resources reaching the caregivers for whom they were intended?
- 2) What is the Department's understanding of whether federal law extends the right to remain in a school of origin to foster children beyond the duration of the school year during which placement occurs? How are those interpretations included (or not included) in the Department's estimates of relevant transportation-related costs?

**DSS Issue 6: Trailer Bill Language (TBL) to Clarify Law Related to Independent Adoptions**

**Budget Issue:** DSS proposes, via TBL, to amend a Family Code provision related to adoption. According to the Department, the proposed change would clarify the application of two differing statutory provisions. As a result, the requirements for a comprehensive evaluation and \$4,500 independent adoption fee when relatives seek to adopt children who are not currently dependents of the court would be reinforced. The Department estimates that without the proposed statutory clarification, what the Department considers misapplications of the law could spiral; and the state could lose up to \$1 million or \$2 million GF in fees paid by relatives for comprehensive evaluations. Instead, those relatives would pay a smaller \$500 fee and an abbreviated evaluation would be conducted.

**Background:** According to DSS, at least one Superior Court has recently misapplied existing Family Code statutes. In that case, DSS states that the El Dorado Superior Court required DSS to apply the abbreviated, rather than comprehensive, process in its evaluation of grandparents seeking to adopt their grandchild. As a result, DSS conducted the less thorough evaluation and charged a lower fee to the grandparents. As of April 2010, the Department estimates that there have been approximately 15 such instances of miscategorizations of adoptions statewide.

According to the Legislative Counsel Digest for the proposed trailer bill, "Under existing law, whenever a petition is filed for the independent adoption of a child, the petitioner is required to pay a nonrefundable fee of \$4,500 to [DSS] or to the delegated county adoption agency for the cost of investigating the adoption petition, subject to certain exceptions. Existing law requires that if the prospective adoptive parent is a foster parent with whom the child has lived for a minimum of 6 months or a relative caregiver who has had an ongoing and significant relationship with the child, that an assessment or home study be conducted, but does not specify a fee for this investigation.

This bill would specify that the provisions governing adoptions without that fee by relative caregivers or foster parents only apply to the adoption of a child who is currently a dependent of the juvenile court."

**Subcommittee Staff Comment & Recommendation:** Staff recommends rejecting the proposed TBL without prejudice as to its merits. An analysis of existing law and any related clarifications is more appropriate for consideration by the relevant Legislative Policy Committees (possibly including the Judiciary and/or Human Services Committees).

**Questions for DSS or DOF:**

- 1) Please briefly summarize the proposal, its genesis, and the assumptions underlying the Administration's estimates of its fiscal impact.

**DSS Issue 7: Trailer Bill Language (TBL) for Proposed Suspensions of CWS Programs**

**Budget Issue:** The Governor's proposed budget for 2010-11 includes TBL to suspend implementation of statutes enacted by AB 340 (Chapter 464, Statutes of 2007) and AB 2985 (Chapter 387, Statutes of 2006). In both circumstances existing law would be implemented when "the Department of Finance determines that sufficient state operations resources have been appropriated."

**Background on AB 340:** The resource family approval pilot established by AB 340 requires a three-year pilot program in up to five counties to establish a single, comprehensive approval process for foster care and adoptive families. This pilot was intended to make the licensing process less cumbersome and to prevent unnecessary delays in finding permanent families for foster children. The current licensing process divides caregivers into relatives, foster family homes, and adoptive homes. All caregivers must meet the same health and safety standards, but the processes for each vary and can be duplicative. This pilot was also included in the state's Program Improvement Plan in response to the 2002 federal review.

The Assembly Appropriations Committee analysis of AB 340 estimated approximately \$150,000 GF in state personnel costs for overseeing the development and implementation of this pilot and up to \$300,000 GF for its final evaluation. The analysis also recognized that the pilot should lead to some offsetting savings. Local assistance funding of \$717,000 (\$242,000 GF) was appropriated (but according to CWDA, never allocated to counties) in 2008-09. DSS also submitted a BCP requesting 4.0 limited-term state positions at a cost of \$440,000 (\$278,000 GF) to implement AB 340 in 2008-09; however, no state operations resources were included in the budget for that year.

**Background on AB 2985:** AB 2985 requires county welfare departments to request credit checks from a credit reporting agency for every foster child upon his or her 16<sup>th</sup> birthday. If a credit report contains negative information or evidence of identity theft, the county must refer the child to an approved credit counseling organization from a list developed by DSS. The Senate Appropriations Committee estimated costs of \$120,000 GF for the counties to conduct the checks. The 2009-10 budget includes \$355,000 (\$229,000 GF) for implementation in the 56 non-Title-IV-E waiver counties.

**Subcommittee Staff Comment and Recommendation:** Staff recommends rejecting the proposed TBL, which would transfer the Legislature's authority to determine the sufficiency of funding for program implementation to the Administration. Staff also recommends holding open the funding for AB 340 implementation.

**Questions for DSS and DOF:**

- 1) Please briefly summarize these proposals.
- 2) What have the Department and counties' efforts to date included with respect to implementing AB 340 and AB 2985?

**DSS Issue 8: Trailer Bill Language (TBL) to Extend Residentially Based Services (RBS) Pilot Program**

**Budget Issue:** DSS proposes TBL to amend and extend the Residentially Based Services (RBS) pilot program established by AB 1453 (Chapter 466, Statutes of 2007), as well as revise the statutory deadline for a resulting plan the Department is required to submit to the Legislature.

**Background on RBS Pilot:** AB 1453 authorized a five-year pilot demonstration project to test alternative RBS program and funding models which are cost-neutral to the GF. The legislation also required DSS to deliver a detailed plan to the Legislature by January 1, 2011 for how to transform the current system of group care for foster children into an RBS system. The envisioned RBS system would provide short-term, intensive, residential treatment interventions along with community-based services and post-residential placement support aimed at reconnecting foster children to their families and communities. It was anticipated that the children enrolled in RBS would require shorter lengths of stay in high-cost group homes and would step down to lower levels of care and to permanent placements more quickly. According to DSS, unanticipated contract and licensing issues contributed to delays in implementing the pilot projects.

**Proposed Changes to Provisions Enacted by AB 1453:** DSS proposes to extend the authorization for the pilot projects and the due date for development of the implementation plan until the pilot demonstration projects can operate for a sufficient amount of time to be fully evaluated. Specifically, the Department proposes to extend the due date for the implementation plan to July 1, 2014 and the authority to conduct the pilots until January 1, 2015. The Department also proposes other changes to statutes governing the RBS pilot.

**Pending Legislation:** AB 2129 (Bass), which is currently awaiting a vote on the Assembly floor, also seeks to extend authorization for the RBS pilot.

**Subcommittee Staff Comment & Recommendation:** Staff recommends rejecting the proposal without prejudice as to its merits. There is a pending policy bill that provides a more appropriate forum for discussion about whether and how to extend this pilot project.

**Questions for DSS:**

- 1) Please briefly summarize the proposal and its anticipated fiscal impacts in 2010-11.

**DSS Issue 9: Positions Related to Recently Enacted Legislation**

**Budget Issue:** The Governor's proposed budget for 2010-11 includes, in a budget change proposal, \$200,000 (\$169,000 GF) in temporary help resources to implement recent legislation, including AB 762 (Bonnie Lowenthal, Chapter 471, Statutes of 2009); SB 781 (Leno, Chapter 617, Statutes of 2009); and AB 1325 (Cook, Chapter 287, Statutes of 2009).

**Background on AB 762 and DSS Request:** As a result of this newly enacted legislation, Residential Care Facilities for the Elderly (RCFEs) may accept bedridden, nonambulatory individuals (those who are unable to transfer independently to and from bed, but do not need assistance turning or repositioning or can otherwise move around without assistance) as residents if they have obtained the appropriate fire clearance. Legislative analysis indicated that the bill had negligible state costs. DSS requests \$57,000 GF in one-time temporary help funding to update regulations, an evaluator manual, and technical assistance guides, as well as train field staff.

**Background on SB 781 and DSS Request:** As a result of this newly enacted legislation, RCFEs must include additional information when providing notice of eviction to a resident, including the reason for the eviction, the effective date of the eviction, and additional information to inform the resident of his or her rights regarding eviction. Legislative analysis indicated no significant costs associated with the bill. DSS requests \$47,000 GF in 2010-11 and \$39,000 GF in 2011-12 in temporary help funding to review facility documentation of the required information in applications, admissions agreements, and reports of eviction, as well as respond to any increased complaints that may result from increased information on how to dispute evictions, and train staff.

**Background on AB 1325 and DSS Request:** As a result of this newly enacted legislation, tribal customary adoption is, for a period of three years, an additional exception to the termination of parental rights for parents of Indian children who are dependents of the juvenile court. The Judicial Council is required to study and report to the Legislature on the effects of tribal customary adoption on children, parents, Indian custodians, tribes and courts. The Assembly Appropriations Committee analysis indicated that costs would be minor and absorbable. The Senate Appropriations Committee analysis indicated that this bill would likely apply to less than 10 children per year, but would create the need for one two-year limited term position, at a cost of \$59,000 GF annually (with additional federal funds). DSS requests \$96,000 (\$65,000 GF) in 2010-11 and \$88,000 (\$59,000 GF) in temporary help funding to conduct implementation workgroup meetings with tribal representatives, counties, adoption agencies, and the Judicial Council.

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

**Questions for DSS:**

- 1) Please briefly summarize the anticipated responsibilities associated with the requested staffing resources.
- 2) For AB 762 and SB 781, why weren't the proposed resources identified as necessary while the bills were pending passage by the Legislature?

# **SUBCOMMITTEE #3: Health & Human Services**

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**Chair, Senator Mark Leno**

**Senator Elaine K. Alquist  
Senator Roy Ashburn**



**April 22, 2010  
Actions Taken**

(Committee Staff: Jennifer Troia)

## **5180 Department of Social Services**

### **Kinship-Guardianship Assistance Payment Program (Kin-GAP) Subsidized Relative Guardianship Proposal**

Held open pending an updated estimate from the Administration at May Revision.

### **Probation Access to Child Welfare Services/Case Management System (CWS/CMS)**

Approved (2-1) (Ashburn no) the proposed funding.

### **Unaccompanied Refugee Minor (URM) Program**

Approved (2-1) (Ashburn no) the proposed funding and position.

### **Proposal for CCL Inspection & Fee Changes**

Held open.

### **Trailer Bill Language (TBL) for Implementation of Federal Fostering Connections to Success & Increasing Adoptions Act (FCSA) of 2008**

Held open.

### **Veto of CWS Funding in 2009-10**

Restored (2-0) (Ashburn not voting) \$74.6 million out of \$80 million GF that was vetoed by the Governor in 2009. When including federal funds, the total resulting restoration is \$120.0 million out of the \$133.0 million reduction that resulted from the veto. The reductions that were sustained include (in '000s):

	GF	Federal Fund
Chafee Federal National Youth in Transition Database	\$61	\$37
Total Child Welfare Training Program	\$2,826	\$4,872
Federal Child & Family Services Review	\$23	\$13
CWS/CMS Ongoing M&O	\$2,000	\$2,266
CWS/Web Project	\$401	\$458

### **Trailer Bill Language (TBL) to Clarify Law Related to Independent Adoptions**

Rejected (2-0) (Ashburn absent) the proposed TBL, without prejudice as to its merits.

### **Trailer Bill Language (TBL) for Proposed Suspensions of CWS Programs**

Rejected (2-0) (Ashburn absent) the proposed TBL. Held open funding for AB 340 implementation.

### **Trailer Bill Language (TBL) to Extend Residentially Based Services (RBS) Pilot Program**

Rejected (2-0) (Ashburn absent) the proposed TBL, without prejudice as to its merits.

### **Positions Related to Recently Enacted Legislation**

Held open.

## **SUBCOMMITTEE #3: Health & Human Services**

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**Chair, Senator Mark Leno**

**Senator Elaine K. Alquist  
Senator Roy Ashburn**



### **Agenda I: Vote-Only Items Held Over from April 8, 2010 Hearing**

Staff recommendations are listed below. Please see the previously published agenda for a discussion of each issue.

#### **4200 Department of Alcohol and Drug Programs (ADP)**

##### **ADP Issue 1: Community-Based Diversion Programs for Drug Offenders**

Hold open the proposed elimination of funding for OTP.

#### **5160 Department of Rehabilitation (DOR)**

##### **DOR Issue 1: Electronic Records System (ERS) Project**

Approve the requested federal funds authority for 2010-11.

##### **DOR Issue 2: Traumatic Brain Injury (TBI) Program**

Approve the requested funding and position authority.

#### **5175 Department of Child Support Services (DCSS)**

##### **DCSS Issue 1: Mothers' Marital Status Trailer Bill Language (TBL)**

Approve the proposed TBL, with an amendment to add a cross-reference to existing law that protects the confidentiality of the information shared.

##### **DCSS Issue 2: Revenue Stabilization Funding**

Approve the requested revenue stabilization funds for 2010-11.

#### **5180 Department of Social Services (DSS)**

##### **DSS Issue 1: ARRA Food Stamp Automation Simplification Projects**

Approve the proposed 2010-11 funding to continue these simplification efforts.

## **SUBCOMMITTEE #3: Health & Human Services**

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**Chair, Senator Mark Leno**

**Senator Elaine K. Alquist  
Senator Roy Ashburn**



### **Outcomes of April 8, 2010 Hearing (Votes Taken on April 22, 2010)**

#### **4200 Department of Alcohol and Drug Programs (ADP)**

##### **ADP Issue 1: Community-Based Diversion Programs for Drug Offenders**

Held open the proposed elimination of funding for OTP.

#### **5160 Department of Rehabilitation (DOR)**

##### **DOR Issue 1: Electronic Records System (ERS) Project**

Approved (3-0) the requested federal funds authority for 2010-11.

##### **DOR Issue 2: Traumatic Brain Injury (TBI) Program**

Approved (3-0) the requested funding and position authority.

#### **5175 Department of Child Support Services (DCSS)**

##### **DCSS Issue 1: Mothers' Marital Status Trailer Bill Language (TBL)**

Approved (3-0) the proposed TBL, with an amendment to add a cross-reference to existing law that protects the confidentiality of the information shared.

##### **DCSS Issue 2: Revenue Stabilization Funding**

Approved (2-1) (Ashburn no) the requested revenue stabilization funds for 2010-11.

#### **5180 Department of Social Services (DSS)**

##### **DSS Issue 1: ARRA Food Stamp Automation Simplification Projects**

Approved (3-0) the proposed 2010-11 funding to continue these simplification efforts.

# **SUBCOMMITTEE #3: Health & Human Services**

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**Chair, Senator Mark Leno**

**Senator Elaine K. Alquist  
Senator Roy Ashburn**



**April 29, 2010**

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

(Diane Van Maren)

## **AGENDA # 1**

**Special Order: Administration's Plan re: Lanterman Developmental Center**

### PLEASE NOTE:

Agenda #2 will follow this discussion.

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 or by calling 916-651-1505. Requests should be made one week in advance whenever possible.

Thank you.

## Department of Developmental Services (DDS)

### Special Order: Administration's Plan for Lanterman Developmental Center

**Budget Issue.** The Administration has submitted an April Finance Letter for the closure of Lanterman Developmental Center. The Finance Letter notes the following key aspects:

- Closure will *only* occur when necessary services and supports are in place and *each* resident of Lanterman has transitioned from the facility. No specific closure date has been set but it is anticipated closure will occur over *at least* a two-year period.
- About 393 residents live at Lanterman and it employs about 1,300 State staff.
- Lanterman continues to experience a steady decline in resident population, ranging from 29 to 47 residents each year since 2006.
- Lanterman has the highest per-resident cost among the Developmental Centers. DDS states it is \$289,000 per resident based on existing expenditures.
- Lanterman's infrastructure is aging and anticipated repairs to both the water and sewer systems are expected to be costly.
- DDS will pursue legislation to implement certain activities related to the closure.

The DDS submitted a Plan for the closure of Lanterman with the Finance Letter. The Plan was submitted pursuant to Section 4474.1 of Welfare and Institutions Code which requires the DDS to provide a Plan to the Legislature not later than April 1 immediately *prior to the fiscal year in which the Plan is to be implemented*, and as part of the Governor's proposed budget.

As required by State statute, the DDS Plan addresses the following:

- Description of the residents at Lanterman.
- Alternative placements for residents.
- Where services will be obtained that, upon closure of the Developmental Center, will no longer be provided by that facility.
- Summary of public testimony from meetings convened as required by the DDS.
- Methods for on-going communication.
- Impact on Regional Center services.
- Potential job opportunities for Developmental Center employees and other efforts made to mitigate the effect of the closure on employees.
- Description of the Lanterman buildings and property.
- Major implementation steps and timelines.
- Fiscal impact of closure.

**Purpose of Today's Subcommittee Hearing.** The purpose of today's Subcommittee hearing is the following:

- For the DDS to present its Plan, focusing on key components, and core next steps.
- To listen to public testimony from consumers, families, State employees, Regional Centers, community-partners and other interested parties regarding the Plan and related concerns. Written testimony may also be submitted through out the process.
- To discuss the monitoring of core next steps and future developments.
- To discuss key components of existing State statute to modify or extend provisions to address future transitions.

**Overview of Key Components of DDS Plan.** *First*, the DDS Plan contains a guiding principle throughout the proposal and that is to meet the individual needs of each resident while he or she continues to live at Lanterman Developmental Center, and to continue this through every aspect of *any* transition into another living arrangement (home, community-based or Developmental Center). The Lanterman Act, as contained in Welfare and Institutions Code, provides the policy and legal framework for this principle.

*Second*, DDS states they intend to build upon the successes of the Agnews Developmental Center closure while recognizing the uniqueness of Lanterman and its community.

Specifically, the Administration's Plan discusses the following *key* components.

**A. Description of Lanterman Residents.** Lanterman provides three levels-of-care for the 393 people in residence (as of March 3, 2010), including: **(1)** General Acute Care Hospital; **(2)** Intermediate Care Facility (ICF); and **(3)** Nursing Facility.

- *Acute Care Hospital.* The hospital averages 7 residents per day with an average length of stay of 7 days per visit.
- *Nursing Facility (NF).* There are 92 residents, or 23 percent of the residents, living on one of the five NF residences.
- *Intermediate Care Facility.* There are 301 people, or 77 percent of the residents, living on one of eleven ICF facilities.

The majority of residents—59 percent-- have lived at Lanterman for *more than* 30 years. The length of stay for the remaining residents shows 15 percent have lived there for 21-30 years, another 15 percent for 11-20 years, 6.5 percent for 5-10 years, and 4.5 percent for fewer than 5 years.

With respect to age, 80 percent are over age 40, with 8.6 percent of these individuals being 65-years or older. Seven residents are between the ages of 18 and 21 years. There are no children residing at Lanterman.

DDS states the residents at Lanterman are diverse in both gender and ethnicity with 59 percent of the population male and 41 percent female. Seventy percent identify as Caucasian, 18 percent Hispanic, 8 percent African American, 4 percent Asian and Pacific Islander, and the remaining percentage identified as Filipino and Other.

The following DDS information summarizes developmental disability and health and safety needs of individuals living at Lanterman:

- 77 percent of consumers have been assessed with profound mental retardation and 13 percent have severe mental retardation.
- A majority of consumers have additional disabilities including 54 percent with epilepsy, 13 percent have autism, and 10 percent have cerebral palsy.
- 74 percent have challenges with ambulation.
- 100 consumers, or 25 percent, have significant health care needs as their primary service need.
- 73 consumers require extensive personal care as their primary service need.
- 91 consumers require significant behavioral support.
- 125 consumers require highly structured services because of a lack of safety awareness or other behavior requiring intensive supervision to prevent self-injury.

**B. Summary of Planning Process for Resident Transition.** The Plan articulates four core components for planning as follows: **(1)** Individualized Program Plan (IPP); **(2)** Placement Planning Process; **(3)** Individualized Health Transition Plan; and **(4)** Monitoring Resident Transition. Each of these is summarized below:

- **Individualized Program Plan.** As required under the Lanterman Act, an interdisciplinary team, working with the consumer and their family, will utilize an intensive person-centered approach to initiate transition planning and identify individual needs.
- **Placement Planning Process.** An assessment and evaluation process will be initiated to determine the viability of any option (community-based or transfer to another Developmental Center). If a resident is recommended for transition to the community, community-based services are identified and a comprehensive transition process is coordinated by State staff, including the following:
  - Day visits to community service providers including the proposed residence, supervised by staff who know the consumer well;
  - Overnight visits or weekend visits to the residential placement if the transition is proceeding successfully; and
  - A minimum of 15 days prior to community movement, the planning team meets to ensure that all services, including medical services, are ready to help ensure a smooth and safe transition.

If concerns arise or it appears that community providers are not able to meet the consumer's needs, the process is delayed or stopped until identified concerns can be addressed.

- **Individualized Health Transition Plan.** Each Lanterman resident will have an Individualized Health Transition Plan (IHTP) developed which will include the resident's health history, and an evaluation by a primary care physician and dentist. A key aspect of this plan is to provide specific information on how the person's health care needs will be met and to identify all health transition service needs.
- **Monitoring Resident Transition.** *First*, DDS will be establishing a "*Resident Transition Advisory Group*" to include members from the Lanterman Resident Council and representation from parents and family members, applicable Regional Centers and DDS staff.

*Second*, the DDS states they will also convene an "*oversight team*", consisting of Lanterman management, expert consultants, and DDS staff to provide an ongoing evaluation of Lanterman's service needs, possible influence of closure activities, and employee attrition. DDS believes this will assist with strategic planning to manage change throughout the closure process.

*Third*, if an individual moves to a community living arrangement, State staff and Regional Center staff are to closely monitor the placement to ensure a smooth transition. *Key* monitoring activities include the following:

- State staff provide follow-up with the consumer at five days, 30 days, six months, and 12 months after the move;
- Regional Center staff conducts face-to-face visit every 30 days for the first 90 days after the move and as determined by the Individual Program Plan thereafter;
- State staff, in coordination with RC staff, provide additional visits, supports and onsite training to the consumer and service provider as needed to address the individual's service needs;
- For the first year following transition from a Developmental Center, consumers receive enhanced Regional Center case management;
- Medically fragile consumers transitioning from Lanterman to homes licensed by the Department of Social Services for consumers with special health care needs will be visited by a nurse at least monthly, or more frequently as appropriate. In addition, these consumers will be seen by a physician at least every 60-days or more frequently if specified in the consumer's healthcare plan;
- DDS conducts daily reviews of Special Incident Reports to ensure consumer health and safety and to identify potential trends in incidents; and
- Every individual who moves from a Developmental Center will be included in the National Core Indicator Study (discussed further below). This study is a valid survey instrument that will allow DDS to collect statewide and Regional Center specific data on satisfaction and personal outcomes of consumers and family members.

**C. Access to Health and Medical Services.** DDS is to will work with the Department of Health Care Services (DHCS), health plans and Regional Centers to assess and ensure the availability of needed health, dental and behavioral services in surrounding communities. If gaps are identified, the DDS says they will work with Regional Centers and the health care communities to ensure resource are available.

DDS notes that Southern California Regional Centers have established partnerships with local health plans that provide medical resources for consumers currently in the community. Memorandums of Understanding have also been established with County Mental Health Plans.

DDS further states that staff supporting the consumer in the community will be trained on implementation of behavioral and mental health support plans, and DDS staff will be available to provide consultation, additional training, and assistance in the modification of plans to respond to emerging needs.

According to recent information, *almost all* of the residents at Lanterman are Medi-Cal eligible and over 75 percent are also eligible for federal Medicare services. This “dual” eligibility will facilitate access to medical and health care services.

As done at Agnews Developmental Center, through legislation guided by Senator Alquist, the DDS proposes to operate an Outpatient Clinic at Lanterman through the closure process. They state the Outpatient Clinic will provide medical, dental and behavioral services to former Lanterman residents to assist in stabilizing them while they are in the process of transferring to new health care providers. Subcommittee staff recommends for the Subcommittee to enact trailer bill legislation to ensure this occurs (See Attachment 2).

**D. Community Resource Development.** The Regional Centers most affected by the proposed closure of Lanterman include: (1) San Gabriel/Pomona; (2) North Los Angeles; (3) Lanterman; (4) East Los Angeles; (5) South Central Los Angeles; (6) Inland; (7) Orange County; (8) San Diego; (9) Tri-Counties (10) Kern; (11) San Andreas; and (12) Westside.

Each Regional Center provides the DDS with detailed Community Placement Plans (CPP) for their service system area. The CPP process, as contained in State statute, is designed to assist Regional Centers in providing necessary services and supports for individuals, as appropriate in their IPP, to move from Developmental Centers to community-based services.

DDS provides supplemental funding to the Regional Centers based on these plans. These plans are updated at least twice annually to ensure continuity of services and appropriate funding levels. This information also flows through the annual budget process.

The DDS Plan states the CPP process will involve significant planning and collaborative efforts. The services and supports needed by each individual, including living options, day services, health care services and other supports will be identified through the planning team’s development of the IPP.

Collectively the key Regional Centers of this area have created the “Southern California Integrated Health and Living Project” in an effort to develop a variety of residential resources. The intent of this collaborative is to assist in resource development for targeted and unique needs, not to substitute or duplicate efforts of other individual Regional Centers.

The DDS states that a wide range of resources is currently under development, including day programs and various types of licensed homes. To the extent possible, Regional Centers with consumers residing at Lanterman will be redirecting their CPP efforts to focus on resources needed by Lanterman residents.

It is the understanding of Subcommittee staff that DDS will provide updated information regarding the CPP for Lanterman as part of the Governor’s May Revision (May 14 release). However, CCP plans will be updated at least twice a year or more if warranted as the needs of individuals transitioning from Lanterman are more comprehensively identified through the person-centered Individual Program Plan.

**E. Community Living Options.** Among other things, a person-centered Individual Program Plan will be used to initiate transition planning to transfer to another Developmental Center (such as Fairview, Sonoma or Porterville), or to engage in evaluating community options. The Lanterman Act, as well as the DDS, places great value on maintaining family contact and keeping close proximity to family members.

Various community options are to be available to consumers including the following: **(1)** supported living services; **(2)** Adult Residential Facilities for Persons with Special Health Care Needs **(3)** Adult Family Homes; **(4)** Family Teaching Homes; and **(5)** Intermediate Care Facilities for Individuals with Developmental Disabilities (ICF-DD).

Three of the above referenced options were more recently developed as part of the Agnews Developmental Center transition and have proven to be successful models. These are briefly described below:

- **Adult Residential Facilities for Persons with Special Health Care Needs.** SB 962 (Chesbro), Statutes of 2005, established licensed residential projects designed for individuals with special health care needs and intensive support needs. Examples of health services that can be provided in this type of home include, but are not limited to, nutritional support; gastrostomy feeding and hydration; renal dialysis; and special medication regimes including injections, intravenous medications, management of insulin, catheterization, and pain management. Nursing staff is on duty 24-hours per day. These homes also have DDS program certification, and mandatory safety features (fire sprinkler system and an alternative back-up power source).

Existing law also requires the following key aspects: **(1)** Development of an Individual Health Care Plan that is updated at least every six months; **(2)** Examination by the consumer’s physician at least once every 60-days; **(3)** A visit at least every month with a Nurse from the Regional Center; **(4)** DDS approval of the program plan and on-site visits to the home at least every six months; and **(5)** Licensure by the Department of Social

Services of the home, including criminal background clearance, annual facility monitoring visits and complaint resolution, and Administrator orientation.

DDS is proposing trailer bill language to expand this model for Lanterman. (See *the DDS Hand Out.*) The DDS proposed trailer bill language does the following:

- Provides direct linkage of the Adult Residential Facilities for Persons with Special Health Care Needs to approved Regional Center Community Placement Plan. This was resources can be more effectively directed.
  - Eliminates language from 2005 regarding the model being a pilot for the Agnews Developmental Center area only.
  - Gives authority for the DDS to establish reimbursement rates for these facilities based on a Regional Centers' Community Placement Plan and any adjustments as approved for health and safety.
  - Requires direct care personnel to have more in-service training as specified and for Administrators to have completed a certification program as specified.
- **Adult Family Homes.** These homes are designed for individuals with behavioral challenges or other specialized needs, and will serve from three to four consumers per home. These homes provide 24-hour on-site staff with specialized expertise to meet the unique needs of the individuals. These homes also have the capacity for on-site crisis response. It should be noted that when a majority of the consumers living in this model of home turns age 60, the home can be re-licensed as a Residential Care Facility for the Elderly (RCFE).
  - **Family Teaching Homes.** Among other things, AB 2100 (Steinberg), Statutes of 2004, added a new "Family Teaching Home" model to the list of residential living options. These homes are designed to support up to three adults with developmental disabilities by having a "teaching family" living next door (usually a duplex). The teaching family manages the individual's home and provides direct support when needed. Wrap-around services, such as work and day programs supports, are also part of this model.

**F. Quality Management System.** As described in the Plan (on page 13), DDS has implemented a "Quality Management System", based upon federal direction, which is focused on consumer and family outcome measures. It starts with establishing clear performance measures, collecting and analyzing data to determine if the expectations are met, and taking steps to correct deficiencies or improve processes and services (remediation and improvement).

A "Quality Management Advisory Group" will be established for Lanterman which is to serve as a guide to the DDS and Regional Centers. This group will include consumers, parents and family members of current Lanterman residents, Regional Centers, Area Board 10, the State Council on Developmental Disabilities, and Disability Rights California.

*In addition* to the IPP, health plan assessment, and monitoring as described under items B and C above in this Agenda, the DDS notes many other quality assurance activities in the Plan, including the following *key* aspects:

- Regional Centers have face-to-face visits with an individual following transition from a Developmental Center at intervals of 5 days, 30 days, 60 days, 90 days 6 months, and 12 months but visits or assistance with follow activities occur as necessary to assure a smooth transition. (These visits are in addition to the actual transition of the individual to his/her new home.)
- Regional Center case managers meet with consumers in out-of-home living options at least quarterly;
- Each Regional Center has a 24-hour response system wherein a duty officer can be reached after hours.
- Licensed community facilities receive an annual Regional Center monitoring visit.
- Special Incident Report information is reviewed regularly by Regional Centers and actions to decrease risks to health and safety are implemented;
- An assessment tool for the Quality Management System, in which life quality assessment information is obtained along with other core data indicators, will be used and it is called the “National Core Indicators”. The DDS states this tool will provide quantifiable data to better inform quality assurance efforts, meet required federal information needs, and provide DDS with data-driven decision making.

**G. Summary of Employee Workforce Information.** Attachment 7 of the Plan summarizes the characteristics of Lanterman employees. About 48 percent of the employees have worked at Lanterman for 10 years or less. Thirty percent have been employed between 11 years and 20 years, and the remaining 22 percent have 20 years or more experience at Lanterman.

Lanterman employee classifications include: **(1)** direct care nursing (50 percent of staff), such as registered nurses, psychiatric technicians, and psychiatric technician assistants; **(2)** Level-of-Care professionals (10 percent), such as physicians, rehabilitation therapists, social workers, teachers, respiratory therapists, physical and occupational therapists, and others; **(3)** Non-Level-of-Care and administrative support (40 percent), such as dietary employees, plan operations, health and safety, quality assurance reviewers, personnel and fiscal services, and facility supervisors and managers.

DDS states they are committed to the establishment and implementation of employee supports that promote workforce stability and provide opportunities for employees to determine their future. They note the expertise of the Lanterman employees and that retention during the transition process is a high priority to assure continuity of services for Lanterman residents. Several employee forums have already been conducted.

A “*Staff Support Advisory Group*” is to be convened and will include Lanterman employee groups, DDS and related bargaining units. DDS states this advisory group will ensure continuity of staffing, that activities meet the needs of employees, and in identifying morale-boosting activities that encourage camaraderie as the facility transitions.

Other key aspects of employee communication will include the following:

- Utilization of the monthly Lanterman employee newsletter regarding progress of activities, a question and answer column and career announcements;
- Regular general employee meetings for information sharing and support;
- Direct access to the DDS website so interested parties can easily access information regarding the Lanterman transition; and
- Use of a “hot line” so employees can submit questions to Lanterman management for a response.

The Plan discusses various employment opportunities and options to be made available to Lanterman employees, including the following *key items*:

- **State Staff in the Community and Trailer Bill Language.** AB 1378 (Lieber), Statutes of 2005, provided for State staff to utilize their expertise in the community to meet the needs of residents (Agnews) transitioned to the community and to retain their State employee status. DDS provided extensive staff training and orientation to prepare employees for transition to community-based services.

Through this program, the State employees’ specialized abilities and knowledge of consumer’s needs have provided to be invaluable. Consumers were supported by experienced staff as they transitioned from Agnews and potential risks to health and safety were decreased. It also provided continuity to families who knew the staff and their level of expertise with their family member.

Other benefits of the program are that it provided a method to retain experienced workers in the developmental services delivery system. It gave service providers access to skilled employees when opening a new home or service. For the employees, they were able to provide valuable expertise in the community and still retain their civil service status.

These employees work through contracts between service providers, Regional Centers or Developmental Centers and maintain their salaries and benefits. This arrangement is *cost neutral* to the State because the provider/Regional Center reimburses the State for the cost.

A total of 129 employees from Agnews participated in the program at its inception. As of March 2010, a total of 88 employees continue to work in the community with former residents transitioned from Agnews.

DDS is proposing trailer bill language to expand this program to include Lanterman employees (*DDS Hand Out*). As noted, this language adds in “Lanterman” employees and also requires DDS to report to the Legislature as noted.

- **Opportunities at other Developmental Centers.** DDS states that opportunities to transfer to other Developmental Centers (Fairview in Costa Mesa; Sonoma in Eldridge; Porterville in Porterville; and Canyon Springs, a State-operated locked facility in Cathedral City).
- **Voluntary Transfer to Other State Positions.** There are several ways for a State employee to pursue this option, and DDS states they will provide assistance, including the use of “State Restriction of Appointments” listings.
- **Employee Career Center.** The DDS will establish a Career Center at Lanterman to provide support and to assist in identifying interests and career opportunities.

**H. Summary of Lanterman Property.** The current campus is located in eastern Los Angeles County on the western end of the City of Pomona, and adjacent to the City of Diamond Bar. Presently the property consists of three separate parcels of 128.8 acres, 141.6 acres, and 16.1 acres for a *total of 286.6 acres*.

The campus includes 120 structures with many of the structures believed to have some historic significance because of their age and architecture. A resource assessment to identify historic structures which may be subject to historic preservation has been completed.

A 1996 report commissioned by the DDS (“Vanir Study”) to develop a strategic plan for infrastructure and environmental issues for the overall Developmental Center system identified significant findings for Lanterman. DDS states that many of the issues identified then are still largely unaddressed today due to limited-funds and other aspects. Further, a recent report by RBF Consulting (Property Assessment) reviewed Lanterman’s infrastructure (water, sewer, gas, storm drainage, electricity).

Key findings for Lanterman from these reports include: **(1)** seismic safety deficits; **(2)** residential and programmatic deficiencies (such as fire suppression); **(3)** compliance issues related to the Americans with Disabilities Act; **(4)** kitchen and food service deficiencies; **(5)** water system upgrades are needed (75 years old); **(6)** presence of hazardous materials and potential contamination sources; **(7)** significant sewer issues; and **(8)** significant boiler system issues.

There are *four active leases* that utilize space including the following: **(1)** Pacific Federal Credit Union; **(2)** Here We Grow Learning Center for child care; **(3)** California Conservation Corps; and **(4)** CalTrans Park and Ride Program. All of these leases expire between 2010 and 2013. Lanterman also has a few informal agreements with ranchers for the use of unused hillsides for cattle and horse grazing.

Regarding underutilized or surplus property, existing State law outlines the process for its disposition. The Department of General Services (DGS) receives notification from a department (such as DDS) that it has excess land. The DGS determines if there is a State use for the property. If DGS determines there is no State need, the property is included in the annual surplus property bill. After the Legislature declares the property surplus, DGS arranges for its disposition. DDS notes that any final disposition of property takes several years to complete.

The proceeds from the sale of surplus State property are to be used to pay the principal and interest on bonds issued pursuant to the Economic Recovery Bond act authorized in the March 2004 election. Once the principal and interest on these bonds are fully paid, the proceeds from the sale of surplus State property are to be deposited into the Special Fund for Economic Uncertainties, or any successor fund. (See the California Constitution.)

**I. Summary of Input Received on the Plan.** Attachment 3 of the Plan contains considerable written comment from residents, families and friends, Lanterman employees, and various interest groups. This information has been provided to the Subcommittee and is also available in hard copy to the public as part of the DDS Plan.

In addition, pages 39 through 41 of the Plan provide a perspective of the comments received to-date. Further, as required by State statute, pages 33 through 36 of the Plan discuss the general impact of the potential closure of Lanterman.

**J. Preliminary Fiscal Information.** The DDS budget includes \$116.5 million (total funds) to serve 393 residents at Lanterman. In addition, funding for Regional Center Operations and the Purchase of Services (POS) for consumers residing in the community is also provided, along with supplemental funds for Community Placement Program (CPP) plans to increase community capacity (both for people moving from a DC to the community, and to deflect consumers from entering into a DC).

The DDS states that generally, the cost of transition of residents into community settings is covered by CPP funding and future savings in Developmental Center costs.

DDS believes it can manage the closure of Lanterman without requesting additional resources if its existing level of funding is maintained. However, DDS states they cannot propose distribution of resources between the two systems until resident needs and community capacity are more fully assessed.

The Plan reiterates that closure will occur after the last resident transitions to his or her new living situation and transition will only occur after services and supports are available in his or her new residence (community-based or another Developmental Center).

At this time the DDS states it is premature to provide a detailed fiscal estimate and therefore, this Plan includes *high-level assumptions* that will be followed by a more detailed fiscal breakdown as soon as resident needs and community capacity are more fully assessed.

Key high-level fiscal assumptions are as follows:

**Developmental Center Costs.** To the extent Lanterman residents transition to another Developmental Center, the costs and applicable funding will transfer accordingly. In addition, the Developmental Center budget will retain funding for the following *key costs*:

- Travel and moving costs associated with transporting residents to new arrangements.
- Provisions of peer informational sessions for residents at Lanterman.
- DDS will temporarily operate an Outpatient Clinic on campus to provide a safety net for medical, dental and behavioral services for residents as they transition, as done at Agnews.
- Continue operation of the Regional Resource Development Project (RRDP) to maintain support to the community currently served by this office.
- Employee Career Center expenditures.
- Administrative staff needed after closure to ensure records and other materials are properly chronicled.
- Maintaining the physical plant until the property is transferred (warm shut-down).
- Employee transition costs, such as paying for vacation/leave and related “cash-out”.

**Community Costs.** DDS states it is committed to ensuring the availability of necessary services and supports for Lanterman residents transitioning to the community. They note that Regional Center costs will be funded using Community Placement Program (CPP) resources and future savings in Developmental Center costs. The Southern California Regional Centers impacted by the Plan presently receive 55 percent of the available statewide CPP funding.

The community costs associated with the proposed Lanterman closure include:

- Community resource development, including residential, day services and related Regional Center staff resources;
- Purchase of Service funding for the ongoing provision of services in the community; and
- Staff resources to coordinate dental and health services in the community, enhanced case management, and quality assurance functions.

DDS also notes that some additional federal funds may be available through the “Money Follows the Person” grant for staffing and consumer costs in the community during the *first year* of transition. More information is forthcoming on this aspect.

**K. Major Implementation Steps and Timeline (Page 37).** The DDS Plan provided a summary of major implementation steps. The Table below provides a *truncated summary* from April 1, 2010 forward. DDS should discuss this timeline today.

**DDS Major Implementation Steps & Timeline (April forward)**

Description of Activity	Dates
Establish and convene Advisory Groups: (1) Resident Transition (2) Quality Management (3) Staff Support	April 2010
Initiate Individualized Transition Planning Process	July 2010
Develop and Implement Individual Health Care Plans for Lanterman Residents	July 2010 to Closure
Establish Dental Coordinator and Health Care Consultant Positions at Certain Regional Centers	July 2010
Assist Lanterman Employees by Providing Information, Training Opportunities, Job Fairs, and Employment Announcements	July 2010 to Closure
Plan for Deployment of State Employees to Community Services and Work with Regional Centers and Providers to Determine Numbers and Types of State Employees Who May Be Interested and For What Functions	2010
Transition of Residents from Lanterman to Other Living Arrangements	2010 to Closure
Establish a Lanterman Developmental Center Business Management Team to Develop a Plan for the Administrative and Physical Plant Activities of Closure	2010
Develop and Open an Outpatient Clinic to Provide Transition Services as Residents Leave Lanterman	2010
Establish Lanterman Consumer Specific Memorandum's of Understanding between Health Plans and Regional Centers	2010
Official Closure of Lanterman	After All Residents Have Moved
Post-Closure Clean-Up Activities at Lanterman	Initial Months Following Closure
Warm Shutdown Begins, and Department of General Services Eventually Determines Property Transfer	Upon Closure and Until Property is Transferred

DDS states that this schedule will be updated as the Plan progresses.

**Other Background—Community Transition Has Been Occurring.** California has gradually been transitioning from the operation of large, congregate living arrangements as offered through Developmental Centers to providing services and support to individuals with developmental disabilities to live in community-based settings. Most recently, Agnews Developmental Center and Sierra Vista (Yuba City), a large State-operated facility, were recently closed.

This transition has occurred due to many factors, including:

- **Coffelt Settlement.** The Coffelt Settlement Agreement of 1993 required the DDS to develop a five-year plan to reduce the resident population of the Developmental Centers by a net of 2,000 individuals. Specifically, the Developmental Center population was 6,410 people and it had to be reduced by 3,966 people from April 1993 to July 1998. This Agreement facilitated the closure of Stockton Developmental Center in 1996 and Camarillo Developmental Center and State Hospital in 1997.
- **Home and Community-Based Waiver.** Implemented in the mid-1990's this Waiver has expanded over the years and has enabled California to receive significant federal fund assistance for community-based services.
- **Olmstead Decision.** The 1999 U.S. Supreme Court decision (“Olmstead v. Linn”) stated that services should be provided in community settings when treatment professionals have determined that community placement is appropriate, when the individual does not object to community placement, and when the placement can reasonably be accommodated.

**Background—Recent Agnews Developmental Center Closure.** Through annual Budget Bill Language, the Legislature directed the DDS to provide comprehensive written reports to the Legislature, and made accessible to the public, every January and May as part of annual budget deliberations.

The DDS submitted its final report on the closure of Agnews Developmental Center to the Legislature on March 25, 2010. (See DDS website for this 36-page report.)

In collaboration with Agnews' residents, families, community partners, Bay-Area Regional Centers, State staff, various stakeholders, and policymakers, total of 327 people were transitioned from living at Agnews to living arrangements in the community, and 20 people transferred to other Developmental Centers. The Agnews transition occurred between July 1, 2004 and March 27, 2009. Agnews planning activities occurred prior to this transition period.

The Agnews closure process was not driven by a specific date for closure, but instead by the availability of housing and support services. The DDS states that the health and safety of each consumer was the highest priority and that transition to the community only occurred when all necessary services and supports were in place.

**Subcommittee Staff Comments and Recommendation.** DDS has submitted its initial Plan for closure of Lanterman Developmental Center. As done with the closure of Agnews Developmental Center, it is important to establish extensive oversight and monitoring by the Legislature to ensure transparency, accountability, and most importantly, the health and safety of people who receive services through the developmental services systems.

With this in mind, it is recommended to: (1) keep this issue “open” to obtain public testimony and additional information, and to discuss at the Governor’s May Revision; (2) take some action today to implement certain monitoring and oversight provisions; and (3) adopt “placeholder” trailer bill language to ensure Lanterman residents and employees have access to assistance that facilitated the Agnews Developmental Center transition. (Placeholder trailer bill language means the language can be modified as it proceeds through the budget process.)

Suggested action items for today are as follows (*all language subject to further discussion*):

1. Adopt Budget Bill Language to require the DDS to provide a comprehensive status update of the Lanterman Plan by January 10 and May 14 of each fiscal year. (*See Attachment 1*)
2. Adopt modified trailer bill language to direct the DDS to provide outpatient clinic services at Lanterman Developmental Center (as done at Agnews Developmental Center). (*See Attachment 2*)
3. Adopt modified trailer bill language to have the Secretary of Health and Human Services Agency to verify protocols as noted for the health and safety of individuals transitioning from Lanterman. (*See Attachment 3*)
4. Adopt modified trailer bill language to provide for cost-based reimbursement for Health Plans serving consumers transitioned from Lanterman to ensure health care coverage (as done for consumers transitioned from Agnews). (*See Attachment 4*)
5. Adopt placeholder trailer bill language provided by the DDS (*DDS Hand Out*) for Lanterman staff to be contracted out, if they choose, to work in the community (as done at Agnews).
6. Adopt placeholder trailer bill language provided by the DDS (*DDS Hand Out*) to expand Adult Residential Facilities for Persons with Special Health Care Needs so this residential model can be provided state-wide.

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

1. DDS, Please provide a summary of *key* aspects of the Plan.
2. DDS, What are the core next steps overall, as well as for the residents of Lanterman and their families?
3. DDS, What workgroups will be convened and how will interested parties stay informed?
4. DDS, What resources are available if people want to transition to a DC?
5. DDS, What are the area Regional Centers doing with their coordinated efforts?

## Attachment 1

### Budget Bill Language for Lanterman Plan Updates

#### Item 4300-001-0001

Provision x.

“The state Department of Developmental Services shall provide the fiscal and policy committees of the Legislature with a comprehensive status update on the Lanterman Plan, by no later than January 10, and May 14, of *each* fiscal year which will include *at a minimum* all of the following:

- (a) A description and progress report on all pertinent aspects of the community-based resources development, including the status of the Lanterman transition placement plan.
- (b) An aggregate update on the consumers living at Lanterman and consumers who have been transitioned to other living arrangement, including a description of the living arrangements (Developmental Center or community-based and model being used) and the range of services the consumers receive.
- (c) An update to the Major Implementation Steps and Timelines.
- (d) A comprehensive update to the fiscal analyses.
- (e) An update to the plan regarding Lanterman’s employees, including employees who are providing medical services to consumers on an outpatient basis, as well as employees who are providing services to consumers in residential settings.
- (f) Specific measures the State, including the Department of Developmental Services, the Department of Health Care Services, and Department of Mental Health, is taking in meeting the health, mental health, medical, dental, and over all well-being of consumers living in the community and those residing at Lanterman until appropriately transitioned in accordance with the Lanterman Act.
- (g) Any other pertinent information that facilitates the understanding of issues, concerns, or potential policy changes that are applicable to the transition of Lanterman Developmental Center.

## Attachment 2

### Lanterman Outpatient Clinic

**Modify Section 4474. 8 to the Welfare and Institutions Code as follows:**

(Underlined section is the proposed modification)

4474.8 Notwithstanding any provision of law to the contrary, the department shall continue the operation of the Agnews Outpatient Clinic, and the Lanterman Outpatient Clinic until such time as the Department of Developmental Services is no longer responsible for the property: at the respective developmental center as applicable.

## Attachment 3

### Assurance from Secretary of Health and Human Services

#### Proposed Trailer Bill Language

#### **Modify Section 4474.4 to the Welfare and Institutions Code as follows:**

(Underlined section is the proposed modification):

Notwithstanding any other provision of law to the contrary, the Secretary of the Health and Human Services Agency shall verify that the Department of Developmental Services and the Department of Health Services have established protocols in place between the departments, as well as with the Regional Centers and health care plans participating in the Medi-Cal Program who will be providing services, including health, dental and vision care, to people with developmental disabilities transitioning from Agnews Developmental Center, and Lanterman Developmental Center.

The Secretary of the Health and Human Services Agency shall provide written verification of the establishment of these protocols to the Joint Legislative Budget Committee, as well as to the fiscal and policy committees of the Legislature which oversee health and human services programs.

The purpose of the protocols is to ensure that a mutual goal of providing appropriate, high quality care and services to children and adults who have developmental disabilities in order to optimize the health and welfare of each individual. Further, it is to ensure that all involved parties, including consumers and families, the state, Regional Centers and providers are clear as to their roles and responsibilities, and are appropriately accountable for optimizing the health and welfare of each individual.

The protocols, at a minimum, shall address enrollment for services, all referral practices including those to specialty care, authorization practices for services of all involved parties, coordination of case management services, education and training services to be provided, the management of medical records and provider reimbursement methods. These protocols shall be provided to the consumers and their families, and available to the public upon request.

**Attachment 4**  
**Reimbursement of Health Plans for Lanterman Consumers**

**Modify Welfare and Institutions Code within the Lanterman Act as follows.**

(a) In order to meet the unique medical health needs of consumers transitioning from Agnews Developmental Center into Alameda, San Mateo, and Santa Clara counties pursuant to the Plan for the Closure of Agnews Developmental Center, and consumers transitioning from Lanterman Developmental Center into various health plans whose Individual Program Plan documents the need for coordinated medical and specialty care that cannot be met using the traditional Medi-Cal Fee-For-Service system, services provided under the contract shall be provided by Medi-Cal managed care health plans who are currently operational in these counties as a county organized health system or a local initiative if consumers, where applicable, choose to enroll. Reimbursement shall be by the Department of Health Care Services for all Medi-Cal services provided under the contract that are not reimbursed by the Medicare program.

(b) Medi-Cal managed care health plans enrolling members referred to in subdivision (a) shall be further reimbursed for the reasonable cost of administrative services. Administrative services pursuant to this subdivision include, but are not limited to, coordination of care and case management not provided by a regional center; provider credentialing and contracting; quality oversight; assuring member access to covered services; consultation with Agnews Developmental Center staff, Lanterman Developmental Center staff, regional center staff, Department of Developmental Services staff, contractors and family members; and financial management of the program, including claims processing. Reasonable cost is defined as the actual cost incurred by the Medi-Cal managed care health plan, including both direct and indirect costs incurred by the Medi-Cal managed care health plan, in the performance of administrative services, but shall not include any incurred costs found by the Department of Health Care Services to be unnecessary for the efficient delivery of necessary health services. Payment for administrative services shall continue on a reasonable cost basis until sufficient cost experience exists to allow such costs to be part of an all-inclusive capitation rate covering both administrative services and direct patient care services

(c) Until the Department of Health Care Services is able to determine by actuarial methods, prospective per capita rates of payment for services for those members who enroll in the Medi-Cal managed care health plans specified in subdivision (a), the Department of Health Care Services shall reimburse the Medi-Cal managed care health plans for the net reasonable cost of direct patient care services and supplies set forth in the scope of services in the contract between the Medi-Cal managed care health plans and the Department of Health Care Services and that are not reimbursed by the Medicare program. Net reasonable cost is defined as the actual cost incurred by the Medi-Cal managed care health plans, as measured by the Medi-Cal managed care health plan's payments to providers of services and supplies, less payments made to the plans by third parties other than Medicare, and shall not include any incurred cost found to be unnecessary by the Department of Health Care Services in the efficient delivery of necessary health services. Reimbursement shall be accomplished by the Department of Health Care Services making

estimated payments at reasonable intervals, with these estimates being reconciled to actual net reasonable cost at least semi-annually.

(d) The Department of Health Care Services shall seek any approval necessary for implementation of this section from the federal government, for purposes of federal financial participation under Title XIX of the Social Security Act (42 U.S.C. Sec. 1396 et seq.). Notwithstanding any other provision of law, this section shall be implemented only to the extent that federal financial participation is available pursuant to necessary federal approvals.

*(The DDS Hand Outs are available at the Subcommittee Hearing from the Department.)*

## **Outcomes from Senate Subcommittee No. 3: Thursday, April 29th**

### **AGENDA #1—Lanterman Developmental Center “Transition” Plan**

**Action.** Adopted 6 actions as noted below. (All language was attached to the Agenda.)

1. Adopt Budget Bill Language to require the DDS to provide a comprehensive status update of the Lanterman Plan by January 10 and May 14 of each fiscal year.  
(See Attachment 1)
2. Adopt modified trailer bill language to direct the DDS to provide outpatient clinic services at Lanterman Developmental Center (as done at Agnews Developmental Center).  
(See Attachment 2)
3. Adopt modified trailer bill language to have the Secretary of Health and Human Services Agency to verify protocols as noted for the health and safety of individuals transitioning from Lanterman. (See Attachment 3)
4. Adopt modified trailer bill language to provide for cost-based reimbursement for Health Plans serving consumers transitioned from Lanterman to ensure health care coverage (as done for consumers transitioned from Agnews). (See Attachment 4)
5. Adopt placeholder trailer bill language provided by the DDS (*DDS Hand Out*) for Lanterman staff to be contracted out, if they choose, to work in the community (as done at Agnews).
6. Adopt placeholder trailer bill language provided by the DDS (*DDS Hand Out*) to expand Adult Residential Facilities for Persons with Special Health Care Needs so this residential model can be provided state-wide.

***AND KEPT THE ITEM “OPEN” FOR FURTHER DISCUSSION AT MAY REVISION***

**Vote:** 2-0 (Senator Ashburn absent)

## **AGENDA #2—Developmental Services (Discussion Items on Page 9)**

### **1. Informational Item: DDS Update on Current-Year Adjustments (Page 9)**

**Action.** Adopted trailer bill language for ICF-DD billing issue.

**Vote:** 2-0 (Senator Alquist absent)

### **2. Proposal to Reduce by Additional \$48.2 million (\$25 m GF) (Page 14)**

Held Issue “Open” pending May Revision.

### **3. Transportation Funding: General Fund Backfill (Page 15)**

- **Comment:** Subcommittee to advise Senator Ducheny and the Joint Legislative Budget Committee of the importance of this funding for inclusion in the supplemental deficiency bill. LAO concurred with this need.

### **4. Request for State Staff to Increase Federal Funds Participation (Page 16)**

**Action.** Approved the DDS request for staff as proposed.

**Vote:** 2-0 (Senator Alquist absent)

# **SUBCOMMITTEE #3: Health & Human Services**

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**Chair, Senator Mark Leno**

**Senator Elaine K. Alquist  
Senator Roy Ashburn**



**April 29, 2010**

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

(Diane Van Maren)

## **AGENDA # 2**

<b><u>Item</u></b>	<b><u>Description</u></b>	<b><u>Page</u></b>
<b>4300</b>	<b>Overall Background</b>	<b>2 - 8</b>
	<b>Discussion Items</b>	<b>9 - 17</b>

### **PLEASE NOTE:**

Agenda #1 regarding the Administration's Plan for Lanterman will be discussed first.

*Only* those items contained in this agenda will be discussed at this hearing. Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

*Please* see the Senate File (available on-line) for dates and times of subsequent hearings.

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee or by calling 916-651-1505. Requests should be made one week in advance whenever possible.

Thank you.

## Department of Developmental Services

### A. OVERALL BACKGROUND (Pages 2 through 8)

**Purpose and Description of Department.** The Department of Developmental Services (DDS) administers services in the community through 21 Regional Centers (RC) and in state Developmental Centers (DC) for persons with developmental disabilities as defined by the provisions of the Lanterman Developmental Disabilities Services Act. Almost 99 percent of consumers live in the community, and slightly more than one percent live in a State-operated Developmental Center.

To be eligible for services, the disability must begin before the consumer's 18th birthday; be expected to continue indefinitely; present a significant disability; and be attributable to certain medical conditions, such as mental retardation, autism, and cerebral palsy.

The purpose of the department is to: **(1)** ensure that individuals receive needed services; **(2)** ensure the optimal health, safety, and well-being of individuals served in the developmental disabilities system; **(3)** ensure that services provided by vendors, Regional Centers, and the Developmental Centers are of high quality; **(4)** ensure the availability of a comprehensive array of appropriate services and supports to meet the needs of consumers and their families; **(5)** reduce the incidence and severity of developmental disabilities through the provision of appropriate prevention and early intervention service; and **(6)** ensure the services and supports are cost-effective for the state.

**Description and Characteristics of Consumers Served.** The department annually produces a Fact Book which contains pertinent data about persons served by the department. As noted below, individuals with developmental disabilities have a number of residential options. Almost 99 percent receive community-based services and live with their parents or other relatives, in their own houses or apartments, or in group homes (various models) that are designed to meet their medical and behavioral needs.

#### Department of Developmental Services—Demographics Data from 2008

<i>Table 1</i> Age	Number of Persons	Percent of Total	<i>Table 2</i> Residence Type	Number of Persons	Percent of Total in Residence
Birth to 2 Yrs.	26,559	12.4	Own Home-Parent	156,204	72.6
3 to 13 Yrs.	59,643	27.7	Community Care	26,744	12.4
14 to 21 Yrs.	36,989	17.2	Independent Living /Supported Living	18,802	8.7
22 to 31 Yrs.	30,716	14.3	Skilled Nursing/ICF	8,811	4.1
32 to 41 Yrs.	22,163	10.3	Developmental Center	2,891	1.3
42 to 51 Yrs.	21,229	9.9	Other	1,594	0.7
52 to 61 Yrs.	12,157	5.7			
62 and Older	5,590	2.6			
<b>Totals</b>	<b>215,046</b>	<b>100.0</b>	<b>Totals</b>	<b>215,046</b>	<b>100.0</b>

**Background on State-Operated Developmental Centers.** State Developmental Centers (DCs) are licensed and federally certified as Medicaid providers via the Department of Health Services. They provide direct services which include the care and supervision of all residents on a 24-hour basis, supplemented with appropriate medical and dental care, health maintenance activities, assistance with activities of daily living and training. Education programs at the DCs are also the responsibility of the DDS.

The DDS operates four Developmental Centers (DCs) — Fairview, Lanterman, Porterville and Sonoma. Porterville is unique in that it provides forensic services in a secure setting. In addition, the department leases Canyon Springs, a 63-bed facility located in Cathedral City. This facility provides services to individuals with severe behavioral challenges.

**Background on Regional Centers (RCs).** The DDS contracts with 21 not-for-profit Regional Centers (RCs) which have designated catchment areas for service coverage throughout the state. The RCs are responsible for providing a series of services, including case management, intake and assessment, community resource development, and individual program planning assistance for consumers.

RCs also purchase services for consumers and their families from approved vendors and coordinate consumer services with other public entities. Generally, RCs pay for services only if an individual does not have private insurance or they cannot refer an individual to so-called “generic” services that are provided at the local level by the state, counties, cities, school districts, and other agencies. For example, Medi-Cal services and In-Home Supportive Services (IHSS) are “generic” services because the RC does not directly purchase these services.

RCs purchase services such as **(1)** residential care provided by community care facilities; **(2)** support services for individuals living in supported living arrangements; **(3)** Day Programs; **(4)** transportation; **(5)** respite; **(6)** health care; and many other types of services.

Services and supports provided for individuals with developmental disabilities are coordinated through the *Individualized Program Plan (IPP)* (or the *Individual Family Service Plan* if the consumer is an infant/toddler 3 years of age or under). The IPP is prepared jointly by an interdisciplinary team consisting of the consumer, parent/guardian/conservator, persons who have important roles in evaluating or assisting the consumer, and representatives from the Regional Center and/or state Developmental Center. Services included in the consumer’s IPP are considered to be entitlements (court ruling).

In addition, as recognized in the Lanterman Act, differences (to certain degrees) may occur across communities (Regional Center catchment areas) to reflect the individual needs of the consumers, the diversity of the regions which are being served, the availability and types of services overall, access to “generic” services (i.e., services provided by other public agencies which are similar in charter to those provided through a Regional Center), and many other factors. This is intended to be reflected in the IPP process.

**Background—Transitioning to Community Services.** The population of California's Developmental Centers has decreased over time. The development of community services as an alternative to institutional care in California mirrors national trends that support the development of integrated services and the reduced reliance on state institutions.

The implementation of the Coffelt Settlement agreement resulted in a reduction of California's Developmental Center population by more than 2,320 persons between 1993 and 1998. This was accomplished by creating new community living arrangements, developing new assessment and individual service planning procedures and quality assurance systems.

The United States Supreme Court decision in *Olmstead v L.C., et al (1999)* stated that services should be provided in community settings when treatment professionals have determined that community placement is appropriate, when the individual does not object to community placement, and when the placement can reasonably be accommodated.

**Budget Act Language—Allows for Transfer Between Items.** Finally, it should be noted that the annual Budget Act contains Budget Act Language which provides for the transfer of funds as necessary between the Developmental Centers Program and the Community Services appropriation (See provision 3 on page 345 of Senate Bill 874, as introduced). The purpose of this language is to enable the DDS to transfer funds, as appropriate, for individuals transitioning from a Developmental Center to the community.

**Summary of Budget Act of 2009.** The Governor proposed a \$334 million (General Fund) reduction, with a corresponding federal fund reduction, in 2009. The Legislature restored \$234 million (General Fund) of this amount in its February 2009 budget, thereby reducing expenditures by only \$100 million (General Fund).

As part of this February action, the Legislature directed the DDS to convene a diverse "workgroup" to assist in developing a collaborative approach in identifying cost reductions and efficiencies. A total of 15 proposals were identified through this process and trailer bill language was developed which was discussed and amended in this Subcommittee.

Unfortunately, the State's fiscal status deteriorated further and the Legislature was compelled by the Governor to reduce by another \$234 million (General Fund) to achieve the Governor's original proposal of reducing by \$334 million (General Fund).

In addition to the \$334 million (General Fund) reduction, with a corresponding federal fund decrease, the Governor vetoed an additional \$50 million (General Fund) from the Early Start Program and directed the CA First Five Commission (Proposition 10 Funds) to provide supplemental support. Such funding was just provided by the Commission on April 21, 2010.

As will be discussed today, the DDS is just beginning to obtain data in the current-year as to how these estimates are bearing out with respect to implementation and actual dollar savings. It should be noted that, in order to avoid a potential current-year deficiency, the DDS did a bottom-line adjustment to their estimate to reflect the savings target.

**Special Session Actions (Eighth Extra-Ordinary) of 2010.** On January 8, 2010, the Governor released his January budget, declared a fiscal emergency and called a Special Session consistent with Proposition 58 of 2004.

Among other things, the Governor proposed to extend for one-year (July 1, 2010 to June 30, 2011) a three percent reduction for certain payments for services purchased by Regional Centers for a reduction of \$99.5 million (\$49.7 million General Fund).

*Exempt* from this reduction are Supported Employment, the SSP supplement for independent living, and services with “usual and customary” rates as established in regulation. In addition, other services may be exempt from this reduction if a Regional Center demonstrates that a non-reduced payment is necessary to protect the health and safety of a consumer and the DDS has granted approval.

In addition, the Governor proposed to extend for one-year (July 1, 2010 to June 30, 2011) a three percent reduction to Regional Center Operations by continuing suspension of several administrative and case management requirements. This results in a reduction of \$16.2 million (\$11.2 million General Fund).

The Legislature adopted the Governor’s 3 percent reduction, with one administrative reporting change, for a total reduction of \$115.7 million (\$60.9 million General Fund) for 2010-11.

The Governor also proposed legislation to redirect a total of \$550 million (Proposition 10 Funds) to backfill for General Fund support in certain health and human services programs. A total of \$200 million (Proposition 10 Funds) was proposed for DDS to offset General Fund support in the Purchase of Services. The Legislature did *not adopt* the Proposition 10 proposal which would have required a vote of the people in June.

**Summary of Budget Appropriation for the Department of Developmental Services.**

The budget proposes total expenditures of \$4.823 billion (\$2.543 billion General Fund), for a *net* increase of \$168.2 million (total funds) over the revised current year for the entire developmental services system.

The Table below summarizes this information by program area.

## Summary of Governor's January Budget for Department of Developmental Services

Program Component	2009-10 January Revised Total Funds	2010-11 January Total Funds	Difference
Community Services	\$4,016,449,000	\$4,178,440,000	\$161,991,000
Developmental Center Program	\$603,834,000	\$606,376,000	\$2,542,000
Headquarters Support	\$34,036,000	\$38,115,000	\$4,079,000
<b>TOTAL, All Programs**</b>	<b>\$4,654,319,000</b>	<b>\$4,822,931,000</b>	<b>\$168,612,000</b>
Regional Center Consumers	242,495	249,975	7,480
Developmental Center Residents	2,151	2,008	-143

\*\* Includes Control Section 8.65 funds. This Control Section will be used as an offset to General Fund expenditures if California receives certain federal fund adjustments.

**Community Services Funding.** There are *two primary components* to the Community Services appropriation—Regional Center Operations, and the Purchase of Services. For Regional Centers' Operations a total of \$525.3 million (total funds) is proposed for 2010-11, or an increase of \$2.5 million (total funds) over the revised current year.

For the Purchase of Services, a total of \$4.148 billion (total funds) is proposed after accounting for several adjustments including the following: **(1)** continuation of the 3 percent reduction of \$99.5 million (total funds); **(2)** annualized affect of reductions from last year which total \$331.2 million (total funds); **(3)** additional reduction of \$25 million (General Fund) per the Governor; and **(4)** augmentation of \$50 million (placeholder) that may occur due to potential reductions to programs in other departments (such as IHSS). (The Governor's Control Section 8.65 is a stand-alone item and pertains to receipt of federal funds.)

The Table below provides a summary of the categories within the *Purchase of Services* funding. This Table reflects *baseline funding prior* to the application of cost-saving items and increases due to proposed impacts from other departments.

### Summary of Regional Center Purchase of Services Funding (Total Funds)

Service Category	2009-10 Revised Current	2010-11	Increased Amount (Total Funds)
Community Care Facilities (CCFs)	\$808.2 million	\$826.8 million	\$18.6 million
Medical Facilities	\$24.6 million	\$24.9 million	\$223,000
Day Programs	\$847.1 million	\$905 million	\$57.9 million
Habilitation Services	\$146.5 million	\$143.5 million	-\$3 million
Transportation	\$241 million	\$250 million	\$9 million
Support Services	\$751.3 million	\$832.2 million	\$80.9 million
In-Home Respite	\$272.3 million	\$304.3 million	\$32 million
Out-of-Home Respite	\$65.5 million	\$71.6 million	\$6.1 million
Health Care	\$98.7 million	\$106.5 million	\$7.8 million
Self Directed Services	\$118,000	\$858,000	\$740,000
Miscellaneous	\$482.2 million	\$545.6 million	\$63.4 million
Early Start Program	\$20.1 million	\$20.1 million	--
Prevention Program	\$27.2 million	\$36.3 million	\$9.1 million
Agnews Developmental Center Shift	\$41.8 million	--	-\$41.8 million
<b>Total Baseline (Prior to policy changes)</b>	<b>\$3.828billion</b>	<b>\$4.068 billion</b>	<b>\$240 million</b>

**Background—Summary of the Categories of Purchase of Services (POS).** A brief description of the above-referenced POS categories is provided below:

- **Community Care Facilities (CCFs).** Regional Centers contract with CCFs to provide 24-hour non-medical residential care to children and adults with developmental disabilities who are in need of personal services, supervision, and assistance essential for self-protection or sustenance of daily living activities.
- **Medical Facilities.** The Regional Centers vendor Intermediate Care Facilities (ICF) for consumers *not* eligible for Medi-Cal. The types of ICFs providing services to individuals with developmental disabilities are: ICF-DD (Developmentally Disabled), ICF-DD-H (Habilitative), ICF-DD-N (Nursing), and ICF-DD-CN (Continuous Nursing). (The Department of Health Services operates the Medi-Cal Program and directly reimburses those ICF providers who serve individuals with developmental disabilities who are eligible for Medi-Cal.)
- **Day Programs.** Day Programs are community-based programs for individuals served by a Regional Center. Day Programs are available when those services are included in a person's Individual Program Plan (IPP).
- **Habilitation Services Program.** This area includes the Work Activity Program and the Supported Employment Program. These programs provide opportunities for individuals with developmental disabilities to work.
- **Transportation.** Regional Centers contract with vendors to provide transportation services when other modes of transportation, such as family, public, self-directed, cannot be appropriately accessible.
- **Support Services.** Regional Centers contract with vendors to provide services and supports which include a broad range of services to adults who live in homes they themselves own or lease in the community.
- **Respite Services (In-Home and Out of Home).** Regional Centers contract with vendors to provide respite services to provide support to family members.
- **Health Care.** Regional Centers contract with vendors to provide health care services that are medical and health care related.
- **Self-Directed Services.** Enacted in 2005, these services are designed to be individually customized to meet the needs of the participant. Individuals eligible to receive Self-Directed Services cannot reside in or receive Day services in group settings. There are 75 enrollees in 2009 and an additional 1,725 people are expected to enroll in 2010-11.
- **Miscellaneous Services.** These services are a broad category and include tutors, special education teacher's aides, recreational therapists, speech pathologists, mobility training specialists and counseling.
- **Early Start.** This program provides services to eligible infants and toddlers from birth up to age 3.
- **Prevention Program.** This program was enacted in 2009 to provide a prevention program for at-risk infants and it will focus primarily on providing intake, assessment, case management, and referral to generic agencies for children through 35-months.

Previously these infants and toddlers were provided services under the Early Start Program.

- **Agnews Developmental Center Shift.** This category of funding was used to identify expenditures for the Agnews Unified Community Placement Plan (for the three Bay Area Regional Centers) to close Agnews. The expenditure for the current-year reflects costs associated with consumers transitioned to the community in 2008-09. For 2010-11 these costs will transition to the overall Regional Center POS line item.

**Developmental Centers Funding.** The revised 2009-2010 reflects a decrease of \$69.4 million (\$30.7 million General Fund) from the Budget Act of 2009 (July) due to furloughs and overtime/holiday reductions. In addition, 233.8 positions (some partial year) were reduced due to a decrease in residents, including the closure of Agnews (March 2009) and Sierra Vista (December 2009).

For 2010-11, the budget reflects a decrease in residents of 143 consumers (from 2,151 consumers to 2,008 consumers). A total of \$606.4 million (\$309.7 million General Fund) is proposed for expenditure.

The Developmental Centers will be discussed in more detail at the May Revision since resident caseload will be updated, along with the Lanterman Plan.

*(Discussion Items begin on next page.)*

## **B. Items for Discussion: Community-Based Services**

### **1. Informational Item: DDS Update on Current-Year Adjustments**

**Fiscal Update.** As referenced above, a series of actions were taken in the Budget Act of 2009 (July) based on the Governor's direction to identify \$334 million in General Fund reductions, along with corresponding federal fund reduction, within the overall DDS area.

The DDS *Hand Out* provides a summary of these actions and anticipated reductions per issue, as estimated in July 2009. (Attached to "hard copy" of this Agenda, and can be obtained electronically from DDS website.)

In the DDS Work Group meeting of *April 19, 2010*, the DDS provided an update on current year implementation.

*Key aspects* of this April 10, 2010 DDS briefing are as follows:

- **General Observations.** DDS is monitoring the reduction proposals based on actual data that is being received. A more comprehensive update will be available at the Governor's May Revision. But, the general observation is that reductions were achieved when limits or restrictions were enacted. Those proposals that were optional, often did not achieve the estimated reduction.

DDS also asserts that in some instances, confounding factors—such as the birth rate being down by 6.9 percent from the last two years-- play a role in discerning the full impact of some of the reductions due to various interrelated factors.

- **Federal Fund Proposals (\$78.8 million GF saved with Federal Funds).** Four items were associated with the receipt of these additional federal funds. DDS should provide a *brief overall update* on the receipt of these federal funds, as well as step-through preliminary, draft trailer bill language regarding the ICF-DD rate issue (billing process).
  - **Additional Services Under Home & Community-Based Waiver (\$13 million).** The DDS obtained federal CMS *approval* to add additional services, such as day care, to this Waiver. No issues have been raised.
  - **Implementation of a "1915 (i)" State Plan Amendment (\$60 million).** This is a new method offered by the federal government in 2005 for covering Home and Community-Based services for Medi-Cal enrollees beginning in January 2007.

This amendment has been submitted to the federal CMS and is pending discussions. Under this amendment, individuals enrolled in Medi-Cal but not presently eligible for the Home and Community-Based Waiver (i.e., not at risk for institutionalization) would be enrolled under the Waiver (and the State would receive additional federal funds). No issues have been raised at this time.
  - **Intermediate Care Facility-DD State Plan Amendment. (\$4.6 million).** This amendment would reconfigure the rate paid to Intermediate Care Facilities for persons with Developmental Disabilities. Specifically, the DHCS and DDS would

use an “all inclusive” rate to capture transportation, Day Program, and related assistance within the ICF-DD rate to bill additional federal funds. This will also be done for Skilled Nursing Facilities under a similar State Plan Amendment which has to be filed separately.

This issue was first proposed in the Budget Act of 2007, and the federal CMS approval will honor past expenditures for California (as such no GF loss). The baseline amount is \$44 million (federal funds) and has been previously accounted for in prior years (pending CMS approval).

This technical billing issue will require trailer bill language for implementation. DDS has provided *preliminary, draft* language for this purpose (*Hand Out*). This language needs to be discussed today.

- **Downsize Large Residential Facilities (\$1.2 million).** Under this action, Regional Centers will not *newly* vendor large facilities (16 beds or more) which do not qualify for federal funds (Medi-Cal) because of their institutional setting. by July 1, 2012, Regional Centers will not be able to purchase services from these existing facilities unless certain conditions are met as specified in statute.

DDS states this is progressing. DDS should provide a *brief update*.

- **Early Start Program: Eligibility Criteria & “At Risk” Program (\$35 million).** Several changes were made to the Early Start Program (birth to age 3) including the following:

- *Regional Center Operations (\$2.1 million).* Reduce staff due to change in criteria. This was achieved.
- *Eligibility Criteria (\$15.5 million).* As of July 1, 2009, toddlers aged 24 months need to have a delay of 50% or greater in one domain, or, 33% or greater in two domains to enter the program. Previously, it was a delay of 33 percent or greater in one of the five domains.
- *Prevention Program (\$19.5 million).* As of October 1, 2009, infants and toddlers who are ‘at risk’ are no longer eligible for Early Start but can participate in a new Prevention Program (non-Lanterman Act). Each Regional Center is to receive a finite allocation to provide intake and assessment, case management, and referral to appropriate generic resources (such as Medi-Cal, California Children Services, and others) for these toddlers.

DDS states that these reductions in Early Start are being achieved but it may be somewhat attributable also to the reduction in births.

DDS should provide *brief comment* on these interactions and the Early Start Program.

- **Behavioral Services Standards (\$19.3 million).** Under this action, specific standards for the purchase of behavioral standards by Regional Centers was implemented. DDS states this service category continues to grow but that the rate of growth has slowed. DDS anticipates some reduction will be achieved but they are doubtful it will achieve the estimated amount. DDS should provide a *brief update*.

- **General Standards (\$45.9 million).** Under this action, Regional Centers are to follow certain specified standards for authorizing the purchase of services, such as using generic services first when available, not purchasing experimental treatments, and using the least costly vendor for a service if this vendor otherwise meets needs identified in the person's Individualized Program Plan (IPP). DDS states that since these standards affect most of the service delivery system, it is not feasible to individual ascertain the affects of these changes. However, DDS notes that Regional Center expenditures for the current-year are within the appropriation. DDS should provide a *brief update*.
- **Temporarily Suspend Services (\$27.4 million).** Certain services were temporarily suspended pending development of the Individual Choice Model, a new service delivery model that offers flexibility in services within a defined budget. The suspended services included: (1) camp; (2) social recreation; (3) education services for minor children; and (4) non-medical therapy. This suspension of services will be lifted upon certification of the DDS that the Individual Choice Budget has been implemented as specified.

Though reductions have been achieved in these areas, DDS notes there are a significant number of Fair Hearings filed to receive these services. The outcomes from many of these hearings are still impending. DDS should provide a *brief update* on this issue.

- **Expansion of In-Home Respite Agency Worker Duties (\$3 million).** DDS states they have not yet received any applications for the provision of incidental medical services by Respite Agencies as described above. As such, no reduction has resulted.

Under this proposal, "In-Home" Respite Agency employees would include certain additional services, *as appropriate*, in their duties. By having In-Home Respite Agency employees perform these services, it is assumed that less respite hours would need to be provided by Home Health Agencies and Licensed Vocational Nurses which are more expensive.

The intent of this proposal was to have non-licensed respite workers provided training by licensed health care professionals to be able to perform incidental medical services as follows: (1) Colostomy and ileostomy-- changing bags and cleaning stoma; (2) Urinary catheter-- emptying and changing bags; and (3) Gastrostomy-- feeding, hydration, cleaning stoma, and adding medication per physician's or nurse practitioner's orders for the routine medication of patients with stable conditions.

This proposal was to achieve a reduction of \$4 million (\$3 million General Fund). This level of savings assumed the following:

- Reduction of 10 percent in the number of respite hours purchased from Home Health Agencies and Licensed Vocational Nurses.
- Corresponding increase of 10 percent in the number of respite hours purchased through In-Home Respite Agencies.
- Increase of \$0.50 per hourly wage (limited to hours providing "skilled" respite services), *plus* a 16.76 percent increase for the employer costs due to the wage

increase (for social security, worker's compensation, unemployment compensation), for In-Home Respite Agencies (employees and employer as noted).

- Assumes Regional Centers may reimburse In-Home Respite Agencies up to \$200 semi-annually for providing training to its employees for the additional services to be conducted.

- **Respite Program—Temporary Service Standards (\$4.2 million General Fund), and Early Start Program: The Change in Federally Required Services (Respite) (\$4.2 million).** DDS states they have seen a decline in the number of consumers accessing respite services. They note there has been a flattening out of the projected growth in these two budget categories and it is not fully possible to discern the impact of each factor separately. Some of the key factors in the decline of consumers accessing respite services as noted by the DDS included the following:

- Less enrollment in the Early Start Program (birth rate down and the change in eligibility);
- The increase in the Family Cost Participation Program (done in 2008-09) could be dampening the growth since parental participation for respite services were increased (in some cases up to 100 percent for higher income families).
- Other changes, such as increased internal reviews by Regional Centers including use of generic resources, increased parental responsibilities, and other items enacted in 2008 probably had some affect.
- The poor economy has resulted in job losses and people possibly staying at home.

DDS conducted a survey of Regional Centers and analyzed Purchase of Services data and it appears that about \$19.6 million will be achieved from this area.

DDS should provide more detail regarding the application of the enacted legislation from 2009, and the various factors that could be affecting expenditures and growth in this area.

- **Custom Endeavors Option (CEO) (\$12.7 million).** DDS state that only 6 consumers are participation in this new program and the reduction level had assumed that 2,583 consumers would participate. Therefore only minimal savings is being achieved.

Under this proposal, a Day Program provider would offer this customized program to a consumer in lieu of their current program. This alternative would be based on a consumer's Individualized Program Plan (IPP).

The reduction level assumed that 5 percent of current consumers would opt out of their existing Day Program and select this alternative. Of those estimated to choose this alternative, half of the consumers would receive 20 hours of services per month and the other half will receive 80 hours of services per month.

The Day Programs affected by this option include: (1) Community Integration Training; (2) Community Activities Support Services; (3) Activity Center; (4) Adult Development Center; and (5) Behavior Management Program.

- **New Services for Seniors (\$1 million).** DDS state that only 5 consumers are participating and it was assumed that 424 would participate in order to obtain the savings. Therefore only minimal savings is being achieved.

The intent of this program is that some aging consumers presently participating in Day Programs would want to “retire” or participate in less intensive services. Under this program individuals desiring a less rigorous Day Program, would be able to choose this alternative. This new program component would be reimbursed at a reduce rate and would have a *lower* staff to consumer ratio of 1 to 8 (as compared to a 1 to 3, 1 to 4, or 1 to 6).

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

1. DDS, Please provide a brief overview of the current-year regarding the changes enacted in the community-based services area.
2. DDS, Please speak specifically to the key current-year items outlined in this Agenda, *and* provide a perspective as to how the DDS is keeping abreast of trends and analyzing data.
3. DDS, Please provide your perspective on Respite services and the Regional Center survey information.
4. DDS, Please step through the key aspects of the proposed trailer bill language for the technical billing issues on the ICF-DD. (Pages 9-10 of the Agenda.)

## **2. Governor's Proposal to Reduce by Additional \$48.2 million (\$25 million GF)**

**Budget Issues.** The Governor's January budget reflects several key adjustments to the local assistance appropriation which is used to fund Purchase of Services (POS) expenditures managed by Regional Centers and Regional Center Operations.

As referenced above, the Governor's January budget assumes **(1)** continuation of the 3 percent reduction on certain payments for services purchased by Regional Centers; **(2)** continuation of the 3 percent reduction on Regional Center Operations; and **(3)** continuation of various other reductions as adopted in the Budget Act of 2009, and referenced above.

*In addition to these*, the Governor is proposing a reduction of \$48.2 million (\$25 million General Fund) by increasing the 3 percent reduction on *both* the Purchase of Services and Regional Center Operations by *another* 1.25 percent for a total of 4.25 percent on each.

Of the proposed \$48.2 million (\$25 million General Fund) reduction, about 82 percent, or \$39.3million (total funds) would be from POS. The remaining amount of about \$8.9 million would be from Operations.

The DDS states they are analyzing options for providing administrative relief to providers to assist in mitigating the additional 1.25 percent reduction to POS expenditures. This information has not yet been provided to constituency groups or the Subcommittee.

DDS also states the existing exemptions for Supported Employment, the SSP supplement for independent living, and services with "usual and customary" rates as established in regulation are not proposed to change. In addition, other services may be exempt from this reduction if a Regional Center demonstrates that a non-reduced payment is necessary to protect the health and safety of a consumer and the DDS has granted approval.

**Subcommittee Staff Recommendation.** It is recommended to hold this issue "open" pending receipt of the May Revision, and to redirect the DDS to provide the Budget Work Group, other interested parties and the Subcommittee with additional information regarding the proposed "administrative relief" for providers.

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

1. DDS, Please provide a brief summary of how the additional 1.25 percent reduction on POS expenditures and Regional Center Operations would affect services.
2. DDS, What is being anticipated as far as providing "administrative relief" for providers?

### **3. Transportation Funding: General Fund Backfill in lieu of Public Transit Funds**

**Budget Issue.** As proposed by the Governor, the Budget Act of 2009 (July) appropriated \$138.3 million (Public Transportation Account Funds) to backfill for General Fund support in the DDS for transportation services provided to consumers. The Administration contended expenditure of these funds, derived primarily from sales taxes on gasoline and diesel fuels could be used for this purpose and met the intent of Section 14506 of the Government Code for expenditure.

However, the recent *Shaw v. Chiang* decision denied the expenditure of the Public Transportation Account Funds for this purpose, as well as for certain other General Fund expenditures.

The Joint Legislative Budget Committee (JLBC) has been notified by the Department of Finance (DOF) of this court ruling and of a current-year deficiency request of \$131.1 million (General Fund) within the DDS budget resulting from this action. The DDS was able to offset \$7.2 million of the \$138.3 million loss through a fund shift resulting from the receipt of increased federal funds in the Early Start Part C grant.

The DOF states in their notification that \$131.1 million (General Fund) will be forthcoming through a supplemental appropriations bill for the current-year.

Receipt of this General Fund backfill is assumed for 2010-11.

**Subcommittee Comment and Recommendation.** The *Shaw v Chiang* decision negates the use of the Public Transportation Account for all transportation services for consumers, including specialized transportation, transportation services to Day Programs, transportation to employment, and for other consumer services and supports.

If funds are not provided before the end of the fiscal year (June 30, 2010), it would be likely that the State would be in violation of the Lanterman Act, as well as the "Olmstead" decision since consumers would not be able to appropriately access their services.

It is recommended for the Subcommittee to advise the JLBC of the importance of this funding and to recommend its approval to them.

**Questions.** The Subcommittee has requested the DDS to respond to the following questions.

1. DDS, Please explain why the \$131.1 million (General Fund) is needed.
2. DDS, If these funds are not appropriated until after June 30, what may occur and what concerns may providers have?

#### **4. Request for State Staff to Increase Federal Funds Participation**

**Budget Issue.** The DDS is requesting an increase of \$515,000 (\$228,000 General Fund) for five two-year limited-term positions to capture additional federal funds and to **(1)** implement the 1915 (i) State Plan Amendment; **(2)** implement billing changes associated with the ICF-DD and Skilled Nursing changes regarding transportation; and **(3)** future issues related to the pending 1115 Medi-Cal Waiver.

As has been discussed, a key component to sustaining the developmental services system is to obtain additional federal funds. DDS states they will generate about \$79 million in additional federal funds for 2009-2010, and \$132.5 million for 2010-11. Most of these increases are due to the new 1915 (i) State Plan Amendment and the ICF-DD changes.

Specifically, the DDS is requesting the following positions:

- **Career Executive Appointment II.** This position would work with the federal CMS and the DHCS to develop and implement the 1915 (i) State Plan Amendment, and the pending 1115 Medi-Cal Waiver being developed by the DHCS. The DDS states a CEA position is needed due to the tremendous breadth of experience and knowledge required with understanding California's developmental services system and the complexities of federal Medicaid law. This position will have responsibility for the policy, program, and day-to-day operations of these new federal programs within DDS and the community service system.

Key activities would include the following:

- Directing policy and technical crafting of the federal 1915 (i) State Plan Amendment, a State Plan Amendment for Skilled Nursing Facility residents, and the development of the DDS infrastructure to maximize federal financial participation.
  - Working with the DHCS, Regional Centers, and various stakeholders on issues arising from the development of the DHCS 1115 Waiver and its implementation.
  - Directing implementation of the internal and community infrastructure needed to carry out the new functions DDS will assume in order to maximize federal financial participation.
  - Representing DDS in negotiations with the federal CMS.
- **Staff Services Manager I.** This position will directly supervise three staff and will do the following:
    - Negotiate and implement contract changes with Regional Centers for policy and program changes;
    - Oversee the development and review of systems and procedures for implementation;
    - Ensure that all claiming, billing and payment of Medi-Cal funds comport with federal and State statute and regulations;

- Assist the CEA in responding to constituency groups, inquiries from the federal CMS and DHCS, and provide critical information to the Legislature;
  - Supervise, guide and train three staff.
- **Two Community Program Specialists II's.** These positions will work under the direction of the CEA and Staff Manager I to development, implement and conduct day-to-day operations of new administrative and payment mechanisms for capturing the federal funds. DDS will be assuming responsibilities for claiming, billing and payment of Medi-Cal funds associated with the ICF-DD and Skilled Nursing transportation issue. (Discussed in issue #1 of this Agenda.)

These positions will also provide assistance with implementation of the 1115 Medicaid Waiver as applicable.

- **Research Program Specialist I.** This position will employ research methodologies and statistical procedures to design and implement program and fiscal analyses of these new programs and to develop and prepare complex data analyses and reports, including for the federal CMS. They will conduct research and statistical modeling of rates and rate methodologies relative to controlling General Fund expenditures and maximizing federal funds in these programs and on an ongoing basis.

**Background—1915 (i) State Plan Amendment.** DDS submitted this Amendment and which as been approved by the federal CMS and is retroactive to October 2009. This will enable California to obtain federal funds for individuals living in the community who are not at-risk for institutionalization and cannot be presently placed on the existing Home and Community-Based Waiver. Additional services will be eligible for reimbursement as well.

**Subcommittee Staff Comment and Recommendation.** Due to the magnitude of work to be accomplished, as well as the complexity, it is recommended to approve the DDS request for positions. It is critically important to obtain these federal funds to achieve General Fund savings and to ensure that services are available and that providers are paid appropriately. The federal CMS will be closely monitoring California and all requirements will need to be met.

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

1. DDS, Please provide a brief summary of the request.

# **SUBCOMMITTEE #3: Health & Human Services**

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**Chair, Senator Mark Leno**

**Senator Elaine K. Alquist  
Senator Roy Ashburn**



**May 6, 2010**

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

**Room 4203**

Committee Staff: Jennifer Troia

<b><u>Item</u></b>	<b><u>Department</u></b>
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<b>4140</b>	<b>Office of Statewide Health Planning &amp; Development</b>
<b>4200</b>	<b>Department of Alcohol &amp; Drug Programs</b>
<b>4170</b>	<b>Department of Aging</b>
<b>5160</b>	<b>Department of Rehabilitation</b>
<b>5175</b>	<b>Department of Child Support Services</b>
<b>5180</b>	<b>Department of Social Services</b>

*(See Table of Contents on pages 2-3 for More Specific Listing of Issues.)*

**Please note: The Committee will discuss only the items contained in this agenda at this hearing.** Please see the Senate File for dates and times of subsequent hearings. The Committee will discuss the issues in the order noted in the agenda, unless otherwise directed by the Chair.

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance from the Senate Rules Committee, 1020 N Street, Suite 255 or by calling 916-651-1505. Requests should be made one week in advance whenever possible.

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**Vote-Only Agenda**

**0530 Office of Systems Integration, Health & Human Services Agency (OSI)**

**5180 Department of Social Services (DSS)**

**OSI & DSS Issue 1: Electronic Benefit Transfer (EBT) Project**

**Budget Issue:** The overall budget for the EBT system in 2009-10, including project management, is \$47.3 million (\$27.0 million GF/TANF). The Administration requests, in a Spring Finance Letter dated April 1, 2010, a decrease of \$10.3 million (\$2.4 million GF) in that same year to both the Department of Social Services Local Assistance budget and corresponding OSI spending authority. The proposed 2009-10 decrease is a result of cost reductions under a new contract. The Administration also requests a decrease of \$20.9 million (\$5.4 million GF) in DSS Local Assistance and a corresponding reduction of \$19.7 million in OSI Spending Authority for 2010-11. The proposed 2010-11 decrease includes contract cost changes, as well as the expiration of limited-terms for staff and the completion of other transition-related tasks.

The Governor's budget for 2010-11 also proposes \$177,000 (\$66,000 GF) to extend, for another two years, two existing limited-term positions that support the EBT system at DSS. One position would continue to provide program support to the counties and the other to OSI. DSS has sought, and been granted authority for, extensions of these two limited-term positions six times since the EBT system was mandated in 1997.

**Background on EBT:** The EBT system eliminates the need for coupons or checks to deliver Supplemental Nutrition Assistance Program (food stamps) and cash aid benefits. Instead, the EBT system provides benefits through automated teller machines (ATMs) and point-of-sale terminals (e.g., in grocery stores). The EBT system works by automating benefit authorization, delivery, redemption, and settlement processes through computers, plastic debit cards, and telecommunications technology. OSI provides state-level project management and oversight for the system.

**Changes in EBT Contract Costs:** The proposed cost reductions in 2009-10 and 2010-11 are due to the transition of EBT services to a new contract (from J. P. Morgan Electronic Financial Services, Inc. [JPMorgan EFS] to ACS State and Local Solutions, Inc. [ACS]). The lowered costs are reflective of decreased costs for EBT services nationwide since 2000, when California executed its first EBT contract with Citicorp (later taken over by JPMorgan EFS). They also reflect a change from an "unbundled" cost structure (with differing rates for food benefits only, cash benefits only, and combined food and cash benefits, along with various other costs for related services and equipment) to a "bundled" rate (e.g. eliminated some costs for related services and equipment and are bundled in the benefit costs).

**Subcommittee Staff Comment & Recommendation:** Staff recommends approving the requested budget decreases contained in the OSI request, as well as the proposed extension of the two limited-term positions at DSS.

## 4140 Office of Statewide Health Planning & Development

### OSHPD Issue 1: Staffing for Health Care Data Requests

**Budget Issue:** OSHPD requests, in a Spring Finance Letter dated April 1, 2010, an increase of \$144,000 in California Health Data and Planning Fund (CHDPF) expenditure authority and the authority to redirect two positions for a two-year limited term. This request is in response to an anticipated increase in workload resulting from the enactment of SBx5 2 (Chapter 1, Fifth Extraordinary Session, Statutes of 2010). SBx5 2 expanded the categories of entities that can request health data from OSHPD.

**Background:** OSHPD collects confidential patient-level data from California licensed hospitals, emergency departments, and ambulatory surgery centers. State statute allows for the release of limited portions of this data to California hospitals, local public health officers and local public health departments, and specified federal public health agencies. All research requests for OSHPD's confidential patient-level data must include a project protocol approved by the Committee for the Protection of Human Subjects (CPHS), thereby necessitating CPHS review of the requests. CPHS is housed within OSHPD and has federal and state mandates to protect the rights of human subjects involved in research.

Prior to passage of SBx5 2, confidential patient-level data for research purposes could be shared, upon request, only with the University of California and similar non-profit education institutions. SBx5 2 unintentionally expanded access to health-related data to include non-profit entities in general. SBx5 2 was a bill intended to address education-related issues, and specifically the federal Race to the Top (RTTP) program. The bill seeks to facilitate educational data sharing in order to make California eligible for additional RTTP funding. One of the goals of the bill was to make educational data available to various non-profit entities that are likely to engage in research. In order to meet RTTP requirements, SBx5 2 requires CPHS to enter into an agreement with an Institutional Review Board (created by SBx5 2 to review requests for educational data).

**Subcommittee Staff Comment & Recommendation:** The Legislature did not intend for the SBx5 2 changes related to education data to also impact patient-level health information. Staff therefore recommends rejecting the proposed resources and position authority for OSHPD to implement those unintended changes. Instead, staff recommends adopting place-holder trailer bill language to narrow the provision in SBx5 2 to its intended purpose. As a result, the statute would affect the accessibility of educational, and not health, data. This action would be consistent with action recently taken by the Assembly's Subcommittee #1 on Health and Human Services.

<b>OSHPD Issue 2: Mental Health Loan Assumption Program Changes</b>
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**Budget Issue:** OSHPD requests, in a Spring Finance Letter dated April 1, 2010, an increase of \$2.5 million (Mental Health Services Fund) in 2010-11 and subsequent years to increase the amount available for Mental Health Loan Assumption Program (MHLAP) awards. The MHLAP awards grants to mental health practitioners working in hard to fill or retain positions within the public mental health system (as determined by County Mental Health Directors). The Mental Health Services Fund was created by Proposition 63 of 2004, the Mental Health Services Act (MHSA). The Department of Mental Health (DMH) estimates that MHSA expenditures will total \$1.3 billion in 2009-2010 and \$1.6 billion in 2010-11.

**Background on MHSA and MHLAP:** The MHSA imposes a one-percent income tax on personal income in excess of \$1 million. The purpose of the Act 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). The MHSA also required development of a five-year plan to remedy the shortage of qualified mental health service providers by making loan forgiveness programs available to current and prospective employees in California's public mental health system. As a result, DMH partnered with the County Mental Health Directors Association (CMHDA) and the Mental Health Services Oversight & Accountability Commission (MHSOAC) to develop a ten year expenditure plan that includes the MHLAP. The chart below shows the significant, still unmet, demand for the program:

<b>MHLAP (March 2009)</b>	
Applications received	1,222
Applications awarded	288
Debt burden of applicants	\$56,544,823
Amount requested	\$15,460,101
Amount awarded	\$2,285,277

The requested funding would allow expansion from 288 to 600 MHLAP awards. The proposed resources would also allow for expansion of professionals eligible for MHLAP awards to include Licensed Professional Clinical Counselors (LPCC) and LPCC interns. Of the total request, \$43,000 would support state operations.

**Subcommittee Staff Comment & Recommendation:** Staff recommends approving the requested resources.

**4170 Department of Aging****CDA Issue 1: Senior Community Service Employment Program**

**Budget Issue:** CDA requests, in a Spring Finance Letter dated April 1, 2010, one-time augmentations of federal fund authority totaling \$848,000 in 2009-10 and \$3,392,000 in 2010-11. The request is based on the receipt of federal funds from the United States Department of Labor (DOL). The current year authority has been requested through a Section 28 letter to the Joint Legislative Budget Committee. The requested funds would provide additional support for the existing Senior Community Service Employment Program (SCSEP) administered by the California Department of Aging (CDA) through the Area Agencies on Aging (AAAs) and must be expended by June 30, 2011.

**Background:** SCSEP provides part-time, work-based training opportunities at local community service agencies for low-income older workers who have poor employment prospects. DOL has provided funding for an additional 434 participant slots statewide. Additional participant slots will be equitably distributed to the local SCSEP projects according to the CDA funding formula. With the requested authority, CDA would be able to carry over any unspent funds allocated to local entities in 2009-10 into 2010-11. The federal grant allows for this timing of fund usage.

**Subcommittee Staff Comment & Recommendation:** Staff recommends approving the requested federal budget authority.

**4700 Department of Rehabilitation (DOR)****DOR Issue 1: Traumatic Brain Injury Program (TBI)**

**Budget Issue:** DOR requests, in a budget change proposal, an increase of \$1.3 million (\$1.2 million special funds from criminal and vehicular offense fines and \$170,000 federal funds) and 2.0 positions to administer the TBI program. This request results from the passage of AB 398 (Monning, Chapter 439, Statutes of 2009), which transitions the TBI program from the Department of Mental Health (DMH) to DOR.

**Background:** See the April 8, 2010 Agenda for more information.

**Subcommittee Staff Comment & Recommendation:** Staff recommends approving one permanent position and one two-year limited-term position. This second limited-term position is in place of the permanent position requested by the department and previously approved by the Subcommittee on April 22, 2010. This updated action is consistent with action taken by the Assembly's Budget Subcommittee #1.

**5180 Department of Social Services (DSS)****DSS Issue 1: Positions Related to Recent Legislation**

**Budget Issue:** The Governor's proposed budget for 2010-11 includes, in a budget change proposal, \$200,000 (\$169,000 GF) in temporary help resources to implement recent legislation, including AB 762 (Bonnie Lowenthal, Chapter 471, Statutes of 2009); SB 781 (Leno, Chapter 617, Statutes of 2009); and AB 1325 (Cook, Chapter 287, Statutes of 2009).

**Background:** See the April 22, 2010 Agenda for more information.

**Subcommittee Staff Comment & Recommendation:** Consistent with actions recently taken in Assembly Budget Subcommittee #1, staff recommends:

1. Rejecting the resources requested for AB 762 on the basis that the fiscal analysis on the bill from the administration indicated that the costs were negligible and absorbable by DSS.
2. Rejecting the resources requested for SB 781 on the basis that the workload is speculative and has not been substantiated to warrant new resources.
3. Approving the resources requested for AB 1325 for one year, in 2010-11, only.

**DSS Issue 2: Promoting Safe & Stable Families (PSSF) - Proposed Trailer Bill Language (TBL)**

**Budget Issue:** The Administration proposes TBL to conform state law to federal requirements, as created by the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) and most recently updated in the Child and Family Services Improvement Act of 2006 (P.L. 109-269). According to the Administration, these conforming policy changes have no 2010-11 fiscal impacts. The Department indicates, however, that the changes would alleviate a potential risk to federal Promoting Safe and Stable Families (PSSF) funding due to non-compliance by the state.

**Background:** The Administration states that current state statute does not reflect the most recent federal requirements (last changed in 2006). Specifically, the proposed TBL would: 1) change the percentage of allowable state administrative costs from the original 15 percent to the current 10 percent; 2) change the programs' service categories from an original two to the current four, and provide current definitions for each category; and 3) change the minimum percentage of spending in each category to the current requirement of 20 percent. The TBL would also make other non-substantive conforming changes, such as updating the program's name throughout state law.

**Subcommittee Staff Comment & Recommendation:** Staff recommends rejecting the proposed TBL, without prejudice as to its merits. An analysis of existing law and any related clarifications are more appropriate for consideration by the relevant Legislative Policy Committees. This recommendation is consistent with recent action by Assembly Budget Subcommittee #1.

### **DSS Issue 3: Proposed Trailer Bill Language (TBL) to Suspend Intensive Treatment Foster Care (ITFC)-Related Provisions of SB 1380**

**Budget Issue:** The Governor's proposed budget for 2010-11 includes TBL to suspend implementation of statutes enacted by SB 1380 (Chapter 486, Statutes of 2008). Similar to the TBL proposed for two other child welfare issues heard by the Subcommittee on April 22, 2010, existing law would be implemented when "the Department of Finance determines that sufficient state operations resources have been appropriated." Again, the effect would be to transfer Legislative authority to the Administration.

**Background on SB 1380 and ITFC:** SB 1380 expanded eligibility and revised operational, reporting, and training requirements for the Intensive Treatment Foster Care (ITFC) program. ITFC was originally established in 1990 to ensure that foster children with emotional challenges could thrive in a family home with therapeutic services, rather than high-level and more expensive group homes. The Assembly Appropriations Committee analysis of SB 1380 indicated that the bill would result in net savings because foster children would be placed in less costly, less restrictive home settings, as opposed to more costly group home environments.

**Subcommittee Staff Comment and Recommendation:** The Administration has indicated that it may be reconsidering whether to continue pursuing this TBL and/or to amend its proposal. To be clear about the Legislature's intent, staff recommends taking action to reject the proposal.

### **DSS Issue 4: Implementation of Federal Fostering Connections to Success & Increasing Adoptions Act (FCSA)**

**Budget Issue:** DSS proposes, via TBL, to add specified costs of transporting a child to his or her school to those that are included in the definition of foster care maintenance payments, to amend statutes related to the placement of siblings in foster care, and to amend statutes governing adoption or foster care programs operated by Indian tribes. According to the Department, these changes are required for the state to conform to requirements of the federal FCSA (P.L. 110-351).

The 2009-10 budget includes \$8.7 million (\$2.2 million GF, for six months beginning in January 2010), and the Governor's 2010-11 budget includes \$17.4 million (\$4.5 million GF), for costs associated with education-related transportation.

**Background:** See April 22, 2010 agenda.

**Subcommittee Staff Comment & Recommendation:** Staff recommends adopting placeholder trailer bill language to conform state law to the FCSA and related budget requests with respect to educational transportation costs, as well as sibling placements, and agreements with tribes or tribal entities. As appropriate and necessary, the recommended placeholder language may also include changes for federal conformity regarding the educational placements of children in foster care.

### **DSS Issue 5: Group Home Financial Audits – Proposed Trailer Bill Language (TBL)**

**Budget Issue:** DSS proposes TBL that would alter the statutorily required trigger for group home and foster family agency (FFA) financial audits. The audits are paid for by these service providers. However, the Governor's budget assumes up to \$300,000 GF savings in 2010-11 as a result of reduced staff workload for reviewing the audits as a result of this proposal.

**Background:** The monthly rates paid to group homes and FFAs for each child under their care are established in state statute and must be consistent with federal requirements that they cover the costs of care and supervision. After a 10 percent reduction that took effect pursuant to ABx4 4 (Chapter 4, Fourth Extraordinary Session, 2009) in 2009, FFA rates range from \$1,430 to \$1,679 per child, per month. As the result of a recent federal district court order that increased rates paid to group homes, currently effective group home rates range from \$2,085 to \$8,835 per child, per month.

As a condition of receiving these funds, organizations that operate group home and FFA programs must have financial audits conducted as required by federal and state laws. The proposed TBL would change the statutory trigger for an audit from when a threshold amount (\$500,000) of federal funds is "received" to when those funds are "expended." According to DSS, these changes would be consistent with federal audit statutes and requirements. The Department indicates that the proposed TBL would reduce the frequency of financial audits for "a few facilities."

**Subcommittee Staff Comment & Recommendation:** Staff recommends rejecting the proposed TBL, without prejudice as to its merits. An analysis of existing law and any related clarifications are more appropriate for consideration by the relevant Legislative Policy Committees.

**DSS Issue 6: Child Welfare Services/Web (CWS/Web) Project**

**Budget Issue:** To support the development of CWS/Web, the Governor's 2010-11 budget for DSS requests, in a budget change proposal, \$436,000 (\$199,000 GF) to: 1) establish one two-year limited-term position, 2) extend an existing managerial position for another two-year limited term, and 3) augment by \$240,000 DSS contracts with county consultants. As the Committee discussed on March 18, 2010, the Governor's budget for CWS/Web project management by Office of Systems Integration (OSI) additionally requests \$1.8 million (\$827,000 GF) for 10 new positions.

The 2009-10 budget for CWS/Web is \$7.1 million (\$3.2 million GF). OSI estimates a total cost of \$202.8 million (\$91.9 million GF) between 2012 and 2014 to complete implementation of CWS/Web and enter its maintenance and operations (M&O) phase.

**Background on CWS/CMS and CWS/Web:** Please see the March 18, 2010 Agenda for more information.

**Stated Rationale for Additional Resources:** The federal Department of Health and Human Services, Administration for Children and Families (ACF) has expressed concerns that the CWS/Web project is significantly understaffed in terms of programmatic and technical resources. DSS currently has seven staff members to assist with its programmatic support for CWS/Web planning. The Department anticipates that their workload will increase dramatically as the project advances into its design and implementation phases.

The Department intends for one of the requested positions to be filled by an individual with knowledge of the adoptions process who can participate in the design, development, testing, training, and implementation activities of the adoptions component of the new CWS/Web system. The request to extend authorization of the second position is for a manager to provide supervision to this individual, as well as three other staff members.

**Subcommittee Staff Comment & Recommendation:** Consistent with the Subcommittee's vote on March 18, 2010 regarding the requested resources for additional OSI staff to support CWS/Web development, staff recommends holding this issue open pending May Revision.

**DSS Issue 7: Community Care Licensing (CCL) - Proposed TBL  
Related to Fingerprinting Fees**

**Budget Issue:** Since 2003-04, TBL has been enacted on an annual basis to suspend existing statute that prohibits DSS from charging a fee for fingerprint and criminal record checks conducted on behalf of applicants seeking a license to provide residential or day care for fewer than six children. According to DSS, failure to continue the suspension of this fee exemption would result in an annual cost to the state of \$391,000 GF.

**Background:** Individuals who seek to operate child and adult facilities, provide care to facility clients, or reside at a community care facility, undergo comprehensive background checks. The checks are intended to ensure that individuals with criminal histories are thoroughly evaluated and/or investigated before they are allowed to have contact with clients. In particular, DSS requires a fingerprint-based background check from both the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI). DOJ bills DSS \$35 per applicant for obtaining this information. The background check for individuals associated with children's facilities who serve six or fewer children also includes a check of the Child Abuse Central Index (CACI). The fee for the CACI check is an additional \$15.

DSS is statutorily prohibited from charging these fees to individuals who seek to provide residential or day care for six or fewer children. However, for the past several years, this statutory prohibition has been suspended; and these individuals have been required to pay for the checks. In 2010-11, DSS estimates that a total of 11,180 applications will fit into these categories. Given the ongoing fiscal challenges faced by the State, CDSS proposes to permanently eliminate the prohibition, rather than continue to pursue annual statutory changes.

**Subcommittee Staff Comment & Recommendation:** Staff recommends adopting placeholder TBL to suspend the provisions prohibiting the charging of these fees for an additional one or two years, rather than permanently repealing the fee prohibition as proposed by the Administration. This action would be consistent with action recently taken by the Assembly's Subcommittee #1 on Health and Human Services.

**DSS Issue 8: CalWORKs – State and County Peer Reviews**

**Budget Issue:** DSS proposes to reduce 2009-10 funding for the state and county CalWORKs peer review process to \$37,000 (TANF funds) and to de-fund the program entirely in 2010-11. The 2009-10 budget for the program was \$221,000 (TANF) in local assistance funding for the counties. DSS also proposes trailer bill language to suspend the statutory requirement for the Department to implement the process statewide by July 2007 and to instead require its implementation only in the year for which a sufficient appropriation is made in the Budget Act.

**Background:** See Agenda from March 18, 2010 for more information.

**Subcommittee Staff Comment & Recommendation:** Staff recommends approving the proposed suspension of funding for the peer review process, but rejecting the Administration's proposal to transfer Legislative authority to determine the sufficiency of program funding to the Department of Finance. Staff correspondingly recommends that the Subcommittee approve placeholder TBL that deletes the last sentence of the proposed TBL.

**DSS Issue 9: Conlan v. Shewry – Positions and Proposed Budget Bill Language (BBL)**

**Budget Issue:** DSS requests, in a Budget Change Proposal, \$113,000 (\$56,000 GF) to establish one new position to review claims filed by IHSS recipients under the *Conlan II* court decisions. DSS also requests to permanently extend one limited-term manager position that would otherwise expire in June 2011 (at an annual cost of \$128,000 [\$64,000 General Fund]). If these requests are granted, the *Conlan II* unit at DSS would consist overall of one Staff Services Manager and three other permanent positions. DSS states that all of these positions are necessary to meet the provisions of the *Conlan II* court order.

In 2009-10, the Legislature approved DSS's request for the creation of one new position and extension of two additional positions, but rejected the request for a fourth position, to review recipients' claims for reimbursement under *Conlan II*.

**Background on *Conlan II* and DSS Workload:** See March 18, 2010 Agenda.

**Budget Bill Language (BBL) Related to *Conlan* Workload:** The Administration also proposes to continue its authority, in BBL, to transfer local assistance funding that would otherwise be directed to counties to instead be used for state operations costs and administratively established positions associated with *Conlan II* workload. As in prior years, the Department of Finance would be required to notify the Legislature of any transfers pursuant to this section. To date, the Administration has used this authority once- to transfer \$57,000 (\$29,000 GF) for the administrative establishment of one position in 2007-08.

**Subcommittee Staff Comment & Recommendation:** Staff recommends approving the requested positions and BBL. In future years, however, the Subcommittee may wish to revisit whether the authority granted to the Administration in the BBL continues to be necessary and consistent with the Legislature's oversight of staffing for the workload associated with implementing these court decisions.

### Discussion Agenda

**0530 Office of Systems Integration, Health & Human Services Agency (OSI)**

**5180 Department of Social Services (DSS)**

<b>OSI &amp; DSS Issue 1: Case Management, Information and Payrolling System Replacement Project (CMIPS II)</b>
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**Budget Issue:** The total 2009-10 budget for CMIPS II is \$117.8 million (\$48 million GF), with \$92.2 million in OSI spending authority. The Administration requests, in a Spring Finance Letter dated April 1, to reduce this funding by \$17.8 million (\$7.2 million GF) for DSS local assistance, with a corresponding reduction of \$8.6 million in OSI spending authority. The Administration also requests to reduce the 2010-11 DSS local assistance budget by \$49.5 million (\$20.1 million GF), with a corresponding reduction of \$49.5 million to OSI spending authority. According to OSI, these reductions reflect a schedule shift due to changes in the CMIPS II development strategy and the transition into the implementation phase of the project. The shift does not affect the total project budget, but rather redistributes costs over the remainder of the project.

OSI also requests authority in 2010-11 for one two-year limited term CMIPS II position to support contract management and project administration activities. OSI proposes to fund this position from its existing budget, based on savings in Data Center costs. In particular, Storage Area Network costs have decreased, resulting in savings. There are currently 31 state staff (21 OSI staff and 10 CDSS staff) and 36 State Support contractor staff dedicated to the CMIPS II project.

**Background on CMIPS and CMIPS II:** OSI provides project management services for automation projects of the Department of Social Services (DSS), including CMIPS. The existing CMIPS is a more than 20-year-old system that offers mainly payroll functions for providers in the In-Home Supportive Services (IHSS) program. CMIPS II is intended to be a web-based solution that integrates off-the-shelf products to perform IHSS case management, payroll, and timesheet processing, as well as reporting and data exchange functions. OSI has indicated that this new system will offer a number of benefits as compared with the existing system, including more timely updates of information; more easily accessible reports; increased work automation; and a greater ability to interface with other data systems.

**CMIPS II Project Delays:** OSI currently anticipates that the design, development and implementation of CMIPS II will be completed in March 2012. This represents a 5-month delay from the anticipated completion date of September 2011 identified during the Subcommittee's April 30, 2009 hearing. This delay, which is at least in part attributed to recent changes in the IHSS program, is in addition to a 3-month delay that occurred when the project started in July 2008.

Procurement planning activities for CMIPS II originally began in fiscal year 1999-00. Procurement was then delayed due to funding reductions in 2003, program changes in 2004, and the efforts of OSI and DSS to ensure a competitive process. Final proposals from bidders were received in August 2006. The incumbent contractor, Electronic Data Systems (EDS), was the sole bidder. The contract award was supposed to be made on July 1, 2007, but negotiations took longer than anticipated. As a result, the contract was awarded to EDS in March 2008. Federal approval of the Implementation Advanced Planning document was also received in March 2008. Project initiation and planning began July 1, 2008.

**Subcommittee Staff Comment & Recommendation:** Staff recommends approving the proposed reductions to the CMIPS II budget for 2009-10 and 2010-11. Staff also recommends holding open the requested position authority.

**Questions for OSI and DSS:**

- 1) What accounts for the unusually long (i.e., 12-year-long) procurement and development processes for CMIPS II? Are there increased costs to the state that have resulted from this elongated process?
- 2) What are the foregone efficiencies in the administration of the IHSS program that have occurred as a result of these delays? What, if any, are the effects of the delays on IHSS staff, consumers, and providers?
- 3) Do the current design, development, and implementation of CMIPS II reflect up-to-date technologies (i.e. including advancements which have occurred since procurement planning began)?

**OSI Issue 2: Statewide Fingerprint Imaging System (SFIS) – Proposed Use for In-Home Supportive Services (IHSS) Program**

**Budget Issue:** The Governor’s budget for 2009-10 includes, in a Budget Change Proposal, an increase in OSI spending authority of \$8.2 million (\$4.4 million GF) for the use of SFIS to collect fingerprint images from In-Home Supportive Services (IHSS) recipients. These funds were already included in the DSS budget, but there was no conforming authority for SFIS or for OSI’s project management role. The Administration is awaiting a formal response from the federal government with respect to its willingness to financially participate in these proposed expenditures, and future, ongoing anticipated costs. The total SFIS budget for 2009-10 includes \$20.1 million (\$9.5 million GF).

The administration also requests position authority for four new SFIS-related positions at OSI. Two of the positions would replace 1.5 contract staff who provide training coordination and application support for the use of SFIS in the CalWORKs, Supplemental Nutrition Assistance, and General Assistance/General Relief programs. The state has contracted these duties out for the last decade. Funded as part of the \$8.2 million mentioned above, the other two positions would support new sites and equipment to begin the use of SFIS for IHSS recipients. OSI currently has five permanent staff members assigned to SFIS and oversees six additional contract staff who work the equivalent of three full-time positions.

**Background on SFIS:** SFIS is a statewide automated system that was created in response to the requirements of SB 1780 (Chapter 206, Statutes of 1996) for applicants and recipients of California Work Opportunity and Responsibility to Kids (CalWORKs) and Food Stamp program benefits to be fingerprint imaged as a condition of eligibility for those programs. OSI provides state-level project management and oversight for SFIS. The state recently entered into a new contract for its maintenance and operations for eight years from September 2009 until September 2017. The fingerprint images contained in SFIS are used to verify eligibility and to check for duplicate aid applications by one individual. The Administration states that the existence of these fingerprint requirements and of the SFIS system deter a significant amount of fraud.

A 2003 audit by the Bureau of State Audits found that DSS “implemented SFIS without determining the extent of duplicate-aid fraud throughout the State,” and that “Social Services did not implement SFIS in a manner that would allow it to collect key statewide data during its implementation of SFIS.” The auditor was therefore “unable to determine whether SFIS generates enough savings from deterring individuals from obtaining duplicate aid to cover the estimated \$31 million the State has paid for SFIS or the estimated \$11.4 million the State will likely pay each year to operate it...”

**Background on Fingerprinting of IHSS Consumers:** See the Agenda from the October 28, 2009 Oversight Hearing of Recent Changes in the IHSS Program by the Assembly Budget Committee & Senate Budget Subcommittee #3 for a comprehensive list of the significant changes to the IHSS program made in the 2009-10 budget. Based

on the 2009-10 appropriation, the Administration estimated that taken together, these program integrity changes would result in an estimated \$130 million GF savings at the enhanced Federal Medical Assistance Percentage (FMAP) provided under ARRA, or \$162 million GF savings at the non-ARRA FMAP rate of 50 percent.

Among these program changes made in 2009 was the requirement, beginning April 1, 2010, for finger imaging of IHSS consumers. Under the requirements of ABx4 19 (Chapter 17, 4<sup>th</sup> Extraordinary Session, 2009), this fingerprinting must take place in the new consumers' homes at the time of their initial assessment for eligibility. Current consumers (460,000) were to be finger imaged at their next reassessment, conducted annually and also in the home. These statutes included exemptions for minors and those physically unable to provide fingerprints due to amputation. They do not require a picture image to be taken of the consumer. Finally, the statutes require DSS to consult with county welfare departments to develop protocols to carry out these requirements.

The Administration is currently conducting pilots to test mobile fingerprint imaging devices that would allow for implementation of these requirements by gathering fingerprints and photo images in recipients' homes, to later be uploaded into SFIS. DSS also intends to utilize social worker and consumer feedback gathered during the pilots to inform its policies and protocols for larger-scale implementation of the new fingerprinting requirements.

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

**Questions for OSI and DSS:**

- 1) What efforts did the Administration undertake to measure the occurrence of duplicate aid fraud in the IHSS program prior to proposing the requirements for recipient fingerprinting?
- 2) On what did the Administration base its estimates for the costs and savings from implementing these fingerprint requirements?
- 3) Please provide a brief update on the recipient fingerprinting pilots, including:
  - a. How the Administration engaged with the counties and with stakeholders in the development of protocols under which to conduct those pilots;
  - b. What equipment is being utilized in those pilots; and
  - c. The anticipated timeline for statewide implementation.
- 4) How and when does the Administration plan to source the equipment for obtaining recipients' finger images?

**4140 Office of Statewide Health Planning & Development (OSHPD)****OSHPD Issue 1: Hospital Seismic Safety Compliance Oversight**

**Budget Issue:** The Governor's proposed 2010-11 budget for OSHPD's Facilities Development Division (FDD) includes \$55.9 million in Hospital Building Fund spending authority. The main source of Hospital Building Fund revenue is fees paid by hospitals when applying for construction plan approval. Of the total FDD budget, \$2.6 million is for the Seismic Retrofit Program. The Seismic Retrofit Program Unit reviews and approves the seismic evaluation reports and compliance plans, performs HAZUS reassessments and monitors hospital seismic compliance reporting. The remaining \$53.4 million is primarily for plan review, construction observations, or other essential duties related to hospital seismic safety compliance projects (including structural and non-structural retrofits and replacement hospital buildings).

**Background on Hospital Seismic Safety Requirements:** Following the 1971 San Fernando Valley earthquake, California enacted the Alfred E. Alquist Hospital Facility Seismic Safety Act of 1973 (Alquist Act), which mandated that all new hospital construction meet stringent seismic safety standards. In 1994, after the Northridge earthquake, the Legislature passed and the Governor signed SB 1953 (Alquist), which required OSHPD to establish earthquake performance categories for hospitals, and established a January 1, 2008 deadline by which general acute care hospitals must be retrofitted or replaced so they do not pose a risk of collapse in the event of an earthquake, and a January 1, 2030 deadline by which they must be capable of remaining operational following an earthquake. SB 1953 also allowed most hospitals to qualify for an extension of the January 1, 2008 deadline to January 1, 2013.

According to the background paper from the Senate Health Committee's informational hearing on March 3, 2010, many of the state's 2,627 hospital buildings meet the January 1, 2013 deadline, are on track to meet it, or qualify for an extension; however, several hundred appear to not be on track to meet the deadline and are not eligible for extensions. These buildings, including many that are owned and operated by major health care systems and provide significant levels of hospital services, face the prospect of being taken out of service if they are not retrofitted or replaced by that time. Hospitals cite a variety of reasons for their inability to meet the deadlines for these buildings, the most prominent being declining patient revenues and difficulty accessing capital.

**Subcommittee Staff Comment & Recommendation:** This is an informational and oversight-related item, and no action is required.

**Questions for OSHPD:**

- 1) Please briefly update the Subcommittee on the implementation of SB 1953 and subsequent, related legislation. Specifically, how is OSHPD working to ensure that hospitals comply with safety and reporting requirements?

- 2) Why have some hospitals put these projects on hold, and how many may be at risk of not meeting the 2013 deadline at this point?
- 3) Based on hospitals' reports to OSPHD, what types of services are currently provided in buildings that are not on track to meet the 2013 deadline?

## 4200 Department of Alcohol & Drug Programs (ADP)

### ADP Issue 1: Women and Children's Residential Treatment Services

**Budget Issue:** The Governor's proposed budget for ADP in 2010-11 includes \$11.2 million for perinatal (before and after childbirth) drug treatment services. Of these funds, \$6.1 million (\$2.5 million GF and \$3.6 million federal funds) are for Drug Medi-Cal services provided to eligible Medi-Cal beneficiaries. The remaining \$5.1 million (all GF) are set aside for designated Women and Children's Residential Treatment Services programs (WCRTS). The proposed \$5.1 million for WCRTS in 2010-11 includes a decrease of \$663,000 when compared to the enacted 2009-10 budget. The decrease was precipitated by the closure of one of the original provider organizations.

**Background on WCRTS:** WCRTS funds support designated programs that were created with federal grants which have since expired. According to ADP, 669 individuals currently receive treatment through these resources. Budget Bill Language (BBL) related to WCRTS from 2009-10 stated, "Of the funds appropriated in this item, \$5,767,000 shall be used to fund existing residential perinatal programs that were begun through the federal Center for Substance Abuse Treatment grants, but whose grants have since expired...All of the funds allocated for programs shall be passed through those counties directly to the designated nine residential treatment programs in each county, respectively." (emphasis added)

One of the original nine programs, in San Luis Obispo County, recently closed. When that provider ceased operating, the Department of Finance maintained funding for the other providers at historic levels and reduced the overall WCRTS funding. This action resulted in a reduction of perinatal treatment capacity statewide and in the sweeping of \$663,000 as GF savings. Given the ambiguity of the budget language with respect to this circumstance, the Administration could alternatively have interpreted Legislative intent to maintain the overall funding base and instead increase the funding allocated to the remaining eight providers.

**Proposed 2010-11 BBL:** The Governor's budget proposes to amend the Budget Bill to reflect the reduced funding and to state that the WCRTS allocation shall now be passed through to "the designated eight residential treatment programs."

**Subcommittee Staff Comment & Recommendation:** Staff recommends adopting an amendment to Provision 2 of Item 4200-104-0001 of the 2010-11 Budget Bill to clarify the Legislature's intent regarding overall WCRTS program funding by deleting the word "eight". Staff also recommends that the 2010-11 appropriation be restored to the original 2009-10 allocation of \$5.8 million for the remaining providers. This action would be consistent with action recently taken by the Assembly's Budget Subcommittee #1.

**Questions for ADP and DOF:**

- 1) How did the Administration determine its course of action with regard to overall WCRTS funding when one of the original nine providers closed?
- 2) What is the scope and capacity of treatment provided with WCRTS funding? How would that capacity change as a result of the proposed \$663,000 reduction?

**5175 Department of Child Support Services (DCSS)****DCSS Issue 1: Proposal for Administrative Process to Establish and Modify Orders**

**Budget Issue:** DCSS proposes, in a Spring Finance Letter dated April 1, 2010, to overhaul the system for establishing and modifying child support orders in California. The proposed system would continue to include a combination of administrative and judicial procedures. However, as compared with the state's current child support system, the proposed system would include more administrative procedures and less judicial involvement.

The Administration estimates that this proposal would result in \$3 million (\$1 million GF) savings for January through July 2011, when DCSS would begin implementation with modifications of court orders. The Administration estimates that savings would grow to \$17.1 million (\$5.8 million GF) in 2011-12, when the changes would also apply to establishment of child support orders. The bulk of the anticipated long-term savings are based on anticipated reductions in costs for court contracts and the employment of attorneys by Local Child Support Agencies (LCSAs). DCSS states that the costs of automation changes required to implement this proposal would be absorbable within its existing automation budget.

**Overview of Child Support System:** The primary purpose of California's child support program is to secure child support payments from absent or non-custodial parents and for custodial parents and their children. Local Child Support Agencies (LCSAs) provide services such as locating absent parents; establishing paternity; obtaining, enforcing, and modifying child support orders; and collecting and distributing payments. When a family receiving child support also receives public assistance (in approximately 20 percent of cases), the LCSAs distribute the first \$50 per month collected from the non-custodial parent to the custodial parent and child. Any additional support collected is deposited into the General Fund to partially offset state costs for public assistance.

**Child Support Procedures Nationwide:** In accordance with federal law, states have considerable flexibility in designing the processes by which they establish and modify child support orders. Across the nation, there is a continuum from highly judicial (court forum, judge presides, attorneys involved) to highly administrative (executive-branch agency sets order with or without hearing, limited attorney involvement) systems. Along the continuum, most states have some form of a hybrid system.

DCSS states that its proposal is most closely modeled after the system in Pennsylvania. One significant difference, however, is that Pennsylvania's administrative process is administered by its judicial branch. The system in Texas also has a number of similarities to DCSS's proposed system. Two major distinctions, however, are that Texas excludes a number of cases from its administrative process (i.e., cases involving domestic violence, foster care, minor parents, and interstate issues) and that Texas's guidelines for establishing child support are less complex than California's.

**California's Existing Process for Establishing Support Orders:** California currently has a judicially-based system for establishing child support orders, with administrative aspects. Court commissioners or family law judges have final authority to establish parentage and to decide on the amount of support to be paid. There are three common paths by which courts arrive at child support orders. The first includes cases in which the parties agree and "stipulate" to a child support order. In these cases, parents do not usually appear in court. According to data from a 2005 review by the Judicial Council, approximately 29 percent of cases were resolved this way at the time.

If a parent does not respond after being served with notice, the court may enter (usually without a hearing) a default judgment based on statutory guidelines regarding the amount of child support to be paid. Default judgments are generally an undesirable result, as they are less likely to be based on a complete factual picture and less frequently adhered to by the child support obligor. In 2005, approximately 39 percent of orders in California were entered by default.

The third path to a child support order involves a court hearing attended by the parties. Sometimes hearings occur in cases that are solely about child support. Other times, hearings also involve other family law issues (e.g., custody). According to DCSS, it takes approximately three months from the time a parent "answers" a notice that the other parent is seeking child support until a court hearing. At the hearing, an LCSA attorney represents the child support agency. The parents and LCSAs may appear by telephone, audiovisual, or other electronic means. Court commissioners, however, must be physically present in the county courthouse. In 2005, contested hearings occurred in approximately 32 percent of child support cases.

**California's Existing Process for Modifying Court Orders:** Current law allows an individual to request a review of his or her child support order if there has been a change in circumstances. Current law also requires LCSAs to mail notice to the parties, at least once every three years, informing them of the right to request that the LCSA review and, if appropriate, seek to modify the child support order. If modification is appropriate, the LCSA files paperwork with the court. Again, when both parties agree, the paperwork can include a stipulation and the parties may not have to appear in court.

**Proposed Process for Establishing and Modifying Orders:** DCSS proposes to create a three-tier process to establish and modify child support orders.

**Tier 1: Office Conference held at the LCSA and administered by a caseworker.** To start the process, the LCSA would file paperwork with the court and then schedule an office conference in approximately 30 calendar days. The LCSA would serve notice of the conference on the parties, along with a proposed order, no later than five calendar days beforehand. The conference itself would be administered by an LCSA caseworker with specialized mediation training. If parentage is at issue, the office conference would be a forum for making that determination (which could include the subpoena of evidence and witnesses and/or consideration of genetic testing results). The parties could participate in person or by phone, and would be given an opportunity

to provide information about their income, expenses, and the amount of time they spend parenting. The rules of evidence that govern admissibility in court hearings (e.g., to establish authenticity of a document) would not apply.

If the parties attend the conference and agree to the terms of support, the Conference Officer would generate a stipulation for the parties to sign immediately. The stipulation would be sent to the court for review and approval, along with a conference summary. If the order is approved, the LCSA would serve the parties by mail with a copy. If the parties do not appear, or appear but do not agree, the Conference Officer would generate a proposed order based on the information available at the time (or the assumption of minimum wage at 40 hours per week if no information is available). The proposed order and conference summary would be sent to the court for review, and would become an interim, enforceable order once the court approves and files it. The LCSA would mail the interim order to the parties. If neither requests a hearing within 20 calendar days, the interim order would become final.

DCSS has stated that court review of interim orders in Tier 1 and Tier 2 should take around five minutes. As a result of its review, a court could approve an order or set the case for hearing.

**Tier 2: Administrative hearing held at the LCSA and administered by a State Attorney (upon request only).** If either party requests a hearing within 20 days of mail service of the interim order, the LCSA would schedule an administrative hearing approximately 30 calendar days out. This hearing would be held at the LCSA or by telephone and presided over by a Hearing Officer (an attorney employed by the state with at least three years experience). The parties could also file a request for a hearing in court instead.

The Hearing Officer would review evidence regarding income, expenses, and parenting timeshares and make findings regarding those issues. Again, court rules regarding evidence admissibility would not apply. The Hearing Officer would then prepare a stipulation or an interim order based on the information presented. The LCSA would send the agreement or the interim order to the court, along with a summary written by the Hearing Officer. Again, the order would be enforceable once reviewed and filed by the court. The LCSA would mail it to the parties, who would have 20 days to request a court hearing.

**Tier 3: Court hearing administered by a Commissioner or Family Law Judge (upon request of the parties or motion of the court).** According to the Department, Tiers 1 and 2 of the proposal would offer an optional path outside the current judicial process to resolve disputes administratively, while reserving the right of the parties to utilize existing judicial processes if they wish to do so. Either party can request a hearing before a Court Commissioner or Family Law Judge at any stage. Following the issuance of an interim order, however, the parties have 20 days within which to make such a hearing request. As under the current system, an LCSA attorney would represent the agency at the hearing. The court would consider the issues anew (“de

novo”) and then issue an order. In another change from the current system, the court commissioners would be allowed to hold hearings from any physical court location in any county. They could also hear cases in person or by telephone, audiovisual or other electronic means.

**Prior Effort to Streamline Order Modifications:** SB 1483 (Chapter 876, Statutes of 2006) established pilot projects to test an expedited child support order modification process. The bill required DCSS and the Judicial Council to conduct an evaluation of the effectiveness of the pilot project and report the results to the Governor and the Legislature by July 1, 2009. To date, the Legislature has not received this report.

**DCSS Arguments in Favor of this Proposal:** The Administration argues that these changes would improve the timeliness of child support services and the efficiency and cost effectiveness of child support operations. According to DCSS, child support customers who participate in the current judicial system experience a lengthy (six to nine months on average), time-consuming process for establishing orders and obtaining support. DCSS intends for the proposed process to reduce the time involved in establishing or modifying orders to an average of sixty days. The Administration also states that the proposed process would encourage non-adversarial interactions and good working relationships between child support agencies and the parties early on in a case. For example, DCSS envisions that the office conference process would be more user friendly and accessible, as it would engage child support customers at the beginning of the process and encourage them to fully participate in all aspects of establishing or modifying child support orders.

**Arguments Raised in Opposition to this Proposal:** A number of stakeholders have expressed concerns with the proposed changes. One repeated objection is that DCSS did not consult with or notify key stakeholders regarding this proposal, which includes sweeping and major changes to the child support system. Other concerns include:

- 1) That there are conflicts of interest in having the same administrative agency (that has related performance-based outcome measures upon which to improve) conduct the administrative process, represent the LCSA in court, and then enforce child support orders;
- 2) That the proposal inaccurately assumes that the courts are the source of current delays in the child support system;
- 3) That the projected cost-savings do not account for needed system and process costs associated with these large-scale changes, or adequately account for the resources it would take for a court to meaningfully review proposed orders; and
- 4) That the process creates a system where access to the courts is unequal, leading to unequal justice, particularly for the most low-income and otherwise vulnerable of clients and families.

**Subcommittee Staff Comment and Recommendation:** Staff recommends rejecting the Spring Finance Letter proposal, as it raises a number of critical, unanswered policy questions. Staff further recommends that the Department be directed to work collaboratively with stakeholders on any future proposals for changes to administrative and judicial processes that may result in better service to families and a more cost-effective child support system.

**Questions for DCSS and DOF:**

- 1) What consultation took place with stakeholders in the development of this proposal? To what extent did the Department attempt to find areas of consensus on the changes needed to improve the child support system?
- 2) Please summarize the Department's methodology for determining the anticipated savings included in the proposal. In particular, how large are the automation costs that the Department considers "absorbable"? How did the Department project how many families or judicial officers would request court hearings?
- 3) How does DCSS envision that caseworkers will be trained to assess credibility and appropriately apply the law in cases where the parties disagree about the facts or contest parentage? What record will the parties have of the basis for caseworkers' determinations in these disputes?
- 4) How do you anticipate that the proposed administrative process would apply in the kinds of circumstances that Texas exempts from its administrative process (i.e., cases involving domestic violence, foster care, minor parents, and interstate issues)?
- 5) What were the results of the SB 1483 pilots related to streamlined modification processes? Why hasn't the Legislature received the required report on those outcomes?

**DCSS Issue 2: California Child Support Automation System (CCSAS)**

**Budget Issue:** The Governor's budget for 2010-11, in a Budget Change Proposal, requests \$49.3 million (\$16.8 million GF) as a technical adjustment to restore base funding for CCSAS. In 2009-10, these resources were provided through re-appropriations from prior years' funding. The Governor's budget also proposes a base increase of \$8.2 million (\$2.7 million GF) for project costs, including increases in maintenance and operations services, help desk support, and the costs of personal computer replacements in 2010-11.

The Administration also proposes, in a Spring Finance Letter dated April 1, 2010, \$14.1 million (\$4.8 million GF) in 2010-11 for one-time costs associated with transitioning the Child Support Enforcement (CSE) system from vendor-provided services to in-house state services. The Finance Letter further requests authority to pursue a non-competitive bid with IBM for transition services. According to DCSS, the bid is non-competitive because the current system which will be transitioned is built entirely on IBM's hardware and software platforms. Additionally, DCSS requests resources for one-time start-up costs for the new State Disbursement Unit (SDU) Service Provider beginning April 1, 2011. The Administration proposes to fund these Spring Finance Letter proposals with re-appropriated funds from 2006-07, 2007-08, and 2008-09.

**Background on CCSAS:** The total budget for CCSAS (including project management, as well as maintenance and operations) in 2009-10 includes \$118.9 million (\$40.4 million GF) for the Child Support Enforcement (CSE) case and financial-management system and \$22.7 million (\$7.7 million GF) for SDU services (central processing for collecting and distributing child support payments). According to DCSS, anticipated total costs between 2003-04 and 2012-13 total \$2.2 billion (\$775.4 million GF) for the CSE and \$239.2 million (\$81.3 million GF) for the SDU. With federal certification completed in December 2008, the system is now funded with a 66 percent federal share.

According to DCSS, the volume and scope of work, web-based architecture, and supporting technologies used by the CSE make it the largest and most complex U.S. public sector system of its kind. The Department is now focused on transitioning this system from a contractor's data center to a state data center. This transition will be phased in over a 9 to 12-month period. DCSS also plans to transition its customer call center infrastructure from a contractor to the state by September 2010. By December 2011, DCSS plans to re-procure the SDU.

**Subcommittee Staff Comment & Recommendation:** Staff recommends approving the technical adjustment proposed in the Budget Change Proposal to restore the base funding for CCSAS. Staff also recommends holding open the requested \$8.2 million (\$2.7 million GF) increase to the base funding. Finally, staff recommends approving the use of new funding of \$4.8 million GF associated with the Spring Finance Letter, and sweeping all unspent DCSS re-appropriation funds. A net amount of approximately

\$1.8 million GF savings should result. Staff should be directed to work with DOF and LAO to operationalize this change and make appropriate changes to Budget Bill Language to conform to the action.

**Questions for DCSS:**

- 1) Please briefly summarize the current status of CCSAS and the changes proposed in 2010-11. Please also summarize the need for the requested \$8.2 million (\$2.7 million) increase to the base funding.
- 2) What are the long-term savings to the state anticipated from the Spring Letter proposal to transition from a contractor-supported and hosted CSE system to a state-supported and hosted CSE system?

# **SUBCOMMITTEE #3: Health & Human Services**

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**Chair, Senator Mark Leno**

**Senator Elaine K. Alquist  
Senator Roy Ashburn**



## **Outcomes from May 6, 2010 Hearing**

Committee Staff: Jennifer Troia

### **Vote-Only Agenda**

**0530 Office of Systems Integration, Health & Human Services Agency (OSI)**

**5180 Department of Social Services (DSS)**

#### **OSI & DSS Issue 1: Electronic Benefit Transfer (EBT) Project**

Approved (3-0) the requested budget decreases contained in the OSI request, as well as the proposed extension of the two limited-term positions at DSS.

**4140 Office of Statewide Health Planning & Development**

#### **OSHPD Issue 1: Staffing for Health Care Data Requests**

Adopted (3-0) place-holder trailer bill language to narrow the provision in SBx5 2 to its intended purpose. As a result, the statute would affect the accessibility of educational, and not health, data. This action is consistent with action recently taken by the Assembly's Subcommittee #1 on Health and Human Services.

#### **OSHPD Issue 2: Mental Health Loan Assumption Program Changes**

Approved (3-0) the requested resources.

**4170 Department of Aging****CDA Issue 1: Senior Community Service Employment Program**

Approved (3-0) the requested federal budget authority.

**4700 Department of Rehabilitation (DOR)****DOR Issue 1: Traumatic Brain Injury Program (TBI)**

Approved (3-0) one permanent position and one two-year limited-term position. This second limited-term position is in place of the permanent position requested by the department and previously approved by the Subcommittee on April 22, 2010. This updated action is consistent with action taken by the Assembly's Budget Subcommittee #1.

**5180 Department of Social Services (DSS)****DSS Issue 1: Positions Related to Recent Legislation**

Voted (3-0) to:

1. Reject the resources requested for AB 762 on the basis that the fiscal analysis on the bill from the administration indicated that the costs were negligible and absorbable by DSS.
2. Reject the resources requested for SB 781 on the basis that the workload is speculative and has not been substantiated to warrant new resources.
3. Approve the resources requested for AB 1325 for one year, in 2010-11, only.

**DSS Issue 2: Promoting Safe & Stable Families (PSSF) - Proposed Trailer Bill Language (TBL)**

Rejected (3-0) the proposed TBL, without prejudice as to its merits. An analysis of existing law and any related clarifications are more appropriate for consideration by the relevant Legislative Policy Committees. This recommendation is consistent with recent action by Assembly Budget Subcommittee #1.

# SUBCOMMITTEE #3: Health & Human Services

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Chair, Senator Mark Leno

Senator Elaine K. Alquist  
Senator Roy Ashburn



May 13, 2010

9:30 a.m. or  
Upon Adjournment of Session  
Room 4203  
(John L. Burton Hearing Room)

(Diane Van Maren)

<u>Item</u>	<u>Department</u>	<u>Page</u>
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4120	Emergency Medical Services Authority	2
4260	Department of Health Care Services	3 to 11
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4260	Department of Health Care Services	15 to 32
0530	California Health and Human Services Agency	33 to 37

**PLEASE NOTE:**

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

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

Thank you.

## **A. VOTE ONLY CALENDAR (Pages 2 through 14)**

### **Item 4120 Emergency Medical Services Authority**

#### **1. Finance Letter on Poison Control**

**Budget Issue.** The Subcommittee is in receipt of a Finance Letter to increase reimbursements by \$5.4 million for the California Poison Control System (System) due to the availability of federal funds obtained by the Managed Risk Medical Insurance Board (MRMIB).

This additional reimbursement would provide a total of \$8.4 million (\$2.9 million General Fund and \$5.4 million reimbursements from MRMIB) for the System for 2010-11.

Working collaboratively, the MRMIB and EMSA were able to submit a Healthy Families State Plan Amendment to the federal CMS for approval to recognize expenditures for poison prevention assistance provided to children from birth to 21 years of age. The existing General Fund support is used to draw the 65 percent federal funding level from MRMIB as provided under the Healthy Families Program.

**Background—CA Poison Control System.** The State provides supplemental funding to the CA Poison Control System as administered by the University of California, San Francisco, School of Pharmacy. The system is a statewide network of experts that provide free treatment advice and assistance to people over the telephone in case of exposure to poisonous or hazardous substances. It provides poison help and information to both the public and health professionals and is accessible, toll-free, 24-hours a day, 7 days a week 365 days a year.

The System has four divisions located at UC Davis, Medical Center in Sacramento, San Francisco General Hospital in San Francisco, Children's Hospital Central California in Fresno and the UC San Diego Medical Center in San Diego. The EMSA states that 75 full-time employees are involved. Calls received by the System pertain to the ingestion of potentially toxic household products, hair products, over-the-counter medications, the use of home cleaners, and even the potential poisoning of pets/animals. Interpreting services in dozens of languages is also provided.

**Subcommittee Staff Recommendation-- Approve.** It is recommended to approve the Finance Letter as proposed. This is consistent with a current-year Section 28 Letter for the Managed Risk Medical Insurance Board regarding receipt of \$5.38 million in federal funds for this purpose. This was approved by the Joint Legislative Budget Committee in March 2010.

## **Item 4260 Department of Health Care Services**

### **1 Newly Qualified Legal Immigrant Adults in Medi-Cal**

**Budget Issue.** The Governor proposed legislation in Special Session to eliminate full-scope Medi-Cal for newly qualified legal immigrant adults in the U.S. for less than five years for a net reduction of \$433,000 (total funds) for 2009-10, and a reduction of \$33.4 million (decrease of \$53.8 million General Fund and increase of \$20.4 million federal funds). Under this DHCS proposal, 48,600 adults would only be eligible to receive emergency services, prenatal care, state-only breast and cervical treatment, long-term care, and tuberculosis services. Other preventive care, medications for chronic conditions, and related full-scope services would not be reimbursed under Medi-Cal.

Due to federal law changes enacted in 1996, federal matching funds are not provided for non-emergency services for this category of individual. Federal law does require states to provide emergency services and will reimburse for these services if they are identified as being an emergency medical service (according to the attending medical staff).

The DHCS states under their proposal to eliminate full-scope services to these individuals, 56 percent of the cost for services would shift to emergency services and would be partially reimbursed by the federal government.

**Prior Committee and Subcommittee Hearings.** This proposal was discussed by the Senate Budget & Fiscal Review Committee in its January 26, 2010 hearing for Special Session and was *not* adopted. Senate Subcommittee #3 received compelling public testimony in its March 25, 2010 hearing and left the issue “open”.

#### **Subcommittee Staff Comment and Recommendation—Reject Governor’s Proposal.**

California has *always* provided legal immigrant adults with full-scope services in Medi-Cal if they otherwise meet all other eligibility requirements (such as income and residency). Medi-Cal uses 100 percent General Fund support for this purpose, but the State is reimbursed by the federal government for those services identified as being an emergency service.

Enactment of the DHCS proposal would most likely (1) impair people’s health, particularly individual’s with chronic conditions; (2) result in increased use of hospital emergency rooms; (3) result in increased uncompensated care costs for hospitals and clinics; and (4) shift some costs to County indigent health care programs.

California has incorporated the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) option to obtain federal funds for legal immigrant children and pregnant women by eliminating the previous five-year waiting period. As such, federal funds are now obtained for this population.

It is recommended to reject the Governor’s proposal and to backfill with \$53.8 million in General Fund support to provide these valuable services.

## **2. Governor's Proposal: Persons Permanently Residing Under Color of Law (PRUCOL)**

**Budget Issue.** The Governor proposed legislation in Special Session to eliminate full-scope Medi-Cal for individuals designated as PRUCOL for a net reduction of \$289,000 (reduction of \$465,000 General Fund) in 2009-2010, and \$39.6 million (reduction of \$63.8 million General Fund) in 2010-11.

Under this DHCS proposal, 17,000 people would only receive emergency services, prenatal care, state-only breast and cervical cancer treatment, long-term care, and tuberculosis services. Other preventive care, medications for chronic conditions, and related full-scope services would not be reimbursed under Medi-Cal.

Due to federal law changes enacted in 1996, federal matching funds are not provided for non-emergency services for this category of individual. Federal law does require states to provide emergency services and will reimburse for these services if they are identified as being an emergency medical service (according to the attending medical staff).

The DHCS states under their proposal to eliminate full-scope services to these individuals, 56 percent of the cost for services would shift to emergency services and would be partially reimbursed by the federal government.

PRUCOL generally means that the immigration authorities are aware of a person's presence and have no plans to deport or remove them from the county. Medi-Cal lists several immigrant statuses that are considered PRUCOL. The various PRUCOL categories are permitted by the Department of Homeland Security to remain in the U.S.

**Prior Committee and Subcommittee Hearings.** This proposal was discussed by the Senate Budget & Fiscal Review Committee in its January 26, 2010 hearing for Special Session and was *not* adopted. Senate Subcommittee #3 received compelling public testimony in its March 25, 2010 hearing and left the issue "open".

**Subcommittee Staff Comment and Recommendation—Reject Governor's Proposal.** California has *always* provided full-scope services to these individuals if they otherwise meet all other eligibility requirements.

Enactment of the DHCS proposal would most likely (1) impair people's health, particularly individual's with chronic conditions; (2) result in increased use of hospital emergency rooms; (3) result in increased uncompensated care costs for hospitals and clinics; and (4) shift some costs to County indigent health care programs.

It is recommended to reject the Governor's proposal and to backfill with \$63.8 million in General Fund support to provide these valuable services.

### **3. Receipt of Federal Funds and Restoration of Family Planning Rates**

**Budget Issue.** The Governor proposed legislation in Special Session to reduce by \$88.7 million (\$15.4 million General Fund and \$73.3 million federal funds) in 2010-11 by reducing Medi-Cal rates for eight specific office codes billed for family planning services. The proposed rate reduction includes Fee-For-Service providers, such as physicians and clinics, and Managed Care health plans.

Senate Bill 94 (Kuehl), Statutes of 2007, increased these eight specified codes since family planning rates had *not* been increased in over 20 years. Family planning clinics had been turning away about 10,000 people per month due to a lack of funding prior to this rate adjustment.

California receives a *90 percent federal match* for these eight specified codes. The reimbursement rate for these codes is the equivalent of the weighted average of at least 80 percent of the federal Medicare rate. This rate adjustment became effective as of January 1, 2008.

About 91 percent of the total Family Planning Access Care and Treatment Program (FPACT) is eligible for a 90 percent federal fund match.

**Prior Committee and Subcommittee Hearings.** This proposal was discussed by the Senate Budget & Fiscal Review Committee in its January 26, 2010 hearing for Special Session and was *not* adopted.

The Governor's proposed rollback was also rejected in 2009.

**Subcommittee Staff Comment and Recommendation—Reject Governor's Proposal.** It is recommended to reject the Governor's proposal and backfill with \$15.4 million (General Fund). It is *not* cost-beneficial for California to turn away a 90 percent federal fund match for these cost-effective services.

#### **4. Governor's Proposal to Eliminate Adult Day Health Care**

**Budget Issue.** The Governor proposed legislation in Special Session to eliminate Adult Day Health Care (ADHC) services for a reduction of \$350 million (\$155.1 million General Fund) assuming a June 1, 2010 implementation date. Under federal Medicaid law, ADHC services are considered "optional" benefits for States to provide.

ADHC services are a community-based day program providing health, therapeutic, and social services designed to serve those at risk of being placed in a nursing home. There are 320 active ADHC providers in Medi-Cal who serve about 37,000 average monthly Medi-Cal enrollees.

Several cost-containment actions have occurred. In 2004, the DHCS placed a moratorium on the expansion of ADHC provides which is still in place. In 2009 a rate freeze was enacted which is proposed for continuation into 2010-11 (per Governor's January budget). Onsite treatment authorization reviews (TARs) were implemented in November 2009 and are estimated to reduce expenditures by 20 percent.

Medical acuity eligibility criteria were placed into statute in 2009 and are to be implemented as of March 2010. DHCS had estimated this would reduce expenditures by another 20 percent but this action was enjoined by the court prior to implementation.

In addition, implementation of reducing ADHC benefits to a maximum of three days per week, as enacted in 2009, was enjoined in September 2009 in the case of *Brantwell v. Maxwell-Jolly*.

**Prior Committee and Subcommittee Hearings.** This proposal was discussed by the Senate Budget & Fiscal Review Committee in its January 26, 2010 hearing for Special Session and was *not* adopted.

The Governor's proposed elimination of these services was also rejected in 2009.

**Subcommittee Staff Comment and Recommendation—Reject Governor's Proposal.** It is recommended to reject the Governor's proposal and to backfill appropriately with General Fund support.

## **5. Request for State Staff Under Federal “Money Follows the Person”**

**Budget Issue.** The DHCS requests an increase of \$349,000 (federal funds) to support three new State positions (two-year limited-term) to meet workload attributable to community transitioning of individuals from nursing homes and other more restrictive environments when community-based support is appropriate and available. These efforts have been ongoing for several years.

The positions include two Nurse Evaluator II's and an Associate Governmental Program Analyst. Key aspects of these positions include the following:

- Review medical histories and assess service needs of potential participants.
- Determine appropriate waiver/program eligibility for participant.
- Consult with transition coordinators to design alternatives for participants with complex needs.
- Serve as a resource to resolve transition issues.
- Consult with lead organizations to address quality management strategies.
- Review and adjudicate requests submitted through Medi-Cal treatment authorizations.
- Assist project team in compiling required State and federal reports.

**Background on Grant for Community Living/Money Follows the Person.** California was awarded a federal grant in 2003 to develop and pilot test an intervention to facilitate the transition of residents in Skilled Nursing Facilities. These funds, coupled with existing Medi-Cal Waiver programs (Assisted Living, Nursing Facility, In-Home Operations), are intended to facilitate the use of community-based services. These efforts are focused on diverting placement of Medi-Cal enrollees from health facilities and offer a menu of social and medically necessary services to assist them to remain in their home or community environments.

A federally required Operational Protocol has been implemented under the grant and a new 1915 (c) Waiver for a Community-Living Support Project for San Francisco is occurring (pertains to Laguna Honda). The overall purpose of these efforts is to transition 2,000 eligible individuals who would otherwise have no option but to live in long-term health facilities to live in the community.

By providing participants long-term services and supports in their own homes for one full-year after discharge from a health care facility, the State receives a 80.79 percent federal fund match.

**Subcommittee Staff Comment and Recommendation—Approve with Adjustment.** The proposal is consistent with Olmstead implementation in California and the positions are warranted. However, a technical reduction of \$124,000 (General Fund) is necessary since the DHCS just obtained federal approval for 100 percent financing of these positions. The Governor's January budget did not reflect this aspect.

## **6. Breast and Cervical Cancer Treatment Program—Eligibility Processing**

**Budget Issue.** The DHCS is requesting an increase of \$523,000 (\$262,000 General Fund) to continue six limited-term positions for another two-years (to June 30, 2012) to conduct eligibility processing for this program. The DHCS states these positions are necessary since staff has been scaled back previously and clients are at risk for not receiving services if this staff is not continued.

Unlike other Medi-Cal programs where County eligibility workers make determinations, DHCS staff performs all the eligibility activities for the Breast and Cervical Cancer Program. This processing includes compliance with federal requirements such as citizenship verification, redetermination functions and new applications.

The DHCS states continuation of these positions are necessary for completing redetermination reviews, obtaining retroactive coverage, and to ensure that people are able to access treatment services in a timely manner. Current workload is expected to continue and may increase due to more Medi-Cal enrollees pervasively.

The positions and a summary of key activities are as follows:

- Associate Governmental Program Analysts. A total of four positions are requested for extension. These positions are to (1) perform initial eligibility determination for new applicants; (2) perform determinations for annual review; (3) perform determinations for retroactive coverage; and (4) provide other assistance related to this work.
- Staff Service Manager I. This position is responsible for (1) supervising; (2) reviewing cases for accuracy in eligibility; (3) interpretation of changes to Medi-Cal as they pertain to this program; and (4) updating policies and procedures.
- Office Technician. This position is responsible for (1) organizing all new applications; (2) assigning cases; (3) sets up forms and redetermination packets; (4) files closed cases; and (5) various support activities related to this work.

**Background—Breast and Cervical Cancer Treatment Program.** Established in 2002, this program provides cancer treatment services through Medi-Cal as appropriate, contingent upon eligibility.

**Subcommittee Staff Comment and Recommendation--Approve.** It is recommended to extend these six positions for the Breast and Cervical Cancer Treatment Program to ensure people have access to treatment.

## **7. Intermediate Care Facility for Developmentally Disabled**

**Budget Issue.** The DHCS is requesting an increase of \$343,000 (\$143,000 General Fund) to extend three limited term positions for another two-years to further develop and administer the Intermediate Care Facility for Developmentally Disabled- Continuous Nursing Waiver. The positions include a Health Program Manager I, a Nurse Evaluator II, and a Research Analyst II.

The purpose of this Waiver is to have a more flexible and effective service delivery model for individuals with developmental disabilities that would provide continuous skilled nursing care in the least restrictive environment. The DHCS states that Waiver sites will be critical to provide care to address the federal Olmstead ruling and the down-sizing of larger facilities.

The DHCS states that these positions will assure the following:

- Compliance with Adults with Disabilities Act (ADA) and Olmstead for consumers on the Waiver;
- Expansion to include additional ICF-DD Continuous Nursing providers in different geographical locations in California;
- Assurance of receipt of federal funds for the expanding Waiver population.

Key activities of these positions include the following:

- Serve as a liaison with the federal CMS, including all administrative oversight, policy development, official correspondence and relating functions.
- Determining the level of care of potential Waiver enrollees to assure appropriate placement.
- Conduct utilization review through adjudication of treatment authorization requests for Waiver services provided to consumers.
- Monitor the health and safety of Waiver consumers through biannual onsite visits that include direct observation.
- Provide ongoing technical assistance with relocation efforts for those consumers who no longer meet the level of care requirement in the Waiver.
- Review and track special incidence reports.
- Provide federally required reports.
- Monitor providers, and review and track special incidence reports.

**Subcommittee Staff Comment and Recommendation--Approve.** The workload appears justified and the Waiver work is necessary to ensure community living and receipt of federal funds. No issues have been raised.

## **8. Medi-Cal Targeted Case Management Program**

**Budget Issue.** The DHCS is requesting an increase of \$890,000 (\$445,000 reimbursement from Counties and \$445,000 in federal funds) to support 8 State positions (two-year limited-term) associated with additional financial federal oversight requirements and corrective action for the Targeted Case Management Program.

The federal CMS has placed Targeted Case Management (TCM) local governmental agency claims on deferral in 2002-03 and has continued to defer claims through the 2007-08 year for a total of \$37.2 million (federal funds). During this timeframe, the federal CMS sent notifications requesting the DHCS to respond to corrective actions to resolve the claims.

These corrective actions included performing desk reviews and audits of cost reports and claims to examine the encounter rates, services costs and certified public expenditures (CPE). DHCS states that these functions need to continue and be expanded for all of the fiscal years in question and going forward.

In addition, the federal CMS has modified its reimbursement methodology for performing cost reporting and additional DHCS staff will be necessary to address the workload.

The federal CMS has not yet issued a permanent federal disallowance and the DHCS wants to avoid this prospect. If the DHCS is not successful, about \$5 million to \$6 million in federal funds would have to be recouped from local government agencies (mainly Counties) for lack of fiscal integrity.

The DHCS has already paid \$37.2 million in TCM claims to the locals but has yet to receive any reimbursement from the federal CMS for this purpose.

Specifically, the eight positions include: (1) a Health Program Audit Manager I; (2) three Health Program Auditor IV's; (3) three Health Program Auditor III's; and (4) an Accountant Trainee.

**Background—Targeted Case Management.** Targeted Case Management provides comprehensive case management services to Medi-Cal eligibles in six target populations—public health, adult probation, outpatient clinics, public guardian, community and linkages. Local government agencies (mainly Counties) use a “certified public expenditure” (CPE) approach to obtain federal reimbursement. Without this federal reimbursement, many of these services would cease.

**Subcommittee Staff Comment and Recommendation--Approve.** Subcommittee staff concurs with the DHCS regarding their concern with fiscal integrity and the need for the State staff.

## **9. Continuation of Health Information Portability & Accountability Act**

**Budget Issue.** The DHCS is requests an increase of \$1.9 million (\$514,000 General Fund) to continue 14 existing limited-term positions for another two-years to address new HIPAA rules, and to continue existing HIPAA compliance work.

Though HIPAA was enacted at the federal level in 1996, both the health care industry and the federal CMS have recognized that HIPAA requirements are far more difficult to implement than originally estimated and have ongoing impacts for all subsequent system changes, requiring longer time periods to fully comply. Several HIPAA rules are still pending release and several have been updated by the federal CMS and required system changes.

The DHCS also notes HIPAA activities will be considerably impacted by the federal Health Information Technology for Economic and Clinical Health Act as contained in the federal ARRA as well. (This issue is discussed in more detail under the CA Health and Human Services Agency item of this Agenda.)

Extensive workload information regarding the requested positions has been provided.

**Additional Background—HIPAA and Needed State Actions.** HIPAA, enacted in 1996, outlines a process to achieve national uniform health data standards and health information privacy in the U.S. It requires the adoption of standards by the federal Secretary of Health and Human Services to support the electronic exchange of a variety of administrative and financial health care transactions. The federal government has published and continues to publish, multiple rules pertaining to the implementation of HIPAA. These rules will be publishes in waves and over the next several years. Among the standards are:

- Electronic transaction and data elements for health claims and equivalent encounter information, claims attachments, health care payment and remittance advice, health plan enrollment and disenrollment, health plan eligibility, health plan premium payments, first report of injury, health claim status and other items;
- Unique identifiers for individuals, employers, health plans and health care providers for use in the health care system;
- Code sets and classification systems for the data elements of the transactions identified (conversion of all local codes to national standard codes); and
- Security and Privacy standards for health information.

**Subcommittee Staff Comment and Recommendation--Approve.** It is recommended to approve continuation of the existing 14 positions for another two-years (June 30, 2012). No issues have been raised.

## **Item 4265 Department of Public Health**

### **1. State Positions for AB 32**

**Budget Issue.** The DPH is requesting an increase of \$299,000 (Air Pollution Control Fund) to support three positions to perform AB 32 implementation activities. The positions include a Research Scientist III—Epidemiologist, Health Program Specialist I, and an Associate Governmental Program Analyst. Presently these positions are vacant.

The DPH states they have a critical role in assessing the potential public health impacts of the greenhouse gas reduction measures, especially any disparate impacts on low-income communities. Further, the Cal EPA and Air Resources Board both concur that a direct appropriation of administrative fees to support these DPH positions is needed.

AB 32 calls for the analysis of the public health impacts of proposed measures to reduce greenhouse gas emissions, and requires that the Air Resources Board consider any disparate impact on vulnerable communities.

Specifically, the DPH will be using these positions to participate in the Climate Action Team process established under Executive Orders S-3-05 and S-20-06 to engage in certain activities relating to AB 32, including implementation of a comprehensive work plan that includes the following:

- Determine the co-benefits and/or unintended health consequences of various AB 32 mitigation measures, including through the use of health impact assessments.
- Develop and implement surveillance systems to evaluate the public health impacts of AB 32 mitigation measures, including any disparate impacts on vulnerable communities.
- Develop and implement risk communication and outreach strategies to facilitate local health department and public sector understanding of the public health co-benefits of AB 32 mitigation measures.
- Develop training and technical assistance modules for local health departments focused on addressing public health aspects of AB 32 implementation at the local level, including modules related to meeting regional greenhouse gas emission targets through land use and transportation planning.
- Foster local and state policy development to address the health aspects of AB 32 implementation.

**Subcommittee Staff Comment and Recommendation—Approve.** The request for positions appears to be consistent with public health functions identified in the enabling legislation, and the use of the special fund is appropriate. It is recommended to approve the request.

## **2. Grant for Environmental Change and Tobacco Cessation**

**Budget Issue.** The DPH has been awarded a total of \$4.7 million (federal funds) by the Centers for Disease Control and Prevention through the Americans Reinvestment and Recovery (ARRA) Act. Per federal requirements, these funds must be expended by February 3, 2012, which is a 24-month period since the award.

These funds will be expended over three State fiscal years (2009-2010; 2010-11; and 2011-12). No State match is required since these are federal grant funds.

The purpose of these grant funds are to (1) address issues of statewide policy and environmental change related to obesity, physical activity, nutrition and tobacco prevention and control; and (2) implement tobacco cessation through “quit lines” and media.

With respect to the current-year, the Joint Legislative Budget Committee received a Section 28 Letter regarding current-year funding of \$815,000 (federal funds) and this was approved in April for the current-year.

With respect to 2010-11, the Subcommittee is in receipt of a Finance Letter requesting an increase of \$2.5 million (federal funds) which consists of \$2 million for local assistance and \$430,000 for five State positions (limited-term). These positions include a (1) Public Health Nutrition Consultant; (2) Health Program Specialist II; (3) Staff Services Manager II; (4) Research Scientist II—Epidemiology; and (5) Health Education Consultant III.

The DPH has provided the Subcommittee with its *entire plan* for the \$4.7 million and it is as follows:

- (1) Use \$2.2 million *and* four limited-term positions to address statewide policy and environmental change (nutrition, physical activity, and tobacco). This will be allocated as follows:
  - Reduce consumption of sugar-sweetened electrolyte beverages. Use \$733,000 to implement a new program to conduct health education activities regarding these drinks in public schools, and in underserved communities.
  - Foster access to school facilities during non-school hours for physical activity. Use \$733,000 to work with stakeholders on strategies (joint use) to enable schools to open their facilities during non-school hours. Mini-grants will be provided to selected low-resource communities which will serve as pilot sites for this purpose. Successful strategies from these sites will be shared and replicated across the State.
  - CA Tobacco Control Program. Use \$733,000 to expand tobacco control activities, such as seeking ways to facilitate increased protection against secondhand smoke in the workplace and policies requiring school campuses to be 100 percent tobacco-free.

(2) Use \$2.5 million *and* two limited-term positions to address tobacco cessation through “quit lines” and media. This will be allocated as follows:

- Increase the use of proactive cessation counseling by 11,000 people over 24-months (22,632 tobacco users were counseled in 2009).
- Expand promotion of the California Smokers’ Helpline statewide through the mass media, health care provider outreach, and a digital advertising campaign targeting young adults, military populations, and college students.
- Increase the capacity of the Helpline through enhanced telephone software and integration of online cessation support.
- Conduct a free nicotine replacement therapy pilot project targeting uninsured, low-income populations which experience a disproportional burden of tobacco use.
- Expand evaluation of the Helpline services for quality improvement, increased effectiveness and efficiency purposes.

**Subcommittee Staff Comment and Recommendation--Approve.** Each of the components have an approved “work plan” approved by the federal Centers for Disease Control (CDC) and the proposal is consist with the requirements contained in the federal grants. No issues have been raised.

## **B. Discussion Items: Department of Health Care Services**

### **1. California Children's Services Program: Need for Systems Review & Data Analysis**

**Budget Issue.** The CCS Program is a complex, core health care program that provides specialized, pediatric health care services to about 200,000 low-income children and young adults annually. About 75 percent of CCS enrollees are Medi-Cal eligible.

The CCS Program is a partnership of the State and Counties. The State establishes standards for pediatric facilities and providers, and oversees the regionalized system that ensures children are directed to physicians and hospitals with pediatric expertise to treat children with complex and rare conditions (CCS-eligible medical conditions).

Generally, program operations such as eligibility determination, authorizations for services and care coordination functions, are administered at the County level, except for a few smaller counties which State regional offices manage. Two years ago the DHCS recalculated how it funds CCS administrative functions at the local level. This has resulted in a limited allocation for these core functions.

Constituency groups have noted that many local CCS offices, along with State regional offices in Sacramento and the Central Valley, are struggling to complete key functions in a timely manner including CCS eligibility determinations, Service Authorization Requests (SARS), and Physician paneling.

As such, the authorization of medical services has been delayed, as well as the timely discharge from hospitals and the acquisition of durable medical equipment. These issues have been prevalent for the past few years and have been discussed previously in Senate Subcommittee hearings. Numerous suggestions have been provided to the DHCS by various constituency organizations who desire to streamline paperwork and utilize limited resources in a more cost-effective manner.

Enrollment of Physicians into the program has also been significantly backlogged and can take up to nine months to be CCS approved. There is a shortage of pediatric subspecialists in California and delays only result in creating medical access problems for CCS children. Several organizations have made suggestions to the DHCS for streamlining this process.

Another suggestion has been to implement "Hospital Liaison Teams" which would establish regional CCS nurses at pediatric tertiary centers to process service authorizations for all Counties located in the region. This has been done on a pilot basis in some areas and has proven to be cost-effective. More could be done in this area.

A continued key concern is also the need for the DHCS to hire a Branch Chief for their Children's Medical Services Branch which is a key position that administers the CCS Program. This critical position has been vacant for over one-year. This has led to repeated concerns and questions regarding the DHCS' leadership in this area, as documented by recent reports and discussions.

**Background: CCS Technical Advisory Meetings in 1115 Medi-Cal Waiver Demonstration Project—Pilot Projects.** Discussion of the CCS Program has also occurred through a CCS Program Technical Advisory Committee established for development of CCS pilot projects to operate under the pending 1115 Medi-Cal Waiver. This 1115 Medi-Cal Waiver is to replace the existing Hospital Financing Waiver which expires in August 2010.

Though discussions are ongoing, the DHCS proposes to proceed with four discrete models to test several delivery approaches. *However*, the core CCS Program would continue to operate as a discrete program while these pilot projects proceed.

In discussions with this Technical Advisory Committee, the DHCS has noted that baseline data, quality metrics, and other data-driven factors are significantly lacking for the program overall and additional data mining and analysis is warranted.

An analysis of the CCS Program conducted by a consultant in September 2009 (*“Considerations for Redesign of the California Children’s Services Program”*) also articulated that additional analyses of data are necessary in order to make informed decisions regarding CCS redesign options.

**Background: What is the CCS Program?** The CA Children’s Services (CCS) Program provides medical diagnosis, case management, treatment and therapy to financially eligible children with specific medical conditions, including prematurity, birth defects, cancer, congenital heart disease, chronic illness, genetic disease and severe 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. CCS depends on a network of Special Care Centers, 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 and Medi-Cal eligible; **(2)** CCS-only (not eligible for Medi-Cal or the Healthy Families Program); 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.

**Prior Subcommittee Action.** In the March 25, 2010 hearing, the Subcommittee rejected the Governor’s proposal to limit enrollment in the CCS Program for children with family incomes between 200 and 250 percent of poverty. This January proposal from the Governor violates the Patient Protection and Affordable Care Act, H.R. 3590, signed by President Obama which requires States to retain current income eligibility levels for children in Children’s Health Insurance Programs (Healthy Families in California) that were in place as of June 16, 2009.

**Subcommittee Staff Comment and Recommendation.** Various constituency groups, such as the Children’s Regional Integrated Service System (CRISS), the Children’s Specialty Care Coalition, the California Children’s Hospital Association, and County CCS Program Director’s have conveyed the need for selected improvements to the CCS Program for several years. Though some changes have occurred at the State-level, most of these have been relatively minor and incremental.

It is time to proceed with a more comprehensive approach for alleviating administrative burdens and to more comprehensively focus limited resources on core system functions.

In addition, with the advent of the State proceeding to test four delivery approaches to CCS Program services under the pending 1115 Medi-Cal Waiver, it is critical to also recognize the need to obtain baseline information on the core CCS Program.

Further, DHCS acknowledges the business practices of the CCS Program need to be analyzed and has just begun to have DHCS internal auditors review the program to seek best practices and areas in which systems can be redesigned for streamlining purposes.

The DHCS needs to consider a more comprehensive approach to address both short-term and longer-term CCS Program needs. To facilitate a comprehensive approach, the following trailer bill *and* Budget Bill Language is proposed as follows:

**Proposed Uncodified Trailer Bill Language is as follows:**

“The Department of Health Care Services (DHCS) shall seek support from one or more foundations to support and develop a study, or studies, of the California Children’s Services (CCS) Program to be provided to interested stakeholders and the fiscal and policy committees of the Legislature by no later than March 2011. Issues to be addressed by these analyses may include the following:

- Systems analysis of core business processes and practices of the program, including service authorization requests (SARs), requests for durable medical equipment and reimbursement processing;
- Review of CCS Provider certification and enrollment process;
- Review of medical eligibility processing;
- Oversight and monitoring of quality of care;
- Identification of best practices for case management and care coordination functions, including discharge planning; and
- Opportunities for the use of web-based tools, telemedicine, e-prescribing and other technologies to reduce costs and to streamline.

It is the intent of the Legislature for this study, or studies, to be used to (1) administratively streamline the CCS Program; (2) serve as a tool to facilitate the development of statewide policies and procedures to improve the program; and (3) serve as a baseline for development of CCS Program pilots implemented through the State’s 1115 Medicaid Waiver. “

**Proposed Budget Bill Language:**

“The department shall convene a diverse workgroup as applicable that, at a minimum, represents families enrolled in the CCS Program, counties, specialty care providers, children’s hospitals, and medical suppliers to discuss the administrative structure of the CCS Program, including eligibility determination processes, the use and content of needs assessment tools in case management, and the processes used for treatment authorizations. The purpose of this workgroup will be to identify methods for streamlining, administrative cost-efficiencies, and better utilization of both State and county staff, as applicable, in meeting the needs of children and families accessing the CCS Program. The department *may* provide the policy and fiscal committees of the Legislature with periodic updates of outcomes as appropriate.”

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

1. DHCS, Please provide a brief overview of the program and the intent behind having DHCS internal auditors conduct a review. What is the timing of this review please?
2. DHCS, From a technical assistance basis, do you have any comment on the proposed trailer bill language or Budget Bill Language?

## **2. Medi-Cal Managed Care Rates**

**Budget Issue.** In the Subcommittee hearing of March 25, 2010, questions were raised regarding the DHCS rate methodology as it pertains to “county-wide averaging” for Two-Plan model regions.

Key components of these concerns are: (1) the methodology does not factor-in safety net provider payments appropriately; (2) it shifts \$7.2 million away from Local Initiatives who are core providers in Two-Plan Model counties and reallocates these funds to commercial health plans participating in the Two-Plan Model; and (3) the DHCS did not fully communicate this change in its budget materials presented to the Legislature.

*First*, beginning for the 2009-2010 rate year, the DHCS administratively implemented a risk-adjustment factor for the Two-Plan Model managed care capitation rates. The effect of this change was not fully recognized until December 2009 by many of the affected plans.

The DHCS contends the purpose of this risk-adjustment is to distribute Medi-Cal payments to health plans based on the health risk of the Medi-Cal enrollees in their plan. They state that it requires a county-wide rate because these rates represent the best estimate of the average cost of a Medi-Cal beneficiary that can enroll in the plan.

DHCS states they did not implement the full impact of their risk adjustment factor in 2009-2010. But instead, implemented a *20 percent risk-adjustment factor* and a no risk factor to 80 percent of a health plans’ specific rate.

To determine risk, instead of using encounter data from the health plans since it is not fully available, the DHCS used the “Medicaid Rx” software model to calculate risk. The Medicaid Rx model is a disease classification system developed in California by UC San Diego. It uses pharmacy data to classify individuals into disease conditions. According to the DHCS, pharmacy data were determined to be the most accurate and complete source of claims-level information for the Medi-Cal Managed Care population.

It should be noted the DHCS proceed with this rate-adjustment in a “budget neutral” manner. As such, Medi-Cal capitation rates were reduced for some, and increased for others, based *solely* on this factor.

When questioned as to why a 20 percent risk-adjustment was chosen, the DHCS contends it was to demonstrate their clear intent to move toward an entire county specific risk adjustment rate. No other rationale has been provided.

The DHCS intends to increase this risk-adjustment factor in subsequent years.

*Second*, the Local Health Plans of California (Local Initiatives) support a risk-adjustment factor. But they believe an additional factor needs to be included in the equation for determining Medi-Cal capitation rates in the Two-Plan Model system.

Specifically, the Local Initiatives are seeking adoption of trailer bill language to include a safety net adjustment factor within the risk-adjustment calculation for county-wide rates. The Local Initiatives have provided data to the DHCS which they contend illustrate the considerable network arrangements they have with Federally Qualified Health Centers (FQHCs) and designated Public Hospitals.

Medi-Cal capitation payments to Local Initiatives have in the past recognized that a portion of their reimbursement is needed to account for the Local Initiatives network arrangements with safety net providers. These safety net providers utilize these payments to support uncompensated care costs for the uninsured and for high volume Medi-Cal providers, among other public-focused expenditures such as medical training, certain case management for involved Medi-Cal enrollees, and access enhancements.

Under the DHCS 20 percent risk-adjustment factor, the Local Initiatives would be reduced by about \$7.2 million in Medi-Cal capitation payments. These funds would be shifted to the commercial health care plans participating in the Two-Plan Model.

**Background—Key Recommendations from the Mercer Report.** The DHCS contracted with Mercer to conduct an analysis regarding Medi-Cal Managed Care Program rates. The key recommendations contained within the Mercer Report (released February 2007 to the Legislature) are as follows:

- Use health plan encounter data and supplemental cost data submitted by the plans in conjunction with other data/information as the base source data for rate development efforts. Improve the usefulness of financial reporting from the contracted health plans by implementing a Medi-Cal specific financial reporting requirement.
- Develop a county or health plan model specific rate development process: (1) Two Plan; (2) GMC; (3) County Organized Healthcare System. Utilize Two Plan Model data for Two Plan Model rate development, COHS for COHS and GMC for GMC. In addition to increasing the underlying data representation by contract type, it would also decrease capitation rate reliance upon a small percentage of the total managed care population. Area/geographic adjustment factors could also be moderated under this scenario.
- Conduct detailed reviews of health plan financial statements to identify appropriate costs and/or other factors for use in developing rates.
  - Validation Tool for encounter and supplemental data;
  - Indicator for efficient plans
- Consider use of maternity supplemental payment method to cover the cost of all deliveries. Use normalized risk.
- Reflect the Administrative Allowance as a percentage of the capitation payment.
- Utilize a combined underwriting profit/risk/contingency.
  - Assumption Range: 2 percent to 4 percent

- Most government programs are closer to 2 percent
- Develop a mechanism to measure the relative risk of each health plan in order to identify adverse/positive selection.
- Consider use of performance incentives to reward better plan performance.

**Subcommittee Staff Comment and Recommendation.** First, Local Initiatives are a core component of the Medi-Cal Managed Care Program and need to be viably sustained as California proceeds through its development and implementation of its 1115 Medicaid Waiver. Health plan net work expansion to address the mandatory enrollment of special needs individuals, including aged, blind and disabled categories of Medi-Cal, will be reliant upon safety net providers to provide specialty care, care coordination, and access to outpatient services.

A core aspect of AB 4X 6, Statutes of 2009, which requires mandatory enrollment of special populations into Medi-Cal Managed Care and serves as an initial framework for the 1115 Medicaid Waiver, specifically recognizes the need to strengthen the safety net as one of the principle goals of the Waiver and of the State.

Second, inclusion of a safety net provider factor seems reasonable and should be placed in statute. Draft language has been discussed with the Local Initiatives and to some degree with the Administration. Work would need to continue before any statutory change was enacted. Suggested placeholder language is as follows:

Amend Section 14301.1 of Welfare and Institutions Code by inserting new (i) as follows:

(i)

(1) In the process of implementing risk-adjusted county-wide capitation rates, the department shall not apply more than a 20% weight to the risk-adjusted county-wide capitation rate and shall implement an adjustment to the rate methodology to reflect health plan payments to safety net providers. This adjustment shall recognize the unique position of safety net providers and no longer have the department's rate setting methodology re-allocate the portion of the final capitation rates intended for safety net providers among the plans participating in the Two-Plan Model as a result of county-wide averaging.

(2) This adjustment shall not impact the actuarial soundness of the rate setting methodology as risk adjustment does not adequately reflect the variation in risk associated with safety net provider utilization and costs.

(3) This adjustment, completed after the department has completed its capitation rate development process, shall be applied as part of the rate package development process for 2010-2011 and thereafter and will account for the difference in payments made to safety net providers by plans in the Two-Plan Model for any risk-adjusted rate cells.

(4) The adjustment, shall be done by county, by health plan, and by category of aid, shall remove the per member per month expenditures to safety net providers for each health plan from their respective plan specific rate prior to county-wide averaging and application of the risk adjustment factor. The per member per month expenditures to safety net providers for each health plan shall be added back to the risk-adjusted county-wide rate that is net of safety net expenditures and this revised risk-adjusted county-wide capitation rate inclusive of health plan specific safety net expenditures shall then be blended with the health plan's

specific capitation rate using 80% weight for the plan specific rate and 20% weight for the revised risk-adjusted county-wide capitation rate.

(5) For the purposes of this adjustment, “safety net providers” shall be defined as Federally Qualified Health Centers and designated public hospitals.

(6) “Per member per month expenditures” shall be defined as those projected expenditures after trend, applicable programmatic changes, and non-medical load have been applied.

Lastly, the DHCS needs to provide more comprehensive details regarding the Medi-Cal capitation rate determination process in their Medi-Cal Estimate package. Staff conversations have already occurred on suggested improvements and should be ongoing in Fall, along with input from the Legislative Analyst’s Office.

It is recommended to adopt placeholder trailer bill language and to continue discussions throughout the budget process.

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

1. DHCS, Please provide a summary of the Medi-Cal capitation rate process for the Two-Plan Model, and how the risk-adjustment factor was determine and calculated.

### **3. Physician Administered Drug Reimbursement Rates**

**Budget Issues.** There are two issues for this item, including a proposed statutory change and a request for State staff to implement the proposed change.

*First*, the DHCS is proposing trailer bill legislation to limit Medi-Cal reimbursement of Physician Administered drugs for a savings of \$26.3 million (\$13.2 million General Fund) effective as of January 1, 2011.

Specifically, the DHCS trailer bill language would limit Medi-Cal reimbursement for Physician Administered drugs to the *lower* of: **(1)** Medi-Cal reimbursement for Pharmacy providers (AWP minus 17 percent); *or* **(2)** federal Medicare rate (ASP plus 6 percent), *unless* federal law requires a higher reimbursement level.

Currently, reimbursement for Physician Administered drugs is generally “Average Wholesale Price” (AWP) minus 5 percent. By comparison, Pharmacies are reimbursed by Medi-Cal at AWP minus 17 percent which is significantly *lower* than Physician Administered drugs.

In addition, the federal Medicare Program reimburses Physician Administered drugs on an “Average Sales Price” (ASP) plus 6 percent. This methodology is *also lower* than the current Medi-Cal Physician Administered drug reimbursement rate.

DHCS states Physician Administered drugs within the Medi-Cal “Fee-for-Service” Program continues to have one of the *highest rates* of reimbursement for drugs administered by Physicians, Clinics or other Outpatient medical facilities.

Physician Administered drugs are drugs administered by providers (Physicians, Clinics, and Outpatient medical facilities), *rather than* dispensed by a Pharmacy. These drugs are usually provided by injection or otherwise need Physician supervision while administered (such as Chemotherapy, Pulmonary medications, Antipsychotics, and others).

DHCS contends this change is necessary due to a federal settlement with “First Data Bank” which, among other things, has resulted in drug data organizations (such as First Data Bank) to state they will no longer be publishing AWP information as of October 2011. Medi-Cal presently utilizes AWP as part of its reimbursement calculation, as do most Medicaid Programs.

*Second*, the DHCS requests an increase of \$169,000 (\$44,000 General Fund) for a Pharmaceutical Consultant position (two-year limited-term) to address rate setting, the study methodology, and related changes to the drug rebate accounting system.

The DHCS states that establishment of reimbursement at AWP minus 17 percent for Physician Administered drugs will require a rate study, review and analysis of all “Healthcare Common Procedure Coding System codes for each drug to assure proper rate setting and rebate collection is done.

It is anticipated this study will cost about \$300,000 (\$150,000 General Fund) to complete and will take several months.

**Background: Federal Medicare and Use of Average Sales Price.** As of 2005, Average Sales Price (ASP) replaced Average Wholesale Price (AWP) as the basis for the payment for most drugs covered under the federal Medicare Program. ASP is based upon manufacturer-reported actual selling price data, including rebates, volume discounts, and other price concessions offered to all classes of trade.

As with any average, some providers obtain drugs at prices above the ASP and some obtain the same drugs at prices below the ASP. Historically, smaller practice settings (such as individual physicians) pay much higher prices due to their lower volume of use and large physician groups and hospitals are able to negotiate the best discounts and price concessions.

ASP values are available on the federal CMS website, which allows any payer to use ASP for payment of medical benefit drugs.

Medi-Cal established the use of ASP in the payment of blood factor and related products in 2003.

**Subcommittee Staff Comment and Recommendation.** It is recommended to approve the proposed trailer bill language as “*placeholder*” language and to approve the request for the Pharmacy Consultant II position (two-year limited-term). These actions will result in savings of at least \$26.3 million (\$13.2 million General Fund), effective as of January 1, 2011, as reflected in the Medi-Cal Program estimate.

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

1. DHCS, Please provide a brief description of the budget request, focusing on the savings and requested trailer bill language.
2. DHCS, Please comment on what may occur in the Medi-Cal Program regarding the removal of the publishing of the Average Wholesale Price (AWP) by data organizations (as of October 2011).

#### **4. Discussion of Bureau of State Audits Report on Medi-Cal Eligibility**

**Budget Issue.** At the request of Senator Ashburn, the DHCS has been requested to respond to a March 2010 Bureau of State Audit (BSA) Report regarding the Medi-Cal Eligibility Quality Control system.

According to the DHCS, the BSA reviewed a total of 3,506 cases of Medi-Cal eligibility processing and identified 215 cases of potential erroneous eligibility. However, upon clarification of these cases, only 95 cases resulted in months of erroneous eligibility of which 69 cases the DHCS says were caused by County eligibility worker error.

The DHCS analyzed the 95 case errors and have identified a maximum Fee-For-Service cost of \$81,597 (total funds).

The DHCS states they have follow-up on the BSA findings as follows:

- Analyzed MEQC data to identify counties with an error rate over 10 percent for the October 2008 – March 2009 base period. These counties included Fresno, Madera, Merced, Monterey, Sacramento, San Joaquin, Santa Cruz and Stanislaus.
- DHCS staff met with each of the counties referenced above to discuss the high error rates and specific error trends of each county. Examples of they types of error trends discussed include redeterminations, mid-year status reports, evaluations of denials and discontinuances, DRA citizenship and checking for other health care coverage.
- DHCS staff also performed focused reviews with Fresno, Madera, Sacramento and San Joaquin counties.
- DHCS performed an overall review of the extent to which the counties corrected the error cases. For the base period of 10/08 – 3/09, 94 percent of errors were corrected. For the base period of 4/09 – 9/09, 96 percent of errors were corrected.

**Background: Medi-Cal Eligibility Quality Control.** This is a federally required program that measures the accuracy of State eligibility determinations, in compliance with State and federal laws.

Since 1999, California has operated this control under a Geographic Sampling Plan (GSP) Pilot Project which allows California to conduct reviews in the 25 counties with the largest Medi-Cal enrollee population (94 percent), supplemented with periodic reviews in the smaller Counties, along with focused reviews of error trends in all 58 counties.

Under the GSP, fiscal sanctions and recoupment of the federal share of misspent/erroneous payments are suspended as long as the GSP is in effect. This provision also suspends recoupment of the State share of these payments from Counties.

The DHCS notes that in order to reinstate fiscal sanctions for County performance, the State would have to discontinue the GSP. However, the DHCS does *not* recommended this option as it would also expose the State to fiscal sanctions by the federal government and

would require a significant increase in State staff to perform MEQC reviews in all 58 counties rather than in the largest 25 counties.

**Background: Payment Error Rate Methodology.** DHCS participates in a federally required Program Integrity Program (PERM) which is conducted once every three years. The federal CMS does not impose fiscal sanctions for PERM eligibility error rates rather it relies on corrective action plans to enforce compliance.

**Background: County Performance Standards.** DHCS also monitors County performance through the review of self-certification of County performance standards that measure the timeliness of County processing of applications and redeterminations. To the extent that Counties do not meet the required timelines for processing applications or redeterminations, the State can impose a fiscal sanction of approximately 2 percent of county administrative payments.

**Subcommittee Staff Comment.** *First*, County performance standards were enacted in 2003 with the original agreement of the DHCS that appropriate resources would be provided to enable Counties to meet the requirements.

However, due to the current fiscal crisis County funds for the cost-of-doing-business adjustment has not been provided since 2008. Therefore pursuant to W&I Code, Section 14154(h)(2), the State cannot impose fiscal sanctions on counties not meeting the performance standards. The Governor is proposing to continue this suspension into 2010-11 for a reduction of \$44.3 million (\$22.1 million General Fund).

In addition to the suspension of the County performance standard funding, the Governor also vetoed \$121.2 million (\$60.6 million General Fund) from County Medi-Cal eligibility processing in 2009.

*Second*, it appears that the DHCS has conducted follow-up to the audit to address concerns.

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

1. DHCS, Please provide a brief summary of *key* actions taken to respond to the audit.

## **5. State Staff for Medi-Cal Management Information System (CA-MMIS)**

**Budget Issue.** The DHCS requests an increase of \$4.3 million (\$585,000 General Fund) to support a total of 35 State positions (three-year limited-term) to continue staffing for the Fiscal Intermediary Medi-Cal Management Information System (CA-MMIS). DHCS states a skilled management and technical team is necessary to provide the project management and oversight to ensure this significant undertaking is implemented successfully.

The new CA-MMIS is to be implemented in system component phases over a five year period. In 2010 work is to begin on the Business Rules Extraction of the existing CA-MMIS and the design, development and implementation of several components will proceed with the final replacement CA-MMIS in place by 2015. DHCS views each phased component as a separate project with a unique start and end date, which will be managed centrally through the DHCS CA-MMIS Project Office (Project Office).

The Project Office will serve as the core group to oversee and monitor the contractors. Key functions of these positions include:

- Review and adjudicate contractor deliverables;
- Ensure application and enforcement of Statewide standards for project management and oversight;
- Provide subject matter insight in areas of expertise;
- Identify, review, verify and document thousands of medical and business rules that constitute the foundation of the CA-MMIS;
- Review and approve contractor plans and methodologies for retrieving business rules;
- Oversight of all systems testing;
- Conduct analyses of deliverables to ensure conformance to contract requirements;
- Prepare reports, documents and publications; and
- Review and adjudicate contractor invoices.

The requested DHCS positions are referenced below. Eleven of the positions are existing limited-term positions which are being requested to extend for three years. The remaining 24 positions are to be newly established for three years.

- |  |       |
|--|-------|
| • Data Processing Manager IV                     | one   |
| • Senior Information Systems Analyst, Supervisor | three |
| • Senior Information Systems Analyst, Specialist | three |
| • Staff Information Systems Analysts             | eight |
| • Systems Software Specialist III                | one   |
| • Associate Information Systems Analysts         | three |
| • Staff Counsel I                                | three |
| • Medical Consultant II                          | one   |

- Nurse Consultant III two
- Pharmaceutical Consultant II one
- Associate Management Auditor one
- Associate Administrative Analyst, Accounting one
- Associate Accounting Analyst one
- Associate Governmental Program Analyst one
- Field Office Administrator II one
- Staff Services Manager I one
- Executive Assistant one
- Office Technician two

The DHCS has provided extensive workload information regarding the role and responsibilities of these positions. In addition, an Associate Governmental Program Analyst is requested for the Department of Public Health for the Office of Family Planning (and its Medi-Cal Program interaction).

DHCS will continue to evaluate workload during the first three years of design, development and implementation activities to further determine workload requirements necessary to continue oversight of contractor operations following implementation of the new CA-MMIS.

**Background: Status Update on CA-MMIS Contract.** The DHCS received federal CMS approval to execute a contract with Affiliated Computer Systems (ACS) in April 2010, after the Department of General Services had provided their approval.

In early May, this contract was finalized with Affiliated Computer Services (Xerox/ACS), the vendor awarded the bid through the department’s Request For Proposal process.

**Need for Replacement.** Medicaid (Medi-Cal) claims payments are usually handled in States through a “Fiscal Intermediary”. The Fiscal Intermediary establishes and maintains the State’s Medicaid Management Information System (CA-MMIS in California). The State “owns” the system but it is operated and updated under contract to the State.

The federal CMS has a technology architecture initiative which has been ongoing for several years to transform the MMIS environment nationwide. All States must meet federal CMS requirements in order to obtain federal funding (usually at an enhanced matching rate of 75 percent to 90 percent).

Specifically, the CA-MMIS processes the payments to providers of the Medi-Cal Fee-For-Service Program, including Physicians, Pharmacies, Hospitals and others. The DHCS notes the existing system is large and complex, consisting of over 90 applications written in seven computer languages, managed through five different software tools, and hosted across three major hardware architectures that include a mainframe, UNIX, and Windows computer servers. This complexity is the result of almost 30 years of changes, making it costly and time consuming to maintain.

Several analyses have articulated that a new procurement is indeed necessary, including (1) an August 2006 report prepared by Eclipse Solutions, an independent contractor to the State; (2) an Attorney General Office report from December 2006; and (3) a Little Hoover Commission report from May 2007.

**Legislative Analyst's Office Finding.** In a recently released analysis, the LAO found that CA-MMIS costs for 2010-11 are likely to be similar regardless of whether the State goes forward with a new CA-MMIS contractor or extends the current contract. They note that any modest difference in short-run costs is not a significant enough factor to delay moving forward with a new long-term contract.

The LAO also states that several analyses have found that procuring a new CA-MMIS is necessary to support programmatic changes and improve Medi-Cal Program fraud detection. Moreover, with the rollout of federal health care reform it will be even critical for the State to have a modern system to effectively manage this change.

**Subcommittee Staff Comment and Recommendation-- Approve.** The new CA-MMIS project will be one of the most complex systems the State has ever implemented. It is imperative for the DHCS, in conjunction with the State Office of the Chief Information Officer (OCIO), to obtain all necessary resources and supports to proceed with the system transition and to have the new CA-MMIS operate successfully.

The LAO has recommended approval of 34 of the 35 requested positions. Specifically they believe these positions are warranted to ensure successful replacement of CA-MMIS and its on-going operations. The LAO recommends *deleting* one Nurse Consultant III position to work on CA-MMIS tasks associated with the development of an "Enhanced Provider Care Case Management network. This network pertains to discussions occurring as part of the development of pilot projects under the 1115 Medi-Cal Waiver. Deletion of this position saves \$15,000 (General Fund) since the DHCS is obtaining an enhanced 90 percent federal financial participation amount.

Subcommittee staff recommends to approve all of the 35 positions since the 1115 Waiver is proceeding and the CA-MMIS project is a critical State project.

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

1. DHCS, Please provide a *brief* summary of the project and the need for the requested positions.
2. DHCS, Please provide a brief update on system transition activities.

## C. Discussion Items: Department of Public Health

### 1. Human Immunodeficiency Virus (HIV) Testing

**Budget Issue and Subcommittee Staff Recommendation.** A significant concern has recently been identified regarding certain HIV testing sites that provide rapid testing to clients.

Existing statute, as cited below, requires HIV testing sites where HIV counselors conduct rapid HIV tests to be trained by the Office of AIDS *and* to receive funding from the Department of Public Health. *However*, due to the Governor's veto of General Fund support for HIV Testing in 2009, there are possibly up to 40 Counties that can no longer provide rapid HIV tests because of the statute's requirement to receive funding from the department.

Existing statute is crafted to enable rapid HIV testing to be provided by HIV counselors, in lieu of meeting the more comprehensive Clinical Laboratory Improvement Act (CLIA) requirements which are intended for laboratories that provide substantive clinical testing. In addition, the statute is narrowly written to enable HIV counselors conducting rapid HIV tests to *not* be construed as a phlebotomy technician. Therefore, only the funding and training references need to be clarified.

Subcommittee staff believes it would be constructive to adopt "placeholder" trailer bill legislation to modify existing statute to remove the reference to State funding but to retain the underlying training component for HIV counseling and testing sites.

It is recommended to adopt "*placeholder*" trailer bill language by amending Section 120917 of Health and Safe Code is as follows:

~~(a) An HIV counselor who is trained by the Office of AIDS and working in an HIV counseling and testing site funded by the department through a local health jurisdiction, or its agents, meets the requirements of subdivision (e) of this section may do all of the following:~~

(1) Perform any HIV test that is classified as waived under the federal Clinical Laboratory Improvement Act (CLIA) (42 U.S.C. Sec. 263a and following) if all of the following conditions exist:

(A) The performance of the HIV test meets the requirements of CLIA and, subject to subparagraph (B), Chapter 3 (commencing with Section 1200) of Division 2 of the Business and Professions Code.

(B) Notwithstanding Section 1246 of the Business and Professions Code, an HIV counselor may perform skin punctures for the purpose of withdrawing blood for HIV testing, upon specific authorization from a licensed physician and surgeon, provided that the person meets both of the following requirements:

(i) He or she works under the direction of a licensed physician and surgeon.

(ii) He or she has been trained in both rapid HIV test proficiency for skin puncture blood tests and oral swab tests and in universal infection control precautions, consistent with best infection control practices established by the Division of Occupational Safety and Health in

the Department of Industrial Relations and the federal Centers for Disease Control and Prevention.

(C) The person performing the HIV test meets the requirements for the performance of waived laboratory testing pursuant to subdivision (a) of Section 1206.5 of the Business and Professions Code. For purposes of this subdivision and subdivision (a) of Section 1206.5 of the Business and Professions Code, an HIV counselor ~~trained by the Office of AIDS~~ who meets the requirements of subdivision (e) of this section shall be “other health care personnel providing direct patient care” as referred to in paragraph (12) of subdivision (a) of Section 1206.5 of the Business and Professions Code.

(D) The patient is informed that the preliminary result of the test is indicative of the likelihood of HIV infection and that the result must be confirmed by an additional more specific test, or if approved by the federal Centers for Disease Control and Prevention for that purpose, a second different rapid HIV test. Nothing in this subdivision shall be construed to allow an HIV counselor ~~trained by the Office of AIDS~~ to perform any HIV test that is not classified as waived under the CLIA.

(2) Notwithstanding Sections 1246.5 and 2053 of the Business and Professions Code, order and report HIV test results from tests performed pursuant to paragraph (1) to patients without authorization from a licensed health care professional or his or her authorized representative. Patients with indeterminate or positive test results from tests performed pursuant to paragraph (1) shall be referred to a licensed health care provider whose scope of practice includes the authority to refer patients for laboratory testing for further evaluation.

(b) An HIV counselor who has been certified pursuant to subdivision (b) of Section 120871 prior to September 1, 2009, and who will administer rapid HIV skin puncture tests shall obtain training required by clause (ii) of subparagraph (B) of paragraph (1) of subdivision (a) prior to September 1, 2011. The HIV counselor shall not, unless also certified as a limited phlebotomist technician, perform a skin puncture pursuant to this section until he or she has completed the training required by the clause.

(c) An HIV counselor who meets the requirements of this section with respect to performing any HIV test that is classified as waived under the CLIA may not perform any other test unless that person meets the statutory and regulatory requirements for performing that other test.

(d) This section shall not be construed to certify an HIV counselor as a phlebotomy technician or a limited phlebotomy technician, or to fulfill any requirements for certification as a phlebotomy technician or a limited phlebotomy technician, unless the HIV counselor has otherwise satisfied the certification requirements imposed pursuant to Section 1246 of the Business and Professions Code.

(e) An HIV counselor shall meet one of the following criteria:

(1) Is trained by the Office of AIDS and working in an HIV counseling and testing site funded by the department through a local health jurisdiction, or its agents.

(2) Is working in an HIV counseling and testing site that meets both of the following:

(A) Utilizes HIV counseling staff that is trained by the Office of AIDS or its agents. The training entity may charge a fee for the training.

(B) Has a quality assurance plan approved by the local health department in the jurisdiction where the site is located and has HIV counseling and testing staff who comply with the quality assurance requirements specified in California Code of Regulations, Title 17, Section 1230. The local health department may charge a fee for the quality assurance plan approval.

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

1. DPH, From a technical assistance basis, please provide your perspective of the proposed placeholder trailer bill language.

## **D. Discussion Items: CA Health & Human Services Agency**

### **1. Health Information Exchange and Federal Grant Award (Finance Letter)**

**Budget Issue.** The Subcommittee is in receipt of a Finance Letter for the California Health and Human Services Agency (CHHS Agency) that requests an increase of \$17.2 million (federal funds) for 2010-11. The federal funds are provided under the Health Information Technology for Economic and Clinical Health Act (HITECH Act of the American Recovery and Reinvestment Act of 2009).

Key issues are (1) expenditure of federal funds; (2) discussion of overall framework; (3) need for State match; and (4) need for Budget Bill Language and placeholder trailer bill language.

The CHHS Agency received a four-year \$38.7 million federal grant for California's Health Information Exchange. The majority of these funds are to be available in the first two-years of the grant, based on the State's performance in spending funds and building health information exchange capacity.

The Finance Letter requests an appropriation of \$17.2 million (federal funds) for 2010-11. Of this amount, \$16.5 million (federal funds) is to contract for a "*Governance Entity*" that will implement a statewide collaborative process for expanding capacity for electronic health information exchange. The remaining amount of \$724,000 is for three positions (limited-term through the grant period) at the CHHS Agency, including a Staff Counsel III, Staff Services Manager II, and a Staff Services Manager I.

In addition to the Finance Letter, \$2.2 million (federal funds) was approved by the Joint Legislative Budget Committee for expenditure in the current-year (approved in April) to commence with various activities.

Under California's Operational Plan, the CHHS Agency is the federal grantee and retains responsibility for administering the federal grant and ensuring all federal grant deliverables are met. CHHS Agency is to coordinate electronic health activities in the State and work with stakeholders, State departments, and the Legislature to support and recommend policy needs for Health Information Technology in California.

"Cal eConnect" (CeC) is California's "Governance Entity" which is a non-profit responsible for meeting the requirements CHSS Agency sets in contract and subsequent amendments. CeC was selected through a Request for Information process.

According to the CHHS Agency, new deliverables will be added to support the next phase of activities as the project proceeds. Generally, CeC will be responsible for establishing ground rules by which health information can be exchanged appropriately among clinicians, hospitals, health plans, patients, and government agencies.

Presently CeC is developing a detailed Implementation Plan based on CHHS Agency's Operational Plan. These activities are being funded with the Section 28 appropriation in the current-year. Key deliverables for this include the following:

- Developing a plan for integrating public workgroups convened during the operational planning process into the CeC organization structure.
- Developing detailed requirements and Request for Proposals for the Health Information Exchange services they will oversee and make available to providers and hospitals.
- Ensuring an effective governance model is in place with well-defined conflict of interest policies, bylaws, policies and procedures, and strong fiscal controls.
- Seating a diverse board in alignment with SB 337 (Alquist), Statutes of 2009, with meetings open to the public.
- Developing a detailed work plan and an initial communications plan.
- Hiring a CEO, developing a staffing plan and operating budget.

The CHHS Agency states the CeC will be conducting the following key activities in 2010 based on the requested \$17.2 million contained in the Finance Letter. In addition to these key activities, the CHHS Agency notes that a portion of funds will be allocated for an independent evaluation process. Key activities include the following:

- Issue public Request for Proposals for services and supporting a vendor selection process by July 2010 (about \$1 million). These initial procurements from CeC will establish a set of Health Information Exchange services that medical providers and hospitals will be able to use. The proposed services will likely include:
  - Entity Registry. This service provides a trusted certificate authority of legal entities that can participate in Health Information Exchange. These legal entities include practices and clinics, hospitals, labs, pharmacies, health plans and others. The service validates and certifies these legal entities, and ensures that they are trusted, safe and secure Health Information Exchange partners.
  - Provider Directory. This service is a directory of providers that exist within each legal entity.
  - Lab Results Router and Translator. This service will securely route electronic lab results from the fulfilling lab to the ordering provider. It may also translate the lab result into a standard message if the fulfilling lab is unable to do the standardization.
- Draft and negotiate vendor contracts and award contracts by September 2010 (about \$7 million).
- Initiate program to support expansion of Health Information Exchange services, expand existing footprints through a Request for Proposal, and award related contracts from November 2010 to February 2011 (\$3 million).

- Fully staff and support technical, business, communications and consumer workgroups (about \$1 million).
- Fully staff and support Board meetings and summit (\$250,000).
- Revise strategic and operational plan, business and sustainability plan by February 2011, and annually thereafter (\$1 million).
- Procurements for connection to State immunization registries and connections to existing Health Information Operations from May 2011 to June 2012 (\$1 million).

The CHHS Agency notes these timelines may be adjusted based on the Implementation Plan currently being developed by the CeC.

With respect to the requested three State positions for the CHHS Agency, key activities will include the following:

- Provide legal resources to address uncovered preemption workload and support the health information exchange standards;
- Coordinate statewide input and present recommended statutory remedies to remove any identified barriers at the State and federal levels.
- Conduct analyses regarding federal grants, federal regulations and reporting requirements.
- Facilitate various projects related to the CeC.
- Assistance with demonstration projects on privacy and security requirements.

**State Match Requirement.** Receipt of these federal funds *requires* a State match as shown in the table below.

**Table: State Match Requirement**

Federal Fiscal Year (FFY)	State Match Requirement
Oct 1 2009 – Sep 30, 2010	0
Oct 1 2010 – Sep 30, 2011	10%
Oct 1 2011 – Sep 30, 2012	14%
Oct 1 2012 – Sep 30, 2013	33%

Based on the State' application and projected annual expenditures, the minimum required match is \$4.05 million over four years. While the match *rate* is predetermined, the actual *amount* is dependent on timing of expenditures and would increase if project milestones and timelines are not met and expenses are delayed to subsequent federal fund years when State match rates are higher. The CHHS Agency plans to provide the match through *in-kind contributions* totaling \$4.38 million for fiscal years 2010-11 through 2012-13.

**Oversight Aspects.** The CHHS Agency contends there are *five* main components to oversight of the CeC. These include the following: (1) Board of Directors, including 22 members as specified in statute; (2) the CHHS will track milestones and oversee all deliverables; (3) CHHS Agency and the CeC are required to complete and be subject to independent audits; (4) an evaluation is required by federal grant; and (5) CHSS convenes a Health Information Exchange Advisory Board, including 19 members, to provide additional perspectives.

**Background: Health Information Technology for Economic and Clinical Health Act.**

Under HITECH, California's eligible providers and hospitals may be eligible for up to \$4 billion in federal "Electronic Health Record" (EHR) incentive payments. Of this amount, up to \$1.4 billion is expected to be administered by the DHCS Medi-Cal EHR Incentive Program.

To receive these payments eligible providers and hospitals must meet federal "meaningful use" requirements which are expected to increase in three specified stages over a five year period. Stage 1 requirements will apply to federal fiscal year 2010-11 and 2011-2012 and are currently being crafted in a federal rule making process. Stages 2 and 3 will apply to federal fiscal years beyond 2012.

HITECH's incentive structure encourages rapid adoption in the first two years of the program, with payments heavily weighted in the first two years and diminishing after that. This is why it is imperative for California to proceed with a detailed Implementation Plan.

It should be noted that the DHCS Medi-Cal Program is engaged in a planning process to coordinate the role of Health Information Exchange activities in improving health outcomes for Medi-Cal enrollees and is in the process of drafting a "Planning-Advance Planning Document" to guide its implementation of "meaningful use" and incentive payments to providers.

**Background: Senate Bill 337 (Alquist), Statutes of 2009.** Among other things, this statute requires the CHHS Agency to develop a Plan to ensure that health information technology capabilities are available, adopted and utilized statewide so that patients do not experience disparities in access to the benefits of this technology due to their age, race, ethnicity, language, income, insurance status geography or other factors.

In addition, it established the California Health Information Technology and Exchange Fund for purposes related to health information technology and exchange. Federal grant funds are to be deposited in this Fund, along with funds received from sources other than the General Fund. The CHHS Agency is also charged with identifying future funding sources in addition to federal funds and exclusive of General Fund support.

**Subcommittee Staff Comment and Recommendation.** *First*, it is recommended to approve the \$17.2 million (federal funds) Finance Letter request and the three positions.

*Second*, it is recommended to modify the Administration's proposed Budget Bill Language as follows:

Notwithstanding Section 28 ~~any other provision of law~~, the Director of Finance may authorize expenditures from the California Health Information Technology and Exchange Fund for the Secretary of the California Health and Human Services in excess of the amount appropriated not sooner than 30 days after providing notification, including a comprehensive description of the request, in writing of the necessity therefore to the Chairpersons of the fiscal and policy committees of the Legislature and the Chairperson of the Joint Legislative Budget Committee, or not sooner than whatever lesser time the Chairperson of the Joint Legislative Budget Committee, or his or her designee, may in each instance determine.

The modifications will maintain the Legislature's fiscal appropriation and oversight authority and will require the CHHS Agency to provide information to both the fiscal *and policy* committees of the Legislature in the event of changes being considered through current-year adjustments. (i.e., The Section 28 process of the annual Budget Act provides for federal fund adjustments, as specified, through the Joint Legislative Budget Committee.)

*Third*, it is recommended to adopt *placeholder* trailer bill language to address the following key aspects of this work:

- Providing a framework for the Operations Plan and Implementation Plan to delineate specific goals and milestones.
- Establishing specific reporting requirements of CHHS Agency for their progress in establishing the Health Information Exchange.
- Providing a framework regarding transparency of the process and conflict-of-interest to ensure public accountability, and transparency of public decisionmaking.
- Defining the membership of the rest of the governance Board.

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

1. CHHS Agency, Please provide a status update on the Implementation Plan and current process.
2. CHHS Agency, Please provide a summary of key next steps.

**DSS Issue 3: Proposed Trailer Bill Language (TBL) to Suspend Intensive Treatment Foster Care (ITFC)-Related Provisions of SB 1380**

Rejected (3-0) this proposal.

**DSS Issue 4: Implementation of Federal Fostering Connections to Success & Increasing Adoptions Act (FCSA)**

Adopted (2-1) (Ashburn no) placeholder trailer bill language to conform state law to the FCSA and related budget requests with respect to educational transportation costs, as well as sibling placements, and agreements with tribes or tribal entities. As appropriate and necessary, the placeholder language may also include changes for federal conformity regarding the educational placements of children in foster care.

**DSS Issue 5: Group Home Financial Audits – Proposed Trailer Bill Language (TBL)**

Rejected (2-1) (Ashburn no) the proposed TBL, without prejudice as to its merits. An analysis of existing law and any related clarifications are more appropriate for consideration by the relevant Legislative Policy Committees.

**DSS Issue 6: Child Welfare Services/Web (CWS/Web) Project**

Held open.

**DSS Issue 7: Community Care Licensing (CCL) - Proposed TBL Related to Fingerprinting Fees**

Adopted (3-0) placeholder TBL to suspend the provisions prohibiting the charging of these fees for an additional one or two years, rather than permanently repealing the fee prohibition as proposed by the Administration. This action is consistent with action recently taken by the Assembly's Subcommittee #1 on Health and Human Services.

**DSS Issue 8: CalWORKs – State and County Peer Reviews**

Approved (3-0) the proposed suspension of funding for the peer review process, but rejecting the Administration's proposal to transfer Legislative authority to determine the sufficiency of program funding to the Department of Finance. Correspondingly, the placeholder TBL deletes the last sentence of the Administration's proposed TBL.

**DSS Issue 9: Conlan v. Shewry – Positions and Proposed Budget Bill Language (BBL)**

Approved (3-0) the requested positions and BBL.

**Discussion Agenda**

**0530 Office of Systems Integration, Health & Human Services Agency (OSI)**

**5180 Department of Social Services (DSS)**

**OSI & DSS Issue 1: Case Management, Information and Payrolling System Replacement Project (CMIPS II)**

Approved (3-0) the proposed reductions to the CMIPS II budget for 2009-10 and 2010-11. Held open the requested position authority.

**OSI Issue 2: Statewide Fingerprint Imaging System (SFIS) – Proposed Use for In-Home Supportive Services (IHSS) Program**

Rejected (2-1) (Ashburn no) the request for \$8.2 million (\$4.4 million GF) in OSI spending authority for 2009-10. Further, swept any funds in the DSS budget that have not yet been spent (or obligated for reimbursement), and adopted corresponding placeholder trailer bill language to eliminate the requirements to fingerprint recipients at assessment and to include any fingerprints on timecards. Staff was directed to work with DOF to determine the total reduction to DSS's budget.

[Did not take action on the conversion of contract positions into state staff.]

**4200 Department of Alcohol & Drug Programs (ADP)****ADP Issue 1: Women and Children's Residential Treatment Services**

Adopted (2-1) (Ashburn no) an amendment to Provision 2 of Item 4200-104-0001 of the 2010-11 Budget Bill to clarify the Legislature's intent regarding overall WCRTS program funding by deleting the word "eight". Restored the 2010-11 appropriation to the original 2009-10 allocation of approximately \$5.8 million for the remaining providers. This action is consistent with action recently taken by the Assembly's Budget Subcommittee #1.

**5175 Department of Child Support Services (DCSS)****DCSS Issue 1: Proposal for Administrative Process to Establish and Modify Orders**

Rejected (3-0) the Spring Finance Letter proposal. Directed the Department to work collaboratively with stakeholders on any future proposals for changes to administrative and judicial processes that may result in better service to families and a more cost-effective child support system.

**DCSS Issue 2: California Child Support Automation System (CCSAS)**

Approved (3-0) the technical adjustment proposed in the Budget Change Proposal to restore the base funding for CCSAS. Held open the requested \$8.2 million (\$2.7 million GF) increase to the base funding. Finally, approved (3-0) the use of new funding of \$4.8 million GF associated with the Spring Finance Letter, and swept all unspent DCSS re-appropriation funds. A net amount of approximately \$1.8 million GF savings should result. Staff was directed to work with DOF and LAO to operationalize this change and make appropriate changes to Budget Bill Language to conform to the action.

## **Outcomes from Subcommittee No. 3: Thursday, May 13th**

### **A. VOTE ONLY CALENDAR (Pages 2 through 14)**

- Motion. To adopt staff recommendation as noted on each item in the Agenda on pages two through fourteen.
- Votes.

For Agenda pages 2, 7, 9, 10, 11, and 13 the vote is 3-0.

For Agenda pages 3, 4, 5, 6, 8, and 12 the vote is 2-1 (Senator Ashburn)

### **B. Discussion Items: Department of Health Care Services (Page 15)**

#### **1. California Children's Services Program: Need for Systems Review**

- Motion. Adopt placeholder trailer bill language (on page 17) and the Budget Bill Language (page 18).
- Vote. 3-0

#### **2. Medi-Cal Managed Care Rates (Page 19)**

- Motion. Adopt placeholder trailer bill language (on pages 21-22)
- Vote. 2-1 (Senator Ashburn)

#### **3. Physician Administered Drug Reimbursement Rates (Page 23)**

- **Motion.** Adopt the Administration's proposal, including placeholder trailer bill language.
- Vote. 3-0

**4. Discussion of Bureau of State Audits Report (Page 25)**

- Oversight issue only.

**5. Medi-Cal Management Information System (CA-MMIS) (Page 27)**

- **Motion.** I move to adopt the Administration's proposal.
- Vote. 3-0

**C. Discussion Items: Department of Public Health (Page 30)**

**1. Human Immunodeficiency Virus (HIV) Testing**

- **Motion.** I move to adopt placeholder trailer bill as noted.
- Vote. 3-0

**D. Discussion Items: CA Health & Human Services Agency (Page 33)**

**1. Health Information Exchange and Federal Grant Award**

- **Motion.** (1) Approve the positions and funding as proposed; (2) modify the proposed Budget Bill Language as noted; and (3) adopt placeholder trailer bill as noted.

# SUBCOMMITTEE #3: Health & Human Services

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Chair, Senator Mark Leno

Senator Elaine K. Alquist  
Senator Roy Ashburn



May 13, 2010

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

Room 4203

Committee Staff: Jennifer Troia

## Agenda II

(Vote-Only Items indicated by \*)

<u>Item</u>	<u>Department</u>	<u>Page</u>
5180	<b>Department of Social Services (DSS)</b>	
	1. Resource Family Approval Pilot (AB 340)*.....	2
	2. In-Home Supportive Services (IHSS) - Local Augmentations from 2009-10*.....	3
	3. Spring Finance Letter - Proposed Changes to State Hearing Procedures and Penalties.....	4

**Please note:** The Committee will discuss only the items contained in this agenda at this hearing. Please see the Senate File for dates and times of subsequent hearings. The Committee will discuss the issues in the order noted in the agenda, unless otherwise directed by the Chair.

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance from the Senate Rules Committee, 1020 N Street, Suite 255 or by calling 916-651-1505. Requests should be made one week in advance whenever possible.

## Vote-Only Agenda

### DSS Issue 1: Resource Family Approval Pilot (AB 340)

**Budget Issue:** The Governor's proposed budget for 2010-11 included trailer bill language (TBL) to suspend implementation of statutes enacted by AB 340 (Chapter 464, Statutes of 2007). Under the proposed TBL, existing law would have been implemented when "the Department of Finance determines that sufficient state operations resources have been appropriated" (emphasis added). On March 22, 2010, the Subcommittee voted (2-0) (Ashburn absent) to reject the proposed TBL, which would have transferred Legislative authority to determine the sufficiency of funding for the pilot program to the Administration. During that same hearing, the Subcommittee held open the budget for AB 340.

**Background on AB 340:** The resource family approval pilot established by AB 340 requires a three-year pilot program in up to five counties to establish a single, comprehensive approval process for foster care and adoptive families. This pilot was intended to make the licensing process less cumbersome and to prevent unnecessary delays in finding permanent families for foster children. The current licensing process divides caregivers into relatives, foster family homes, and adoptive homes. All caregivers must meet the same health and safety standards, but the processes for each vary and can be duplicative. This pilot was also included in the state's Program Improvement Plan in response to the 2002 federal review.

The Assembly and Senate Appropriations Committees' analyses of AB 340 estimated approximately \$150,000 GF in the first year for state personnel costs to oversee development and implementation of this pilot (and in one analysis, additional funds for its final evaluation). These analyses also recognized that the pilot should lead to some offsetting savings. Local assistance funding of \$717,000 (\$242,000 GF) was appropriated in 2008-09. DSS also submitted a BCP requesting 4.0 limited-term state positions at a cost of \$440,000 (\$278,000 GF) to implement AB 340 in 2008-09; however, no state operations resources were included in the budget that year. DSS never allocated the 2008-09 local assistance that the Budget Act appropriated to the counties.

In 2009-10, the Governor's budget included \$1.8 million (\$786,000 GF) in local assistance funding for AB 340 implementation. As part of the 2009 May Revision, this 2009-10 funding for the program was suspended.

**Administration Actions:** The Administration has recently stated that its elimination of local assistance funding for AB 340 was warranted by a reference in the existing statute authorizing the program. Specifically, Section 16519.5 (q) of the Welfare and Institutions Code states that AB 340 "shall be authorized to continue through the end of the 2010-11 fiscal year, or through the end of the third full fiscal year following the date that funds are made available for its implementation, whichever of these dates is later" (emphasis added). According to the Administration, because no funds had been

appropriated for the state-level activities, the Administration determined that no corresponding local pilot activities would take place.

**Subcommittee Staff Comment and Recommendation:** It appears that the Administration may have overstepped its bounds by assuming that the Administration itself was authorized to determine the sufficiency of funding appropriated for this program (i.e., the very same authority the Administration explicitly sought in the 2010-11 budget and that the Subcommittee recently rejected). Staff recommends that the Subcommittee restore, in 2010-11, local assistance funding for this program. Staff should be directed to work with the Administration, Legislative Analyst's Office (LAO), and County Welfare Directors Association (CWDA) to determine the amount of this restoration. In addition, to ensure appropriate implementation of the pilot, staff further recommends that the Subcommittee authorize some, but not all, of the previously requested limited-term positions at DSS. Specifically, limited-term state operations costs shall not exceed \$150,000 GF annually.

## **DSS Issue 2: In-Home Supportive Services (IHSS) – Local Augmentations from 2009-10**

**Budget Issue:** Of the \$54.2 million (\$21.9 million GF) in new funding for DSS and county IHSS anti-fraud/program integrity efforts in 2009-10, \$10 million GF was set aside for “additional fraud prevention, detection, referral, and investigation” at the local level. With matching federal and county funds, the total amount available statewide for those additional local efforts was \$26.4 million. (For more information on overall IHSS anti-fraud/program integrity efforts statewide, please see the March 18, 2010 Agenda.) The Governor's 2010-11 budget proposes an additional \$28.3 million (\$10.0 million GF) to provide this augmentation again in the budget year.

**Budget Bill Language (BBL) Authorizing 2009-10 Augmentation:** This augmentation was enacted by Section 576 of ABx4 1 (Chapter 1, Fourth Extraordinary Session, Statutes of 2009), which added Section 18.55(b), copied below, to the Budget Act of 2009:

(b) The sum of \$10,000,000 is hereby appropriated from the General Fund in augmentation of Schedule (2) of Item 5180-111-0001 of Section 2.00 of the Budget Act of 2009 for the purpose of fraud investigations and additional program integrity efforts related to the In-Home Supportive Services Program. The amount appropriated in this subdivision represents the total allowable to be claimed for these purposes within this section. The State Department of Social Services shall allocate funding based on a distribution method developed in consultation with the counties. Each county shall submit a plan to the department that includes the program integrity and fraud investigation activities that the

county plans to pursue, and the department must approve the plan prior to distribution of the funds appropriated in this subdivision.

**Background:** As discussed at the hearing on May 6, 2010, forty-five counties submitted plans for these additional fraud prevention and investigation funds. Those plans were developed by County Welfare Directors and District Attorneys' (DAs) offices and reviewed by Boards of Supervisors and DSS.

With some minor exceptions when federal or state funds are available, local District Attorneys' offices are principally funded on a discretionary basis out of county General Funds. According to the California Department of Justice, approximately \$1.2 billion total was spent on prosecution activities statewide (based on 2006-07 data).

**Other Anti-Fraud/Program Integrity Measures in the 2009-10 Budget:** In addition to these local funding augmentations and the recipient fingerprinting discussed on May 6, 2010, as well as previously existing IHSS quality assurance efforts, the 2009-10 budget included the following IHSS reforms, with varying implementation dates:

1. Criminal background checks and appeals processes for IHSS providers;
2. The requirement for providers to attend an orientation;
3. Authorization to send targeted mailings to providers and recipients and to conduct unannounced home visits, pursuant to developed protocols and in targeted cases, when there is cause for concern about program integrity;
4. Limits on the use of P.O. boxes by providers to receive paychecks;
5. Training for social workers on fraud prevention;
6. Notification to providers about their clients' authorized hours and service levels; and
7. Certifications on timesheets, after notice of possible criminal penalties for fraud.

**Subcommittee Staff Comment & Recommendation:** The BBL quoted above included a one-time appropriation of funds for this local augmentation in 2009-10. Given the fiscal crisis facing the state and the lack of analysis regarding savings that can be expected to result from these expenditures, staff recommends rejecting the proposed funding to continue this one-time augmentation of local activities in 2010-11.

## Discussion Agenda

### DSS Issue 1: Proposed Changes to State Hearing Procedures and Penalties

**Budget Issue:** DSS proposes, in a Spring Finance Letter dated April 1, 2010, two changes to the state hearings process. The first change would modify the existing

structures for when the state pays penalties to benefit recipients whose state hearing decisions are not issued in a timely manner. The second would allow state hearings to be held by video conference, unless there is a finding of good cause for a face-to-face hearing. In the alternative, if these changes are not approved DSS seeks \$1.4 million (\$931,000 GF) in additional resources [\$900,000 (\$431,000 GF) for 6.0 new Administrative Law Judge (ALJ) positions and \$500,000 GF for penalty costs].

**Background on State Hearings and Penalties for Untimely Decisions:** California provides due process to recipients of welfare-to-work, Supplemental Nutrition Assistance Program (food stamps), Medi-Cal, In-Home Supportive Services (IHSS) and Foster Care/Adoption Assistance benefits through state hearings conducted by ALJs who work for DSS's State Hearings Division. Federal mandates require that the state adjudicate these claims within 90 days for most programs, or 60 days for food stamps.

Existing court orders (from *King v. McMahon* and *Ball v. Swoap*) require the state to pay a daily penalty to the claimant for each day over 60 or 90 days, as applicable, that an ALJ issues a written decision in a claimant's favor. The penalty rate starts at a minimum of \$5.00 per day. In each month that 95 percent of all decisions are not completed within 90 days, the daily penalty rate increases by \$2.50. In each month that 95 percent of cases are timely decided, the rate decreased by \$2.50. The penalties are paid with 100 percent GF, as no federal financial participation is available.

In 2008-09, timeliness was 95.6 percent overall. The most recent information available indicated that the average timeliness rate for state hearings was 93.9 percent overall. The current daily penalty rates are \$7.50 for CalWORKs, \$5 for food stamps, \$35 for Medi-Cal, and \$5 for other non-CalWORKs. DSS paid \$251,000 GF in penalties in 2008-09, and \$192,000 GF from July 2009 through March 2010. DSS projects that penalty payments in the current year will likely exceed \$500,000 GF. According to DSS, this increase in late decisions and resulting penalties is attributable to an increase in caseload without a corresponding increase in staff with which to adjudicate cases. For example, from 2005-06 to 2008-09, DSS indicates that there was a 23 percent increase in the number of hearing requests statewide (from 69,825 to 86,079) and a 26 percent increase in the number of hearings held. The Department also states that recent furloughs have placed additional strain on its state hearings capacity.

**Proposed Changes to Hearing and Penalty Procedures:** DSS maintains four offices throughout the state. However, in some cases, ALJs still have to travel overnight for hearings. To minimize travel, ALJs have recently conducted approximately four percent of hearings by videoconference and another seven percent by telephone. To participate in a videoconference currently, the parties to the claim still appear at a county hearing facility. The claimants are currently given the option to have an in-person hearing. According to DSS, less than one percent of claimants given that choice to have a face-to-face hearing have exercised it under the current system. The Department now seeks to clarify the law to formalize its authority to continue use of video-conferencing to facilitate hearings. Under the proposal, claimants could continue to request a face-to-face hearing; however, the request would only be granted if they could show "good

cause” for the ALJ’s physical presence. According to the Department, good cause would be defined in regulations, after consultation with advocates and counties.

Under the proposal, the timeliness standard would also be codified and reduced from 95 to 90 percent. The proposal would additionally establish exemptions for when penalties do not apply. Specifically, there would be no penalties in cases: 1) that do not involve a question related to current benefits or services (approximately 60 percent of cases), 2) in which the person received benefits at or above the level they were entitled to receive pending the hearing decision, or 3) where the application of a recent change in state or federal law (within the last 12 months) is an issue in the case.

**Concerns Expressed by Advocates:** Some advocates have expressed opposition to this proposal. Their main concerns center on the ways that they believe the proposal undermines and defeats due process. In addition, they raise questions about a number of changes included in the proposed trailer bill language – e.g., the elimination of reporting requirements established by the courts.

**Subcommittee Staff Comment & Recommendation:** Given the due process-related and other significant policy questions at issue in this Spring Finance Letter, staff recommends that the Subcommittee reject the proposed trailer bill language at this time. Staff does, however, recommend that the Subcommittee approve approximately \$450,000 total funds (\$215,500 GF) (final amount to be determined after consultation with the Administration) for three additional ALJs to alleviate workload-related demands.

**Questions for DSS:**

- 1) Please briefly summarize the reasons for the recent increases in late decisions and corresponding penalties. How much of the increased delays is likely due to furloughs (which may be about to end)?
- 2) To what extent have you tracked the impact of hearings held by video conference on the timeliness of hearing decisions? To what extent have you sought advocates and participants’ feedback on these “pilot” activities?
- 3) How prepared would the Department be for the proposed, significant increase in the use of video conferencing? Does the state already have the necessary quantity of equipment and technical support?
- 4) What are the circumstances the Department might expect to constitute good cause for face-to-face hearings? How would participants know that they had the right to request those face-to-face hearings?

# SUBCOMMITTEE #3: Health & Human Services

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Chair, Senator Mark Leno

Senator Elaine K. Alquist  
Senator Roy Ashburn



May 21, 2010

9:30 a.m. or  
Upon Adjournment of Session  
Room 4203  
(John L. Burton Hearing Room)

(Diane Van Maren)

## AGENDA # 1

<u>Item</u>	<u>Description</u>	<u>Page</u>
	<b>Vote Only</b>	2 to 12
4440	Department of Mental Health	2 to 5
4260	Department of Health Care Services: Family Health Programs	6 to 7
4265	Department of Public Health	8 to 11
4300	Department of Developmental Services	12
	<b>Discussion</b>	13 to 43
4265	Department of Public Health	13 to 29
4300	Department of Developmental Services	30 to 43

### PLEASE NOTE:

*Only* those items contained in this agenda will be discussed at this hearing. Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

*Please* see the Senate File (available on-line) for dates and times of subsequent hearings.

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Thank you.

## **I. VOTE ONLY ISSUES (Pages 2 to 12)**

### **A. Item 4440—Department of Mental Health**

#### **1. Patton State Hospital Capital Outlay Project**

**Budget Issue.** The Governor’s January budget for the DMH includes a request for reappropriation of \$7.7 million (General Fund) for working drawings (\$711,000) and construction phases (\$7 million) of the “satellite” kitchens at Patton State Hospital.

In addition, the budget includes a reappropriation of \$35.8 million (bond funds) for the “main” kitchen (working drawings of \$2.7 million, and construction phases of \$33.1 million) at Patton State Hospital.

The DMH states these reappropriations are needed due to current delays.

**Subcommittee Staff Recommendation—Deny Reappropriation for GF Portion.** No issues have been raised regarding the main kitchen (using bond funds).

However, due to the fiscal crisis and need to provide direct health and human services to individuals during this time of the Great Recession, it is recommended to deny the \$7.7 million (General Fund) reappropriation for the satellite kitchens. This action results in General Fund savings for core program services.

#### **2. CA Health Interview Survey (Issue 450)**

**Governor’s May Revision Issue.** The DMH proposes an increase of \$800,000 (MHSA Funds) to continue the development and administration of the mental health components of the University of California, Los Angeles Center for Health Policy Research’s “CA Health Interview Survey (CHIS).

The CHIS is an assessment tool that collects data on health status and access to health care services in California. The survey is conducted every two years. Data collection and dissemination are made possible through a collaborative effort between the DHCS, DPH, the Public Health Institute, the MHSA Oversight Commission and the DMH.

**Subcommittee Staff Recommendation--Approve.** The CHIS survey is the largest health survey conducted in the United States and is well known for providing incredibly useful data regarding demographics, trends, and other assessments.

MHSA funds were used for this purpose in 2009 as well. These MHSA funds would be appropriated from the “State” administrative portion of funds.

No issues have been raised.

### **3. Funds for Evaluation of MHSA (Issue 479)**

**Governor's May Revision Issue.** The DMH is requesting an increase of \$1 million (MHSA Funds) to contract with the Petris Center, located at UC Berkeley, to provide an independent evaluation of the effectiveness of MHSA programs and services. The DMH states they will coordinate with various entities, including the OAC Commission.

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

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

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

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

With respect to the evaluation of the MHSA, the OAC has established a two phase process as follows:

Phase I. As of July, 2010, the OAC will have completed Phase I, a 10-month assessment to design the scope of work of the evaluation. This assessment has incorporated significant stakeholder input and review, which consists of broad stakeholder representation from mental health consumer and family advocates, County Mental Health, and community mental health agencies.

Phase II. An evaluation contractor will be selected by the OAC in Fall 2010 through a competitive bidding process. Phase II is the evaluation implementation to be conducted over a two-year period by the contractor to be selected. The Petris Center and other contractors may apply to conduct this evaluation through the competitive process.

The OAC has \$500,000 (MHSA Funds) for the next two-years in its baseline budget for this purpose.

This \$1 million would augment the \$500,000/year for two years currently budgeted for this substantial, multi-year evaluation to ensure a more robust evaluation of the impact of the voter-approved MHSA to improve mental health service delivery and provide public accountability.

**Subcommittee Staff Recommendation—Shift Funds to Oversight Commission.** As noted above, the OAC Commission already has responsibility to provide an evaluation of the MHSA in two phases. the OAC has already commenced with a framework and process to be built upon.

In order to concentrate the evaluation efforts, ensure a public process, and utilize a competitive bid contracting process, it is recommended to appropriate the \$1 million (MHSA Funds) identified in the May Revision for the DMH into the OAC's budget (Item 4560—MHSA Oversight and Accountability Commission).

#### **4. Technical Adjustment to Transfer of Traumatic Brain Injury Program.**

**Governor's May Revision Issue.** In a prior Subcommittee hearing the transfer of this program to the Department of Rehabilitation as required by AB 398, Statutes of 2009, was adopted. However, due to an oversight by the DMH, a technical adjustment to the budget is necessary to remove \$149,000 (reimbursements) from Item 4440-101-0311. There is no policy issue related to this action.

**Subcommittee Staff Recommendation--Approve.** This is purely a technical adjustment. It is recommended to adopt.

## **B. Item 4260—Department of Health Care Services**

### **1. Legislative Oversight of DHCS CA-MMIS**

**Budget Issue and Subcommittee Staff Recommendation.** The Subcommittee approved the DHCS request for 35 State positions to continue staffing for the Fiscal Intermediary Medi-Cal Management Information System (CA-MMIS) on May 13, 2010. The new CA-MMIS is to be implemented in system component phases over a five year period. In 2010 work is to begin on the Business Rules Extraction of the existing CA-MMIS and the design, development and implementation of several components will proceed with the final replacement CA-MMIS in place by 2015.

In order to facilitate the Legislature being informed on its progress, the following uncodified trailer bill language is proposed by Subcommittee staff:

“The Department of Health Care Services (DHCS) shall provide the appropriate fiscal and policy committees of the Legislature with quarterly reports on the transition and takeover progress efforts of the Medi-Cal Fiscal Intermediary Contract. These quarterly reports shall be provided within 30-days of the close of each quarter, commencing July 1, 2010 through December 2012. These quarterly reports shall contain the following information:

- (1) A project status summary that identifies the progress or key milestones and objectives for the quarter on transition and takeover efforts.
- (2) Copies of any oversight reports developed by contractors of the DHCS for the California Medi-Cal Management Information System (CA-MMIS) project and any subsequent responses from the DHCS.

Upon request from the Chair of the Joint Legislative Budget Committee, the DHCS shall provide updates on the Implementation Advanced Planning Document provided to the federal Centers for Medicare and Medicaid Services pertaining to the CA-MMIS project.

It is recommended to adopt the above uncodified trailer bill language.

## **2. Family Health Estimate Package for CCS, CHDP & GHPP (Issues)**

**Governor's May Revision Issue.** The May Revision for the CA Children Services (CCS) Program, the Child Health Disability Prevention Program and the Genetically Handicapped Persons Program proposes the following:

- CCS            increase of \$ 5 million (General Fund)
- CHDP        decrease of \$91,000 (General Fund)
- GHPP        increase of \$5.4 million (General Fund)

This May Revision reflects changes that pertain to caseload. No policy changes. Caseload projects are estimated to be (1) 44,345 children for CCS-only (a 2.6 percent increase over the current year; (2) 23,732 people for the CHDP (an insignificant difference over the current years; and (3) 1,430 people for the GHPP (a 2.9 percent increase).

**Subcommittee Staff Comment and Recommendation—Approve.** The Family Health estimate for the CCS, CHDP and GHPP contains no new policy issues, only caseload and technical adjustments. No issues have been raised. It is recommended to approve the May Revision.

## **C. Item 4265—Department of Public Health**

### **1. Loan Repayment: Occupational Lead Prevention Account & Drinking Water Operator Certification Special Account (Issues 401 and 402)**

**Governor’s May Revision Issue.** The Governor’s May Revision proposes a series of Special Fund transfers and loans to assist in General Fund relief.

For the DPH, the Department of Finance proposes the following Budget Bill Language for this purpose:

Occupational Lead Poisoning Prevention Account  
Item 4265-401. Notwithstanding Provision 1 of Item 4265-011-0070, Budget Act of 2008, the \$1,100,000 loan authorized, shall be full repaid to the Occupational Lead Poisoning Prevention Account by July 1, 2012.

Drinking Water Operator Certification Special Account  
Item 4265-402. Notwithstanding Provision 1 of Item 4265-011-0247, Budget Act of 2008, the \$1,600,000 loan authorized, shall be fully repaid to the Drinking Water Operator Certification Special Account by July 1, 2012.

**Subcommittee Staff Comment and Recommendation—Approve.** The effect of this language is to defer the repayment of money loan from these two special funds to the General Fund for one-year. This action will save General Fund support.

### **2. Amyotrophic Lateral Sclerosis/Lou Gehrig’s Disease Research (Issue 502)**

**Governor’s May Revision Issue.** SB 1502 (Steinberg), Statutes of 2008, created the ALS/Lou Gehrig’s Disease Research Fund to benefit the ALS Association. This enabling legislation created a tax check-off. Funds from this check-off are appropriated in the DPH as a “pass-through” to directly to the ALS Association.

The May Revision proposes to appropriate a total of \$\$521,000 (tax check-off) for this purpose.

**Subcommittee Staff Recommendation—Approve.** This proposal is consistent with the enabling legislation and it is recommended for approval.

### **3. Genetic Disease Testing Program—Modification to Project (Issue 556)**

**Governor’s May Revision Issue.** The DPH proposes an increase of \$868,000 (Genetic Disease Testing Fund) to fund a System Software Specialist III position (18-month limited-term) and to reflect changes in scope to the Business System Upgrade Project (Project) which the DPH contends will result in decreased expenditures in 2011-12 through 2014-15.

Of the proposed amount, a net of \$608,000 (Genetic Disease Testing Fund) is reflected in the contract line item. This is composed of the following:

- Increase of \$792,000 Oracle Contract
- Increase of \$13,862 One-Time Project Costs (contract)
- Decrease of \$198,000 Continuing IT Project Costs (contract)
- Net increase of \$103,519 Data Center Services (DHCS hosting)

The DPH states this approach reflects going from a replacement system to a more straightforward system upgrade which would decrease the project costs from \$3.5 million (Genetic Disease Testing Fund) to \$2.8 million (Genetic Disease Testing Fund). This is due to a shorter project time-line as well as module variations.

**Background—Business System Upgrade Project.** The Genetic Disease Screening Program is fee support and was discussed in the April 15 hearing generally. The program is seeking to upgrade its accounting and revenue collection, order and inventory management functions that will integrate into its “Screening Information System”.

**Subcommittee Staff Recommendation—Approve.** The DPH states this approach will result in savings over the course of the project as noted. No issues have been raised.

#### **4. Federal Ryan White Grant Funds—Local Assistance (Issue 560)**

**Governor’s May Revision Issue.** DPH requests a *net* increase of \$668,000 (federal funds) in budget authority due to adjustments in the Health Resources and Service Administration (HRSA) Part B HIV Care Grant as noted below. These funds were awarded to DPH based on a formula by HRSA.

• Current 2010-11 Budget Authority	\$123,035,000
• Increase in Base Grant	\$ 692,000
• Increase in Emerging Communities Grant	\$ 9,000
• Decrease in Minority AIDS Initiative Grant	-\$ 33,000
• Adjusted Authority	\$123,703,000
• <b>May Revision Request for Authority</b>	<b>\$ 668,000</b>

DPH states the net increase of \$668,000 will be used to support certain Local Health Jurisdictions and a small number of community-based organizations to provide HIV care program services for medical care, such as physician visits and laboratory tests. The Office of AIDS allocates HIV Care Program funds to Local Health Jurisdictions via a formula allocation process.

In addition, the DPH states they received recent clarification from HRSA that the award also includes Minority AIDS Initiative (MAI) funds. Previously MAI funds were awarded as a separate grant with a different budget period, not as part of the Ryan White award.

Kern County is the only county in California that meets HRSA’s statutory requirements for Emerging Communities. These funds are awarded to DPH but are allocated separately to Kern. The goal of the Emerging Communities funding is to: (1) enable emerging communities that do not qualify for Ryan White Act Part A funding, but have 500 to 999 cumulative AIDS cases, to receive a separate formula funding ward to provide HIV care.

DPH allocates MAI funds to 19 Local Health Jurisdictions with the highest number of non-white living with HIV/AIDS cases. The goals of this are to (1) evaluate and address disproportionate impact of HIV/AIDS on African Americans and other minorities; and (2) provide outreach and education services to increase minority participation in ADAP.

**Background.** California has been receiving these funds for 20-years. They state that these funds are used to fill in gaps in care not covered by other sources. Specifically, these funds will enable people living with HIV/AIDS to utilize services such as: (1) outpatient and ambulatory health services; (2) case management services; (3) early intervention services; (4) health insurance premium and cost sharing assistance; (5) home and community-based health services; (6) home health care; (7) hospice services; (8) housing services; (9) local pharmaceutical assistance; (10) mental health services; (11) treatment adherence counseling; and many other life saving services.

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

## **5. Adjust Licensing & Certification Program for LTC Ombudsman (Issue 553)**

**Governor's May Revision Issue.** The Administration is requesting two adjustments to the Licensing and Certification Program, including **(1)** a decrease of \$973,000 (Federal Health Facilities Citation Penalties Account for 2010-11 (one-time); and **(2)** a reduction of \$680,000 in the General Fund transfer to the Licensing and Certification Fund so that these funds can be appropriated to the CA Department of Aging (CDA) to support the Long-Term Care Ombudsman Program in 2010-11. This General Fund transfer to the L&C fund is a portion of the reimbursement paid by State facilities to the DPH for licensing and certification activities.

These two actions result in a net reduction of \$1.653 million for 2010-11 which would be redirected to support the Ombudsman Program for 2010-11. The L&C Program has stated unequivocally that this short-term fix will not adversely impact health and safety.

The DPH Licensing and Certification Program (L&C Program) is seeking this adjustment as a *short-term fix* for the shortfall in the Long-Term Care Ombudsman Program which resulted from insufficient funds in the Federal Health Facilities Citation Penalties Account (0942-605). This special account serves as a funding source for L&C's Temporary Manager Program and for the CDA's Long-Term Care Ombudsman Program.

The DPH notes that funds coming into this special account are inconsistent and unpredictable and not sufficient to support ongoing activities of these programs in 2010-11.

This is a one-time fix to continue the CDA's Long-Term Care Ombudsman Program. The Office of the State Long-Term Care Ombudsman in the CDA develops policy and provides oversight to 35 local Long Term Care Ombudsman Programs statewide. As advocates for residents of LTC facilities, local Ombudsman representatives promote resident's rights and provide assurances that these rights are protected. About 1,000 State-certified Ombudsman volunteers and paid staff in the local programs identify, investigate and seek to resolve complaints and concerns on behalf of about 296,000 residents in nearly 1,400 nursing facilities.

**Background—Federal Health Facilities Citation Penalties Account.** This special account derives its revenues from Civil Penalties paid by Long-Term Care health facilities to the federal CMS. The L&C Program, as the designated State agency for the federal CMS, conducts federal certification surveys through a federal grant.

The federal CMS has its own prescribed process for review and issuance of deficiencies and assessment of penalties. Once settled, if the outcome is that the federal CMS receives a payment from a health care provider, they remit a portion back to the DPH via an electronic transfer. As such, the L&C Program is not a participant in the federal process, or is not apprised of the status of deficiencies and penalties. As such, the L&C Program contends it is difficult to project the level of revenues and the frequency with which these revenues will be remitted to the State.

**Subcommittee Staff Recommendation—Approve.** The L&C Program has presented a very viable short-term fix to facilitate funding for the Ombudsman Program. It is recommended to approve the proposal.

## **D. Item 4300—Department of Developmental Services**

### **1. Technical Reduction for “Gap” Funding Since Assumption Not Relevant**

**Background and Subcommittee Staff Recommendation.** The DDS estimate for the Purchase of Services component of the Regional Centers’ estimate for 2010-11 contains a \$1.4 million (General Fund) assumption regarding “gap” funding due to the time period of when an Intermediate Care Facility for DD (ICF-DD) is in a transition period and may not be certified to be a Medi-Cal provider due to a change in ownership (does not pertain to not meeting federal standards here). DDS reflects \$1.4 million in General Fund support to backfill for the perceived loss of federal matching Medicaid (Medi-Cal) funds during this transition period.

However, after discussions with the DDS and the Department of Public Health (DPH), it is apparent that this assumption is *no longer necessary*. Certain administrative processes have now been clarified and there is no longer a period (or gap) of time whereby federal matching funds are not applicable, as long as all federal CMS requirements are otherwise being met.

It is recommended to delete the \$1.4 million (General Fund) for the “gap” funding from Item 4300-101-0001 since this assumption is no longer applicable. There is no affect on any health or safety issue here. It is just deleting an old, no longer applicable assumption.

### **2. Reappropriation of Capitol Outlay for Porterville Kitchen (Bond Funds)**

**Governor’s May Revision Issue.** The DDS suspended project activities on this bond funded project at the direction of the DOF, due to the State’s deteriorating cash position in the Pooled Money Investment Account (in December 2008). At the time of this freeze, the DDS had already transferred the working drawings funds necessary for the lease revenue financed portion of the Porterville new main kitchen to the Architectural Revolving Fund and working drawings were underway. However, the working drawings were not sufficiently completed to enable the State Public Works Board to include this project in the Spring 2010 sales.

DDS is requesting reappropriation language for the Porterville new main kitchen project from the Budget Acts of 2006 and 2008.

No General Fund moneys are involved in this project, only bond funds.

**Subcommittee Staff Recommendation—Approve.** It is recommended to please reappropriate the construction balance of the lease revenue bond funds to enable the DDS to complete this project once the bonds are sold.

## II. ITEMS FOR DISCUSSION

### Item 4265—Public Health (Selected Issues)

#### 1. AIDS Drug Assistance Program (ADAP)

**Governor’s May Revision Issue.** Over 38,000 people with HIV/AIDS will receive drug assistance through the ADAP for 2010-11. The May Revision proposes a *reduction* of \$28.6 million (decrease of \$32.7 million General Fund) as compared to January as shown in Table #1 below. The Office of AIDS states this reduction does not reflect any additional programmatic changes beyond the jail coverage change proposed in the Governor’s January budget.

**Table #1:** Comparison of Governor’s January Budget and May Revision for ADAP

Fund Source	January 2010	May Revision	Difference
General Fund	\$158.3 million	\$125.6 million	-\$32.7 million
AIDS Drug Rebate	\$210.9 million	\$210.3 million	-\$0.6 million
Federal Funds—Ryan White	\$92.9 million	\$97.6 million	+4.7 million
<b>TOTALS</b>	<b>\$462.1 million</b>	<b>\$433.6 million</b>	<b>-\$28.6 million</b>

Table #2 below provides a more detailed comparison of the ADAP expenditure components. As noted below, the key differences pertain to prescription drug costs and the Pharmacy Benefit Manager (PBM) Operation expenditures.

**Table #2:** Detailed Comparison of ADAP Adjustments as proposed in January

ADAP Local Assistance Components	January Budget 2010-11	May Revision 2010-11	Difference
Basic Prescription Costs	\$456,950,000	\$448,534,000	-\$8,416,000
Average Wholesale Price Rollback	--	-\$16,194,000	-\$16,194,000
True Out-Of-Pocket Costs	--	-\$3,192,000	-\$3,192,000
Eliminate Services to Jails	-\$10,889,000	-\$9,852,000	\$1,037,000
Shift Medi-Cal Newly Qualified Legal to ADAP	--	\$272,000	\$272,000
Shift Medi-Cal PRUCOL people to ADAP	--	\$1,632,000	\$1,632,000
<b>Subtotal of Prescription Costs</b>	<b>\$446,061,000</b>	<b>\$421,200,000</b>	<b>-\$24,861,000</b>
Basic Pharmacy Benefit Manager	\$14,782,000	\$14,349,000	-\$433,000
Administrative Reduction from 2009 (PBM)	-\$500,000	-\$500,000	0
Change in Non-Approved Transaction Fee Savings	--	-\$3,349,000	-\$3,349,000
Eliminate Services to Jails	-\$348,000	-\$315,000	\$33,000
Processing for Shift of Medi-Cal: Legals & PRUCOL	--	\$33,000	\$33,000
<b>Subtotal PBM Operations</b>	<b>\$13,934,000</b>	<b>\$10,218,000</b>	<b>-\$3,716,000</b>
<b>Total Drug Expenditures</b>	<b>\$459,995,000</b>	<b>\$431,418,000</b>	<b>-\$28,578,000</b>
Local Health Officers: Administration of Enrollment & Eligibility	\$1,000,000	\$1,000,000	0
Medicare Part D Premiums	\$1,000,000	\$1,000,000	0
Tropism Assay (for clinical indication)	\$133,000	\$133,000	0
<b>Total Support and Administration</b>	<b>\$2,133,000</b>	<b>\$2,133,000</b>	<b>0</b>
<b>TOTAL ADAP Program Expenditures</b>	<b>\$462,128,000</b>	<b>\$433,550,000</b>	<b>-\$28,578,000</b>

Specifically, the Office of AIDS states the proposed net reduction is attributable to the following:

- Updated drug expenditure data which results in a reduction in the linear regression expenditure estimate (as modeled by the Office of AIDS).
- Reduction in projected drug expenditures resulting from the federal settlement with First Data Bank regarding the value of the Average Wholesale Price (AWP).
- Change in the Medicare Part D True Out-Of-Pocket (TrOOP) through federal health care reform legislation which enables ADAP client's to count expenditures to move from the "donut hole" to catastrophic coverage.
- Continuation of the Administration's change in coverage for incarcerated individuals;
- Increase in the Ryan White Part B Grant award of \$4.7 million (federal funds) for ADAP.
- Increase in ADAP due to the Governor's proposal to eliminate Newly Qualified Legal Immigrants and Persons Residing Under the Color of Law (PRUCOL) from the full-scope Medi-Cal benefits.
- Change in the reimbursement structure of the next Pharmacy Benefit Manger contract.

Each of these key changes is discussed below.

- **A. Updated Data for Basic Prescription Costs and Liner Methodology.** The Office of AIDS utilized updated actual data through February 2010 for both expenditures and revenues (rebates) in their Linear Regression Model. This updated data provided seven more data points (data from August 2009 through February 2010) than available for the January budget development. This is the same methodology and model as used for the January budget. According to the Office of AIDS, the change in this trend reflects a *reduction of \$8.8 million, or a reduction of 1.88 percent.*
- **B. Average Wholesale Price Rollback from Federal Settlement.** ADAP, as does the Medi-Cal Program, uses a drug reimbursement rate based on the Average Wholesale Price of drugs. Through a federal settlement related to First Data Bank and the published prices of AWP for certain drugs, a *one-time* adjustment factor is to be made which lowers the value of AWP for certain brand drugs. ADAP implemented this change as of March 10, 2010.

The Office of AIDS states that a *savings of \$4.6 million (General Fund)* is to be achieved in the current-year, *and an estimated savings of \$16.2 million (General Fund)* is projected for 2010-11 from this adjustment.

The Office of AIDS acknowledges this calculation is based on existing data but that it is an estimate with *several moving variables* since ADAP clients (ADAP-Only, ADAP-Medicare Part D, ADAP-with insurance) vary and the AWP rollback calculation is affected by this variation.

- **C. Medicare Part D and “True-Out-Of-Pocket (TrOOP).** California’s ADAP interacts with the federal Medicare Part D drug benefit, implemented in 2006. The income level and assets of federal Medicare Part D enrollees determines the level of prescription assistance they receive under the federal program. The ADAP is the payer of last resort and serves as a *wrap-around* for enrolled clients because it is cost-beneficial to the State.

A Medicare Part D enrollee’s TrOOP spending— a person’s prescription payment obligation during the Medicare Part D coverage gap, or “donut hole”—determines how one advances through the various Part D coverage levels. This rule typically leads to ADAP clients (who are also in Medicare Part D) to remain “stuck” in the Part D coverage gap, and thus shifting more to ADAP coverage for this period.

The new federal Patient Protection and Affordable Care Act allows for ADAP expenditures to count towards a person’s “TrOOP effective as of January 1, 2011. As such federal Medicare Part D coverage will provide more support, and ADAP will experience savings from this action.

This issue was discussed in the Subcommittee hearing of April 15, 2010, and it was believed a savings would result in ADAP due to this federal law change.

The Office of AIDS calculated this adjustment to result in a *savings of \$3.2 million* (General Fund) in 2010-11 (effective January 1, 2011) due to a cost-shift to the federal Medicare Program which results from the federal law change.

- **D. Reduction of \$10.2 million to Discontinue ADAP in Jails.** As discussed in Special Session and in Subcommittee on April 15, 2010, the Administration proposes a *reduction of \$10.2 million* (\$8.3 million General Fund and \$1.9 million in lost ADAP Rebate Fund) by eliminating funding for county jails effective as of July 1, 2010. The reduction amount was updated at the May Revision and reflects about \$1 million (total funds) less in savings than January due to updated calculations.

The Administration states that the *\$8.3 million (General Fund) saved from this action are invested* within the ADAP to assist in meeting State expenditures in 2010-11.

They note that Local Health Jurisdictions are responsible for inmate care in jails as referenced in existing State Statue (Section 29602 of Government Code and Section 4011, et seq and 4015(a) of Penal Code).

The Office of AIDS administratively began funding county jails for inmates needing AIDS anti-retroviral drugs in 1994 due to the increasing fiscal impact on Local Health Jurisdictions in meeting their mandate to provide medical services to their incarcerated populations. Presently, thirty-six counties receive funding from the State to serve incarcerated individuals in 44 jails, or about 2,093 people.

The Office of AIDS states the *existing* process for reimbursing these 36 counties is as follows:

1. Jail pharmacy submits claim of \$100 (drug cost) to Pharmacy Benefit Manager.

2. Pharmacy Benefit Manager submits invoice of \$110.05 for payment to State ADAP. This invoice consists of \$100 drug cost + \$6.00 transaction fee and \$4.05 pharmacy dispensing fee.
3. State ADAP pays Pharmacy Benefit Manager \$110.05.
4. Pharmacy Benefit Manager reimburses Jail pharmacy at \$104.05 (drug cost and pharmacy dispensing fee).
5. State ADAP invoices drug manufacturer \$100, and the drug manufacturer pays State a drug rebate of \$32 (average rebate for ADAP jail clients) to ADAP.

The Office of AIDS notes that five counties—San Francisco, Santa Clara, San Diego, Contra Costa and Los Angeles— support their own jail programs. Santa Clara County is able to access 340b federal pricing through their county hospital (Valley Medical Center). As such, other counties may be able to establish relationships through their Local Health Jurisdictions to access this low-cost pricing via hospitals or applicable clinics.

- **E. Update on Ryan White HIV/AIDS Federal Funding.** In April, the federal HRSA informed the DPH of California’s award of federal Ryan White HIV/AIDS grant funds. The ADAP received an *increase of \$4.7 million* from this grant which is then used as an off-set to General Fund expenditures for 2010-11.
- **F. Proposed Shift of Newly Qualified Legal Immigrants and PRUCOLS to ADAP.** The ADAP May Revision reflects the Governor’s Medi-Cal Program proposal to eliminate Newly Qualified Legal Immigrants and PRUCOL Individuals. Two adjustments are shown for ADAP, including (1) \$1.9 million for drug expenditures and (2) \$33,000 for PBM processing fees, for a total increase of \$1.937 million.

The Subcommittee has already rejected the Governor’s May Revision proposal in Medi-Cal to remove these individuals from full-scope coverage. *Therefore, the ADAP increase of \$1.937 million is not necessary.*

Further, because the Office of AIDS calculates ADAP Drug Rebate revenues off of expenditures, including the augmentation of \$1.937 million, the ADAP Drug Rebate revenue needs to be *reduced by \$191,000* to appropriately reflect this adjustment.

- **G. Change in Non-Approved Transaction Fee.** As discussed in Subcommittee on April 15, 2010, the Office of AIDS is proceeding with a new Request for Proposal for the ADAP Pharmacy Benefit Manager (APBM). The new contract is to be effective July 1, 2010 and includes *two changes* that the Office of AIDS states will save ADAP funds.

First, it will have a lower reimbursement for “non-approved” transaction fees (will now be \$3.00 per transaction versus the present \$6 per transaction). Due to prescribing aspects, sometimes a pharmacist needs to revise a prescription before it is “approved”. The PBM must conduct administrative work on all claims, including those not approved (“non-approved”). Second, there will be a limit of five times for which a non-approved transaction and be submitted. These actions are to *save \$3.3 million*.

- **H. ADAP Rebate Fund—Reserves Limited and Rebates Still Being Negotiated.** 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).

*First*, the ADAP May Revision is *only* reflecting a reserve of **\$7.4 million** (ADAP Rebate Fund). Subcommittee staff does *not believe* this is a “prudent” reserve for the following reasons:

- ADAP Fund Condition Statement at May Revision reflects revenues of \$192.7 million. Typically a lower end “prudent” reserve is at least 5 percent of the revenues generated which would be at **least \$9.6 million**.
- Interest rates are low now and all State Special Funds, such as ADAP, are not capturing as much “earned interest income” as they once did and they could drop further during the course of the budget year.
- According to the Office of AIDS, there is a historic seasonal trend to drug expenditures, and therefore rebate revenues, in that the first half of the fiscal year is lower as compared to the second half (i.e., July to December expenditures and revenues from rebates is lower); However the existing revenue estimate method does not take this fluctuation into account (Page 16 of ADAP Estimate). This normally would not be significant, but given the very low reserve margin of \$7.4 million, Subcommittee staff believes it could become a concern later in the fiscal year.

*Second*, new supplemental rebate negotiations with each of the eight antiretroviral drug manufacturers took place on May 5-7, 2010. *Only three of the eight manufacturers* finalized supplemental rebates with the ADAP Crisis Task Force (i.e., “supplemental” rebates negotiated nationally). The Task Force hopes to complete the remaining supplemental rebate agreements by July 1, 2010, but the Office of AIDS of course cannot be certain that this will indeed occur.

*Third*, the federal Patient Protection and Affordable Care Act, signed by President Obama in March, makes changes to the federal *mandatory* Medicaid rebate calculation which *may* impact ADAP. Specifically, the federal Medicaid rebate calculation was increased for *both* brand name drugs (from 15.1 percent to 23 percent of “average manufacturer price”), and generic drugs (from 11 percent to 13 percent), effective as of January 1, 2010 (retroactive). The Office of AIDS notes they are *seeking additional information* regarding the increased rebates under Medicaid to discern how ADAP may be affected.

The Office of AIDS states they *do not anticipate* any reduction in rebates from this federal action, but it is not yet resolved.

*Fourth*, the minimal May Revision reserve of \$7.4 million assumes that all of the ADAP assumptions will indeed, hit the mark. Though the Office of AIDS has prepared an earnest, data-driven Estimate for ADAP, there are several moving parts, including the Average Wholesale Price (AWP) rollback (discussion “B”, above) which is to save \$4.6 million in the current-year and \$16.2 million in 2010-11 (total of \$20.8 million across the two years).

The Estimate notes (page 4) that this savings assumption relies on several “hypothetical” savings calculations in order to develop the estimate. This is completely understandable for a “new” assumption. However, it is a considerable savings and if it does not hit its mark, then a draw on the reserve may be needed.

**Background—ADAP Uses a Pharmacy Benefit Manager.** The AIDS Drug Assistance Program was established in 1987 to help ensure that HIV-positive uninsured and under-insured individuals have access to drug therapies.

The state provides reimbursement for drug therapies listed on the ADAP formulary (over 180 drugs). The formulary includes antiretrovirals (about 30), opportunistic infection drugs, hypolipidemics, anti-depressants, vaccines, analgesics, and antibiotics. Since the AIDS virus can quickly mutate in response to a single drug, medical protocol calls for inclusion of at least three different anti-viral drugs for patients.

**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-- Modify.** The ADAP is a core State health care program which has been cost-beneficial to the State.

*First*, it is recommended to reject the Administration’s ADAP assumption regarding Newly Qualified Legal Immigrants and PRUCOLS. The Subcommittee’s prior action of May 13th continues to provide full-scope Medi-Cal benefits to these individuals. Therefore a reduction of \$1.937 million (GF) from expenditures and a reduction of \$119,000 in ADAP Drug Rebate revenues should be reflected (i.e., net reduction of \$1.8 million due to revenue loss aspect).

*Second*, the Governor’s May Revision provides a very modest reserve of only \$7.4 million. The potential risk of the pending supplemental rebates (Taskforce still working), and the AWP

rollback issue, could sway ADAP into a precarious situation during the course of the budget year if these assumptions do not fully occur.

Therefore, it is *also recommended* to provide an increase of \$10 million (General Fund) to increase the reserve to a total of \$19.2 million (i.e., net adjustment of \$1.8 million, plus existing \$7.4 million reserve and \$10 million augmentation). This would provide a 10 percent reserve. This seems more “prudent”, particularly given the level of risk in two *key* assumptions.

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

1. Office of AIDS, Please provide a clear walk-through of each of the key items as noted please (using the Agenda items as a reference please).
2. Office of AIDS, budgets are estimates based on the best available assumptions at the point in time. Of the many assumptions in this ADAP estimate, which ones may have the most potential risk in not meeting their estimated amount?
3. Office of AIDS, the DHCS Medi-Cal Program is proposing a “hard” cap on providing Medi-Cal Program enrollees with only six prescriptions per month, except for “life-threatening” medications. From a professional, technical assistance perspective, what may this mean for the ADAP, including those medications which are needed for people to maintain their drug therapy regime?

## **2. Restoration of Governor's Veto's from Budget Act of 2009**

**Budget Issue.** Through the Joint Budget Conference Committee, the Legislature directed limited resources, including AIDS Drug Rebate Funds, federal funds, and General Fund support, to develop a prudent plan for program expenditures within the Office of AIDS. Difficult decisions were made in an effort to maintain core HIV/AIDS services, such as education and prevention efforts, HIV testing, therapeutic monitoring of T-Cells for drug efficacy, HIV counseling, and early intervention projects.

With his blue pen, the Governor vetoed a total of \$52.1 million (General Fund) from these critical programs. With this veto, the following occurred:

- Deleted \$22.4 million (General Fund) from HIV/AIDS education and prevention programs, leaving no State support for these programs;
- Deleted \$8.2 million (General Fund) from the HIV Counseling and Testing Program, leaving no State support for this program;
- Deleted \$7.3 million (General Fund) from AIDS Therapeutic Monitoring Program;
- Deleted \$7.4 million (General Fund) from the AIDS Early Intervention Projects, leaving no State support for these projects;
- Deleted \$5.8 million (General Fund) from the AIDS Home and Community-Based Care Projects, leaving no State support for these projects;
- Deleted \$992,000 (General Fund) from HIV/AIDS Housing, leaving no State support for this program.

California has *historically* been a national model for its HIV/AIDS prevention, education, surveillance and epidemiologic studies, counseling and treatment programs.

It is because of *joint* federal, State, and community-based efforts that this model has been effective. The Governor's veto effectively eliminated the State's commitment to these vital efforts to mitigate the spread of HIV/AIDS, to support early intervention efforts, and to facilitate cost-beneficial community-based services. The public health of a State is reliant on core, fundamental policies and practices that are reflected in these HIV/AIDS programs and services. State support of these programs is cost-beneficial and sustains healthy communities.

The Office of AIDS annual chart, updated for May Revision, clearly reflects the dollars lost in comparing across the fiscal years for local assistance programs (See Hand Out).

**Subcommittee Staff Recommendation.** It is recommended to appropriate \$52.1 million (General Fund) to backfill the HIV/AIDS Programs which were vetoed by the Governor in the Budget Act of 2009 (July).

### **3. Federal CMS Grant Funds for Licensing & Certification Program (L&C)**

**Governor’s May Revision Issue.** The L&C Program requests an increase of \$17.6 million (federal funds) to permanently establish 124.8 positions to enable the L&C Program to complete as much of the federal certification activities (related to Medicare and Medi-Cal) as possible given the level of federal grant funds made available (federal fiscal years from October 2009 through September 2010).

With respect to the current-year, a total of \$9.4 million (federal funds) and authority to administratively establish 93.6 positions was reviewed by the Joint Legislative Budget Committee, chaired by Senator Ducheny, and no issues were raised.

The federal CMS grant requires completing *specific prioritized* workload for multiple facility types. This workload is prioritized into Tiers 1 through 4, with Tier 1 being the highest priority. L&C Program notes that historically, the federal CMS has only provided enough resources for them to accomplish most of Tier 1 activities and a portion of Tier 2.

The L&C Program proposes to expend the \$17.6 million (federal grant funds) in the following key areas:

- L&C Program Staff. A total of 124.8 staff as noted below. Extensive workload information has been provided to the Subcommittee regarding all of these positions.
  - Medical Consultant I 1.0
  - Health Facility Evaluators—Nurses 76.0
  - Health Facility Evaluator I’s 5.75
  - Health Facility Evaluator Supervisors 17.0
  - Pharmacy Consultant II, Specialist 1.0
  - Nutrition Consultant II 1.0
  - Program Technicians (key Evaluator support) 17.0
  - Staff Counsel 1.0
  - Various Professional Staff Support 5.0
- Contract with Los Angeles County—Increase by \$2.5 million. The State has always contracted with Los Angeles County for this purpose and provides funding to them based upon specified standards and costs.
- State Contract for “Recruitment” \$48,000. This contract will facilitate the hiring of L&C Program staff, particularly the clinical staff. (It should also be noted that the L&C Program also uses many other personnel recruitment tools for hiring.)
- Minor Equipment \$706,000. This is for lap-top computers and related items used in the field by the Survey Teams to enter data and conduct survey work.

The L&C Program has been working on efficiencies and meeting regularly with the federal CMS regarding federal grant compliance and federal survey activities, including compliance with existing workload mandates. Federal CMS has recognized a marked improvement over the last few years in L&C Program workload accomplishments. *As a result of this work, the federal CMS has significantly increased California's federal grant for this purpose.*

Even with the increased federal funds, L&C Program acknowledges they will not be able to complete 100 percent of the Tiered federal workload requirements for the budget year because the federal grant does not provide *full funding* for California. But full expenditure of this federal grant increase, coupled with continued improved performance by California will be critical to further discussions and negotiations with the federal CMS to cover even more of the L&C Program workload as appropriate.

*Finally*, it should also be noted the L&C Program has revised its training schedule to ensure that the requisite training of new Health Facility Evaluator Nurses can be completed promptly and effectively.

**Background—Federal CMS Tiers.** The federal CMS requires specific activities to be conducted by the L&C Program as noted below.

- Tier 1. This includes extensive activities related to periodic Skilled Nursing Facility surveys, Home Health Agency surveys, and surveys for Intermediate Care Facilities for Developmentally Disabled.
- Tier 2. This includes “targeted” surveys for selected facility types and validation surveys for facilities that are certified by a federally-recognized accrediting organization.
- Tier 3. This includes increased periodic inspection of Non-Long Term Care facilities.
- Tier 4. This includes initial certification activities of all facility types.

The federal CMS's rationale for this tiered priority ranking is that States should not be certifying new provides unless there is the ability to provide some basic level of assurance to the public that the facilities that are already certified are undergoing quality review.

The L&C Program must meet federal CMS state agency performance requirements and can be penalized (reduced award in federal grants) for failing to meet the standards.

**Overall Background—Purpose of Licensing & Certification.** The DPH L&C Program conducts licensing and certification inspections (surveys) in facilities to ensure their compliance with minimum federal certification and state licensing requirements in order to protect patient health and safety. Encouraging provider-initiated compliance, quality of care improvement and promoting research regarding the quality and effectiveness of health care services is also a key component of the L&C Program mission.

The L&C Program is responsible for investigating complaints from consumers, consumer representatives, the Ombudsmen, and anonymous sources. L&C is a statutorily mandated enforcement agency.

Certification is a federal prerequisite for health facilities and individual providers wanting to participate in and receive reimbursement from both Medicare and Medicaid (Medi-Cal). The DPH is the designated entity under contract with the federal CMS to verify that health facilities meet certification standards. Federal grant funds are allocated to California to conduct work associated with Medicare. In addition, L&C fees are collected from the various facilities and are placed into the L&C Fund. General Fund support is also provided for some facilities to support L&C functions of State facilities (such as Developmental Centers).

There are over 7,000 public and private health care facilities throughout the state, including hospitals, nursing homes, clinics and home health agencies.

**Subcommittee Staff Recommendation--Approve.** *First*, the L&C Program should be acknowledged and congratulated for achieving program efficiencies and making improvements to be recognized by the federal CMS for such a considerable federal grant increase. This is well-earned.

The L&C Program has provided appropriate information for the workload and the functions proposed clearly meet the purposes of the federal CMS federal fund grant.

**Questions.** The Subcommittee has requested the Center for Health Care Quality-- Licensing and Certification is within this DPH Center-- to respond to the following questions:

1. DPH, Please provide a *brief* summary of the *key* aspects of the proposal.

#### **4. Quality & Accountability Payment System for “Freestanding” Nursing Facilities**

**Governor’s May Revision Issue.** The Governor’s May Revision proposes to **(1)** revise and implement a new rate-setting methodology for Freestanding Nursing Facilities (NFs) reimbursed under the Department of Health Care Services (DHCS) administered Medi-Cal Program (so called AB 1629 method); *and* **(2)** to fund positions within the Department of Public Health (DPH) to improve the overall quality of care rendered to patients residing in these NFs.

Today’s discussion will *focus on the DPH component* of this proposal please.

The DPH requests an increase of \$2.2 million (Reimbursements from the DHCS) to support 38.5 permanent positions with the L&C Program, and to provide an increase of \$168,000 to Los Angeles County for their contract (for L&C purposes as has been historically done.

The \$2.2 million in 2010-11 will be funded by the DHCS using their *existing* General Fund and matching federal funds (Medi-Cal federal funds). *In future years*, funding will be obtained through NF Quality Assurance Fees and matching federal funds. (This aspect, including proposed trailer bill language, will be discussed in detail in the Wednesday, May 26th hearing as noted in the Senate File.)

The 38.5 DPH positions are as follows:

- Health Facility Evaluator—Nurses 15.0
- Staff Counsel 0.5
- Research Specialist 1.0
- Staff Services Manger I and Associate Analysts 20.0
- Associate Programmer Analyst 1.0
- Management Services Technician 1.0

The DPH will *incrementally phase-in* the requested staff to **(1)** conduct State licensing surveys (i.e., compliance with State law) of 50 percent of the NF’s; and **(2)** conduct onsite staffing audits of NFs to determine compliance with 3.2 nursing hours per patient day (nurse hours ratio) requirement). DPH states that 19 of these staff will *require a State car* since they will work independently, spending 90 percent of their time in the field conducting staffing audits.

As noted by the staffing compliment, above, the DPH will be doing staffing audits, and data mining research, in addition to the important survey work and related follow-up, to comprehensively discern whether the nurse hours ratios are being met by each facility.

By the end of 2010-11, the DPH anticipates *one-third* of the NFs will have received a 3.2 nurse hours ratio staffing audit. For 2011-12, DPH states *all* NFs will receive this staff audit review of nurse hours ratio *and* 50 percent will also receive a State licensing survey. This is the result of the staff phase-in approach which is tied to having a *General Fund neutral proposal in 2010-11*, and then using NF Quality Assurance Fees (QAF matched with federal funds for this purpose beginning in 2011-12).

DPH will also publish a report detailing these audit findings.

**Background—Summary of Administration’s Freestanding Skilled Nursing Facility Quality and Accountability Proposal.** The existing AB 1629 Medi-Cal NF reimbursement system functions independent of any facility citations or notices of violation issued by the DPH’s L&C Program, federal CMS quality assurance measures, or the results of family, resident, or staff satisfaction surveys.

Extensive stakeholder conversations have occurred regarding the rate structure and quality assurance measures for several years (both extensively last year, as well as intermittently in other years).

The Administration recognizes that changes need to occur to improve the efficient use of Medi-Cal expenditures in this area and to provide improved quality of care for patients. They note that about *two-thirds of all NF days statewide* are paid for by the Medi-Cal Program.

They propose to revise and implement changes to the existing Medi-Cal rate reimbursement system for NF facilities to improve quality of patient care and accountability with State law and licensing standards. This is a *multi-year effort* proposal by the Administration.

Their key *overarching aspects* of this proposal are as follows:

- Extend the NF Quality Assurance Fee (QAF) under AB 1629, including changes as referenced below.
- Provide for increased oversight of NF staffing requirements and enforcement of penalties of non-compliance (as referenced in above DPH budget proposal).
- Provide NF facilities that meet performance targets with financial incentives of supplemental quality and accountability payments.

*According to the Administration* (DHCS and DPH), the Governor’s May Revision is intended to reward or penalize NFs for the overall quality of care provided to their residents. The following outlines the DHCS’ key components to be conducted in 2010-11 (*all focused on the reimbursement piece and its operation*).

- Modify the 2010-11 Medi-Cal Quality Assurance Fee (QAF) on each NF, including Multi-Level Facilities;
- Assess a penalty for non-payment of the QAF, beginning in 2010-11 *up to* 50 percent of the unpaid fee.
- Continue to collect all QAF including any penalties and interest until the amount is paid in full, regardless of the QAF sunset date of July 31, 2012.
- Where applicable, make recommendations to DPH that license renewal be delayed until the DHCS has recovered the full amount of the QAF due.
- Phase-in other NF Medi-Cal reimbursement rate changes over several years, including **(1)** a proposed 3.93 percent rate increase (General Fund-neutral) if federal ARRA extended (to June 30, 2012) or 3.14 percent if it is not extended; and **(2)** cap NF

reimbursement for professional liability insurance at the 75th percentile and place these savings into a special fund (as referenced below).

- Establish a NF Quality Assurance and Accountability Special Fund which will be used in 2011-12 as a *supplemental* payment pool for rewarding NFs that meet identified quality measurements.
- Disallow reimbursement for legal costs related to causes that have not been found in favor of the facilities.
- Working with stakeholders, establish and publish quality and accountability measures and benchmarks
- Fund DHCS positions (seven) and consultant contractor to advise the DHCS in the planning and implementation of the rate change methodology.

Other DHCS aspects would proceed in 2011-12 and 2012-13.

*(The Administration's proposed trailer bill language, as well as the DHCS requested positions and funding for May Revision, will be discussed on Wednesday, May 26th, as noted in the Senate File.)*

**Background—“Quality Assurance Fees”.** California presently uses a “Quality Assurance Fee” for the “AB 1629” nursing home rate methodology. These fees are collected from NF Facilities on a quarterly basis and are used by the State to obtain additional federal funds to provide rate adjustments intended to improve quality. Generally, within specified requirements, federal Medicaid law allows states to collect fees from providers for expenditure in the Medicaid Program (Medi-Cal Program in California). Several states use these “Quality Assurance Fees” to support their programs.

The QAF has enabled NF facilities to obtain rate adjustments and for the State to save General Fund (since the QAF revenues are used, along with federal funds, for these adjustments).

**Subcommittee Staff Recommendation—Approve DPH Staff.** Phasing-in the DPH staff to conduct the 3.2 nurse hours ratio audit seems reasonable and is *very* overdue. Full monitoring of the nurse hours ratios, along with public accountability and L&C targeted survey work, needs to proceed in an accelerated manner.

With the present fiscal environment and the need to re-craft the rate methodology and QAF, the 2010-11 approach of redirecting DHCS funds (General Fund and matching federal funds) will ensure that funds are immediately available for the DPH to proceed.

**Questions.** The Subcommittee has requested the Center for Health Care Quality-- Licensing and Certification is within this DPH Center-- to respond to the following questions:

1. DPH, Please provide a brief summary of the request regarding the key components.
2. DPH, Specifically how will the 3.2 nursing hour ratio be audited/determined?
3. DPH, Has an exemption from the Administration regarding the purchase of State cars been obtained? (As required by Executive Order S-14-09 (July 2009))

## **5. The Safe, Clean, and Reliable Drinking Water Supply Act of 2010**

**Governor's May Revision Issue.** The DPH is requesting expenditure authority for 2010-11 and 2011-12 to implement this bond measure (SB X7 2, Cogdill, Statutes of 2009) which will be on the November 2, 2010 ballot. Voters would need to authorize the issuance and sale of bonds to fund water improvements in the State. If it is approved, the measure specifies that it is to take effect immediately. State agencies are expected to move swiftly to distribute funds to eligible projects.

The 2010 Water Bond is an \$11.1 billion proposition intended to fund the overhaul of the State's water supply system. Among the water bonds' components are funding programs allocated to the DPH to administer, including \$80 million for drought relief (Chapter 5—Section 79720 of Water Code), and \$1 billion for Groundwater Protection and Water Quality (Chapter 10—Section 79770 of Water Code).

The DPH is responsible for overseeing the appropriation of grants and loans for infrastructure improvements to public water systems and related actions to meet safe drinking water standards under both State and federal law.

The DPH May Revision expenditure authority request includes the following:

- \$103 million in local assistance funds for 2010-11
- \$501,000 for State support in 2010-11 (seven staff)
- \$208.3 million in local assistance funds for 2011-12
- \$5.3 million for State support in 2011-12 (45 staff)

Specifically, the DPH is proposing to use \$80 million in pending bond funds for the meeting the State's 20 percent match requirement to leverage federal funds under the Safe Drinking Water Program (as described below and discussed in detail in the Subcommittee hearing of April 15th). These funds will provide about \$126 million in federal capitalization grants. Chapter 5 of the Water Bond measure provides for this purpose.

Chapter 10 of the measure provides \$1 billion in funding to DPH to provide grants and loans for projects that prevent or remediate contamination of groundwater that serves as a source of drinking water. DPH expects that it could use *up to* \$93 million of the pending bond measure for 16 water projects in 2010-11 using *existing* Proposition 84 criteria. (This criteria was discussed in detail in the Subcommittee hearing of April 15th).

DPH also desires to work with stakeholders, particularly disadvantaged communities, to address modifying the strict criteria and deadlines in the Proposition 84 program. These discussions are to occur during the course of 2010-11. Upon passage of the pending bond measure, the DPH intends to solicit pre-applications, create priority lists, evaluate applications, conduct technical evaluations of projects, issue funding agreements and process reimbursement claims.

In addition, the DPH wants to re-examine its existing emergency grant program (water needs based upon unforeseen occurrences) operated under Proposition 84 with the intent to provide more assistance to disadvantaged communities here as well. The pending water bond would provide for the allocation of funds in this area as well. DPH expects to allocate at least \$10 million annually for this purpose.

**Background—Safe Drinking Water Program.** Enacted in 1997, under this program California receives federal funds to finance low-interest loans and grants for public water system infrastructure improvements. In order to draw down these federal capitalization grants, the State must provide a 20 percent match. Further, the State must submit an annual “Intended Use Plan” which describes California’s plan for utilizing the program funding.

The program is comprised of five set-aside funds, as well as a loan fund. The set asides are as follows:

- Drinking water source protection (15 percent);
- Technical assistance to small water systems (up to 2 percent);
- Water system reliability/capacity development (2 percent);
- State water system program management activities (up to 10 percent);
- Administrative costs (up to 4 percent).

California will be receiving *increased federal grant funds* due to a change in the federal allocation, and from *increased Congressional funding* (H.R. 2996).

With respect to the 20 percent State match, General Fund support was used for a period of time, then a portion of Proposition 13 bonds (until fully expended), then a portion of Proposition 50 bonds, and now a portion of Proposition 84 bonds.

**Background—Public Drinking Water.** The DPH has statutory authority to administer California’s public Drinking Water Program and has since 1915. The program provides for ongoing surveillance and inspection of public water systems, issues operational permits to the systems, ensures water quality monitoring is conducted and takes enforcement actions when violations occur. They oversee the activities of about 8,000 public water systems (including both small and large water systems) that serve more than 34 million Californians.

The DPH is also designated by the federal Environmental Protection Agency (EPA) as the primacy agency responsible for the administration of the federal Safe Drinking Water Act for California.

California’s total need for water system infrastructure improvements is in excess of \$39 billion, as reported through a needs assessment conducted in 2007. The majority of public water systems are not able to finance necessary improvements on their own and require State and federal assistance.

**Prior Subcommittee Hearing.** In the Subcommittee hearing of April 15th, the DPH administered Drinking Water Program was discussed extensively, including all funding sources and the various criteria components.

**Subcommittee Staff Recommendation—Approve 1-year (2010-11) Only.** As noted above and as discussed in the Subcommittee hearing of April 15th, California has extensive water infrastructure needs for our public drinking water system. The DPH has operated a well managed, well established program for many years. Given the timing of the Water Bond measure, and the existing project lists, it is recommended to provide an appropriation for 2010-11 only.

This one-year appropriation will enable the DPH to implement immediately upon approval by the voters in the November election, *and* will enable the Legislature to further discuss and review criteria and projects for the 2011-12 fiscal year.

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

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

## Item 4300--Department of Developmental Services

### A. Background

**Summary of Governor's May Revision for DDS.** The Governor's May Revision proposes total expenditures of \$4.8 billion (\$2.7 billion General Fund) for the DDS as shown in the Table below.

**Table: Governor's May Revision for DDS**

Developmental Services Governor's May Revision	Current Year May Revision	2010-11 May Revision	Difference
Community Services	\$4,016,331,000	\$4,154,933,000	\$138,602,000
Developmental Centers	\$601,931,000	\$625,711,000	\$23,780,000
Headquarters Support	\$33,862,000	\$37,652,000	\$3,790,000
<b>TOTAL, All Programs**</b>	<b>\$4,652,124,000</b>	<b>\$4,818,296,000</b>	<b>\$166,172,000</b>
<b>General Fund</b>	<b>\$2,458,720,000</b>	<b>\$2,748,877,000</b>	<b>\$290,157,000</b>
Reimbursements	\$2,049,790,000	\$1,957,371,000	-\$132,419,000
Federal Funds	\$89,563,000	\$56,951,000	-\$32,612,000
Lottery	\$410,000	\$391,000	-\$19,000
Program Development Fund	\$2,370,000	\$3,572,000	\$1,202,000
CA Children and Families First	\$50,000,000	\$50,000,000	\$0
Mental Health Services Act Funds	\$1,121,000	\$984,000	-\$137,000
Developmental Disabilities Services	\$150,000	\$150,000	\$0

The May Revision reflects an overall increase of \$166.2 million (increase of \$290.2 million General Fund) as compared to the revised current-year.

A key reason for the General Fund increase is the Governor rescinded his January budget proposal to seek voter approval to redirect \$200 million in Proposition 10 Funds (CA Children and Families First) to backfill for General Fund support in DDS Community Services, specifically for the Purchase of Services at the Regional Centers.

It should also be noted that the Table above does *not* reflect General Fund savings that would result from an extension of the federal ARRA for another six months (from December 2010 to June 30, 2011).

Since this extension is pending before Congress, the Administration has established Control Section 8.65 to serve as a technical adjustment mechanism (i.e., federal funds received, corresponding General Fund support reduced) for *all* affected departments, including the DDS. The May Revision assumes an overall General Fund offset for these federal funds.

The Control Section reflects a total of \$39 million for 2009-10 and \$212.8 million for 2010-11 for the DDS as shown below::

- \$165.4 million (federal funds) for federal ARRA six month extension.
- \$32.9 million (federal funds) for Part C grant for the Early Start Program.
- \$39 million (federal funds) for 2009-10 and \$14.5 million (federal funds) for 2010-11 for a State Plan Amendment for Intermediate Care Facilities—DD (ICF-DD), which is discussed in more detail below.

Key adjustments for Community Services (funding to Regional Centers) and the Developmental Centers will be discussed below. The Headquarters appropriation is adjusted to reflect the end of furloughs, as is the direction of the Governor, beginning in 2010-11.

**Budget Act Language—Allows for Transfer Between Items.** Finally, it should be noted that the annual Budget Act contains Budget Act Language which provides for the transfer of funds as necessary between the Developmental Centers Program and the Community Services appropriation (See provision 3 on page 345 of Senate Bill 874, as introduced). The purpose of this language is to enable the DDS to transfer funds, as appropriate, for individuals transitioning from a Developmental Center to the community.

## **B. Discussion Issues: Community Services**

**Background: Summary of Governor's May Revision.** The May Revision for 2010-11 proposes expenditures of \$4.155 billion (\$2.4 billion General Fund) for the Regional Centers. Of the total amount, \$3.639 billion is for the Purchase of Services and \$516.1 million is for Regional Center Operations.

The May Revision reflects a *decrease* of \$23.5 million (increase of \$172.6 million General Fund) as compared to the January budget for 2010-11. Specific May Revision proposals are discussed individually, after the *key baseline adjustment* summary.

*Key baseline adjustments* include the following listed below. Due to prior Senate Subcommittee #3 actions taken in other departments, such as the DHCS and DSS, the Senate Subcommittee #3 actions on these key baseline adjustments listed below will "conform". or be consistent with, those prior Senate Subcommittee (or full Senate Committee) actions.

- Deletion of Proposition 10 Funds. Increase of \$200 million (General Fund) to reflect the Governor rescinding his January budget proposal to seek voter approval to redirect \$200 million in Proposition 10 Funds (CA Children and Families First) to backfill for General Fund support. This conforms to the Senate action in Special Session to *not* adopt the Proposition 10 redirection in the first place.
- Caseload Reduction. DDS estimates a total caseload of 243,704 consumers in the community which reflects a reduction of 6,271 from the January projection. A reduction of \$29 million (total funds) is reflected in Purchase of Services, and a reduction of \$13 million to Regional Center Operations due to this revised lower caseload level. No issues have been raised.
- Continuation of 3 Percent Reduction to Regional Centers. The May Revision reflects technical adjustments to the 3 percent based on expenditures and caseload. For the Purchase of Services a reduction of \$99.6 million (\$49.7 million General Fund) is reflected and for Regional Center Operations a reduction of \$15.7 million (\$10.8 million General Fund) is reflected. This conforms to the Legislature's action in Special Session implemented through trailer bill legislation (AB 8X 4, Statutes of 2010).
- Continues all Adjustments from 2009. The May Revision continues all proposals enacted last year, and generally discussed in the Subcommittee hearing of April 29, 2010, which affect the Purchase of Services and Operations used to achieve the \$334 million (General Fund) reduction. These actions are reflected in the trends.
- Adult Dental Services. Continuation of \$12 million to purchase necessary dental services for Adults receiving services through the Regional Centers who do not have insurance for this coverage, This became necessary due to the elimination of Adult Dental Services as a Medi-Cal benefit in 2009. Individuals with developmental disabilities are entitled to these services.

- Dental Treatment Review. An increase of \$800,000 is reflected to support an interagency agreement with the DHCS to enable Regional Centers to utilize the infrastructure and expertise of the Denti-Cal Program (Medi-Cal) to review treatment plans and approve claims for dental services. This avoids higher expenditures by enabling Regional Centers to pay for services at these lower rates.
- Adult Day Health Care. The DDS budget includes an increase of \$28 million (total funds) to reflect the Governor's proposal to eliminate Adult Day Health Care Services in the Medi-Cal Program administered by the DHCS.

Subcommittee #3 *rejected* the Governor's proposal to eliminate this valuable service on April 29, 2010; therefore, this \$28 million (total funds) backfill is *not needed* for the purpose of the Senate Subcommittee's actions. *This is a conforming action.*

- Proposed Fund Shift Due to Governor's Proposed CalWORKS Changes in DSS. The Governor proposes to eliminate the CalWORKS Program administered by the DSS. This issue will be discussed by the Subcommittee in the Department of Social Services Program next week, as noted in the Senate File. DDS utilizes a portion of the federal Title XX block grant funds to support low-income consumers as provided. Since the Lanterman Act is an entitle program, funds are shifted between General Fund support and federal Title XX contingent upon the expenditure of funds within CalWORKS. Therefore, the DDS budget will be adjusted to conform to the Senate Committee's action taken in the DSS budget next week as noted in the Senate File.
- State Supplemental Payment (SSP). The DDS budget includes an increase of \$2.7 million (General Fund) to reflect the Governor's proposal to reduce the maximum monthly SSP grant to aged and disabled individuals to the maintenance of effort floor in the SSI/SSP Program administered by the DSS.

This adjustment is *not needed if* the Governor's proposed reduction is not enacted in the DSS budget. This issue will be discussed in the Senate Committee under the DSS next week. The action taken by then will result in a conforming action in the DDS budget (i.e., a reduction if the DDS reduction does not occur, and an increase of General Fund support if the action is taken).

- Reduction Proposals in Other Departments Not Yet Calculated. In addition to the above references, the Governor's May Revision includes service reduction proposals in Medi-Cal and the In-Home Supportive Services (IHSS) Program.

The DDS budget does *not* reflect adjustments for these and has not calculated them as yet. In the event actions are taken in other departments, corresponding adjustments will be needed to continue services to consumers served by the Regional Centers.

- Self Directed Services Implementation. Implementation of the Self Directed Services Waiver will occur in April 2011 which results in a decrease of \$3.9 million (total funds) for 2010-11 due to this delay. Regional Center implementation will be phased-in over an eight-month period. It is anticipated that 75 consumers will participate. No issues have been raised.

- Quality Assurance Contract. A technical budget error needs to be corrected from the Governor's January budget for this contract whose outcomes and analysis is required by State statute. Specifically the DDS notes that an increase of \$1.8 million (General Fund) needs to be reflected. No issues have been raised.

(Specific issues for discussion begin below.)

## **1. Intermediate Care Facilities for Developmentally Disabled (ICF-DD) --Billing**

**Governor’s May Revision Issue.** The Budget Act of 2007 required DDS and DHCS to obtain federal CMS approval to *reconfigure* (“bundle”) the rate paid to ICF-DD facilities to include Day Program and Transportation Services expenditures received by residents of these facilities for the purpose of receiving federal fund support (federal Medicaid (Medi-Cal) funds).

California submitted a “State Plan Amendment” (SPA) for this to occur and has been assuming *baseline* receipt of \$44 million (federal funds) for each fiscal year, in lieu of General Fund support, since 2007.

Federal CMS approval of the SPA and resolution of a billing mechanism for past-years has *just occurred*. A *net* savings of \$53.5 million (General Fund) is reflected in the May Revision and is composed of the following components as shown in the Table below.

**Table: ICF-DD State Plan Amendment**

<b>General Fund Information</b>	<b>2007-08</b>	<b>2008-09</b>	<b>2009-2010</b>	<b>2010-11</b>	<b>Total</b>
Include additional services, such as “look-alike” Day Programs.	\$3,000,000	\$3,000,000			\$6,000,000
Apply federal ARRA 11.59% to base expenditures.		\$8,171,000	\$10,895,000	\$5,452,000	\$24,518,000
Higher expenditures than previously estimated (included federal ARRA where applicable).	\$4,338,000	\$4,995,000	\$4,624,000	\$5,759,000	\$19,716,000
Include Targeted Case Management Services in bundled rate.				\$6,000,000	\$6,000,000
<b>SUBTOTAL of GF SAVINGS</b>	<b>\$7,338,000</b>	<b>\$16,166,000</b>	<b>\$15,519,000</b>	<b>\$17,211,000</b>	<b>\$56,234,000</b>
Regional Center Cost	-\$781,000	-\$635,000	-\$585,000	-\$692,000	-\$2,693,000
<b>TOTAL NET GF SAVINGS</b>	<b>\$6,557,000</b>	<b>\$15,531,000</b>	<b>\$14,934,000</b>	<b>\$16,519,000</b>	<b>\$53,541,000</b>

The billing mechanism to be used for this process was discussed in Subcommittee on April 29, 2010. Placeholder trailer bill language was adopted at this time pending further discussion with the federal CMS, DHCS, the ICF-DD facilities and Regional Centers. This discussion was important in order to **(1)** maintain the integrity of the Individual Program Planning (IPP) process; **(2)** capture all federal funds available; and **(3)** clarify the roles and responsibilities of the billing processes, including those needed for prior years.

Targeted Case Management (TCM) services, case management services provided for specific client groups which the federal CMS recognizes for reimbursement, were recently added to the package for receipt of additional federal funds. This will require a separate State Plan Amendment but should present no issues.

Payment for administrative costs need to be provided to the Regional Centers, as well as the ICF-DD providers due to **(1)** certain federal CMS requirements; **(2)** the need to process prior-years' billing information; and **(3)** the need to include Day Program, TCM and Transportation Services expenditures in billing procedures. The administrative costs for the Regional Centers are shown in the Table above (i.e., \$6.2 million total of which \$2.7 million is General Fund).

DDS states the ICF-DD administrative costs are \$30.6 million (\$6.2 million for administrative costs and \$24.4 million associated with Quality Assurance Fees). These expenditures are billed under the Medi-Cal Program and administered by the DHCS.

In addition, the federal CMS allowed California to claim the federal ARRA enhanced rate of 66.59 percent (11.59 percent higher) which increased General Fund savings considerably.

Trailer bill language has been updated to account for these various changes.

**Subcommittee Staff Comment and Recommendation.** This issue was previously discussed in the April 29, 2010 Subcommittee hearing. Agreement has now been reached to reflect **(1)** increased services to be billed; **(2)** use of the enhanced federal ARRA match; **(3)** Regional Center administrative costs; **(4)** ICF-DD facility administrative costs; and **(5)** modified trailer bill language to meet federal CMS requirements, DHCS requirements and involved constituency group needs.

It is recommended to approve the May Revision proposal and adopt the *revised* trailer bill language as placeholder.

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

1. DDS, Please provide a *brief* summary of the key components of this proposal.

## **2. Governor's Proposal to Reduce by Additional \$48.2 million (\$25.3 million GF)**

**Governor's May Revision Issue.** The Governor's May Revision technically updates his January proposal to reduce by an additional \$48 million (\$25.3 million) the local assistance appropriation used to fund Purchase of Services expenditures managed by Regional Centers, and Regional Center Operations. The allocation of this proposed reduction was only recently decided by the Administration (in late April).

The proposal would increase the existing 3 percent reduction for Purchase of Services and Regional Center Operations by *an additional 1.25 percent* for a total of 4.25 percent each. The proposed total of 4.25 percent reduction would be affective from July 1, 2010 to June 30, 2011, inclusive, as contained in proposed trailer bill language.

Of the proposed reduction **(1)** \$41.5 million (\$20.7 million General Fund) would be from the Purchase of Services; and **(2)** \$6.6 million (\$4.6 million General Fund) would be from Regional Center Operations.

DDS states the *existing exemptions* for Supported Employment, the SSP supplement for independent living, and services with "usual and customary" rates as established in regulation *would apply* to the additional 1.25 percent. In addition, other services may be exempt from this reduction if a Regional Center demonstrates that a non-reduced payment is necessary to protect the health and safety of a consumer and the DDS has granted approval.

The Subcommittee discussed this proposal in its April 29, 2010 hearing. At that time DDS was analyzing options for providing administrative relief to providers to assist in mitigating the proposed additional 1.25 percent reduction to Purchase of Services expenditures.

DDS is *now proposing trailer bill language* to add Section 4791 to Welfare and Institutions code which gives Regional Centers authority to *temporarily* (from July 1, 2010-11 through June 30, 2012) modify personnel requirements, functions, or qualifications or staff training requirements for providers, except for licensed or certified residential providers, whose payments are reduced. In the early 1990's, similar temporary exemptions as noted above were enacted to provide relief from certain administrative requirements for providers.

The Regional Center may only approve these modifications if it **(1)** does not present a health or safety issue; **(2)** results in a consumer receiving services in a more restrictive environment; **(3)** negatively impacts the availability of federal funds; and **(4)** would violate any State licensing or labor laws or other provisions of Title 17. The language requires all temporary modifications to be done in writing as specified.

The language also directs the DDS to suspend for one-year certain quarterly and semiannual reports provided by residential providers, and self-assessments provided by Day Programs and In-Home Respite Agencies.

**Background: Special Session Actions (Eighth Extra-Ordinary) of 2010.** On January 8, 2010, the Governor released his January budget, declared a fiscal emergency and called a Special Session consistent with Proposition 58 of 2004.

Among other things, the Governor proposed to extend for one-year (July 1, 2010 to June 30, 2011) a three percent reduction for certain Purchase of Services payments for a reduction of \$99.5 million (\$49.7 million General Fund). In addition, the Governor proposed to extend for one-year (July 1, 2010 to June 30, 2011) a three percent reduction to Regional Center Operations by continuing suspension of several administrative and case management requirements. This results in a reduction of \$16.2 million (\$11.2 million General Fund). The Legislature adopted the Governor's 3 percent reduction, with one administrative reporting change, for a total reduction of \$115.7 million (\$60.9 million General Fund) for 2010-11.

**Subcommittee Staff Recommendation— Hold Open.** If one is to reduce by an additional \$48 million (\$25.3 million General Fund) as proposed by the Governor, an across-the-board reduction as proposed by the DDS spreads the impact of a reduction through-out the community service system and potentially creates less harm on the consumer.

It is recommended to hold this issue "open" to obtain additional insights regarding the proposed trailer bill language and pending May Revision discussions.

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

1. DDS, Please provide a brief summary of the additional 1.25 percent reduction for POS and Operations, and describe the proposed trailer bill language.

### **3. Proposed Amendment to Existing Statute Regarding Exemptions**

**Budget Issue.** As discussed in the Subcommittee hearing of April 29, 2010, various actions were taken to achieve a \$334 million (General Fund) reduction within the DDS system last year. An issue discussed during the hearing, as well as in the DDS budget stakeholder meeting of April 19th, pertained to the process and consistency for notifying and informing consumers of possible exemptions from certain service reductions.

As a result of these conversations, agreement has been reached between the DDS, Regional Centers, Disability Rights of California and other stakeholders, on modifying existing State statute to articulate that consumers need to be informed of the exemption process. The proposed trailer bill language is as follows:

Section 4701.1 of the Welfare and Institutions Code is *added* to read:

The written notice required by Section 4701 shall inform the recipient and authorized representative of:

(1) Whether or not the individual is eligible for an exemption or exception to the action the service agency proposes to take as specified in Sections 4648, subdivision (a)(6)(D); 4648.35, subdivision (d); 4648.5, subdivision (c); 4659, subdivision (d); 4686.5, subdivision (a)(3)(A); 4689, subdivision (i); 4689.05, subdivisions (a) and (d) and Government Code Sections 95004, subdivision (b) and 95020, subdivision (e)(3); and

(2) the specific law supporting any exemption or exception specified above.

**Subcommittee Staff Recommendation.** It is recommended to adopt the amendment to existing statute to reflect the compromise.

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

1. DDS, Has consensus been reached on this language?

## C. Discussion Issues: Lanterman Developmental Center

**Governor's May Revision Issue.** The May Revision identifies several components pertaining to the Lanterman Developmental Center transition. These are as follows:

- Transitioning. Adjustments within the Developmental Center resident population, as discussed in item D, below in this Agenda, which assumes more people will be transitioning from Lanterman to the community over the course of 2010-11.

Specifically the DDS assumes 100 people will transition, whereas it was assumed in January that 37 people would transition. It should be noted that this is an estimate, and that people will only transition as appropriate with necessary services and supports (as discussed in the April 29th hearing).

DDS assumes that 25 percent of the people transitioned to the community will occur in the first half of the 2010-11 fiscal year.

- Regional Center Community Placement Plan. As discussed in the April 29th hearing on the DDS Lanterman Plan, there is a Community Placement Plan (CPP) process which is funded annually and is contained in existing State statute. The purpose of CPP is to provide community-based services for individuals to receive community services and supports to live in the least restrictive environment as directed by the Lanterman Act.

Working with the Regional Centers and Lanterman Developmental Center staff and many others, the DDS has identified \$50.7 million (total funds) of the existing CPP funds, or 65 percent of these total funds, to dedicate to the operational, assessment, start-up, and placement needs for individuals transition from Lanterman Developmental Center to the community. It should be noted that this is an estimate and may evolve as the process progresses.

Key components of this include the following:

- \$12.8 million is for Regional Center Operations
- \$37.9 million is for the Purchase of Services

- Regional Center Staffing. An additional increase of \$3.5 million (federal funds) is in Regional Centers Operations to fund certain RC staff needed for the development of living arrangement resources, dental services and health services. A similar arrangement was done for the Agnews Developmental Center transition.

**Budget Act Language—Allows for Transfer Between Items.** Finally, it should be noted that the annual Budget Act contains Budget Act Language which provides for the transfer of funds as necessary between the Developmental Centers Program and the Community Services appropriation (See provision 3 on page 345 of Senate Bill 874, as introduced). The purpose of this language is to enable the DDS to transfer funds, as appropriate, for individuals transitioning from a Developmental Center to the community.

**Prior Subcommittee Action— April 29, 2010.** As a Special Order of Business, the Subcommittee discussed the Administration’s Lanterman Plan and received public testimony. Actions taken included the following (language was distributed at the hearing):

1. Adopted Budget Bill Language to require the DDS to provide a comprehensive status update of the Lanterman Plan by January 10 and May 14 of each fiscal year.
2. Adopted modified trailer bill language to direct the DDS to provide outpatient clinic services at Lanterman Developmental Center (as done at Agnews Developmental Center).
3. Adopted modified trailer bill language to have the Secretary of Health and Human Services Agency to verify protocols as noted for the health and safety of individuals transitioning from Lanterman.
4. Adopted modified trailer bill language to provide for cost-based reimbursement for Health Plans serving consumers transitioned from Lanterman to ensure health care coverage (as done for consumers transitioned from Agnews).
5. Adopted placeholder trailer bill language provided by the DDS for Lanterman staff to be contracted out, if they choose, to work in the community (as done at Agnews).
6. Adopted placeholder trailer bill language provided by the DDS to expand Adult Residential Facilities for Persons with Special Health Care Needs so this residential model can be provided state-wide.

**Subcommittee Staff Recommendation—Approve Resources.** It is recommended to adopt the funding identified by the DDS within their May Revision to provide for the planning assessment, resource development, start-up of services, Regional Center staff, and related needs.

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

1. DDS, Please provide a brief summary of the proposed changes as noted above for the Lanterman transition.

## **D. Discussion Issues: Developmental Centers**

**Background on State-Operated Developmental Centers.** State Developmental Centers (DCs) are licensed and federally certified as Medicaid providers via the Department of Health Services. They provide direct services which include the care and supervision of all residents on a 24-hour basis, supplemented with appropriate medical and dental care, health maintenance activities, assistance with activities of daily living and training. Education programs at the DCs are also the responsibility of the DDS.

The DDS operates four Developmental Centers (DCs) — Fairview, Lanterman, Porterville and Sonoma. Porterville is unique in that it provides forensic services in a secure setting. In addition, the department leases Canyon Springs, a 63-bed facility located in Cathedral City. This facility provides services to individuals with severe behavioral challenges.

### **1. Baseline Developmental Center Estimate**

**Governor's May Revision Issue.** The May Revision proposes a total of \$625.7 million (\$310 million General Fund) which reflects a decrease of \$15.2 million (increase of \$300,000 General Fund) for the Developmental Centers to provide services to 1,979 residents which reflects a reduction in resident population of 29 consumers, as compared to January (based on an average population calculation). The proposed net decrease is primarily due to administrative reductions of \$20.5 million from the Governor's Executive Order (S-01-10) pertaining to a 5 percent Workforce Cap reduction, and related items.

**Subcommittee Staff Recommendation—Approve.** It is recommended to approve the Developmental Center baseline estimate since the Subcommittee had not yet taken action on the DC budget specifically.

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

1. DDS, Please provide a *brief summary* of the DC budget.

## **2. Sonoma Developmental Center Fire Alarm Upgrade.**

**Governor's May Revision Issue.** The DDS requests an increase of \$5.2 million (General Fund) for the construction phase of a Fire Alarm Upgrade Project at Sonoma Developmental Center, contingent upon an approved working drawing. The following Budget Bill Language is proposed with this request:

5. Notwithstanding any other provision of law, the department shall not expend any of the \$5,195,000 provided in augmentation of this item for the construction phase of the Sonoma Developmental Center fire alarm upgrade project until such expenditures are approved by the Director of Finance and until 30-days after notification in writing to the Joint Legislative Budget Committee and the chairpersons of the committees of each house of the Legislature that consider appropriations.

According to the DDS, this project includes installation in 16 remaining buildings, as all other required buildings have been upgraded.

In 2004 the State Fire Marshall cited Sonoma for not having the required annual testing of the fire alarm systems. At the time there was no monetary penalty assessed by the State Fire Marshall. However, Sonoma was required to submit a Plan of Corrective Action to the Department of Public Health for this identified licensing and certification deficiency to be corrected by no later than 2012-13. The State Fire Marshall approved this timeline.

In 2006, Sonoma was again cited for the fire alarm system and a firm date for the full installation was directed to be no later than June, 2013.

**Subcommittee Staff Recommendation—Approve.** Due to the health and safety concerns associated with this minor repair project, as well as the citations and Plans of Corrective Action, it is recommended to approve the DDS request.

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

1. DDS, Please provide a *brief summary* of the request.

**Senate Subcommittee #3--VOTE ONLY List for Friday, May 21**

This list corresponds to the Agenda for this day.

**A. Item 4440—Department of Mental Health---Page 2**

1. Patton State Hospital Capital Outlay Project

**Recommendation-- Deny Reappropriation for GF Piece  
Vote: 3-0**

2. CA Health Interview Survey (Issue 450)

**Recommendation-- Approve  
Vote: 3-0**

3. Funds for Evaluation of MHSA (Issue 479)

**Recommendation—Shift Funds of \$1 million from DMH to Oversight Commission  
Vote: 3-0**

4. Technical Adjustment to Transfer of Traumatic Brain Injury Program.

**Recommendation--Approve  
Vote: 3-0**

**B. Item 4260—Department of Health Care Services Page 6**

1. Legislative Oversight of DHCS CA-MMIS

**Recommendation—Adopt Uncodified trailer bill as noted on Agenda, with the following *amendment added*:**

The Office of the State Information Officer shall provide continued oversight of this project.  
The Bureau of State Audits may also review the project.

**Vote: 3-0**

2. Family Health Estimate Package for CCS, CHDP & GHPP (Issues

**Recommendation--Approve  
Vote: 3-0**

**C. Item 4265—Department of Public Health Page 8**

1. Loan Repayment: Occupational Lead Prevention Account & Drinking Water Operator Certification Special Account (Issues 401 and 402)

**Recommendation—Approve**

**Vote: 2-1**

2. Amyotrophic Lateral Sclerosis/Lou Gehrig’s Disease Research (Issue 502)

**Recommendation—Approve**

**Vote: 3-0**

3. Genetic Disease Testing Program—Modification to Project (Issue 556)

**Recommendation—Approve**

**Vote: 3-0**

4. Federal Ryan White Grant Funds—Local Assistance (Issue 560)

**Recommendation—Approve**

**Vote: 2-0 (Senator Ashburn abstained)**

5. Adjust Licensing & Certification Program for LTC Ombudsman (Issue 553)

**Recommendation—Approve**

**Vote: 2-1 (Senator Ashburn)**

**D. Item 4300—Department of Developmental Services Page 12**

1. Technical Reduction for “Gap” Funding Since Assumption Not Relevant

**Recommendation—Delete \$1.4 million (GF) since assumption is no longer applicable**

**Vote: 3-0**

2. Reappropriation of Capitol Outlay for Porterville Kitchen (Bond Funds)

**Recommendation—Approve**

**Vote: 3-0**

# **SUBCOMMITTEE #3: Health & Human Services**

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**Chair, Senator Mark Leno**

**Senator Elaine K. Alquist  
Senator Roy Ashburn**



**May 24, 2010**

**1:30 a.m. or  
Upon Adjournment of Session  
Room 4203  
(John L. Burton Hearing Room)**

(Diane Van Maren)

## **AGENDA # 1 VOTE ONLY ITEMS**

<b><u>Item</u></b>	<b><u>Description</u></b>	<b><u>Page</u></b>
4280	Managed Risk Medical Insurance Board, Selected Issues	2 to 3
1.	Access for Infants and Mothers (AIM)	2
2.	Major Risk Medical Insurance Program (MRMIP)	3
3.	County Health Initiative Matching Fund	3

### **PLEASE NOTE:**

*Only those items contained in this agenda will be discussed at this hearing. Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.*

*Please see the Senate File (available on-line) for dates and times of subsequent hearings.*

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee or by calling 916-651-1505. Requests should be made one week in advance whenever possible.

## VOTE ONLY ITEMS

### 4280 Managed Risk Medical Insurance Board

#### 1. Access for Infants and Mothers (AIM) Program

**Governor's May Revision Issue.** The MRMIB budget for the Access in Infants and Mothers (AIM) Program proposes technical adjustments to reflect a 1.8 percent annual growth rate which results in a total annual enrollment of 11,276 pregnant women (monthly average of 940). Due to a continuing decline in revenues from Proposition 99 Funds (Cigarette and Tobacco Product Surtax Funds), there are less revenues to transfer into the Perinatal Insurance Fund for the AIM Program.

Total expenditures are \$60.9 million (\$25.4 million Perinatal Insurance Fund and \$35.6 million federal funds) for 2010-11 and are estimated to provide coverage for the year.

The LAO has also reviewed the AIM estimate and recommends its approval.

**Background.** The AIM Program covers uninsured and underinsured pregnant women in families between 200 percent and 300 percent of the federal poverty level if they have no other insurance. Beginning July 1, 2004, infants born to AIM women were being automatically enrolled in the HFP at birth. Infants born to AIM mothers who enrolled in AIM prior to July 1, 2004, remained in AIM through two years of age.

**Subcommittee Staff Recommendation—Approve.** It is recommended to adopt the May Revision.

## **2. Technical Adjustments for Major Risk Medical Insurance Program**

**Governor's May Revision Issue.** Due to declining revenues in Proposition 99 (Cigarette and Tobacco Product Surtax Fund), the MRMIB is requesting approval of Budget Bill Language to shift its receipt of \$295,000 from one account within Proposition 99 (Physician Services) to another account within Proposition 99 (Unallocated Account). Both accounts are applicable for expenditure within the MRMIP. The proposed Budget Bill Language is as follows:

4280-112-0236—For transfer by the Controller from the Unallocated Account, Cigarette and Tobacco Products Surtax Fund to the Major Risk Medical Insurance Fund, for the Major Risk Medical Insurance Program.....(\$295,000)

The Administration notes this action provides no additional revenue for the MRMIP but it does allow for the six accounts within Proposition 99 to remain balanced due to declining revenues as noted.

**Background.** The MRMIP provides comprehensive health insurance benefits to individuals who are unable to purchase private coverage because they were denied individual coverage or were offered coverage at rates they could not afford. Caseload for this program varies as funding is available.

**Subcommittee Staff Recommendation—Approve.** It is recommended to adopt the May Revision. This is a minor technical adjustment and no issues have been raised.

## **3. Minor Adjustments to the County Health Initiative Matching Program.**

**Governor's May Revision Issue.** The MRMIB proposes an increase of \$476,000 (\$167,000 in County Health Initiative Funding-- from the Counties, and \$309,000 in federal S-CHIP funds) This adjustment reflects increased caseload of 443 children among the three pilot counties of San Francisco, Santa Clara and San Mateo. This is a standard adjustment for May Revision.

**Background.** Existing statute provides for county governments and public entities to provide local matching funds to claim federal S-CHIP funds (Healthy Families) for county children's health expansion programs to serve children otherwise eligible for State Children's Health Insurance Programs (S-CHIP) (Healthy Families in CA) who have incomes between 250 and 300 percent of the federal poverty level.

Three counties participate in this program—San Francisco, Santa Clara and San Mateo.

**Subcommittee Staff Recommendation—Approve.** It is recommended to adopt the May Revision. This proposal adjusts the level of federal funds provided to these counties as provided in existing State statute. No issues have been raised.



# SUBCOMMITTEE #3: Health & Human Services

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Chair, Senator Mark Leno

Senator Elaine K. Alquist  
Senator Roy Ashburn



May 24, 2010

1:30 p.m. or  
Upon Adjournment of Session

Room 4203

Committee Staff: Jennifer Troia

## Agenda II

(Vote-Only Items indicated by \*)

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**Please note:** The Committee will discuss only the items contained in this agenda at this hearing. Please see the Senate Daily File for dates and times of subsequent hearings. The Committee will discuss the issues in the order noted in the agenda, unless otherwise directed by the Chair.

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## Vote-Only Agenda

### 0530 Office of Systems Integration

#### OSI & DSS Issue 1: Interim Statewide Automated Welfare System (ISAWS)

**Budget Issue (#104):** OSI and DSS request, as part of the May Revision, to reduce the budget for ISAWS by \$14.3 million in (DSS) Local Assistance funding, with a corresponding reduction of \$12.2 million in OSI spending authority for project management (in Item 0530-001-9732). As a result, the budget for ISAWS in 2010-11 would include \$9.6 million (\$3.8 million GF). OSI also proposes a reduction of 16 positions dedicated to ISAWS in July 2010. The remaining eight staff would perform project close-out activities through December 2010. This request allows for the contingency that the final migration could be delayed for a maximum of five months.

**Background:** See Agenda for March 18, 2010.

**Subcommittee Staff Comment and Recommendation:** Staff recommends approving the requested reductions in the 2010-11 budget and staffing for ISAWS.

#### OSI & DSS Issue 2: Child Welfare Services (CWS)/Web Staffing

**Budget Issue:** OSI requests \$1.8 million (\$827,000 GF) for ten new positions to support the continuing development of CWS/Web, a replacement system for the existing CWS/CMS. These ten positions would be in addition to 12 existing OSI positions and up to another six OSI-contract staff currently supporting this phase of the project. The 2009-10 budget for CWS/Web is \$7.1 million (\$3.2 million GF). The Governor's 2010-11 budget for DSS also requests, in a budget change proposal, \$436,000 (\$199,000 GF) to: 1) establish one two-year limited-term position, 2) extend an existing managerial position for another two-year limited term, and 3) augment by \$240,000 DSS contracts with county consultants. Including the requested funds for OSI and DSS staff, the 2010-11 budget for the project would increase to \$9.4 million (\$4.3 million GF). OSI estimates a total cost of \$202.8 million (\$91.9 million GF) between 2012 and 2014 to complete the implementation of CWS/Web and enter into its M&O phase.

**Background:** See Agendas for March 18 and May 6, 2010.

**Subcommittee Staff Comment & Recommendation:** Staff recommends approving the requested positions and contract funding.

### **OSI & DSS Issue 3: LEADER Replacement System**

**Budget Issue:** OSI requests an increase of \$44.3 million as the planning phase of the LRS project ends and the design, development, and implementation phase begins. Including the proposed resources, the 2010-11 budget for LRS would be \$45.6 million (\$23.3 million GF/TANF). This proposal also includes an additional six-month delay of the beginning of the system's development (beyond a six-month delay enacted in the 2009-10 budget). The 2009-10 LRS project planning budget is \$1.3 million (\$671,000 GF/TANF). OSI anticipates total average costs for LRS development and implementation of \$102.2 million annually, for a total of \$408.6 million over four years (\$208.6 million GF/TANF, \$173.3 million federal funds and \$26.7 million county funds) before reaching the M&O phase of the project after December 2014.

**Background on LEADER and LRS Project:** See Agenda for March 18, 2010.

**Subcommittee Staff Comment & Recommendation:** Staff recommends approving the requested 2010-11 funding for LRS. Staff also recommends that the Subcommittee continue to receive updates from OSI on the progress of negotiations and anticipated costs for the overall design, development, and implementation.

### **OSI & DSS Issue 4: Statewide Fingerprint Imaging System (SFIS)**

**Budget Issue:** The total SFIS budget for 2009-10 includes \$20.1 million (\$9.5 million GF). As discussed on May 6, 2010, the Administration has requested position authority for two new state positions that would replace 1.5 contract staff currently providing training coordination and application support for the use of SFIS in the CalWORKs, Supplemental Nutrition Assistance (food stamps), and General Assistance/General Relief programs. The state has contracted these particular duties out for a decade.

**Background on SFIS:** SFIS is a statewide automated system that was created in response to SB 1780 (Chapter 206, Statutes of 1996) for applicants and recipients of California Work Opportunity and Responsibility to Kids (CalWORKs) and Food Stamp program benefits to be fingerprint imaged as a condition of eligibility for those programs. OSI provides state-level project management and oversight for SFIS. The fingerprint images contained in SFIS are used to verify eligibility and to check for duplicate aid applications by one individual. The Administration states that the existence of these

fingerprint requirements and of the SFIS system deter an unquantifiable, but significant, amount of fraud.

A 2003 audit by the Bureau of State Audits found that DSS “implemented SFIS without determining the extent of duplicate-aid fraud throughout the State,” and that “Social Services did not implement SFIS in a manner that would allow it to collect key statewide data during its implementation of SFIS.” The auditor was therefore “unable to determine whether SFIS generates enough savings from deterring individuals from obtaining duplicate aid to cover the estimated \$31 million the State has paid for SFIS or the estimated \$11.4 million the State will likely pay each year to operate it...”

Earlier this month, the United States Department of Agriculture sent a letter to the Director of DSS that again encouraged the state to reconsider “the costs associated with finger imaging.” The letter continued on to state that “there are serious concerns that finger imaging may be a barrier to participation among many of the hard to reach eligible populations who wish to enroll” in the food stamps program and that “most states satisfy the requirement to establish a system to prevent duplicate participation by matching names with social security numbers, which is far less costly than finger imaging yet is equally effective at detecting duplicate participation.”

**Other Mechanisms for Preventing Duplicate Aid Fraud:** With the exceptions of Texas, Arizona, and the City (but not state) of New York, all other states prevent duplicate aid fraud without finger imaging. In California, other mechanisms for verifying the identities of prospective recipients and preventing duplicate aid fraud include:

1. A “file clearance” that is performed whenever an application is received for a public assistance program including Medi-Cal, CalWORKs, and Food Stamps;
2. A federally required match of the Income Eligibility Verification System (IEVS) for all applicants to the three programs; and
3. The existence of stringent work participation requirements and requirements for ongoing contacts with social workers in the CalWORKs program.

The file clearance involves a check of county and state databases to determine whether an applicant already has an active case file or has previously been a recipient of one or more of the programs. As a result, old case file information can be updated (rather than creating the need for a new, potentially duplicate case file). This process also serves the purpose of flagging any applications received for persons who already have an active case, so that the county may follow up.

The IEVS match involves a coordinated data exchange among various benefit programs using a standardized format for matching purposes. The databases used include, but are not limited to, information from the State Wage Information Collection Agency, Unemployment/disability compensation information, benefits/wage information from the Social Security Administration (SSA), Internal Revenue Service (IRS)/Franchise Tax

Board (FTB) unearned income data, Social Security number (SSN) verification information from SSA, and inter/intra-county duplicate benefit matches. Counties use this information to determine eligibility and benefits levels.

**Subcommittee Staff Comment & Recommendation:** The Subcommittee previously rejected staffing and funding requests connected to fingerprinting of In-Home Supportive Services (IHSS) recipients. Given the lack of evidence that SFIS saves the state more than it costs, staff recommends that the Subcommittee further de-fund the remainder of the system's costs. Staff should be directed to work with the Administration to determine close-out costs and remaining GF savings for 2010-11. Staff further recommends adopting placeholder trailer bill language to eliminate the requirements for finger imaging of CalWORKs and food stamp participants. Finally, consistent with this action, staff recommends rejecting the request to convert 1.5 contract staff to 2.0 permanent state staff.

#### **4140 Office of Statewide Health Planning & Development (OSHPD)**

##### **OSHPD Issue 1: Deferral of General Fund (GF) Loan Repayment**

**Budget Issue:** The May Revision proposes to defer repayment of a total of \$32 million in loans to the General Fund (GF) from the Hospital Building Fund (Item 4140-011-0121) and Health Data and Planning (Item 4140-011-0143) Special Funds. As a result, the state would receive \$32 million in GF relief during the 2010-11 budget year. For \$12 million of these loans, no repayment date is specified in law. However, for the remaining \$20 million in loans from the Hospital Building Fund, a repayment date of June 30, 2011, was specified in SBx3 2 (Chapter 2, Statutes of 2009). Therefore, to accomplish this proposal, the Subcommittee would need to adopt amended budget bill language to delay this date.

The Hospital Building Fund holds revenue from fees paid by hospitals when applying to OSHPD for approval of construction plans. The fee is equivalent to two percent of total costs of construction and covers OSHPD's costs for plan review through completion of the construction project, which can take up to seven to ten years. The projected fund balance for the end of 2009-10 is \$111.8 million. Revenues for 2010-11 are projected at \$50.6 million, as compared to expenditures of \$55.9 million. Therefore, OSHPD does not anticipate any material impacts on its operation of programs funded by these Special Funds in 2010-11 as a result of this proposal.

**Subcommittee Staff Comment and Recommendation:** Staff recommends approval of the extension of the date for repayment of these loans to the GF. Consistent with this action, staff also recommends adopting budget bill language to change the date of Hospital Building Fund loan repayment from June 30, 2011 to June 1, 2012.

**4170 Department of Aging (CDA)****CDA Issue 1: Federal Grant for the Chronic Disease Self-Management Program**

**Budget Issue (#103):** CDA requests, in a May Revision Finance Letter, \$620,000 (an increase of \$594,000 in Item 4170-101-0890 for local assistance and a corresponding change in Item 4170-101-0001, as well as an increase of \$26,000 for state operations in Item 4170-001-0890, with a corresponding change to Item 4170-001-0001) in 2010-11. The Department intends to request \$380,000 (\$354,000 Local Assistance and \$26,000 State Operations) in 2011-12, for a total of \$1.0 million in federal funding authority. These requests are based on the federal government's award of American Recovery and Reinvestment Act (ARRA) stimulus grant funding for the state to implement new or to expand existing Chronic Disease Self-Management Programs (CDSMPs). CDA also requests budget bill language to allow unspent funds (in Item 4170-101-0890) from 2010-11 to be carried over and expended through March 30, 2012, if necessary.

**Background:** CDSMP is the most widely used patient empowerment program that works to engage persons with chronic conditions in behavioral changes that improve their health. Research has demonstrated that CDSMP participation leads to a reduction in emergency room visits and other acute care costs, while improving health outcomes. Local Area Agencies on Aging and health departments in Los Angeles, Napa/Solano, Orange, San Diego, San Francisco and Sonoma counties will coordinate with community partners to offer CDSMP services under this grant. Target populations will include at least 3,000 ethnically diverse older adults with low-incomes, limited/non-English speaking individuals, individuals who are eligible for Medi-Cal and/or older veterans.

**Subcommittee Staff Comment and Recommendation:** Staff recommends approving the requested federal funds authority and budget bill language.

**CDA Issue 2: Health Insurance Counseling and Advocacy Program (HICAP) – Federal Funds Augmentation**

**Budget Issue (#104):** CDA requests, in a May Revision Finance Letter, an increase of \$567,000 in ongoing federal funding authority for Local Assistance costs associated with HICAP (reflected in changes to Item 4170-101-0890 and Item 4170-101-0001). The request results from an increase in the state's basic HICAP grant from the federal Centers for Medicare and Medicaid Services (CMS).

**Background:** HICAP is the state's equivalent of the federal State Health Insurance Assistance Program (SHIP), a Medicare counseling and education program that offers

community education, individualized health insurance counseling, informal advocacy services, and legal referrals. There are over 4.3 million Medicare beneficiaries in California who are potential consumers of HICAP services. Twenty-four local HICAPs rely on staff, as well as paid volunteers, to carry out these activities. CDA also has a state HICAP office.

**Subcommittee Staff Comment and Recommendation:** Staff recommends approving the requested increase in federal funds authority.

### **CDA Issue 3: Shift of Funding for Long-Term Care Ombudsman**

**Budget Issue (#101):** CDA proposes, in a May Revision Finance Letter, a one-time shift of \$680,000 GF from the Department of Public Health (DPH) to CDA (reflected as an increase to Item 4170-101-0001 of \$680,000 and a reduction to Item 4170-103-0942 of the same amount). The request results from a deficiency in funding from the Federal Citation Penalty Account (FCPA) that was anticipated to be used for base costs of the Ombudsman program. This proposal corresponds to a related proposal by DPH (which was approved by the Subcommittee on May 21, 2010) to concurrently reduce its GF appropriation to divert a portion of its GF transfer to the Licensing and Certification Special Fund to offset the FCPA deficiency.

Total 2009-10 Local Assistance funding for the Ombudsman program is \$5.8 million (no General Fund). Including this proposed shift of funding, the proposed 2010-11 Local Assistance budget for the program is \$4.2 million (\$680,000 General Fund). There are currently 147 paid staff members in the program statewide.

**Background on Long-Term Care Ombudsman:** The Office of the State Long-Term Care Ombudsman, which oversees 35 local Ombudsman programs, is located within CDA. These local Ombudsman offices and their approximately 1,000 certified volunteers identify, investigate, and seek to resolve complaints and concerns on behalf of approximately 296,000 residents of long-term care facilities, including Skilled Nursing Facilities (SNFs), Intermediate Care Facilities (ICFs), and Residential Care Facilities for the Elderly (RCFEs).

**Funding of the Long-Term Care Ombudsman:** Historically, the Ombudsman program has been funded via federal funds and state GF. In 2003-04, the program also began receiving a \$1.5 million appropriation from the Federal Health Facilities Citation Penalties Account (Penalties Account). DPH also receives funds from the Penalties Account to fund managers or receiverships that allow facilities to continue to operate pending corrections or closures. The Penalties Account is a special fund managed by DPH and funded by civil penalties paid by health care facilities to the federal Centers for Medicare and Medicaid Services (CMS).

In 2008-09, state budget reductions eliminated all GF resources for the Ombudsman program, a total of \$3.8 million (half of the program's total funding at the time). As a

result, approximately 40 percent of the total paid Ombudsman staff statewide lost their positions. In an effort to ameliorate these reductions and restore some positions in 2009-10, the Legislature passed and Governor signed AB 392 (Chapter 102, Statutes of 2009), which provided for an additional one-time appropriation of \$1.6 million for local Ombudsman programs from the Penalties Account. Since that time, DPH has revised the fund condition statement for the Penalties Account to reflect a deficiency of \$680,000. To make up for this deficiency in 2009-10 and reimburse local Ombudsman programs that have already provided services in anticipation of receiving the funds at issue, the Department of Finance has proposed, via a Section 28.5 letter, a transfer of \$700,000 GF from DPH to CDA. To prevent additional cuts to the Ombudsman programs in 2010-11, this May Revision proposal would transfer \$680,000 from DPH to CDA.

**Anticipated Consequences if this 2010-11 Proposal is Not Approved:** If this fund shift is not approved and no other resources are identified to backfill the \$680,000 in funding for Ombudsman programs, CDA states that local Ombudsman offices will terminate approximately 25 additional staff members, cut services, and reduce their hours of operation. The Department states that the Ombudsman program's mission to advocate for and investigate complaints made by residents of long-term care facilities would be compromised.

**Subcommittee Staff Comment & Recommendation:** Staff recommends approving the requested 2010-11 shift of resources from DPH to CDA for the Ombudsman program. This conforms to actions already taken regarding DPH's budget.

## **4200 Department of Alcohol & Drug Programs (ADP)**

### **ADP Issue 1: Revisions to Drug Medi-Cal (DMC) & Related ARRA Estimates**

**Budget Issue (#s 101 & 500):** ADP requests, as part of the May Revision, to revise its estimates of the caseload and utilization of services in the Perinatal DMC and Regular DMC programs. In comparison with the Governor's January budget proposal, the Department anticipates an additional 104 clients in the perinatal program and 9,724 in the Regular DMC program. As a result, the total Perinatal DMC caseload would include 8,916 individuals. The total Regular DMC caseload would include 277,400 individuals. (These changes would be reflected as an increase of \$13,000 in Item 4200-102-0001 and of \$14,000 in Reimbursements for Perinatal DMC, as well as an increase of \$5.3 million in Item 4200-103-0001 and \$5.7 million in Reimbursements for Regular DMC.) The total 2009-10 enacted budget for DMC was \$194.8 million (\$79.3 million GF) for local assistance and \$7.8 million (\$3.3 million GF) for state operations.

These 2010-11 estimate changes assume that the increased Federal Medical Assistance Percentage (FMAP) of 61.6 percent that is available under the American

Recovery and Reinvestment Act (ARRA) will be available through the state's 2010-11 fiscal year. Due to the timing of DMC payments, ADP estimates that DMC services--as opposed to claims--would thus be eligible for enhanced FMAP until around three months prior to ARRA expiration. At this enhanced FMAP rate, the Department also estimates that the above caseload changes will result in an additional \$632,000 in additional ARRA funds available to the Department. As a result, the Department requests, as part of the May Revision, to increase Item 4200-102-0001 by \$2,000 and increase Item 4200-103-0001 by \$630,000. The Department anticipates a corresponding GF decrease of the same total.

**Background:** Since 1980, the DMC program has provided medically necessary drug and alcohol-related treatment services to Medi-Cal beneficiaries who meet income eligibility requirements (up to 250 percent of the Federal Poverty Level (FPL)). Services include Outpatient Drug-Free, Naltrexone (medication used to treat alcohol or opioid dependence), Narcotic Treatment, and Day Care Rehabilitative and Residential Treatment for eligible pregnant and postpartum women.

**Subcommittee Staff Comment and Recommendation:** These caseload changes are technical adjustments to set the baseline 2010-11 caseload for the Perinatal and Regular DMC programs. As part of the May Revision, the Administration has also proposed significant reductions in the scope of DMC services. Those reduction proposals will be considered separately. Staff recommends approving the requested caseload changes.

Staff also recommends approving the requested changes to account for increased ARRA funds. The reflection of the corresponding GF impact will conform to actions taken regarding the proposed Control Section 8.65.

## 5170 State Independent Living Council (SILC)

### SILC Issue 1: Aging and Disability Resource Connection (ADRC) Federal Grant

**Budget Issue (#101):** SILC requests, in a May Revision proposal, \$169,000 federal funds authority to establish a seventh Aging and Disability Resource Connection site in California (reflected by the addition of Item 5170-001-0890). No state funds are requested, as the in-kind services of SILC and its contractors can meet federal matching requirements. SILC is requesting the remaining \$30,000 of the total \$199,000 grant in the state's 2009-10 fiscal year through the Section 28.5 process. Contingent on the state's performance in this first year of grant funding, additional funds of up to \$540,000 may be granted by the federal Administration on Aging in future years.

**Background on ADRCs:** ADRC programs are community-based programs to assist individuals with disabilities, older adults, and caregivers as they learn about and gain

access to long-term services and supports, ranging from in-home services to nursing facility care. The programs also serve as a resource to health and other professionals who provide services to these target populations.

**Subcommittee Staff Comment and Recommendation:** Staff recommends approval of the requested 2010-11 federal funds authority.

## 5175 Department of Child Support Services (DCSS)

### DCSS Issue 1: Revision to Estimates of Federal Incentive Funding and State Disbursement Unit (SDU) Costs

**Budget Issue (#101):** DCSS requests, as part of the May Revision, adjustments to reflect: 1) a projected reduction of \$671,000 in federal performance-based incentive funds that the state will receive in 2010-11, and 2) expected growth in the volume of SDU transactions by 13.1 million transactions, at an additional cost of \$6.3 million (\$2.2 million GF and \$4.2 million federal funds). The decrease in anticipated federal incentive funds also results in a \$2.2 million GF cost to backfill the previously anticipated federal funds for local assistance. These adjustments would be reflected by a decrease of \$621,000 to Schedule (1)(a) of Item 5175-101-0001, an increase by \$6,348,000 of Schedule (1)(b) of Item 5175-101-0001, as well as an increase of \$1,617,000 to Item 5175-101-0890 and a corresponding change to Item 5175-101-0001.

As part of the May Revision, there was also an additional reduction of \$621,000 (\$211,000 GF) to the Department's overall budget.

**Background on Federal Incentive Funds:** As detailed further in the Agenda for April 8, 2010, the federal government awards incentive funds to state child support programs based on specific performance measures, including paternity establishment, collections of child support, and overall cost effectiveness. In federal fiscal years 2009 and 2010, the total pool of incentive funds available to states is \$504 million. DCSS previously estimated that California would receive incentive funds of \$41.7 million in the state's 2009-10 fiscal year and \$40.4 million in 2010-11. As a result of better performance by other states, the Department is now revising the 2010-11 estimate downward to \$38.2 million.

**Background on the SDU and California Child Support Automation System (CCSAS):** The SDU is one of two components of CCSAS. With a total budget of \$22.6 million (\$7.7 million GF) in 2009-10 and a proposed budget of \$26.3 million (\$9.0 million GF) in 2010-11, the SDU provides central processing for collecting and distributing child support payments in the state. The SDU provider is paid on a per transaction (e.g., collection via credit card payment, disbursement via paper check) basis. As a result of a recent increase in the number of transactions, the Department now estimates an increased volume of SDU transactions in 2010-11.

According to the Department, collections and disbursement transactions are influenced in part by the source of the collection. For example, the number of Unemployment Insurance Benefit (UIB) intercepts has increased significantly as the unemployment rate has increased. UIB intercepts are submitted electronically to the SDU on a bi-weekly basis (two to three times per month), whereas income withholdings for some of those non-custodial parents may have been submitted by their previous employer on a monthly basis. Thus, this shift from employment to unemployment can increase the number of collection and disbursement transactions, even though the amount of child support collected may decrease.

**Subcommittee Staff Comment & Recommendation:** Staff recommends approving these estimate changes (which will also conform, as appropriate, to other actions taken).

### **DCSS Issue 2: Revision to Estimate of American Recovery & Reinvestment Act (ARRA) Funds**

**Budget Issue (#999):** DCSS requests, as part of the May Revision, to decrease by \$1.9 million the anticipated ARRA stimulus funding available to the Department (reflected in Item 5175-101-0890). The corresponding GF impact of this change is not reflected in the budget bill at this time because of the Administration's proposed Control Section 8.65 of the budget bill. (This proposed Control Section language, which will be heard as a Health issue, would give the Department of Finance broad authority to adjust General Fund, Federal Trust Fund, and Reimbursement expenditures from Health and Human Services (HHS) programs impacted by ARRA.)

**Background:** Among other changes, the federal Deficit Reduction Act of 2005 tightened the rules regarding federal financial participation (FFP) in child support expenditures by restricting the ability of states to use incentive funds in order to draw down additional federal matching funds. After its passage, California chose to backfill the loss of FFP on incentives with a combination of General Fund (GF) and matching FFP to hold local assistance funding levels steady. More recently, ARRA restored the ability of states to receive federal matching funds for their use of child support incentive funding. As a result, the Governor's budget proposes to replace the prior State GF backfill with restored FFP. Specifically, given the anticipated incentive funding discussed in the prior agenda item, DCSS anticipates receiving \$75.4 million in matching FFP and scoring \$25.2 million GF savings. The proposed adjustment to arrive at that total is tied to the previously discussed changes in estimates of federal incentive funding the state will receive in the Budget Year.

**Subcommittee Staff Comment & Recommendation:** Staff recommends approving the proposed reduction to Item 5180-101-0890 of the budget bill. The reflection of the corresponding GF impact will conform to actions taken regarding the proposed Control Section 8.65.

### DCSS Issue 3: California Child Support Automation System (CCSAS)- Increase to Baseline Funding

**Budget Issue:** In addition to other proposals related to CCSAS discussed by the Committee on May 6, 2010, the Governor's budget includes a base increase of \$8.2 million (\$2.7 million GF) for project costs, including increases in maintenance and operations services, help desk support, and the costs of personal computer replacements in 2010-11. According to DCSS, the bulk of these costs are related to the previously approved transition of application hosting from a contractor's data center to the state's Office of Technology Services. The remaining costs are for hardware and software maintenance.

**Background on CCSAS:** See Agenda for May 6, 2010.

**Subcommittee Staff Comment & Recommendation:** In addition to prior actions taken by the Subcommittee regarding CCSAS funding, staff recommends approving the requested \$8.2 million (\$2.7 million GF) increase to its base funding.

## 5180 Department of Social Services (DSS)

### DSS Issue 1: Estimate Changes and Adjustments

**Budget Issue:** DSS proposes, as is customary during the May Revision, to update caseload estimates based on more recent trend data than was available at the time of the Governor's January budget release. In particular, the May Revision proposes a net increase of \$1.1 billion (increases to federal and other funds, with an offsetting decrease of \$410.3 million GF) over the Governor's budget due to caseload changes. January and May estimates of the average monthly caseloads associated with a number of major programs in 2010-11 include:

Program	Governor's Budget	May Revision
<b>CalWORKs</b>	605,542 cases	580,527 cases
<b>Kinship Guardianship Assistance Program (Kin-GAP)</b>	14,670 cases	13,404 cases
<b>Child Welfare Services (including Title IV-E waiver counties)</b>	145,834 cases	139,608 cases
<b>Foster Care (including Title IV-E waiver counties)</b>	59,307 cases	55,599 cases
<b>Adoption Assistance Program</b>	87,769 cases	86,855 cases

<b>Food Stamp Program</b>	1,137,766 households	1,220,101 households
<b>Supplemental Security Income/State Supplementary Payment (SSI/SSP)</b>	1,279,645 cases	1,266,112 cases
<b>In-Home Supportive Services (IHSS)</b>	489,972 cases	466,292 cases

To reflect corresponding changes in the programs' budgets, DSS requests the following technical changes to the budget bill:

<b>Program</b>	<b>Item</b>	<b>Change Since Governor's Budget</b>
<b>CalWORKs / Kin-GAP</b>	5180-101-0001	-\$311,715,000
	5180-101-0890	\$451,869,000
<b>Foster Care</b>	5180-101-0001	-\$2,922,000
	5180-101-0890	-\$24,237,000
	5180-101-8004	\$535,000
	5180-141-0001	-\$657,000
	5180-141-0890	-\$2,366,000
<b>Adoption Assistance Program</b>	5180-101-0001	\$9,253,000
	5180-101-0890	\$5,701,000
<b>Supplemental Security Income/State Supplementary Payment (SSI/SSP)</b>	5180-111-0001	-\$25,628,000
<b>In-Home Supportive Services (IHSS)</b>	5180-111-0001	-\$67,749,000
	5180-611-0995	\$999,653,000
<b>Child Welfare Services (CWS)</b>	5180-151-0001	-\$13,796,000
	5180-151-0803	\$186,000
	5180-151-0890	-\$3,280,000
	5180-651-0995	\$33,263,000
<b>Other Assistance Payments</b>	5180-101-0001	\$1,127,000
	5180-101-0122	\$36,000
	5180-101-0890	\$1,232,000
	5180-601-0995	\$2,743,000
<b>County Administration and Automation Projects</b>	5180-141-0001	\$1,191,000
	5180-141-0890	\$29,025,000
	5180-641-0995	-\$2,890,000

<b>Program</b>	<b>Item</b>	<b>Change Since Governor's Budget</b>
<b>Title IV-E Waiver</b>	5180-153-0001	\$1,605,000
	5180-153-0890	\$11,202,000
<b>Remaining DSS Programs</b>	5180-151-0001	-\$993,000
	5180-151-0890	\$9,487,000
	5180-651-0995	\$1,209,000

Among other changes, May Revision estimates also reflect the Administration's rescission of the Governor's earlier proposals to reduce the state's participation in the wages of In-Home Supportive Services (IHSS) providers to minimum wage and to eliminate services for IHSS recipients with a functional index score of less than 4.0. These changes are reflected as increases of \$271.8 million GF and \$1.9 billion (\$650.8 million GF), respectively. A new IHSS proposal that replaced these prior proposals will be discussed by the full Budget Committee on Tuesday, May 25, 2010. Similarly, the May Revision finance letter for DSS reflects erosions of savings associated with prior proposals that the Administration has rescinded or that did not take effect as anticipated (i.e., Proposition 10 funding shifts, redirections of county savings, and expanded eligibility for federal financial participation in foster care), updated estimates of federal stimulus funding, and technical adjustments, including budget bill language, to allow for carry-over funding for counties participating in a federal foster care waiver.

**Subcommittee Staff Comment & Recommendation:** Staff recommends adopting these caseload and other estimate adjustments, which will conform as appropriate to other actions that have been or will be taken.

### **DSS Issue 2: Temporary Emergency Food Assistance Program (TEFAP) Fund Shift**

**Budget Issue (#s 504, 505):** DSS proposes, as part of the May Revision, to transfer federal expenditure authority for TEFAP from state operations to local assistance. The transfer is technical and is intended to help ensure timely reimbursement to local food banks and the California Foodlink for food commodity purchases and associated administrative costs.

**Background:** Under TEFAP, surplus agricultural commodities are distributed to California emergency feeding organizations. DSS expects to receive \$9.6 million in 2010-11 for this 100 percent federally funded program.

**Subcommittee Staff Comments & Recommendation:** Staff recommends approving this transfer of federal expenditure authority.

**DSS Issue 3: County Match Requirement for Food Stamps  
Administrative Costs**

**Budget Issue:** The County Welfare Directors Association (CWDA) proposes trailer bill language (TBL) to allow counties, during 2010-11 and 2011-12, to draw down a portion of increasing food stamps administration funding without a county match above and beyond an existing Maintenance of Effort (MOE) requirement. Food stamps administrative costs are generally shared at a ratio of 50 percent federal funds, 35 percent GF, and 15 percent county funds. Apart from this county share, each county has a combined MOE for food stamps administration and CalWORKs that is tied to 1996-97 expenditure levels. Under this proposal, counties would be able to draw down up to 70 percent of the additional funding (50/50 state/federal funds) without being required to pay a match. Counties that can supply additional matching funds could draw down the remaining funds (50/50 county/federal funds).

**Background:** See Agenda from April 8, 2010.

**Subcommittee Staff Comments & Recommendation:** Staff recommends adopting placeholder TBL to effectuate this proposal for a two-year time period.

**DSS Issue 4: Inter-County Transfer Process for Nutrition Assistance**

**Budget Issue (#108):** The May Revision proposes savings of \$23,000 (\$6,000 GF) and trailer bill language (TBL) to establish an ICT process for food stamps clients. For an estimated 586,000 clients who also receive CalWORKs benefits (“assistance food stamps”), the simplified ICT process would be effective January 1, 2011. For an estimated 1.2 million individuals who receive Medi-Cal, but not CalWORKs benefits, or no public assistance [“non-assistance food stamps” (NAFS)], the ICT process would begin July 1, 2011. DSS estimates that 0.16 percent of all CalWORKs cases transfer to a different county in California in any given month, and that the same rate of transfer is likely to apply to assistance food stamp clients. DSS also estimates that approximately 3,800 Medi-Cal/NAFS will transfer to another county in 2010-11.

**Background:** Currently, if a recipient of food stamps moves from one county to another within California, his or her benefits are terminated at the end of the month and he or she must then reapply in the new county of residence. This results in a delay or interruption in benefits, and in unnecessary administrative duplication. The CalWORKs and Medi-Cal programs already use an ICT process to prevent uninterrupted benefits for recipients of those programs who move to a different county.

**Pending Policy Bill:** After its passage by a 13-0 vote out of the Assembly Appropriations Committee, AB 2018 (Skinner) is currently awaiting a vote on the Assembly floor. This bill appears to be the same as this May Revision proposal, except

that the effective dates differ slightly (i.e. the bill begins an ICT process for all cases on January 1, 2011, rather than having some wait until July 1, 2011).

**Subcommittee Staff Comment & Recommendation:** Given the currently pending policy bill seeks to address this same issue, staff recommends rejecting, without prejudice, the Inter-County Transfer process and related TBL that are proposed as part of the May Revise.

### **DSS Issue 5: 2009-10 Veto of Child Welfare Services Funding**

**Budget Issue:** When he signed the amendments to the 2009-10 budget contained in ABx3 1 (Chapter 1, 3<sup>rd</sup> Extraordinary Session, Statutes of 2009) in July 2009, the Governor used a line-item veto to make an unallocated reduction of \$80.0 million GF to CWS and foster care programs. After the Administration allocated the vetoed funding across programs, the total cut to CWS was \$133 million, including \$53.5 million in federal fund losses corresponding to the GF reductions.

On April 22, 2010, the Subcommittee restored \$74.6 million out of \$80 million GF that was vetoed by the Governor in 2009. When including federal funds, the total resulting restoration was \$120.0 million out of the \$133 million reduction that resulted from the veto. The Assembly's Subcommittee #1 on Health & Human Services subsequently voted to restore the full \$80 million GF and \$130 million total funds.

**Background:** See Agenda for April 22, 2010.

**Subcommittee Staff Comment and Recommendation:** In conformity with the Assembly Subcommittee's action, staff recommends that the Subcommittee rescind its prior action and instead approve a full restoration of the vetoed funds.

### **DSS Issue 6: Probation Access to CWS/Case Management System (CWS/CMS)**

**Budget Issue:** DSS proposes, in an estimate premise introduced in the Governor's budget and revised as part of the May Revision, \$1.4 million (\$918,000 GF) in expenditures for 560 probation officers to receive training on using the CWS/CMS system and for 385 of those probation officers to newly gain access to the system.

On April 22, 2010, the Subcommittee approved the requested funding for these new activities. The Assembly's Subcommittee #1 on Health & Human Services subsequently voted to reject this new funding, instead asking the Department to use existing CWS/CMS and training resources for the requested purposes.

**Background:** See Agenda for April 22, 2010.

**Subcommittee Staff Comment & Recommendation:** In conformity with the Assembly Subcommittee's action, staff recommends that the Subcommittee rescind its prior action and instead reject the requested funds.

### **DSS Issue 7: Title IV-E Eligibility Training Proposal**

**Budget Issue (#508):** DSS proposes, as part of the May Revision, an increase of \$1.1 million (\$500,000 GF) for consultant services to develop a website containing eligibility requirements for federal financial participation under Title IV-E of the Social Security Act (IV-E) and to develop training curricula for county welfare and probation department staff. According to the Department, these services would help the state better meet federal training requirements consistent with the state's federal Program Improvement Plan and would help avoid potential federal funding disallowances in the future.

**Background:** About 71 percent of the state's approximately 60,000 children in foster care are currently eligible for federal financial participation through Title IV-E in the costs of their care. To be eligible for IV-E benefits, children must come from families who meet the income tests that applied to the 1996 Aid to Families with Dependent Children (AFDC) program (which no longer exists). For children who are eligible for federal financial participation in the costs of foster care under Title IV-E, the ratio of federal/non-federal foster care costs is determined by the state's Federal Medical Assistance Percentage (FMAP). Non-federal foster care costs are shared at a ratio of 40/60 by the state/counties. As a result of this outdated and frozen standard, a decreasing number of children are eligible over time.

**Subcommittee Staff Comment & Recommendation:** Staff recommends approving some, but not all, of the requested resources for Title IV-E eligibility training improvements. Specifically, total GF costs shall not exceed \$350,000 (with corresponding federal funds to be determined by the Administration, after consultation with Subcommittee staff).

### **DSS Issue 8: Kinship-Guardianship Assistance Payment Program (Kin-GAP) / Subsidized Relative Guardianship Proposal**

**Budget Issue:** The 2009-10 budget for Kin-GAP includes a total of \$144.9 million (\$110.5 million GF). The Governor's budget for 2010-11 proposed trailer bill language (TBL) to allow the state, beginning October 1, 2010, to opt into newly available federal financial participation in the costs of a subsidized relative guardianship program that is similar to the state's existing Kin-GAP program. However, Kin-GAP is currently part of the state's CalWORKs program; and its state and county expenditures count toward the MOE requirement imposed on the state as a condition of receiving federal Temporary Assistance to Needy Families (TANF) funds for the CalWORKs welfare-to-work program. The state's Kin-GAP expenditures are also eligible for American Recovery

and Reinvestment Act (ARRA) Emergency Contingency Fund (ECF) resources. Thus, the Administration has more recently confirmed that while ECF is in effect, the GF relief from continuing to include Kin-GAP in the TANF ECF calculation continues to be greater than the relief that would be achieved by implementing the federally subsidized guardianship program. As a result, the May Revision rescinds the January proposal to opt into the subsidized relative guardianship program as of October 1, 2010.

As part of the May Revision, the Administration instead proposes new trailer bill language (TBL) to allow for implementation of the federally supported subsidized relative guardianship program contingent upon a declaration by the Director of DSS that no further TANF ECF resources are available. At the time this agenda was written, the specifics of that proposed language had not yet been provided.

**Background on Kin-GAP and Federal Funding:** See Agenda from April 22, 2010.

**Subcommittee Staff Comment & Recommendation:** Staff recommends adopting May Revision changes to reflect the Administration's rescission of its prior proposal to implement a subsidized relative guardianship program as of October 1, 2010. Further, staff recommends rejecting the newly proposed concept for TBL. The conversion of Kin-GAP to a federally subsidized program that meets all of the newly enacted federal requirements involves a complex set of policy changes. If the state opts into this new federal program, those policy issues should be fully considered by the Legislature.

### **DSS Issue 9: Proposal for CCL Inspection & Fee Changes**

**Budget Issue:** DSS proposes, in a Spring Finance Letter and corresponding Trailer Bill and Budget Bill Language (TBL and BBL), to overhaul, effective January 1, 2011, statutory licensing inspection requirements. The Administration also proposes to raise facility application and annual fees by 10 percent. The BBL would allow the Department of Finance to reduce the GF authority for CCL commensurate with the amount of additional fee revenue that CCL receives (anticipated to be \$1.4 million for six months of 2010-11 and \$2.8 million annually thereafter). DSS has indicated that the costs for automation changes associated with this proposal would be absorbed as part of its ongoing system maintenance costs.

**Background:** See Agenda from April 22, 2010.

**Subcommittee Staff Comments & Recommendation:** Staff recommends rejecting this proposal at this time. Although the Department's approach to reprioritizing limited resources appears to be very promising and the need for more frequent licensing visits is urgent, the underlying details should be more fully considered by the policy committees of the Legislature or by the Budget Committee after stakeholders and the Department have had more time to work together regarding this overhauling of licensing procedures across multiple categories of facilities. Therefore, staff also recommends

that the Subcommittee direct the Department to continue working with stakeholders on a policy and/or a future budget proposal.

**DSS Issue 10: California Work Opportunities and Responsibility to Kids (CalWORKs) - Extension of authority for ARRA Funding**

**Budget Issue:** ABx4 4 (Chapter 4, Fourth Extraordinary Session, Statutes of 2009), a 2009-10 budget trailer bill, established authority for the state to implement the benefits of the Temporary Assistance to Needy Families (TANF) Emergency Contingency Fund (ECF) available under the American Recovery and Reinvestment Act (ARRA) of 2009. At both the state and federal level, TANF ECF is currently authorized through September 30, 2010. Since the passage of ABx4 4, however, there has been a national effort to extend federal authority for the program through at least federal fiscal year 2011. In order to allow for the likely extension of ECF, Section 10545.2 of the state's Welfare & Institutions Code must be updated. This change would be consistent with assumptions in the Governor's budget and May Revision regarding the extension of TANF ECF.

In addition, under federal guidance issued in January 2010, states are encouraged to use ECF funds for subsidized employment for "needy youth" with low-incomes between the ages of 18 and 24. However, state law does not currently include all federally-eligible youth in this category as allowable recipients of ECF-funded programs.

**Subcommittee Staff Comment & Recommendation:** In order to continue TANF ECF in California if the federal government extends the program, staff recommends adopting the following amendments to Section 10545.2(a) of the Welfare & Institutions Code as budget trailer bill language:

10545.2(a) This chapter shall become inoperative on ~~October 1, 2010, and as of January 1, 2011,~~ upon the expiration of federal authority for the Emergency Contingency Fund, as provided in the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), or subsequent federal legislation that extends the Emergency Contingency Fund program, and on that date is repealed.

Staff also recommends adopting placeholder TBL to ensure that TANF ECF-funded subsidized employment programs in California can serve all categories of federally-allowable needy low-income youth between the ages of 18 and 24.

**DSS Issue 11: In-Home Supportive Services Program (IHSS) – Contract Funding for Report on Quality Assurance and Fraud-Related Efforts**

**Budget Issue:** As part of the 2010-11 IHSS anti-fraud proposals discussed in prior agendas, including the Agendas for March 18 and May 6, 2010, DSS proposes an increase of \$500,000 (\$264,000 GF) to contract with California State University (CSUS) to assist in the development of a required report to the Legislature. The report, as required by ABx4 4 (Chapter 4, Fourth Extraordinary Session, Statutes of 2009), must result from a stakeholder process and the collection and review of specified information regarding prevention and early detection of fraud, as well as referrals of suspected fraud and final convictions for fraud.

As previously detailed, the Department did also receive funding and authority for 12 new IHSS program integrity/anti-fraud positions in the 2009-10 budget. In addition, the Subcommittee acted on May 6, 2010 to repeal a narrow set of the larger requirements created in 2009-10 (i.e., those related to the fingerprinting of IHSS consumers and the inclusion of fingerprints on providers' timesheets) that would no longer need to be implemented if that action becomes a part of the enacted 2010-11 budget.

**Subcommittee Staff Comment & Recommendation:** Staff recommends approval of a reduced amount of funding for contractor assistance in the Department's development of the required report. Specifically, staff recommends approval of a total of \$150,000 from all funding sources (with the corresponding GF impact to be determined by the Administration, after consultation with Subcommittee staff).

## Discussion Agenda

### 5180 Department of Social Services (DSS)

**DSS Issue 1: Group Home Litigation and Related Proposals**

**Budget Issue (#s 507, 509, 510):** The monthly rates paid to group homes and foster family agencies (FFAs) for each child under their care are established in state statute and must be consistent with federal requirements that they cover the costs of care and supervision. In particular, group home rates are determined by a complex Rate Classification Level (RCL) system that has been in effect for 20 years and that attempts to measure the hours of care and supervision, social work, and mental health services provided to children, while allowing for weightings based on the experience and educational background of staff. The current RCL system does not measure or evaluate outcomes or the quality of services provided to children in group homes.

Related to group home and foster family agency rates, the May Revision proposes:

1. \$234.4 million (\$69.6 million GF) in new costs to comply with a federal district court order in the *California Alliance of Child and Family Services v. Cliff Allenby*, which granted a rate increase to group homes based on the lack of COLAs applied to the current RCL system in recent years. As a result, the rates paid to group homes increased by approximately 32 percent, and now range from \$2,085 to \$8,835 per child, per month.
2. \$34.1 million (\$24.3 million GF) in eroded savings from a court injunction that halted a ten percent rate reduction which was adopted in 2009-10 for group homes. That rate reduction is now in effect for FFAs only. The resulting FFA rates range from \$1,430 to \$1,679 per child, per month.
3. \$863,000 (\$446,000 GF) in new costs for one new state operations position and funding for consultants, so that the Department can conduct a rate study and move toward a restructuring of the current group home rate-setting system.
4. Trailer bill language (TBL) that would impose a moratorium on group home applications. In the alternative, if the moratorium is not enacted, the Department again proposes to suspend the implementation of SB 1380 (Chapter 486, Statutes of 2008).

**Additional Background:** According to data from the Child Welfare Services/Case Management System (CWS/CMS), the overall number of children in child-welfare supervised foster care has been steadily declining for a number of years (from 116,900 children in July 1999 to approximately 66,000 in October 2009). The number of children placed in group homes also declined during that time, from approximately 10,600 to around 7,000.

According to DSS, the proposed temporary moratorium is not expected to affect the state's ability to find placements for foster children, as there is currently an over-capacity of available group home beds. The Department states that as of February 2010, there were approximately 8,700 licensed group home beds available in California and approximately 6,000 children in group home placements. The Department also indicates that such a moratorium would allow DSS to redirect staff to work on policies and rate-setting for alternatives to group home placements.

Absent the moratorium, DSS again proposes to suspend its implementation of SB 1380. As detailed in the May 6, 2010 Agenda, SB 1380 was enacted to allow for expanded eligibility and revised operational, reporting, and training requirements for the Intensive Treatment Foster Care (ITFC) program. ITFC was originally established in 1990 to ensure that foster children with emotional challenges could thrive in a family home with therapeutic services, rather than high-level and more expensive group homes. The Assembly Appropriations Committee analysis of SB 1380 indicated that the bill would result in net savings because foster children would be placed in less costly, less restrictive home settings, as opposed to more costly group home environments.

**Subcommittee Staff Comment and Recommendation:** Staff recommends approving the revised estimates of increased group home rate-related costs and the erosion of savings from the prior rate reduction. Staff also recommends:

1. Adopting placeholder TBL to require DSS to establish a **working group to develop revisions to the current system of setting reimbursement rates for group home providers**. Any recommended changes in the group home rate-setting system must also consider the larger context for how the system can better incorporate a spectrum of placements and services that promote positive outcomes for children and families. These shall include addressing mental health and other critical services for children and youth, the provision of services in home-like settings, supporting families and relatives, and other quality improvement concepts. The working group shall include legislative policy and budget staff and stakeholders representative of foster youth, providers, children's advocates, county welfare and probation staff, and workers.
2. **Adopting placeholder TBL to enact a one-year moratorium** on group home rate-setting activity that incorporates authority for the department to make exceptions to the moratorium, which may, as appropriate, be based on information provided by county placing agencies, including county welfare and probation agencies. The Department should also be required to provide feedback from the year of implementation for the Legislature's review.
3. **Rejecting TBL that would make implementation of SB 1380 contingent on any other provisions.**
4. **Approving the creation of the requested state operations position, but for a three-year limited-term;** and
5. **Approving \$250,000 of the \$750,000 in requested funding for consulting and contracts**, including county consultants. Total GF impact would be determined by the Administration, after consultation with Subcommittee staff.

**Questions for DSS:**

- 1) Please briefly summarize the recent trends in foster care caseload and group home placements statewide. Please also summarize the recent litigation impacting group home rates.
- 2) Please summarize the Department's staffing, contracting, and moratorium proposals. How do these proposals fit into the larger context of the Department's vision for a foster care system that better incorporates a spectrum of placements and services that promote positive outcomes for children and families?

**DSS Issue 2: Proposal to Continue Suspension of the Mutual Consent – Confidential Intermediary Program for Sibling Contact (AB 2488)**

**Budget Issue:** DSS proposes savings of \$3.0 million (\$1.7 million GF) in avoided state operations and local assistance costs from continuing to suspend implementation of AB 2488 (Chapter 386, Statutes of 2006). The new suspension appears to be indefinite, although it continues to indicate the Legislature’s intent that counties already implementing the provisions added by AB 2488 shall continue to do so to the extent possible.

**Background:** AB 2488 created a confidential intermediary program intended to facilitate contact between siblings in the circumstance that at least one of them was adopted. In 2008-09, the Governor vetoed funding for implementation of AB 2488, stating that implementation of the program would be delayed for one year as a budget balancing reduction. The Legislature subsequently delayed program implementation to July 1, 2010 (except to the extent that counties already implementing its provisions continue to do so).

**Subcommittee Staff Comment & Recommendation:** Notwithstanding the merits of fully implementing AB 2488, staff recommends approving trailer bill language for an additional one-year suspension of its provisions. As a result, Section 9205(i) of the Family Code would read:

“(i) Implementation of the amendments made to this Section by Chapter 386 of the Statutes of 2006 shall be delayed until July 1, 2011. It is the intent of the Legislature that counties that are already implementing some or all of the changes made to Section 9205 of the Family Code by Chapter 386 of the Statutes of 2006 shall continue to implement these provisions, to the extent possible.”

**Questions for DSS:**

- 1) Please briefly summarize the process by which siblings separated through adoption can currently locate each other and what the laws established by AB 2488 change.

**DSS Issue 3: Proposal to Continue Suspension of Placements of Children in Foster Care with Developmental Disabilities in For-Profit Group Homes (AB 1462)**

**Budget Issue:** DSS proposes, in the May Revision, \$99,000 (\$63,000 GF) in cost avoidance from suspending state operations efforts related to implementation of AB 1462 (Chapter 64, Statutes of 2007). Specifically, the proposed trailer bill language (TBL) would suspend implementation of laws enacted by AB 1462 until “sufficient state

operations resources have been appropriated for its implementation to develop program procedures, policies and regulations, and to develop fiscal procedures, such as cost reporting and claiming.”

**Background:** AB 1462 authorized the use of for-profit group homes for placement of children with developmental disabilities, under specific circumstances, and when a county could not find a non-profit group home with a program that could meet the child’s needs. As a result, counties would be able to draw down federal financial participation and by using county funds as the required match. No state General Fund resources could be used for placement into a for-profit facility. AB 1462 also limited foster care payments made to for-profit agencies to no more than five children per county at any one time. In addition, the placements cannot exceed a maximum of 12 cumulative months. The Department released an information notice regarding these changes in state law to county welfare and probation departments in January 2008. In 2008-09, the Legislature delayed implementation of AB 1462 until July 1, 2010 and denied a related budget change proposal requesting state operations resources for DSS.

**Subcommittee Staff Comment & Recommendation:** Staff recommends rejecting the proposed TBL, which would allow for determination by the Administration as to when sufficient resources for these responsibilities have been appropriated by the Legislature.

**Questions for DSS:**

- 1) Please describe the state operations workload associated with these requirements (as distinguished from the work that counties must do in order to implement the laws created by AB 1462).

**DSS Issue 4: Defense Appropriation Act Funding for Food Stamps Administration**

**Budget Issue:** The May Revision proposes \$10.5 million GF savings (with corresponding reductions in federal and county funds) from the use of \$30.0 million in newly available federal funds appropriated by the Department of Defense Appropriations Act of 2010 (P.L. 111-118). These new federal funds do not require a state match and must be used to supplement, not supplant, current state funds for the Supplemental Nutritional Assistance Program (still commonly referred to as “food stamps” in California). DSS proposes to use the funds for a portion of new administrative costs resulting from caseload growth in food stamps (specifically for “non-assistance” cases, or those in which recipients do not also receive CalWORKs).

The overall enacted budget for food stamps administration in 2009-10 is \$989.4 million (\$418.4 million GF), while the May Revision for 2010-11 includes \$1.2 billion (\$492.1 million GF).

**Caseload Growth:** The average monthly numbers of Californians receiving food stamps in recent and upcoming years (according to DSS's annual estimates as of each prior November and not including CFAP recipients) are below.

<b>State Fiscal Year</b>	<b># of Households</b>	<b># of Individual Recipients</b>
2007-08	850,346	2,138,702
2008-09	1,004,507	2,442,705
2009-10	1,337,016	3,213,770
2010-11	1,575,940	3,752,354

Roughly 32,000 additional individuals receive benefits in the state-funded California Food Assistance Program (CFAP).

**Subcommittee Staff Comment & Recommendation:** Staff recommends approving the proposed one-time use of these federal funds.

**Questions for DSS:**

- 1) Please briefly summarize the proposed use of these federal funds and the caseload growth in recent years.

# **SUBCOMMITTEE #3: Health & Human Services**

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**Chair, Senator Mark Leno**

**Senator Elaine K. Alquist  
Senator Roy Ashburn**



**May 24, 2010**

## **Agenda II Outcomes**

Committee Staff: Jennifer Troia

### **Vote-Only Agenda**

#### **0530 Office of Systems Integration**

##### **OSI & DSS Issue 1: Interim Statewide Automated Welfare System**

Approved (2-0) (Ashburn absent) the requested reductions in the 2010-11 budget and staffing for ISAWS.

##### **OSI & DSS Issue 2: Child Welfare Services (CWS)/Web Staffing**

Approved (2-0) (Ashburn absent) the requested positions and contract funding.

##### **OSI & DSS Issue 3: LEADER Replacement System**

Approved (2-0) (Ashburn absent) the requested 2010-11 funding for LRS. The Subcommittee also requested updates from OSI on the progress of negotiations and anticipated costs for the overall design, development, and implementation.

##### **OSI & DSS Issue 4: Statewide Fingerprint Imaging System (SFIS)**

Eliminated (2-0) (Ashburn absent) any funding for SFIS that would remain after close-out costs related to the system's elimination. Staff was directed to work with the Administration to determine those close-out costs and the remaining GF savings for 2010-11. Correspondingly, adopted placeholder trailer bill language to eliminate the requirements for finger imaging of CalWORKs and food stamp participants. Finally, rejected the request to convert 1.5 contract staff to 2.0 permanent state staff.

**OSI & DSS Issue 5: Case Management, Information and Payrolling System Replacement Project (CMIPS II)**

Approved (2-0) (Ashburn absent) the requested position authority.

**4140 Office of Statewide Health Planning & Development****OSHPD Issue 1: Deferral of General Fund (GF) Loan Repayment**

Approved (2-0) (Ashburn absent) the extension of the date for repayment of these loans to the GF. Correspondingly, adopted budget bill language to change the date of Hospital Building Fund loan repayment from June 30, 2011 to June 1, 2012.

**4170 Department of Aging (CDA)****CDA Issue 1: Federal Grant for the Chronic Disease Self-Management Program**

Approved (2-0) (Ashburn absent) the requested federal funds authority and budget bill language.

**CDA Issue 2: Health Insurance Counseling and Advocacy Program (HICAP) – Federal Funds Augmentation**

Approved (2-0) (Ashburn absent) the requested increase in federal funds authority.

**CDA Issue 3: Shift of Funding for Long-Term Care Ombudsman**

Approved (2-0) (Ashburn absent) the requested 2010-11 shift of resources from DPH to CDA for the Ombudsman program. This conforms to actions already taken regarding DPH's budget.

**4200 Department of Alcohol & Drug Programs (ADP)****ADP Issue 1: Revisions to Drug Medi-Cal (DMC) & Related ARRA Estimates**

Approved (2-0) (Ashburn absent) the requested caseload changes and the requested changes to account for increased ARRA funds. The reflection of the corresponding GF impact will conform to actions taken regarding the proposed Control Section 8.65.

**5170 State Independent Living Council (SILC)****SILC Issue 1: Aging and Disability Resource Connection (ADRC)  
Federal Grant**

Approved (2-0) (Ashburn absent) the requested 2010-11 federal funds authority.

**5175 Department of Child Support Services (DCSS)****DCSS Issue 1: Revision to Estimates of Federal Incentive Funding and  
State Disbursement Unit (SDU) Costs**

Approved (2-0) (Ashburn absent) these estimate changes (which will also conform, as appropriate, to other actions taken).

**DCSS Issue 2: Revision to Estimate of American Recovery &  
Reinvestment Act (ARRA) Funds**

Approved (2-0) (Ashburn absent) the proposed reduction to Item 5180-101-0890 of the budget bill. The reflection of the corresponding GF impact will conform to actions taken regarding the proposed Control Section 8.65.

**DCSS Issue 3: California Child Support Automation System (CCSAS)-  
Increase to Baseline Funding**

Approved (2-0) (Ashburn absent) the requested \$8.2 million (\$2.7 million GF) increase to its base funding.

**5180 Department of Social Services (DSS)****DSS Issue 1: Estimate Changes and Adjustments**

Approved (2-0) (Ashburn absent) these caseload and other estimate adjustments, which will conform as appropriate to other actions that have been or will be taken.

**DSS Issue 2: Temporary Emergency Food Assistance Program  
(TEFAP) Fund Shift**

Approved (2-0) (Ashburn absent) this transfer of federal expenditure authority.

**DSS Issue 3: County Match Requirement for Food Stamps  
Administrative Costs**

Adopted (2-0) (Ashburn absent) placeholder TBL to effectuate this proposal for a two-year time period.

**DSS Issue 4: Inter-County Transfer Process for Nutrition Assistance**

Given the currently pending policy bill seeking to address this same issue, rejected (2-0) (Ashburn absent) without prejudice the Inter-County Transfer process and related TBL that are proposed as part of the May Revise.

**DSS Issue 5: 2009-10 Veto of Child Welfare Services Funding**

Rescinded (2-0) (Ashburn absent) prior Subcommittee action and instead approved (2-0) (Ashburn absent) a full restoration of the vetoed funds.

**DSS Issue 6: Probation Access to CWS/Case Management System (CWS/CMS)**

Rescinded (2-0) (Ashburn absent) prior Subcommittee action and instead rejected (2-0) (Ashburn absent) the requested funds.

**DSS Issue 7: Title IV-E Eligibility Training Proposal**

Approved (2-0) (Ashburn absent) some, but not all, of the requested resources for Title IV-E eligibility training improvements. Specifically, total GF costs shall not exceed \$350,000 (with corresponding federal funds to be determined by the Administration, after consultation with Subcommittee staff).

**DSS Issue 8: Kinship-Guardianship Assistance Payment Program (Kin-GAP) / Subsidized Relative Guardianship Proposal**

Adopted (2-0) (Ashburn absent) May Revision changes to reflect the Administration's rescission of its prior proposal to implement a subsidized relative guardianship program as of October 1, 2010, but rejected the newly proposed TBL.

**DSS Issue 9: Proposal for CCL Inspection & Fee Changes**

Rejected (2-0) (Ashburn absent) the proposal at this time. Directed the Department to continue working with stakeholders on a policy and/or a future budget proposal.

**DSS Issue 10: California Work Opportunities and Responsibility to Kids (CalWORKs) - Extension of authority for ARRA Funding**

Adopted (2-0) (Ashburn absent) the following amendments to Section 10545.2(a) of the Welfare & Institutions Code as budget trailer bill language:

10545.2(a) This chapter shall become inoperative on ~~October 1, 2010, and as of January 1, 2011,~~ upon the expiration of federal authority for the Emergency Contingency Fund, as provided in the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), or subsequent federal legislation that extends the Emergency Contingency Fund program, and on that date is repealed.

Additionally adopted placeholder TBL to ensure that TANF ECF-funded subsidized employment programs in California can serve all categories of federally-allowable needy low-income youth between the ages of 18 and 24.

**DSS Issue 11: In-Home Supportive Services Program (IHSS) – Contract Funding for Report on Quality Assurance and Fraud-Related Efforts**

Approved (2-0) (Ashburn absent) a reduced amount of funding for contractor assistance in the Department's development of the required report. Specifically, approved a total of \$150,000 from all funding sources (with the corresponding GF impact to be determined by the Administration, after consultation with Subcommittee staff).

**Discussion Agenda**

**5180 Department of Social Services (DSS)**

**DSS Issue 1: Group Home Litigation and Related Proposals**

Approved (2-0) (Ashburn absent) the revised estimates of increased group home rate-related costs and the erosion of savings from the prior rate reduction and:

1. **Adopted placeholder TBL to require DSS to establish a working group to develop revisions to the current system of setting reimbursement rates for group home providers.** Any recommended changes in the group home rate-setting system must also consider the larger context for how the system can better incorporate a spectrum of placements and services that promote positive outcomes for children and families. These shall include addressing mental health and other critical services for children and youth, the provision of services in home-like settings, supporting families and relatives, and other quality improvement concepts. The working group shall include legislative policy and budget staff and stakeholders representative of foster youth, providers, children's advocates, county welfare and probation staff, and workers.
2. **Adopted placeholder TBL to enact a one-year moratorium** on group home rate-setting activity that incorporates authority for the department to make exceptions to the moratorium, which may, as appropriate, be based on information provided by county placing agencies, including county welfare and probation agencies. The Department should also be required to provide feedback from the year of implementation for the Legislature's review.
3. **Rejected TBL that would make implementation of SB 1380 contingent on any other provisions.**
4. **Approved the creation of the requested state operations position, but for a three-year limited-term; and**

5. **Approved \$250,000 of the \$750,000 in requested funding for consulting and contracts**, including county consultants. Total GF impact would be determined by the Administration, after consultation with Subcommittee staff.

**DSS Issue 2: Proposal to Continue Suspension of the Mutual Consent – Confidential Intermediary Program for Sibling Contact (AB 2488)**

Approved (2-0) (Ashburn absent) trailer bill language for an additional one-year suspension of its provisions. As a result, Section 9205(i) of the Family Code would read:

“(i) Implementation of the amendments made to this Section by Chapter 386 of the Statutes of 2006 shall be delayed until July 1, 2011. It is the intent of the Legislature that counties that are already implementing some or all of the changes made to Section 9205 of the Family Code by Chapter 386 of the Statutes of 2006 shall continue to implement these provisions, to the extent possible.”

**DSS Issue 3: Proposal to Continue Suspension of Placements of Children in Foster Care with Developmental Disabilities in For-Profit Group Homes (AB 1462)**

Rejected (2-0) (Ashburn absent) the proposed TBL, which would allow for determination by the Administration as to when sufficient resources for these responsibilities have been appropriated by the Legislature.

**DSS Issue 4: Defense Appropriation Act Funding for Food Stamps Administration**

Approved (2-0) (Ashburn absent) the proposed one-time use of these federal funds.