

AGENDA**PART II****ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES****ASSEMBLYMEMBER HOLLY MITCHELL, CHAIR****MONDAY, MAY 20, 2013****UPON ADJOURNMENT OF SESSION - STATE CAPITOL ROOM 4202****VOTE-ONLY CALENDAR**

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VOTE ONLY**4140 OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT**

ISSUE 1: WET REAPPROPRIATION

Office of Statewide Health Planning & Development (OSHPD) requests that \$2,217,000 in unexpended 2012-13 Proposition 63 (Mental Health Services Act/MHSA) funds be reappropriated for WET programs and the Mental Health Loan Assumption Program.

The full 2012-13 WET (Proposition 63) appropriation was \$22.8 million, of which OSHPD has expended \$20.6 million, leaving \$2.2 million in yet unexpended funds which OSHPD is requesting to be reappropriated. According to OSHPD, there are a variety of program-specific reasons for the funds not being fully expended, including: 1) the MHLAP designates funding for every county, although some counties do not have professionals with qualifying educational loans in certain years; 2) sometimes students drop out of the stipend program; and, 3) OSHPD did not receive a sufficient number of applications to expend all of the Song-Brown funding.

Of the \$2.2 million proposed to be reappropriated, \$632,000 will be allocated to the MHLAP through 2017-18. OSHPD expects the applicant pool to increase as counties recruit provider to meet increased demand (in part associated with Affordable Care Act implementation). The remaining \$1.5 million will be used to implement the second 5-year WET plan, and the priorities identified in that plan.

This item was heard by the Subcommittee on May 6, 2013, at which time the Subcommittee took an action to approve of the request. However, the identical reappropriation is now included in AB 111, and therefore should no longer be included in the 2013 Budget Act, in order to avoid identical reappropriations in multiple bills.

4265 DEPARTMENT OF PUBLIC HEALTH

ISSUE 1: GENETIC DISEASE SCREENING PROGRAM ESTIMATE

The Genetic Disease Screening Program estimate was discussed at the Subcommittee's hearing on March 4, 2013. The item was held open consistent with all estimate packages given that they are often revised and updated at May Revision. The May Revision contains only a \$2,700 reduction and no other changes to the January estimate for this program.

January Budget

The Department of Public Health (DPH) proposes total expenditures for both the current and budget years to remain at \$87.7 million (Genetic Disease Testing Fund) for local assistance. This program is fully fee supported. According to DPH, this program has experienced reductions in costs in some past years directly reflecting reductions in the birth rate in those years; however, this year the birthrate has remained fairly constant, and therefore program costs are constant as well.

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

Prenatal Screening Program. This program provides screening of pregnant women who *consent* to screening for serious birth defects. The fee paid for this screening is about \$150. Most prepaid health plans and insurance companies pay the fee. Medi-Cal also pays it for its enrollees. There are three types of screening tests to pregnant women in order to identify individuals who are at increased risk for carrying a fetus with a specific birth defect. All three of these tests use blood specimens, and generally, the type of test used is contingent upon the trimester. Women who are at high risk based on the screening test results are referred for follow-up services at state-approved “Prenatal Diagnosis Centers.” Services offered at these Centers include genetic counseling, ultrasound, and amniocentesis. Participation is voluntary, and the November 2012 estimate projects to screen approximately 408,022 pregnant women in 2012-13 and 413,999 in 2013-14.

Newborn Screening Program. This program provides screening for all newborns in California for genetic and congenital disorders that are preventable or remediable by early intervention. The fee paid for this screening is \$113. Where applicable, this fee is paid by prepaid health plans and insurance companies pay the fee. Medi-Cal also pays it for its enrollees. The Newborn Screening Program screens for over 75 conditions, including certain metabolic disorders, PKU, sickle cell, congenital hypothyroidism, non-sickling hemoglobin disorders, Cystic Fibrosis, and many others. Early detection of these conditions can provide for early treatment that mitigates more severe health problems. Informational materials are provided to parents, hospitals and other health care entities regarding the program and the relevant conditions and referral information is provided where applicable. The November 2012 estimate projects to screen approximately 510,028 newborns in 2012-13 and 517,499 in 2013-14.

4440 DEPARTMENT OF STATE HOSPITALS

ISSUE 1: CONVERT CONTRACT POSITIONS TO CIVIL SERVICE POSITIONS

The Department of State Hospitals (DSH) requests authority for 22 new permanent positions and funding to be transferred from contracts in the Sex Offender Commitment Program and the Mentally Disordered Offender Program.

DSH states that this transfer from contracted positions to state civil service will allow the affected programs to hire civil service psychologists to meet the current workload, and comply with Government Code section 19130(b)(3).

ISSUE 2: REAPPROPRIATION FOR PERSONAL DURESS ALARM SYSTEM PROJECTS

DSH requests reappropriation authority of unencumbered funds from 2012-13 to 2013-14 to complete the Personal Duress Alarm System (PDAS) Projects.

DSH explains that the unencumbered funds from 2012-13 resulted from initial implementation delays with the PDAS at Napa State Hospital, which caused upgrade delays at Metropolitan and Patton State Hospitals in the current fiscal year. The 2012 Budget Act included \$22.8 million General Fund for the PDAS, and the remaining balance of that amount is to be reappropriated to the budget year.

ITEMS TO BE HEARD

4560 MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION

ISSUE 1: OVERVIEW & PROPOSITION 63 EVALUATION MASTER PLAN

The Mental Health Services Oversight & Accountability Commission (MHSOAC) is requesting 6 permanent positions and Mental Health Services Act (MHSA/Prop 63) funding of \$947,000 for 2013-14 and \$1,791,000 in 2014-15 to implement the Evaluation Master Plan. The positions requested include:

- Research Scientists II (2)
- Research Program Specialist II (2)
- Staff Information Systems Analyst (1)

PANELISTS

- Mental Health Services Oversight & Accountability Commission
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

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

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

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

- **Community Services and Supports for Adult and Children’s Systems of Care.** This component funds the existing adult and children’s systems of care established by the Bronzan-McCorquodale Act (1991). County mental health departments are to establish, through its stakeholder process, a listing of programs for which these funds would be used. Of total annual revenues, 80 percent is allocated to this component.

- **Prevention and Early Intervention.** This component supports the design of programs to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for unserved and underserved populations. Of total annual revenues, 20 percent is allocated to this component.
- **Innovation.** The goal of this component is to develop and implement promising practices designed to increase access to services by underserved groups, increase the quality of services, improve outcomes, and promote interagency collaboration. This is funded from five percent of the Community Services and Supports funds and five percent of the Prevention and Early Intervention funds.
- **Workforce Education and Training.** The component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness. In 2005-06, 2006-07, and 2007-08, 10 percent of total revenues were allocated to this component, for a total of \$460.8 million. Counties have 10 years to spend these funds.
- **Capital Facilities and Technological Needs.** This component addresses the capital infrastructure needed to support implementation of the Community Services and Supports, and Prevention and Early Intervention programs. It includes funding to improve or replace existing technology systems and for capital projects to meet program infrastructure needs. In 2005-06, 2006-07, and 2007-08, 10 percent of total revenues were allocated to this component, for a total of \$460.8 million. Counties have 10 years to spend these funds.

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

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

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

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

MHSOAC Budget				
	2012-13 Estimate	2013-14 January Proposal	2013-14 May Revise Proposal	Change From January to May 2013
Total Funds (Prop 63)	\$6,925	\$6,916,000	\$7,863,000	\$947,000 (13.7%)
Positions	21.7	21	27	6

Evaluation Master Plan. The MHSOAC is mandated to evaluate the outcomes of investments made through the MHSA. Moreover, significant pressure has been put on the state by the press and public regarding the lack of evaluation of Proposition 63-funded programs. On March 28, 2013, the MHSOAC approved an Evaluation Master Plan, which prioritizes possibilities for evaluation investments and activities over a three to five year course of action.

The MHSOAC Evaluation Master Plan is the result of findings from interviews with approximately 40 key informant interviews, along with county visits. The plan focuses on individual, system, and community outcomes; provides specific evaluation activities and a general system by which to prioritize those and future evaluation activities; and identifies strategies for the successful completion of all items described and prioritized in the plan. While the major focus of the plan is on the MHSA, the scope of the plan is broader.

The criteria applied to the evaluation questions include:

- **Consistency with MHSA:** Are the questions consistent with the language and values of the Act?
- **Potential for quality improvement:** Will answers to the questions lead to suggestions for and implementation of policy and practice changes?
- **Importance to stakeholders:** Are the questions a high priority to key stakeholders?
- **Possibility of partners:** Are there other organizations that might collaborate and/or partially fund the activity?
- **Context and forward looking:** Are there changes in the environment that make the questions particularly relevant? (e.g., the evolving health care environment; political concerns)?
- **Challenges:** Do the questions address areas that are creating a challenge for the system?

The criteria for the evaluation activity include:

- **Feasibility:** How likely is the evaluation activity to produce information that answers the evaluation questions?
- **Cost:** How many resources are needed to do the activity well?
- **Timeliness:** How long will it take to complete the evaluation activity?
- **Leveraging:** Does the evaluation activity build upon prior work of the MHSOAC or others?

MHSOAC staff describe the Evaluation Plan as a fully-developed "dashboard" that creates the ability to assess and compare many different programmatic elements of Proposition 63 across all of the counties, on an ongoing basis.

The proposed budget year expenditures are less than in 2014-15 for a variety of reasons, including: 1) the Commission intends to utilize existing resources, including existing external contracts, in the budget year; and, 2) data systems will be further developed in subsequent years, which will increase costs.

Prop 63 Administrative Cap

The original Prop 63 statute included a state administration cap of 5 percent of the Prop 63 revenues. Subsequent legislation, AB 100 (budget trailer bill, Chapter 5, Statutes of 2011), reduced the cap to 3.5 percent. The Department of Finance states that this proposal will cause state administrative expenditures to exceed the cap by approximately \$2.5 million. According to the Department of Finance (DOF), the cap currently is \$39.5 million. DOF explains that there are significant fluctuations in Prop 63 revenue from year to year, and even within the year. Therefore, the state has exceeded the cap before, only to find that overall revenue, and therefore the cap, has increased later in the same year. DOF believes that this proposal is a sufficiently high priority to warrant exceeding the cap, potentially temporarily. Should revenues fail to increase sufficiently to bring this proposal back under the cap; the Administration will propose decreases in Prop 63 state administrative funding in other areas, either through next year's budget or through a mid-year bill.

STAFF COMMENTS/QUESTIONS

Subcommittee staff has asked MHSOAC to provide a brief overview of the Commission and its major activities, and to present this proposal.

4140 OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT**ISSUE 1: THE CALIFORNIA ENDOWMENT GRANT**

The Office of Statewide Health Planning & Development (OSHPD) has received a grant from The California Endowment (TCE) of \$52 million for over four years for the purpose of workforce development. Therefore, OSHPD is requesting expenditure authority in two components as follows:

1. Health Professions Education Foundation -- \$31 million

- 2013-14: \$14 million
- 2014-15: \$9 million
- 2015-16: \$7.9 million
- 2016-17: \$82,000

2. Song-Brown Program -- \$21 million

- 2013-14: \$7 million
- 2014-15: \$7 million
- 2015-16 \$7 million

PANELISTS

- Office of Statewide Health Planning & Development
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

On January 18, 2013, TCE announced its commitment of \$225 million to be invested in efforts to assist the State of California in its implementation of the federal Affordable Care Act (ACA), which is expected to bring an estimated 6.9 million uninsured Californians into health coverage. Of this \$225 million, \$90 million is dedicated to funding efforts to expand the primary care healthcare workforce. This \$90 million includes the \$52 million grant to OSHPD that is being proposed here. OSHPD states that the impact of these funds will be: 1) 625 more scholarships and loan repayments to students and practitioners providing direct patient care in underserved communities; and, 2) 4,166 more physicians, family nurse practitioners and physician assistants trained in primary care and providing direct patient care in underserved communities in each of the grant years.

Health Professions Education Foundation (Foundation)

The Foundation is the state's only non-profit, public benefit corporation statutorily created to provide financial assistance to students and providers in exchange for providing direct patient care in a medically underserved area (MUA) of California. The Foundation, which operates within OSHPD, has awarded 5,394 scholarships and loan repayments totaling over \$47 million to allied health, nursing, mental health, and medical students and professionals throughout the state since 1990. Six Foundation programs will receive this grant funding as shown in the following table:

PROGRAM	MAXIMUM AWARD AMOUNT
Allied Scholarship	\$8,000
Allied Loan Repayment	\$8,000
Health Professions Education Scholarship	\$50,000
Health Professions Education Loan Repayment	\$50,000
Licensed Mental Health	\$15,000
Steven M. Thompson Loan Repayment	\$105,000

Song-Brown Healthcare Workforce Training Program (Song-Brown)

Song-Brown provides grants to California health professions education institutions providing clinical training to Family Practice medical residents and primary care family nurse practitioners and physician assistant students. These residents and students are required to complete training in underserved areas, including MUAs, Health Professional Shortage Areas, Medically Underserved Populations, Primary Care Shortage Areas, and in multicultural and rural communities. Since 2006, Song-Brown has provided funding to 319 health professions education and training programs and supported more than 14,189 residents and students, who in turn practice direct patient care in MUAs. Song-Brown-providers deliver primary care services in all University of California teaching hospitals, 61 percent of county facilities, and in many community health centers.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked OSHPD to present this proposal.

ISSUE 2: MENTAL HEALTH WORKFORCE, EDUCATION & TRAINING

OSHPD requests that \$7,839,000 in unexpended and unencumbered Mental Health Services Act (MHSA) Workforce, Education and Training (WET) funds, from 2008-09 through 2011-12, be appropriated through fiscal year 2017-18 for WET programs.

PANELISTS

- Office of Statewide Health Planning & Development
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

As discussed in detail in the Subcommittee's agenda for April 15, 2013, the MHSA WET program was transferred from the former Department of Mental Health (DMH) to OSHPD in 2012, as part of the elimination of the DMH. The WET program seeks to address the shortage of mental health providers in California. Particularly severe shortages exist for mental health practitioners with skills to work effectively with the following populations: children, transition-aged youth, older adults, and diverse ethnic/cultural populations. Current WET programs include stipends to mental health care students; the Mental Health Loan Assumption Program (MHLAP) that repays educational loans; grants to train Physician's Assistants in mental health via the Song-Brown program; expansions to psychiatric residency programs; a Technical Assistance Center to increase the employment of consumers and family members; identification of Health Professional Shortage Areas in mental health, and funding for county Regional Partnerships. OSHPD is in the process of developing the second 5-year WET plan, as required by the MHSA.

Of the total \$7,839,000 appropriation that OSHPD is requesting, \$1,650,000 make up an unexpended balance being transferred from the former DMH for which OSHPD must receive expenditure authority through the budget in order to utilize that funding. The remaining \$6,189,000 are funds that were appropriated in prior years for WET activities, however were not expended. The Administration explains that these funds cannot be "reappropriated" because they exceeded the standard 3-year appropriation time-frame without being expended, and therefore reverted back to the MHSA fund. These unspent funds were for stipends, Psychiatric Residency, Statewide Technical Assistance, Mental Health Loan Assumption Program, and Song-Brown. OSHPD states that the intent of the MHSA is that WET funds be available for up to ten years, however this longer-than-usual time frame was not specified in the original appropriation, and therefore the funds reverted back to the MHSA Fund, where they were distributed to counties. According to OSHPD, the California Mental Health Directors Association is supportive of this proposal given its consistency with the intent of the MHSA.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked OSHPD to present this proposal.

4265 DEPARTMENT OF PUBLIC HEALTH**ISSUE 1: ZERO BASE BUDGETING**

As discussed in the Subcommittee's agenda on March 4, 2013, the Governor's proposed January budget announced the implementation of Zero Base Budgeting (ZBB) in select departments, including the Department of Public Health (DPH). At that time, DPH noted that updated information on their efforts would be provided at May Revise and such a report has been included in the revised budget, as described below.

PANELISTS

- Department of Public Health
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

On December 8, 2011, the Governor issued an Executive Order to begin utilizing "Zero- Base Budgeting" (ZBB). The DPH was one of four departments selected to pilot ZBB for 2013-14. The DPH began the first phase of implementing ZBB in three of its programmatic areas: 1) contracting functions; 2) the Baby BIG program; and, 3) the Women, Infants and Children (WIC) program.

The ZBB approach differs significantly from traditional budgeting. Whereas in traditional budgeting a department incrementally builds upon its prior year budget by either adding or subtracting funds from existing programs, in ZBB, the department builds its budget from the ground up, reassessing how it currently spends and allocates resources within each program.

DPH staff describes the process undertaken with these first three programs as not a pure ZBB approach, but rather a hybrid that focuses on program outcomes. According to DPH, the ZBB process has been very time-intensive, so much so that any department undertaking this process needs to recognize that it will take the place of other work. Moreover, DPH's goal has been to take the time to study these programs deeply in order to gain an accurate understanding of the strengths and weaknesses of the programs, what aspects of the programs are working well, what aspects are not, and what ways the same services could be provided in more efficient ways. DPH states that this is not strictly a budget cutting exercise, and instead describes it as a way to improve the quality and efficiency of programs.

May Revision Report

The report included in May Revision outlines the findings and recommendations that each of the three participating programs reached. The following is a summary:

WIC ProgramFindings:

- Emphasis on Process vs. Outcomes
- Internal Processes Too Dispersed
- Heavy Emphasis on Monitoring Local Lead Agencies
- Lack of Resources for Vendor Integrity and Food Cost Containment Efforts

Recommendations:

- Develop Outcome Measures
- Leverage Other Program Data to Evaluate Program Effectiveness
- Consolidate Functions Within WIC Division
- Reallocate Staff Resources for Vendor Integrity and Program Evaluation

BabyBIGFindings:

- Need to Consider Entire Product Cycle Costs
- BabyBIG Expenses Must be Carefully Monitored
- Pre-Production and Production Costs have Increased Significantly
- The Current BabyBIG Fee Will Not Cover Production Costs
- Collection of More Blood Plasma Is Critical
- Demand for BabyBIG May Exceed Vaccine Supply
- Prevention Efforts Could be Cost-Effective

Recommendations:

- Strengthen Administrative Support
- Raise BabyBIG Vaccine Fee
- Produce More Blood Plasma
- Monitor Utilization
- Develop Criteria and Policies for BabyBIG Distribution
- Increase Prevention Efforts Through Partnerships
- Investigate Handling Fee
- Consider Continuous Appropriation for BabyBIG

ContractingFindings:

- Cost of Contracting Product Cycle
- Wide Variation in Contracting Costs Among Programs
- High Cost to Contract Amendments
- Heavy Emphasis on Compliance
- Relatively Few Resources for Technical Assistance

Recommendations:

- Do It Right The First Time
- Reduce Compliance Costs
- Focus on Program Goals and Objectives
- Improve Linkage Between Contracting and Program Evaluation
- Offer More Technical Assistance
- Explore Other Ways to Allocate Funds

The DPH May Revise report on ZBB also includes general conclusions and recommendations about using ZBB, which include:

1. ZBB Should be Win-Win
2. Incorporate Performance-Based Budgeting Concepts
3. Consider Starting with Non-General Fund Supported Programs
4. Emphasize Reallocation, Not Reduction
5. Develop the Program's Value Chain
6. Map the Product Cycle
7. Calculate the Unit Cost Per Output
8. Don't Let the Perfect Be the Enemy of The Good

Overall, DPH states that it is pleased with the outcomes of the ZBB effort. Specific improvements that have resulted include: 1) WIC is re-engineering its vendor management strategies and implementing new cost containment strategies; 2) BabyBIG has initiated new efforts to change business processes and consider new ways to generate revenue; and, 3) DPH has formed a Contract Simplification Workgroup to streamline the contracting process and improve contractor performance by integrating program evaluation into the contracting process.

The Administration states that each department involved in ZBB approaches it somewhat differently. DPH intends to use this process on a few programs each year. Generally, the process is intensive and takes a couple of months, after which DPH leaves any follow-up recommendations or actions to the specific program.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked DPH to present their report and respond to the following:

1. What, if any, proposals or recommendations does DPH plan to pursue as a result of this project?
2. What is the Administration's overall plan for the future of ZBB?

ISSUE 2: AIDS DRUG ASSISTANCE PROGRAM (ADAP) ESTIMATE***May Revise***

The May Revise estimate reflects three new major assumptions:

- 1) ***Medi-Cal Expansion.*** The estimate assumes that the Medi-Cal program will be expanded in 2014 to cover most childless adults up to 138 percent federal poverty, and therefore most ADAP clients will become eligible for Medi-Cal in 2014. This assumption is based on 9,853 clients moving to Medi-Cal resulting in savings of \$91,349,440.
- 2) ***Key ACA Provisions.*** Two other key provisions of the Affordable Care Act are expected to have significant impacts on ADAP, including the requirement for people to have health insurance ("individual mandate"), and the new health insurance marketplace, named Covered California.
- 3) ***Ryan White Grant Adjustments.*** As a result of sequestration, the Health Resources and Services Administration projects that California should expect a five percent (\$5.3 million) reduction to the 2013 Ryan White Part B funding.

The Governor's May Revise proposes the following changes to the ADAP estimate from the proposed January budget:

Current Year (2012-13):

- \$18.9 million reduction in estimated rebate fund revenue; and,
- \$15 million increase in federal fund expenditure authority for Ryan White ADAP Earmark Award.

Budget Year (2013-14):

- \$8.5 million (7.5 percent) federal fund reduction due to federal legislative changes in how allocations are made to states; and,
- \$5.3 million (5.0 percent) federal fund reduction due to the sequestration order signed into law on March 1, 2013.

Overall, ADAP resources are projected to be \$46.1 million less than the revised fiscal year 2012-13 estimate and \$38.8 million less than the resources estimated in the 2013-14 Governor's January Budget. Due to estimated reduced expenditures, the program projects a \$39.6 (16.2 percent) Special Fund reserve.

The most significant change in the May Revise, from January, is the inclusion of caseload shifts to Covered California and Medi-Cal, in anticipation of a Medi-Cal expansion and full implementation of the Affordable Care Act (ACA). The January budget estimate included caseload shift to the county Low Income Health Program (LIHPs) only. The estimate includes \$91.3 million in ADAP savings as a result of the expected Medi-Cal expansion.

The budget also assumes that ADAP clients obtaining coverage through Covered California may be simultaneously enrolled in either ADAP or the Office of AIDS Health Insurance Premiums (OA-HIP) program. For those remaining enrolled in ADAP, ADAP will cover just the individual's pharmaceutical copays and deductibles. OA-HIP will cover an individual's premiums, as it currently does for individuals with commercial coverage.

January Budget

The Governor's Budget for 2013-14 proposes \$416.8 million in total funding for ADAP, which includes no General Fund. This represents a \$38.6 million (\$13.2 million GF) reduction from the current year ADAP budget. The substantial General Fund reduction reflects the anticipated decreased demand for the program given an expected caseload shift from ADAP to both the existing county-operated LIHPs as well as through Medi-Cal and the Health Benefits Exchange once the ACA is fully implemented in 2014.

PANELISTS

- Department of Public Health
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

ADAP provides HIV/AIDS drugs for individuals who could not otherwise afford them (up to \$50,000 annual income). Drugs on the ADAP formulary slow the progression of HIV disease, prevent and treat opportunistic infections, and treat the side effects of antiretroviral therapy.

ADAP LOCAL ASSISTANCE BUDGET					
(In thousands)					
Funding Source	2011-12 Actual	2012-13 Projected	2013-14 Proposed	BY to CY Change	% Change
General Fund	\$4,651	\$13,285	\$0	(\$13,285)	(100%)
Federal Fund	118,767	125,876	105,179	(20,697)	(16%)
Special Fund	284,298	299,274	250,547	(48,727)	(16%)
Reimbursements	74,064	17,150	61,161	44,011	256%
Total Expenditures	\$481,780	\$455,585	\$416,887	(\$38,698)	(8%)

As shown in the table above, the Governor's proposed budget reflects a net decrease in ADAP local assistance General Fund of \$13.2 million from the 2012-13 budget. The General Fund reduction reflects the expected caseload shift from ADAP to LIHPs in 2013.

Caseload in ADAP is projected to be 37,167 in 2013-14 as compared to 40,464 in 2012-13, reflecting this caseload transition to LIHPs and other new ACA-created coverage.

Current Year (2012-13)

In last year's budget, the Office of AIDS (OA) at DPH projected a substantial caseload shift from ADAP to LIHPs, as they have done in the current proposed budget for 2013-14. The updated November 2012 estimate reflects that last year's caseload shift was approximately 20 percent less than projected, thereby resulting in less savings than anticipated. Nevertheless, increases in federal funds and ADAP rebate funds have provided the necessary funding for the current year, without affecting the level of General Fund in the program.

Budget Year (2013-14)

The Governor's proposed budget reflects a decrease of \$38 million over the revised current year budget. This decrease allows for the reduction of all \$13 million in General Fund from the program. In order to develop the ADAP estimate, the OA uses a linear regression model to estimate caseload and corresponding program costs. This is then adjusted to reflect various assumptions about the program, including the following:

- *Increase in Pharmacy Benefit Manager (PBM) Costs.* The federal Health Resources and Services Administration (HRSA) instituted a new mandate on states to conduct six-month ADAP client eligibility re-certification, which results in increased workload and costs for the ADAP PBM. The increased PBM costs are \$778,539 in 2012-13 and \$671,484 in 2013-14.
- *Revised and Updated Estimate of Caseload Shift to LIHPs.* All of the following have led to a revised caseload shift estimate: 1) availability of updated data; 2) lengthening the average delay from when ADAP screens clients for LIHP eligibility to when LIHP makes an eligibility determination; 3) changing Alameda County's LIHP implementation date; 4) merging the impact of the Pasadena LIHP with the Los Angeles County LIHP; and, 5) allowing potentially LIHP-eligible ADAP private insurance and Medicare Part D clients to remain co-enrolled in ADAP for coverage of medication co-pays and deductibles.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked DPH to present this estimate and to respond to the following question.

1. If the department has projected caseload shifts inaccurately how will the Administration address any resulting shortfall?

ISSUE 3: LICENSING & CERTIFICATION ESTIMATE***May Revision***

The Licensing & Certification (L&C) program requests authority to:

- 1) Transfer \$342,000 from the L&C Fund into a subaccount specific to the Nursing Home Administrator Program, as part of the full implementation of AB 1710 (Statutes of 2012), which eliminated the Nursing Home Administrator Fund in order to standardize all fees into one report and allow for the fees to be adjusted based on program needs.
- 2) Add 21.3 new positions, to be supported by the program's existing appropriation (supported by licensing fees).

January Budget

The L&C Program total estimated 2013-14 budget includes \$184.16 million, an increase of \$1.4 million (.7% increase) over the current year (2012-13). The \$1.4 million increase reflects two new proposals related to audits staffing and healthcare associated infections data reporting.

PANELISTS

- Department of Public Health
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

L&C licenses, regulates, inspects and/or certifies health care facilities in California, on behalf of both the state and federal governments. L&C regulates approximately 19 different types of health care facilities, such as hospitals and nursing homes, and also oversees the certification of nurse assistants, home health aides, hemodialysis technicians, and the licensing of nursing home administrators.

L&C's field operations are implemented via 14 district offices throughout the state, and through a contract with Los Angeles County. The field operations investigate complaints about facilities, primarily long-term care facilities, conduct periodic facility surveys, and assess penalties. L&C receives approximately 6,000 complaints per year, and 10,000 entity-reported incidents.

Funding for L&C is predominantly revenue from licensing fees, which are used to match federal funds. DPH also receives reimbursement funding from DHCS for conducting federal certification work for Medi-Cal and Medicare. The only General Fund in L&C is a \$5 million appropriation for licensing work related to state-owned facilities.

Health Facility License Fee Report

Existing statute requires the L&C Program to annually publish a Health Facility License Fee Report (DPH Fee Report) by February of each year. The purpose of this annual DPH Fee Report is to provide data on how the fees are calculated and what adjustments are proposed for the upcoming fiscal year.

The DPH Fee Report utilizes the requirements of existing statute for the fee calculations, and makes certain “credit” adjustments. The DPH notes that these “credits” are most likely one-time only and that fees are calculated based solely on the statutorily prescribed workload methodology as contained in statute.

The “credits” are applied to offset fees (e.g., hold the fee stable or reduce the fee) for 2013-14 and total \$15.1 million. They are as follows:

- \$3.5 million credit for miscellaneous revenues for changes in ownership and late fees; and,
- \$11.6 million credit from the program reserve (which is largely a result of vacancies due to the state’s hiring freeze).

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked DPH to present this estimate.

ISSUE 4: WOMEN, INFANTS & CHILDREN (WIC) ESTIMATE

May Revise

The revised estimate reflects reduced resources of \$80 million, as follows:

- Increased appropriation \$35.547M
- Decrease due to Sequester (\$44.555M)
- Decrease in reallocations/transfers (\$71.572M)
- Net decrease (\$80.580M)

January Budget

DPH requests an increase of \$35.5 million in federal funds and \$2 million in WIC Manufacturer Rebate Funds for the WIC program. This requested increase in expenditure authority is a result of the expectation that the WIC participant levels will increase by 1.32 percent and an increase in food costs of 2.56 percent. Additionally, manufacturer rebates are anticipated to increase by 4.2 percent based on the anticipated increase in participation and the increased per-can rebate received under the infant formula rebate contract.

PANELISTS

- Department of Public Health
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

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

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

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

WIC participants receive services for an average of two years, during which they receive individual nutrition counseling, breastfeeding support, and referrals to needed health and other social services. From a public health perspective, WIC is widely acknowledged as

being cost-effective in decreasing the risk of poor birth outcomes and improving the health of participants during critical times of growth and development.

WIC Funding

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

- **Food.** Funds for food that reimburses WIC authorized grocers for foods purchased by WIC participants. The USDA requires that 75 percent of the grant must be spent on food. WIC food funds include local Farmer's Market products.
- **Nutrition Services and Administration.** Funds for Nutrition Services and Administration (NSA) Funds that reimburse local WIC agencies for direct services provided to WIC families, including intake, eligibility determination, benefit prescription, nutrition, education, breastfeeding support, and referrals to health and social services, as well as support costs. States manage the grant, provide client services and nutrition education, and promote and support breastfeeding with NSA Funds. Performance targets are to be met or the federal USDA can reduce funds.
- **WIC Manufacturer Rebate Fund.** Federal law requires states to have manufacturer rebate contracts with infant formula providers. These rebates are deposited in this special fund and must be expended prior to drawing down Federal WIC food funds.

Caseload

DPH expects caseload to increase by 1.32% annually based upon a five-year average in participation rates, as shown in the chart below.

WIC CASELOAD (By Federal Financial Year)							
	2007	2008	2009	2010	2011	2012	5-Year Ave.
Average Annual Participation	1,378,794	1,412,210	1,439,006	1,459,406	1,466,321	1,472,347	
Percent Increase		2.42%	1.90%	1.42%	0.47%	0.41%	1.32%

Maximum Reimbursement Rate Methodology

The maximum amount that vendors are reimbursed for WIC food is based on the mean price per redeemed food instrument type by peer group with a tolerance for price variances (referred to as MADR). Effective May 25, 2012, USDA directed CA WIC to remove 1-2 and 3-4 case register WIC vendors from the MADR-determination process and instead set MADR for these vendors at a certain percentage higher than the average redemption value charged by vendors with five or more registers in the same geographic region. The USDA was concerned that California was paying 1-2 and 3-4 cash register stores up to 50 percent higher than prices paid to other vendors. The WIC program submitted a plan to USDA to address price competitiveness, MADR methodology and cost containment on October 3, 2012, and anticipates a decision from USDA shortly.

Federal Sequestration

It is possible that federal sequestration will result in a major reduction to the WIC program. President Obama submitted a report to Congress identifying potential sequestration should Congress be unable to come to a long-term deficit reduction deal by January 2013. The report identifies a possible 8.2 percent reduction (approximately \$543 million nationally) to the WIC program. However, DPH points out that the USDA committed to fully funding the WIC program to meet caseload needs, likely by transferring SNAP (food stamps) funds to WIC.

STAFF COMMENTS/QUESTIONS

On May 6, 2013, the Subcommittee considered a budget change proposal from the Department of Health Care Services (DHCS) to provide resources to DHCS to provide assistance to DPH with WIC vendor disqualification appeals. Subcommittee members asked the following questions, for which the Administration supplied the answers subsequent to the hearing:

1. How long will the WIC moratorium be continuing?

Response: *We are informed by CDPH that it has not determined an end date of the vendor moratorium. CDPH is working closely with USDA to finalize, implement, and evaluate its cost containment plan.*

In any case, WIC is engaged in a heightened compliance enforcement effort that naturally results in filed appeals. When the moratorium is lifted, this workload will necessarily experience a substantial increase in filed appeals that cannot be absorbed.

2. Can you provide the breakdown of violations based on stocking requirements vs. moratorium on new vendors?

Response: *WIC is currently engaging in enhanced enforcement efforts of the federal regulations controlling its program. According to CDPH, for FY 2012-13, it has performed 156 routine monitoring visits and compliance buys---events that lead to disqualification actions and filed appeals at OAHA. By comparison, CDPH reports that prior to FY 2012-13, it performed 50 such activities. These provider sanctions and disqualification actions necessarily trigger a significant rise in the number of disqualification appeal requests coming to OAHA.*

This continuing pattern of enforcement can best be demonstrated by looking at the monthly appeal filings received by OAHA. For example, in July of 2012, OAHA received 5 filed appeals to challenge disqualification. Thirty five appeals were filed for the month of January 2013. In first nine months of 2012-13 FY, OAHA has received 60 disqualification actions. This is a marked increase from the 49 appeals we received in FY 2011-12 (in 2009-10, we received 26.)

If the growth pattern stabilizes, by the close of the fiscal year, we will have 81 disqualification enforcement cases. However, the pattern is one of escalation, not stabilization. Consequently, there is good reason to believe that these numbers will grow, not level off. When the moratorium is lifted, there will be yet another dramatic increase in filed actions due to denied applications.

The primary actions taken by WIC, which has resulted in filed appeals, are as follows:

- Pattern of Over Charging items*
- Pattern of Charging for a greater number of WIC items than those actually sold*
- Pattern of selling non-WIC items with WIC purchase vouchers*
- Pattern of vendors failing to record the WIC price value on voucher at the time of sale*
- Failure to post proper price signs on shelves/items*
- Failure to comply with stocking requirements*
- Failure to require participants to sign the vouchers at the time of the sale*

Of these violations, we most frequently see appeals of the following issues:

- 87% for pattern of overcharging items*
- 54% - Charging more WIC items on the voucher than the actual sale.*
- 33% - Selling non-WIC items on the WIC vouchers.*

3. What is the workload associated with denials?

Response: *When WIC denies an application or a reauthorization, it follows a robust process to substantiate its action. The provider is given 30 days to appeal that action to OAHA.*

Whenever a filed appeal comes to OAHA, it is set for hearing. With denials, the informal hearing process must be completed within 120 days of the request for hearings. The case must be assigned, the notice sent, the file created, both parties submit their documents and position statements, a face-to-face hearing is conducted, post-hearing statements/documents are allowed, and the record is thereafter closed. The hearing officer must then prepare and finalize a Report of Findings, which is thereafter transmitted to the parties.

The vendor may, if not successful at the informal hearing, appeal the matter to an ALJ within 30 days. Again, the process starts, which usually involves counsel. The notice is sent, it is assigned to an ALJ, motions are considered (venue, continuances, dismissals). Pre and post-hearing briefs may be submitted. A hearing is conducted and a decision is issued.

4. **How do you appeal a denial and on what grounds if there is a moratorium?**

Response: *When a vendor's application for enrollment is denied, they file a request for hearing at OAHA. However, if the vendor is not enrolled because of the moratorium, the request for hearing is rejected. The vendor has no appealable issue if its application is not accepted due to the restrictions applied because of the moratorium.*

The Subcommittee has asked DPH to present this estimate.

4440 DEPARTMENT OF STATE HOSPITALS**ISSUE 1: PATIENT MANAGEMENT AND BED UTILIZATION**

The Department of State Hospitals (DSH) requests \$1.8 million General Fund and 18 positions to establish a Patient Management Unit.

PANELISTS

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

The proposed Patient Management Unit will be dedicated to managing patient bed needs in order to maximize the utilization and capacity of state hospitals. The unit is planned to increase patient security by providing improved placements. It will also help to reduce wait lists by identifying all available beds throughout the hospital system, by maintaining a centralized patient population data repository to track patient referrals, transfers, wait lists, rejections, and demographics. This Unit will be responsible for coordination of county bed purchases and the coordination of county placements for new admissions, establishment, and oversight of patient placement resolution and appeal processes, management of patient data and liaison functions between DSH, California Department of Corrections and Rehabilitation and county clinicians.

The January budget for DSH was covered in the Subcommittee's hearing on April 3, 2013. The agenda for that hearing describes the department's goal to transform the state's hospitals into an actual hospital system, from its historical mode of operation, which has been as a collection of distinct, independent facilities. Within this vein, current practice is for judges or courts throughout the state to refer patients specifically to the hospital that is geographically closest, regardless of the availability of space at that hospital and or the other hospitals at any given time. The referrals also lack any consideration of the fact that the facilities are not all the same and have varying abilities to meet different types of patient needs.

The proposed unit includes four positions dedicated to data collection and management and research. DSH states that these positions, in addition to other responsibilities, would be responsible for taking on research projects to help the state better understand the state hospitals' population and answer questions such as what the causes are of the increase in the wait list.

STAFF COMMENTS/QUESTIONS

This proposal appears consistent with the department's stated goal of creating an actual hospital *system* that operates as a system. Currently, there is no coordination between the facilities with regard to waiting lists, patient referrals, space available, and the redirection of referrals to more appropriate facilities. Nevertheless, this is a substantial new policy proposal that warrants substantial review by the Legislature, and therefore should be included in the January budget, rather than the May Revision. Legislative staff, lack sufficient time to fully evaluate the workload justification for the proposed number and types of staff being proposed for the new Unit.

ISSUE 2: ACTIVATION OF ADDITIONAL INTERMEDIATE CARE AND ACUTE UNITS

DSH requests \$22.1 million (\$16 million General Fund and \$6.1 million reimbursements) and 173 positions to increase treatment capacity by 155 beds.

PANELISTS

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

DSH has indicated a steady increase in the waiting list for state hospital beds from an average of 250 per week to the current size of approximately 382. In response, DSH is proposing to activate four new units and the conversion of one unit at three state hospitals, for a total increase of 155 beds, to address the wait lists for Incompetent to Stand Trial (IST) and Mentally Disordered Offender (MDO) commitments.

DSH has indicated to staff that they began implementing this expansion in February of this year. DSH will absorb current year (2012-13) costs and this request for \$22.1 million is for the budget year, 2013-14. The specific number of new beds, their location, and intended patient type is described in the table below:

HOSPITAL	# NEW BEDS	POPULATION SERVED
Atascadero	35	IST
Coalinga	35	MDO
Coalinga	50	SVP
Metropolitan	35	LPS
Atascadero (conversion)	35	IST
Vacaville (temporary activation)	37	PC 2684
TOTAL	120	

IST - Incompetent to Stand Trial
MDO - Mentally Disordered Offender
SVP - Sexually Violent Predator
LPS - Lanterman Petris Short (Civil Commitments)

STAFF COMMENTS/QUESTIONS

While it appears to be justified to increase capacity in the state hospital system, given the increasing waiting list, this is a substantial new policy proposal that warrants review beyond what is possible in the May Revision process and timeline. Subcommittee staff has asked DSH to present this proposal and respond to the following questions:

- 1) What is the reason that the budget materials describe this as an increase of 155 beds "to serve an additional 120 patients" rather than serving an additional 155 patients?

- 2) The finance letter for this proposal states that this expansion is intended to increase capacity for the growing waitlist of IST and MDO, yet the expansion includes new beds for additional types of commitments as shown in the chart above?
- 3) What are the physical resource challenges, if any, of adding beds to these facilities?
- 4) How does DSH derive the number of positions needed per new bed?
- 5) Given that implementation began in February, what is the reason that this proposal was not provided to the Legislature either through the January budget, or a spring finance letter?

ISSUE 3: CONTINUED ACTIVATION OF THE CALIFORNIA HEALTH CARE FACILITY STOCKTON & VACAVILLE & SALINAS VALLEY PSYCHIATRIC FACILITIES STAFF REDUCTIONS & RETENTIONS

This item contains three proposals all related to staffing at the three CDCR psychiatric facilities, including:

- 1) DSH requests authority for \$4.2 million General Fund (partial year, \$8.4 million full year) and 44.3 positions (partial year, 59 full year) to increase the staff at the California Health Care Facility (CHCF) in Stockton to adjust relief factors for staff at CHCF consistent with existing hospital standards and ensure sufficient staffing ratios for appropriate treatment.
- 2) DSH requests authority to decrease \$22.6 million General Fund and 164.2 positions at the Vacaville and Salinas Valley Psychiatric Facilities to reflect the migration of 450 beds to the newly-constructed California Health Care Facility (CHCF) in Stockton.
- 3) DSH requests an increase of \$8.4 million General Fund and 16.8 positions to be retained at Vacaville and Salinas to improve treatment for patients at these two facilities.

PANELISTS

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

The Coleman Federal Court is the result of a lawsuit brought against CDCR asserting that they were not providing adequate mental health care to inmates. As a result, when inmates require in-patient mental health care, they are referred to DSH, which refers them to either Salinas Valley Psychiatric Program (SVPP) or the Vacaville Psychiatric Program (VPP). Significant waiting lists have developed at these two facilities, resulting in the court directing California to address the waiting lists on a faster time-line. DSH (and the former DMH) and CDCR have worked closely with the "special master" of the Coleman Federal Court to develop a plan to reduce or eliminate the waiting lists at the SVPP and VPP. The former-DMH and CDCR jointly submitted a proposed three-pronged approach to the court, which approved of the plan. Specifically, to reduce the waiting lists, the DMH and CDCR began: 1) moving patients who have been stabilized to ASH; 2) moving other patients who are deemed very stable to CSH; and, 3) converting the "L Wing" of the California Medical Facility (which houses the VPP) to an Intermediate Care Facility Level of Care to accommodate over 100 temporary patients.

DSH indicates that there has been a sudden, still-unexplained, spike in the waiting list to approximately 382. DSH does not know the cause of the increase but currently is attempting to analyze the cause(s).

In October of 2009, the CDCR signed a Resolution of Approval with the Federal Receiver to construct 1,722 medical and mental health beds. In the Coleman case, the court ordered the CHCF in Stockton to be activated, begin patient admissions by July 2013, and be completed to full occupancy by December 2013. The CHCF will be operated as a fully integrated correctional medical facility by DSH, CDCR, and the Federal Receiver. DSH will be responsible for 514 beds for High Custody/Level IV inmates/patients, to be referred to as the Stockton Psychiatric Program (SPP).

The SPP will begin accepting patients in July of 2013, through both direct admission and by transferring patients from VPP and SVPP. A total reduction of 450 beds will occur at VPP and SVPP.

January Budget

As included in the Governor's January budget, DSH-Stockton activation totaled \$114.9 million and 931 positions. DSH states that it has undertaken outreach and education efforts to affected staff at Vacaville and Salinas, thereby providing information about employment opportunities at SPP. The hiring plan has been phased in over a two-year period to accommodate building activations, licensing and patient movement plans. DSH expects to fill all positions by December 2013. The January 2013-14 budget did not include the savings from staff reductions at VPP and SVPP, and DSH indicated that this savings would be reflected in the May Revision.

The Subcommittee reviewed this issue and proposal on April 3, 2013 and approved of the requested resources for CHCF of approximately \$100 million General Fund.

May Revise

The May Revision has three key proposals related to the activation of the new CHCF in Stockton:

- 1) ***An increase in staff at CHCF (Stockton).*** DSH proposes 59 additional staff above the 931 included in the CHCF staffing plan, and \$8.4 million General Fund for full year resources. According to DSH, they took a closer look at staffing needs and made an assessment that a higher level of staffing is appropriate and necessary.
- 2) ***The expected transfer of staff from Vacaville and Salinas to Stockton.*** Based strictly on current staffing levels and the number of "beds" transferring from Vacaville and Salinas to Stockton (described as the "Blueprint"), the reduction of staff at Vacaville and Salinas would be 486.5 (full year positions) for savings of \$45.2 million.
- 3) ***An increase in retained staff at Vacaville and Salinas.*** Rather than taking the full reduction in staff and savings, as could be projected based on patient migration to Stockton, DSH is proposing to retain approximately 234.2 full-year positions at Vacaville and Salinas, thereby reducing savings by \$22.3 million (to \$22.9 million). DSH expects to lay-off 133 despite this proposed retention.

	"Blueprint"				May Revision Proposal			
	Full-Year		Half-Year		Full-Year		Half-Year	
	Position Reduction	Funding Reduction	Position Reduction	Funding Reduction	Position Reduction	Funding Reduction	Position Reduction	Funding Reduction
Salinas	-271.5	-\$24.8	-135.8	-\$12.4	-189.5	-\$16.1	-94.8	-\$9.1
Vacaville	-215.0	-\$20.4	-107.5	-\$10.2	-62.8	-\$6.9	-31.3	-\$5.1
Total	-486.5	-\$45.2	-243.3	-\$22.6	-252.3	-\$22.9	-126.1	-\$14.2

The proposed retention of staff includes the following positions:

- Patient Treatment Teams (30 registered nurses)
- Patient Admission and Discharge (21 positions, various classifications)
- Patient Escorts and Staff Relief (167 Medical Technical Assistants)

STAFF COMMENTS/QUESTIONS

The proposed increase in staffing levels at all three CDCR facilities seems sudden and unexpected to staff. Staffing levels have been dictated by the Coleman Court, which according to DSH, is not requiring this proposed higher level of staffing and therefore it is unclear what is suddenly driving DSH to seek higher staffing levels. Furthermore, this unexpected proposed augmentation seems somewhat inconsistent with the efforts and communication from DSH last year related to increasing accountability and transparency in their budgeting process.

The Subcommittee approved of the resources for Stockton earlier this year with the expectation, that substantial savings would be contained in the May Revise as patients and staff transfer from Vacaville and Salinas. Instead, DSH has reinvested a significant portion of those savings into increased staff. It is surprising and unclear as to the reasons that this need for additional staff was unknown to DSH just a couple months ago.

The Subcommittee has asked DSH to present these three proposals together and respond to the following questions:

1. What is the reason that the proposal shows the CHCF augmentation at \$4.2 million for *3/4 of the year* and twice that (\$8.4 million) for a full year? Should it not be a quarter increase rather than double?
2. Are the proposed higher staffing levels required by the Coleman Court?
3. How long have the current staffing levels been in place and what were they based on? What has led DSH to believe that the staffing levels at the three CDCR facilities are too low?
4. How does DSH determine appropriate staffing levels?

5. At the Stockton facility, DSH is proposing approximately \$120 million and 980 positions to operate 514 beds, while only proposing a reduction of \$22 million and 252 positions to offset the 450 beds that are transferred from the other CDCR facility? What accounts for the huge discrepancy in cost of the new beds as compared to the beds currently operated?
6. Why is this being presented as a May Revise proposal, instead of as part of the Governor's Budget or April Letters?
7. What would be the downside of including this proposal in the next Governor's Budget to give the Legislature the appropriate time to consider?

ISSUE 4: TRANSFER POSITIONS FOR CENTRALIZED ADMINISTRATION

DSH requests authority to transfer \$1.4 million and 19 positions from Vacaville and Salinas Valley Psychiatric Facilities to DSH headquarters in Sacramento in order to perform centralized administrative tasks such as financial services, human resources, and risk management. There would be no General Fund impact as a result of this transfer.

PANELISTS

- Department of State Hospitals
- Department of Finance
- Legislative Analyst's Office
- Public Comment

BACKGROUND

The positions proposed to be transferred are "non-level-of-care" (do not provide direct care to patients) positions and they provide oversight of fiscal, personnel and risk management. DSH states that this transfer will align the administrative functions already located at DSH headquarters on behalf of CHCF-Stockton.

STAFF COMMENTS/QUESTIONS

The Subcommittee has asked DSH to present this proposal and respond to the following:

- 1) What is the purpose of transferring these positions to Sacramento?
- 2) What impact will this have on the operations at Vacaville and Salinas, and on the current staff in those positions?