

**AGENDA**  
**ASSEMBLY BUDGET SUBCOMMITTEE NO. 1**  
**ON HEALTH AND HUMAN SERVICES**

**Assemblymember Mervyn Dymally, Chair**

**MONDAY, MAY 10, 2004**  
**STATE CAPITOL, ROOM 444**  
**4:00 PM**

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## Consent Calendar

### ITEM 4120 EMERGENCY MEDICAL SERVICES AUTHORITY

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#### ISSUE 1: IN-HOUSE LEGAL COUNSEL – FINANCE LETTER

Emergency Medical Services Authority (EMSA) requests one position, to be funded with already budgeted EMSA funds that are now being spent on contract legal services, to establish an in-house legal counsel for EMSA at a projected savings of \$28,000 annually. The Administration's budget provides \$167,000 for the EMSA to contract with the Attorney General's Office to prosecute paramedic misconduct cases and to provide legal advice and services to EMSA for the drafting of new regulations and the interpretation of EMSA policies, procedures and statutes.

**Motion:** Adopt Finance Letter

### ITEM 4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

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#### ISSUE 2: ANNUAL FINANCIAL REPORTING SYSTEMS

The budget proposes to expend \$200,000 from the Health Planning and Data Fund on consulting services to begin the process of replacing the Office's old, mainframe-based systems for tracking, adding, validating, revising, and disseminating annual financial disclosure reports submitted by the general acute care hospitals and long-term care facilities. Failure of the system could prevent the Medi-Cal program from setting long-term care rates and allocating disproportionate share payments to qualifying general acute care hospitals.

The funding is for contractual services to conduct a thorough review of the existing systems and develop recommendations for re-engineering the systems using current technology. Once a solution is developed a subsequent budget change proposal will be developed to identifies the necessary hardware, software and staffing requirements.

No General Fund is proposed.

**Motion:** Approve the Finance Letter.

### ITEM 5160 DEPARTMENT OF REHABILITATION

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#### ISSUE 1: SOCIAL SECURITY REIMBURSEMENT REDUCTION – FINANCE LETTER

The Administration's proposed budget projected receiving \$20.8 million in reimbursements from the Social Security Administration for the 2003-2004 fiscal year. It now appears that reimbursements will be between \$3 million and \$4 million less than projected. Therefore, to

avoid a deficiency in the 2004-2005 fiscal year the Administration is proposing \$4.269 million in cost cutting measures and budget redirections to reduce the projected funding gap.

Social Security Reimbursements in state operations personal services is proposed to be reduced by \$2.771 million, local assistance is proposed to be reduced by \$1.498 million and \$2.771 million in various funding is to be redirected from operating expenses and equipment to offset the personnel services reduction. Specifically, the proposal would; reduce assistive technology grants to independent living centers by \$960,000; eliminate the contract for the Center for the Partially Sighted for a savings of \$538,000; reduce state operations support by \$2.8 million; and redirect \$771,000 of efficiencies in the Vocational Rehabilitation Services Program and \$2 million in establishment grants

If the reductions and redirections are not made the Department will have to layoff 107.5 positions, 93.5 of whom would be Vocational Rehabilitation Program direct services staff. This, in turn, would cause a change in the order of selection, which only would permit provision of services to the most significantly disabled clients. Additionally, it would result in increased General Fund costs as the less disabled caseload is directed to the Habilitation Services Program for services.

The proposed reductions and redirections will allow the Department to remain within its budget authority and maintain existing vocational rehabilitation service levels.

**Motion:** Adopt the Finance Letter

## VOTE ONLY AGENDA

### ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

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#### ISSUE 1: PUBLIC HMO CERTIFIED PUBLIC EXPENDITURES

The proposed budget contains a 6 percent Quality Improvement Assessment Fee on all Medi-Cal managed care plans. The state will realize a net gain of 25 percent of the fee. The 6 percent fee will generate \$300 million from the plans. The state will keep \$75 million and will match the remaining \$225 million of the assessment fee with \$225 million from the federal government, for a total of \$450 million to be distributed to the Medi-Cal plans. The state will then increase the reimbursement to the plans and distribute the funds. The remaining \$75 million will remain as a revenue to the state. The 2003-2004 budget contained a Quality Assessment Fee but it was not able to be assessed for technical reasons.

A second tool is available to the state to increase the funding to Medi-Cal managed care plans. Hospitals rely on a voluntary intergovernmental transfer (IGT) from the public hospitals to the state for a match for federal funds, the funds are then distributed to hospitals through contract negotiations conducted by the California Medical Assistance Commission (CMAC) with the hospitals. The voluntary intergovernmental transfer will provide \$800 million of federal funds for hospital reimbursement for Medi-Cal services. The IGT is limited by the amount of savings the state receives from its hospital contracting program and the federal upper payment limit on the amount hospitals may be reimbursed for Medi-Cal services. The same opportunity is available for use by the public HMOs.

A third tool is available and that is a governmental entity certifying to the Centers for Medicare and Medicaid Services that it provided services to Medi-Cal beneficiaries and that the cost of the service was less than the rate of reimbursement for the services. The proposal is to adopt placeholder trailer bill language which defines County Organized Health Systems and Local Initiatives as governmental entities for purposes of the Medi-Cal Program. There is no General Fund effect of the program.

**ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL****ISSUE 2: NON-CONTRACT HOSPITAL AUDITS****BACKGROUND:**

The budget proposes to add 41 staff to increase the number of field audits of home offices of large corporate healthcare chains and hospitals that do not contract with the Medi-Cal Program. The projected net savings to accrue from the increased audits is \$3.83 million General Fund, \$7.65 million Total Funds in the budget year. The annualized savings are projected to be \$15.3 million General Fund, \$30.6 million Total Funds. The staff costs are projected to be \$4.709 million, \$2.354 million General Fund. \$2.998 million would be for salaries and \$1.711 million for operating expenses and equipment.

The Medi-Cal Program reimburses hospitals approximately \$3.5 billion for acute care services delivered to Medi-Cal beneficiaries. Of that, 20 percent, \$700 million is paid to hospitals that do not contract with the state to provide general acute care services to Medi-Cal beneficiaries. All hospitals that receive reimbursement from the Medi-Cal Program must file an annual cost report with DHS. There are 440 licensed hospitals in the state and 428 of them submit cost-reports to the state. Of the 428 cost reports that are filed with the state, 210 are for non-contract hospitals. Annual cost-settlements are performed by the state to determine the proper amount of cost reimbursement due the hospital. The remaining 218 cost reports are for hospitals that are under contract with the CMAC but they are cost-base reimbursed for services that are not covered by their contract with CMAC.

There are 62 large corporate healthcare chains that own many hospitals in the state. The home offices are required to file cost reports annually to report total costs and the methods for allocating costs to individual hospitals and non-healthcare businesses they own. The home office costs are reimbursed through allocating the costs to individual hospital cost reports. The Audits and Investigation Unit of DHS performs primarily limited field/desk audits of the non-contracting hospitals and limited field audits of 13 of the 62 home office cost reports. The remaining 49 are accepted as filed without an audit. Full field audits allow the Department to do a detailed analysis of the hospitals' books and records to determine the proper amount the Medi-Cal program should reimburse the hospitals for health care services delivered to Medi-Cal beneficiaries.

**ITEM 4300 DEPARTMENT OF DEVELOPMENTAL SERVICES****ISSUE 1: FAMILY COST PARTICIPATION ASSESSMENT PROGRAM**

As part of the 2003 Budget Act the Legislature required the Department of Developmental Services to develop a system of enrollment fees, co-payments, or both, to be assessed against parents of children between the ages of 3 and 17 years of age who live in the parent's home, receive regional center purchased services, and are not Medi-Cal eligible. The report was due to the Legislature on or before April 1, 2004. It was to include a system of co-payments and a detailed plan of implementation.

**Basic Principles of the Plan:**

When developing the proposal, the following principles were considered:

- All families who are financially able to participate in the cost of services provided to their children should do so.
- Family cost participation shall be developed in such a manner that will not create an unacceptable financial burden, will maintain the integrity of the family, and encourage families to continue caring for their children in their own home.
- Family cost participation will not compromise the health and safety of consumers receiving services.
- The assessment of family cost participation will not impact the Individual Program Plan (IPP) process that reflects the consumers' goals, objectives, and services and supports. The families' responsibility will be applied as part of the purchase of service authorization process.
- Consideration will be given to the number of family members dependent on the income and the number of children who receive services through the regional center, while either in the family's home or out-of-home, including developmental centers.
- The system must be simple and cost-effective to administer (e.g., costs to administer the system cannot exceed the ongoing realized savings).
- The amount of the family cost participation assessment will be less than the amount of the parental fee for 24-hour, out-of-home placement in order to encourage families to continue caring for their children in their own home.
- The system must not affect the Department's eligibility for other funding sources (i.e., waivers, Medi-Cal, etc.).
- The system must react to changes in family economic conditions or unforeseen, unusual family hardships, and allow for the re-determination of the level of cost participation based on those changes.

**Services:**

Three services would be considered when determining the family's cost assessment:

- Respite
- Day Care
- Camping

All other services provided by the regional center system were determined to have a direct impact on consumers, and therefore, were not considered for inclusion in the assessment

process. It is essential that the needs of consumers remain as the main priority to ensure that their health and safety is not compromised.

The level of services would be determined during preparation of the IPP with the participation of the consumer, family, regional centers, and others, as appropriate. The amount of services and supports purchased by the regional center would be guided by the proposed Statewide Purchase of Services Standards and subject to any exceptions granted by the Regional Center to protect the health and safety of the consumer, or to prevent the consumer's movement to a more restrictive living environment.

**Income:**

Families with children with developmental disabilities who are between the ages of 3 and 17 years of age and receive one or more of the targeted services would be required to submit income verification to the regional center to determine their level of participation in the provision of those services. Families whose annual gross income is less than 400 percent of the Federal Poverty Level (FPL), as adjusted by family size, would not be assessed. Families whose annual gross income is 400 percent or more above the FPL, as adjusted by family size, would share in the cost of services provided to their children. The family's share of cost participation would be re-determined annually to assess the appropriate level of cost participation. A re-determination could be made sooner if there was a significant change in family circumstance, such as a severe illness that added a financial burden on the family, or a miscalculation of the assessment amount.

**FAMILY COST PARTICIPATION ASSESSMENT**

Calculating the Family Cost Participation Assessment:

You will need the number of exemptions you claimed and your annual gross income from your most recent federal or State income tax return, W-2 form or payroll stub. Then follow the directions below.

Federal Poverty Level	FCPA* % of POS	Family of Two Annual Gross Income	Family of Three Annual Gross Income	Family of Four Annual Gross Income	Family of Five Annual Gross Income	Family of Six Annual Gross Income	Family of Seven Annual Gross Income	Family of Eight Annual Gross Income
400%	5%	\$48,480	\$61,040	\$73,600	\$86,160	\$98,720	\$111,280	\$123,840
500%	10%	\$60,600	\$76,300	\$92,000	\$107,700	\$123,400	\$137,100	\$154,800
600%	15%	\$72,720	\$91,560	\$110,400	\$129,240	\$148,080	\$166,920	\$185,760
700%	20%	\$84,840	\$106,820	\$128,800	\$150,780	\$172,760	\$194,740	\$216,720
800%	30%	\$96,960	\$122,080	\$147,200	\$172,320	\$197,440	\$222,560	\$247,680
900%	40%	\$109,080	\$137,340	\$165,600	\$193,860	\$222,120	\$250,380	\$278,640
1000%	50%	\$121,200	\$152,600	\$184,000	\$215,400	\$246,800	\$278,200	\$309,600
1100%	60%	\$133,320	\$167,860	\$202,400	\$236,940	\$271,480	\$306,020	\$340,560
1200%	70%	\$145,440	\$183,120	\$220,800	\$258,480	\$296,160	\$327,360	\$371,520
1300%	80%	\$157,560	\$198,380	\$239,200	\$280,000	\$320,840	\$361,660	\$402,480

\*Family Cost Participation Assessment (FCPA)  
Percentage of Purchase of Services (% of POS)

**Examples**

**Example Number 1**

A family of five persons, including the mother, father, and three minor children, one child with developmental disabilities residing in the home, is authorized 72 hours per quarter of vouchered respite services as indicated in the IPP. The family's annual gross income is \$280,000, which is 1300 percent above the FPL. Using the Family Cost Participation Assessment Program (FCPAP) schedule, the family would be obligated to participate in 80 percent of the 72 hours, or 58 hours per quarter, of respite services; therefore, the regional center would pay for 14 hours

per quarter. Using the hourly rate budgeted for voucher respite of \$8.57, the family's participation would amount to \$497.06 per quarter, or \$165.69 per month.

**Example Number 2:**

A family of four persons, including the mother, father, and two children between the ages of 3 and 17 years of age, one child with developmental disabilities residing in the home, is authorized 72 hours per quarter of vouchered respite services, even though the family indicates a need of 90 hours per quarter. The regional center determines that limiting the respite hours to the level of 72 hours stated in the Purchase of Service Standards will not compromise the health and safety of the consumer. The family's annual gross income is \$73,600 which is 400 percent above the FPL. Using the FCPAP schedule, the family would be obligated to participate in 5 percent of 72 hours, or 4 hours per quarter, of respite services; therefore, the regional center would pay for 68 hours per quarter. Using the hourly rate budgeted for vouchered respite of \$8.57, the family's participation would amount to \$34.28 per quarter, or \$11.43 per month.

**Regional Center Staffing**

An increase in funding for regional center operations would be required to administer the

**FCPAP, as follows:**

**2004-05:** Approximately \$570,000 and 11 positions would be needed to perform the cost participation assessment function at the regional centers beginning January 2005.

**2005-06:** Approximately \$912,000 and 18 positions would be needed to continue the initial assessments and begin the re-determination process for those families who were phased-in in 2004-05.

**2006-07:** Approximately \$770,000 and 15 positions would be needed on an on-going basis for this function.

**General Fund Savings:**

In calendar year 2002, approximately 22,448 non-Medi-Cal-eligible consumers 3 to 17 years of age lived in their parents' home. It is estimated that approximately 6,793 of these consumers family income is equal to or greater than 400% of the federal poverty level, which is the threshold included in the proposal.

**Actual 2002-03 Purchase of Services Expenditures  
for 22,448 Consumers Meeting Family Cost Participation Assessment Program Criteria**

Budget Category	FCPAP Services				Non-FCPAP Services	Total Services
	Respite	Day Care	Camping	Subtotal		
Out of Home					\$600,725	\$600,725
Day Programs*					9,702,061	9,702,061
Transportation					770,884	770,884
Support Services					21,071,806	21,071,806
In-Home Respite	\$35,302,658			\$35,302,658		35,302,658
Out-of-Home Respite	359,931	\$11,637,776		11,997,707		11,997,707
Health Care					6,384,305	6,384,305
Miscellaneous			\$1,063,823	1,063,823	25,941,048	27,004,871
<b>FY 2002-03 Total</b>	<b>\$35,662,589</b>	<b>\$11,637,776</b>	<b>\$1,063,823</b>	<b>\$48,364,188</b>	<b>\$64,470,829</b>	<b>\$112,835,017</b>

\*The majority of Day Program costs are temporary in nature and are transitional until children begin school.

Of the \$13.6 million in targeted service costs, a savings of \$570,000 in 2004-05, \$3.1 million in 2005-06, and \$3.5 million in on-going years would be realized due to the family's cost participation assessment.

The indirect fiscal impact on the Purchase of Services Standards costs in 2004-05 from implementation of the FCPAP cannot be estimated at this time. Recent budgetary and programmatic changes in the regional center system, including service-level rate freezes, unallocated reductions, and proposed Purchase of Services Standards for 2004-05, have impacted the Purchase of Services Standards costs to the extent that a reliable estimate currently cannot be developed. It is expected that execution of long-term proposals, such as Purchase of Services Standards and the FCPAP in 2004-05, and the restructuring of certain service provider rates and implementation of the Self-Directed Services waiver in 2005-06 will address the issue of rising purchased service costs for consumers with developmental disabilities served by the regional centers.

## **ITEM 4300 DEPARTMENT OF DEVELOPMENTAL SERVICES**

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### **ISSUE 2: HOME AND COMMUNITY BASED WAIVER FEDERAL FUNDS**

During the last few years the state has been aggressively pursuing federal funds. From the 1999-2000 fiscal year through the 2003-04 fiscal year the Department has increased federal funds from \$519 million to \$882 million. The federal funds under the Home and Community Based Waiver (HCBW) increased from \$270 million to \$546 million. The funding increase from Department's waivers include, in addition to the HCBW, the Targeted Case Management Waiver, Title XX Social Services Block Grant Funds and the Early Start Program,

The growth in the funding has saved the state general fund through shifting Medi-Cal eligible clients to waiver services. In addition it has permitted the state to be flexible and assisted the state in complying with the Coffelt Settlement and the Olmstead Decision. In addition, the federal funds have been used to enhance quality assurance measures and service monitoring.

Additional federal funds can be realized. Additional federal funding will result the inclusion of South Central Los Angeles Regional Center (SCLARC) on the Home and Community-Based Waiver. Also, when the state receives federal CMS approval for the Targeted Case Management adjustment, the state may be able to receive retroactive funding on this adjustment. Finally, California may be able to receive additional federal funding for the Early Start Program and for certain residential care facilities—Intermediate Care Facilities for the Developmentally Disabled.

The Department of Health Services has been informed by the federal Centers for Medicare and Medicaid Services that California will be able to obtain retroactive approval to 1999-2000 for SCLARC. This retroactive availability of increased federal funds is not captured in the Governor's budget. As such, SCLARC billings for consumers eligible for the Waiver can be recognized for 1999-2000, 2000-01 and part of 2002-03. According to data the Senate obtained from the Department of Health Services, a total of \$29.9 million in additional reimbursements to the Department of Developmental Services can be used to offset the General Fund.

## ITEMS TO BE HEARD

### ITEM 0530 SECRETARY HEALTH AND HUMAN SERVICES AGENCY

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#### ISSUE 1: COST CONTROL COMMISSION

Chapter 672, Statutes of 2003 (AB 1528, Cohn), established the California Health Care Quality Improvement and Cost Containment Commission. The Commission is to be convened by the Governor. The Commission is to be composed of 27 members, 17 of whom shall be appointed by the Governor, four by the Senate Committee on Rules and four by the Speaker of the Assembly.

The purpose of the Commission is to research and recommend appropriate and timely strategies for promoting high quality care and containing health care costs (both public and employer-sponsored). The Commission is directed to issue a report by January 1, 2005 on these strategies and shall examine specified key areas, including: (1) assessing California's health care needs and available resources; (2) lowering the cost of health care coverage; (3) improving the quality of health care; (4) increasing the transparency of health care costs and the relative efficiency with which care is delivered, and (5) the use of disease management, wellness, prevention, and other innovative programs to keep people healthy while reducing costs and improving health outcomes.

The Governor proposes an increase of \$364,000 (General Fund) and two positions—a Career Executive Assistant III and an Associate Governmental Program Analyst-- to staff the California Health Care Quality Improvement and Cost Containment Commission as contained in AB 1528, Statutes of 2003. The two requested positions would be limited term appointments until June 30, 2005. Of the requested total amount, \$150,000 (General Fund) is designated for external content experts from the research, university, and foundation community to investigate and analyze the specified key areas noted above, as well as other factors that contribute to the rising cost of health care. The Administration is also seeking approval of trailer bill legislation to extend by one year the reporting date to the Legislature (i.e., January 1, 2005 to January 1, 2006).

**Motion:** Approve the budget request, including the trailer bill date change. Also, utilize the Managed Care Fund, in lieu of the General Fund, as established in Section 1341.4 of the Health and Safety Code for this purpose.

**Amend Section 1341.4 as follows:** (a) In order to effectively support the Department of Managed Health Care in the administration of this law, there is hereby established in the State Treasury, the Managed Care Fund. The administration of the Department of Managed Care shall be supported from the Managed Care Fund.

(b) For the 2004-05 and 2005-06 fiscal years only, up to \$350,000 from the Managed Care Fund may be used annually to support staff and related functions associated with the California Health Care Quality Improvement and Cost Containment Commission, established by Chapter 672, Statutes of 2003. (c) In any fiscal year, the Managed Care Fund shall maintain not more than a prudent 5 percent reserve unless otherwise determined by the Department of Finance.

## **ITEM 4120 EMERGENCY MEDICAL SERVICES AUTHORITY**

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### **ISSUE 1: PARAMEDIC INVESTIGATIONS – FINANCE LETTER**

The Emergency Medical Services Authority is requesting \$17,000 from the Emergency Medical Services (EMS) Personnel Fund, the redirection of \$87,000 already budgeted from the fund and one Personnel Years to establish a Special Investigator position in the Enforcement Unit of EMSA. The request will be funded out of the EMS Personnel Fund which is 100 percent fee supported.

The Enforcement Unit is responsible for investigating alleged violations of the Health and Safety Code and recommending disciplinary action against the licenses of EMT-P's (paramedics). There are over 13,000 paramedics in California and the number increases yearly. The Enforcement Unit has experienced a substantial increase in the cases and this has led to a significant backlog of cases needing investigation. The number of cases needing investigation has grown from 20 in the 1993-1994 fiscal year to 351 in the 2002-2003 fiscal year. The staffing levels have not increased since September of 1997. EMSA currently has a backlog of 18 paramedic investigation cases that are of high risk to the public and 19 that are a probable risk to the public.

#### **COMMENTS:**

EMSA, please briefly describe for the Subcommittee the need for the position and the status of the funding source.

**ITEM 4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT****ISSUE 1: HOSPITAL CHARGE MASTER REPORTING**

Chapter 582 of the Statutes of 2003 (AB 1627, Frommer) expands the Office of Statewide Health Planning and Development's (OSHPD) hospital data reporting program to include three additional data items. Beginning July 1, 2004, each hospital is required to submit to OSHPD a copy of its charge description master (CDM), a list of 25 commonly charged services or procedures and an estimate of the percentage change in gross patient revenue due to price changes.

The budget requests \$118,000 from the California Health Data and Planning Fund in the budget year to implement the new hospital CDM reporting requirements. The amount includes \$20,000 in one-time costs to develop systems for tracking, collecting, storing and disseminating the required reports and to develop an informational web-site. The remaining \$98,000 is for on-going costs to provide staff resources to perform report collection activities and to maintain the reporting systems. No General Fund or additional Personnel Years are proposed.

**COMMENTS:**

OSHPD, please outline for the Subcommittee the new reporting requirements on hospitals.

**ITEM 4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT****ISSUE 2: MENTAL HEALTH PRACTITIONER EDUCATION FUND**

The Administration's budget proposal for 2004-2005 would expend \$206,000 from the Mental Health Practitioner Education Fund and establish .8 positions to implement the Licensed Mental Health Provider Education Program (LMHPEP). All personnel and operating costs related to LMHPEP will be supported through a \$10.00 surcharge on the bi-annual license renewal of psychologists, marriage and family therapists and licensed clinical social workers. The California Mental Health Planning Council that review, assess and makes policy recommendations regarding all components of the mental health systems to the Legislature and the California Department of Mental Health was a major proponent for the creation of the Mental Health Provider Education Fund and LMHPEP.

LMHPEP was established by Chapter 437, Statutes of 2003 (AB 938, Yee) in the Office Statewide Health Planning and Development's Health Professions Education Foundation. The Foundations is required to implement the LMHPEP and provide loan repayment grants to licensed mental health service providers. The LMHPEP will serve licensed psychologists, marriage and family therapists and licensed clinical social workers who provide patient care in a publicly funded facility or in a mental health professional shortage area.

No General Fund is proposed.

**COMMENTS:**

OSHPD, please outline for the Subcommittee the need for the program.

**ITEM 4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT****ISSUE 3: VOCATIONAL NURSE EDUCATION PROGRAM**

Chapter 437, Statutes of 2003 (AB 938, Yee) established the Vocational Nurse Education Program (VNEP) in the Health Professions Education Foundation in the Office of Statewide Health Planning and Development. The Foundation is charged with the development and implementation and administration of the Vocational Nurse Education Program. The budget proposes to expend \$131,000 from the Vocational Nurse Education Fund and establish .7 positions for the VNEP. All costs of the program will be supported by a \$5.00 surcharge on the biennial license renewal of Licensed Vocational Nurses. There is no General Fund cost to the proposal.

In addition, the Administration is proposing to raise the expenditure authority for the Registered Nursing Education Fund by \$650,000. The Board of Registered Nursing was authorized by Chapter 437 to raise the biennial licensure renewal for registered nurses by \$10.00 and the funds are deposited in the Registered Nursing Education Fund. The Fund provides grants and loan repayments for Registered Nurses. The increased fee will pay for a larger grant and loan repayment amounts and/or an increased number of annual awards.

No General Fund is proposed.

**COMMENTS:**

OSHPD, please describe the Vocational Nurse Education Program and the Registered Nursing Education Program.

**ITEM 4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT****ISSUE 4 SEISMIC SAFETY RETROFIT PROGRAM:**

The Administration is proposing to add 50 permanent positions to the Facilities Development Division of the Office of Statewide Health Planning and Development to meet the seismic safety statutory requirements. Chapter 740, Statutes of 1994 (SB 1953, Alquist) mandates general acute care hospitals to meet specific seismic safety requirements by January 1, 2008, or if a hospital meets specific criteria, an extension to January 1, 2013, may be granted. All hospitals must be compliant by the end of January 2030. In order to have sufficient time to complete construction, hospitals must submit construction projects to the Office of Statewide Health Planning and Development, Facilities Division by 2004 and 2009 to comply with 2008 and 2013 deadlines. There are 1,000 hospital buildings that are rated as a collapse hazard and they must be retrofitted, replaced or removed from acute care hospital service. The compressed time frame for compliance has placed severe demands on the Facilities Development Division to provide timely turnaround of current and future hospital construction projects.

In addition, the Office is also requesting a shift in the Seismic Retrofit Program funding source. Currently, the fund is reimbursed from the Office of Emergency Services (OES) Hazard Mitigation Grant Program (HMGP). The Program is to be terminated September 30, 2004, the end of the Federal Fiscal Year. The program traces back to the Federal Emergency Management Agency which awarded in 1997 the Facilities Development Division \$10 million through OES, HMGP following the Northridge Earthquake to expedite the review and approval of seismic evaluation reports and compliance plans. The grant was reduced from \$10 million to \$8 million. The new funding source would be the Hospital Building Fund. The fund receives a statutorily required fee of 1.64 percent of estimated hospital construction costs for the review and approval of hospital construction plans and the monitoring of construction. The Fund received \$47 million fees in the 2002-2003 Fiscal Year, representing a total construction value of \$2.13 billion.

**COMMENTS:**

OSHPD, please describe the need for the positions and the cost to hospitals if the positions are not improved.

**ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL****ISSUE 1: OFFICE OF INSPECTOR GENERAL REPORT****BACKGROUND:**

The Department of Health Services states that it will pay \$4.4 billion, total funds, for prescription drugs and medical supplies in the 2004-2005 Fiscal Year. The Department collects rebates from the pharmaceutical manufacturers for these products. The State also collects rebates on behalf of County Organized Health Care Systems and the Family PACT Program. The rebates are projected to total to approximately \$1.4 billion in the 2004-2005 Fiscal Year.

Rebates are billed quarterly to pharmaceutical manufacturers on a per claim basis, the Department will bill for over 50 million claims this year. A pharmaceutical manufacturer may dispute any claim and that dispute must be resolved between the Department and the manufacturer. The collection of manufacturer rebate moneys owed to the state has been a long-standing issue with the Department.

In a 1996 report, the Bureau of State Audits identified about \$40 million in past, owed rebates to the state. In an April 2003 report, the Bureau estimated the aged rebates owed to the state had increased to \$216 million in total funds as of September 2001. The Federal Government's Department of Health and Human Services' Office of Inspector General' conducted an audit of California's Medi-Cal Drug Rebate Program and released the results in January 2004. The primary conclusion of the report was that as of June 2002 the Medi-Cal Program had an unsettled drug rebate balance of \$1.3 billion in total funds.

The Department disagreed with the conclusions expressed in the Office of Inspector General report. The Department of Health Services submitted an estimate of the uncollected balance to the Office of Inspector General, \$818 million in total funds as of June 002. The Department noted to the Inspector General there were several instances where bad data was used in the analysis. Furthermore, the Department provided examples of errors that can cause a pharmaceutical manufacturer to dispute a drug rebate billing. Since then, the Department observes the amount of unresolved/outstanding rebates has been reduced to approximately \$302 million in total funds as of June 2002 from payments made by pharmaceutical manufacturers. The Department states that a significant portion of the \$302.3 million balance represents rebates that have been billed but may not be collectable (see table below).

Rebate Year	Adjusted Invoice Total	Paid Principal	Outstanding Principal	% Outstanding
1991 Total		87,373,776.36	10,527,082.10	11%
1992 Total		158,367,043.53	9,376,960.19	6%
1993 Total		186,551,266.93	7,841,143.05	4%
1994 Total		222,572,042.27	15,975,535.10	7%
1995 Total		258,967,817.84	18,280,764.12	7%
1996 Total		304,036,120.87	11,291,575.62	4%
1997 Total		332,728,549.83	18,698,537.95	5%
1998 Total		448,490,996.77	23,510,502.27	5%
1999 Total		584,595,599.74	40,422,018.09	6%
2000 Total		729,581,742.97	60,170,578.83	8%
2001 Total		916,739,533.59	57,268,817.47	6%
2002 Total		556,142,364.12	28,985,008.13	5%
Total	5,088,495,377.74	4,786,146,854.82	302,348,522.92	6%

Following is the outstanding balance from the OIG audit period forward:

Outstanding Balances 3Q02 - 3Q03				
Rebate Year	Rebate Quarter	Invoiced Principal	Paid Principal	Outstanding Balance
2002	3	\$343,034,344.50	\$329,176,965.18	\$13,857,379.32
2002	4	\$336,352,939.19	\$320,485,824.10	\$15,867,115.09
2003	1	\$364,082,424.21	\$326,147,097.04	\$37,935,327.17
2003	2	\$684,472,641.90	\$390,705,966.70	\$293,766,675.20
2003	3	\$408,288,917.46	\$372,299,307.25	\$35,989,610.21
Grand Total		\$2,136,231,267.26	\$1,738,815,160.27	\$397,416,106.99

There is a perception that the department has a large uncollected balance of rebate monies due from manufacturers to the state. The perception is inaccurate. The outstanding balance is, in great part, due to usual billing errors by pharmacies, and other errors introduced into the rebate accounting system, such as the example here which greatly overstated the outstanding balance for the 2<sup>nd</sup> quarter of 2003, highlighted above.

Over the last three years the Legislature has provided the Department of Health Services with additional resources to collect pharmaceutical manufacturers rebates. The actions include: increased resources to implement the new rebate tracking system in the Budget Act of 2001; added four new staff to assist in processing aged rebates and enacted trailer bill legislation to prevent the loss of state drug rebates if manufacturers retroactively reduced their prices to

reduce rebates in the Budget Act of 2002; and provided eleven new staff to assist in processing aged rebates in the Budget Act of 2003.

The 2004-2005 Fiscal Year budget projects the state will collect \$29.5 million, \$14.750 million General Fund, of the \$302.3 million balance. Of the \$29.5 million, \$5.9 million will be collected in 2003-04 and \$23.6 million is for 2004-05.

**COMMENTS:**

Department of Health Services, please provide the Subcommittee a brief overview of the issues raised in the OIG Report.

**ITEM 4260 DEPARTMENT OF HEALTH SERVICES MEDI-CAL****ISSUE 2: LONG-TERM CARE INTEGRATION****BACKGROUND:**

The proposal would redirect the funding for county planning and development grants for the integration of long-term care. The budget proposes \$1.15 million, General Fund and \$450 thousand federal funds for the program. The funding would be for the competitive procurement process for grants of up to \$1,000,000 to local organizing groups for the purposes of implementing long term care integration pilot projects. Several counties have received planning and development grants for the past five years and two counties, San Diego and Contra Costa are prepared to submit administrative action plans to the state on June 30<sup>th</sup> of this year. The administrative action plan is the document that is required by the state for approval of an integrated pilot. San Diego's plan builds on "Healthy San Diego," the county's Medi-Cal Geographic Managed Care model. Contra Costa's action plan is the result of a collaboration between the local initiative, Contra Costa Health Plan, and Adult and Aging Services (Program descriptions are in the handout).

Integrating home and community-based services with Medi-Cal managed care represents a cost effective approach to enhancing service delivery while maintaining overall budget neutrality for acute, primary and long-term care expenditures. Legislation passed in 1995 authorized up to five pilot programs to integrate the financing and administration of long-term care for MediCal beneficiaries. As specified in the statute, the goal of Long Term Care Integration was to ensure that people with disabilities remained as independent as possible for as long as possible. It was expected that the savings achieved through capitation would be used by the projects to enhance service capacity. Care coordination, the centerpiece of integrated services:

- Makes a specific care coordinator responsible for organizing and arranging for an individual's overall care.
- Helps locate and access hard to find services.
- Ensures that people remain independent and in their homes for as long as possible.

Since the original 1995 enabling legislation, there have been several legislative interventions to assist with implementation. In 1997, the Department of Health Services announced a revised implementation strategy that would allow counties to incrementally phase in integration activities. In 1998, the Legislature provided \$1.15 million for planning and development grants and to establish the Center for Long Term Care Integration to provide technical assistance to the applicants. This has continued through the current fiscal year.

Several counties have demonstrated sustained commitment to achieving an integrated service delivery system. Contra Costa, Marin, San Diego, Santa Cruz and Monterey counties and CalOPTIMA (Orange County) have made incremental steps toward integration and with support could move forward to fully integrated systems in the near future. In total, seventeen counties have explored either coordinated, integrated or capitated approaches to long-term care service delivery.

The following trailer bill language would permit the Department to engage in a competitive procurement for Long Term Care Integration Pilot Projects.

## **WELFARE AND INSTITUTIONS CODE**

### **SECTION 14145-14145.3**

14145. (a) Beginning with the 1998-99 fiscal year and contingent on appropriation of funds through the Budget Act, the department may contract with a nonprofit entity, incorporated in California that has been formed for the purpose of serving as the center for long-term care integration. The center may serve as a focal point for facilitating the development of community-based local organizing groups through a public-private partnership.

(b) The nonprofit center may do all of the following:

(1) Serve in an advisory capacity to the key stakeholders in long-term care integration, including consumers, consumer advocacy groups, researchers, representatives of service providers and purchasers, and local and state policymakers.

(2) Assemble, organize, and make available technical information, data, expertise, and models on long-term care integration from across the state and nation.

(3) Assist local communities with long-term care planning and analysis, development of service delivery and financing systems, statewide data sharing, and private fund development.

(4) Coordinate goals and activities with the State Department of Health Services.

(c) The center may build and sustain working partnerships by developing and supporting a cross-county, statewide network of consumers, providers and funders, as well as maintaining an ongoing relationship with the state.

(d) The center may assist the local organizing groups (LOGs) in seeking local financial support, as well as to obtain foundation matching funds for statewide grant-making.

(e) The center may coordinate and disseminate long-term care planning information by identifying key long-term care development issues, and disseminating the information to local planning groups, as needed.

(f) The center may facilitate implementation by identifying and sharing useful tools and resources, designing models for service protocols of the local long-term care integration pilot projects, coordinating information systems, standardizing assessment elements, and providing low-cost training and technical assistance to the LOGs as they progress through common tasks necessary for local development and implementation.

(g) The center may collect and track information across LOG sites.

(h) The center may prepare annual progress reports, and shall provide these reports to the department and the budget committees of the Legislature.

~~14145.1. (a) The department may administer grants for purposes of this article, that shall be awarded through a request for application process.~~

~~— (1) Grants may be awarded to local organizing groups (LOGs) that are existing or new community based nonprofit organizations or government entities for purposes of implementing long term care integration pilot projects, pursuant to Article 4.05 (commencing with Section 14139.05).~~

~~— (2) Grants may be available for LOGs in the planning phase, or the development phase of the project, or both. Planning phase grants shall be limited to a maximum award of fifty thousand dollars (\$50,000). Development phase grants shall be limited to a maximum award of one hundred fifty thousand dollars (\$150,000). The planning phase includes activities related to initial planning for a long term care integration pilot project (LTCIPP). The development phase includes activities for implementing the planning phase, up to actual implementation of the pilot project.~~

~~— (b) Criteria for grant selection shall include, but not be limited to, the following:~~

~~— (1) For planning phase grants:~~

~~— (A) Identification of a LOG committed to development of a LTCIPP that includes major stakeholders, including, but not limited to, consumers, community based providers, institutional providers, and public entities.~~

~~— (B) Evidence of local government support for development of a LTCIPP.~~

~~— (C) A description of current and planned consumer involvement.~~

~~— (D) A plan for the use of funds.~~

~~— (E) Specification of goals and objectives, and a work plan for achieving them.~~

~~— (F) A proposed strategy for project evaluation.~~

~~— (2) For development phase grants:~~

~~— (A) Identification of the authorized grantee sanctioned by the local government entity.~~

~~— (B) Identification of an entity for operation of the LTCIPP.~~

~~— (C) Definition of a governance structure.~~

~~— (D) An adopted work plan that includes all of the following:~~

~~— (i) A vision statement describing the long term care system for the community.~~

~~— (ii) Description of the covered scope of services and programs to be integrated at the local level.~~

~~— (iii) Description of the target population.~~

~~— (iv) Plan for integration of funding for those services.~~

~~— (E) Specific work goals for the development phase.~~

- ~~—(F) A work schedule for completion.~~
- ~~—(C) A proposed strategy for project evaluation.~~
- ~~—(3) Both planning phase and development phase grant funds may be used for, but are not limited to, the following purposes:~~
  - ~~—(A) Staff support.~~
  - ~~—(B) Consulting contracts.~~
  - ~~—(C) Community organizing support.~~
  - ~~—(D) Data analysis.~~
- ~~—(c) Grantees shall be required to match a portion of the grant awarded, either with cash, or in kind contributions totaling 20 percent of the total grant. The match required by this subdivision shall be supplemental to the funds appropriated for the LTCIPP.~~

*Beginning with the 2004-05 fiscal year, the department may administer grants of up to \$1,000,000 to local organizing groups for the purposes of implementing long term care integration pilot projects. Subject to the Department's approval, applicants for the grants must submit an administrative action plan which details how the money will be spent and proposes a timeline of implementation activities. Local organizing groups shall be required to demonstrate a commitment to start-up.*

14145.3. (a) The department shall develop at least, but not limited to, one alternative model to the Long-Term Care Integration Pilot Program authorized under Article 4.3 (commencing with Section 14139.05) that shall be designed to achieve the goals set forth in Section 14139.11.

(b) The department or, at the discretion of the department, the center for long-term care integration referred to in subdivision (a) of Section 14145, shall consult with an established waiver technical advisory committee to assist in the development of an alternative model or models pursuant to subdivision (a).

(c) No reimbursement or compensation shall be provided to committee members referred to in subdivision (b).

(d) The department shall report the recommendations of the waiver technical advisory committee to the Legislature on or before December 1, 2003.

<b>COMMENTS:</b>
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Department of Health Services, please describe for the Subcommittee the planning process that counties have engaged in to achieve long-term care integration.

Department of Health Services, please outline for the Subcommittee what the time frame and process would be for a selective procurement for Long Term Care Integration Projects.

**ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH****ISSUE 3: PROPOSED REPEAL OF TRAILER BILL LANGUAGE****BACKGROUND:**

The Administration has proposed the repeal of several pieces of legislation that were adopted in 2003. Each piece of legislation went through the Legislature's policy-making process. Repeal of the legislation would not produce fiscal savings to the state in the budget year. The legislation includes: AB 1676 (Dutra), Statutes of 2003, HIV Prenatal Testing; AB 71 (Horton), Statutes of 2003, Tobacco Product; SB 322 (Ortiz), Statutes of 2003, Stem Cell Research; SB 617 (Speier), Statutes of 2003, Tissue Banks; and SB 308 (Ducheny), Statutes of 2003, Targeted Case Management.

**COMMENTS:**

Department of Health Service, please describe how the existing statute is related to the 2004-2005 budget.

**ITEM 4300 DEPARTMENT OF DEVELOPMENTAL DISABILITIES****ISSUE 1: STAFFING FOR ADDITIONAL FEDERAL FUNDS**

To secure additional federal funds the following is proposed: \$266,000 General Fund to provide the funding for one Staff Services Manager 1 and two Associate Government Program Analysts; and \$200,000 General Fund for contractual services. The proposal is to secure additional funding for the Early Start Program and for services provided by Intermediate Care Facilities for the Developmentally Delayed (ICF/DD).

The efforts to secure additional federal funds for the Early Start Program will be difficult and problematical and require new resources to prepare the waiver proposal and work with the Department of Health Services and the Federal Government.

Infants and toddlers from birth to 36 months may be eligible for early intervention services if through documented evaluation and assessment they meet one of the criteria listed below:

- have a developmental delay in either cognitive, communication, social or emotional, adaptive, or physical and motor development including vision and hearing; or
- have established risk conditions of known etiology, with a high probability of resulting in delayed development; or

- 
- are at high risk of having a substantial developmental disability due to a combination of risk factors.

The Department of Developmental Services will work with the Department of Health Services to define allowable costs of ICF/DDs so that federal reimbursements can be maximized. Currently the state uses a narrow definition of allowable costs and that limits the ability of the state to recover additional federal funds. The efforts of the staff focused on the DD system will be focused on redefining services ICF/DDs as an all-inclusive services to all the facilities to pay vendors who provide the services.

The consultant services are necessary to facilitate the development of the waiver requests and working with the Department of Health Services and the Centers for Medicare and Medicaid Services.

**COMMENTS:**

Department of Developmental Services, please outline for the Subcommittee what will need to be done and the time frame to develop the necessary materials to submit to the federal government.

**ITEM 4300 DEPARTMENT OF DEVELOPMENTAL SERVICES****ISSUE 2: SPECIAL NEEDS TRUSTS****BACKGROUND:**

The Society of California Care Home Operators (SOCCO) requests Regional Centers be granted the authority to seek reimbursement from the funds held in special needs trusts for clients of the Regional Center System. The SOCCO states that given the fiscal constraints placed on the state's resources and the escalating costs of maintaining the Regional Center System and providing care and services to the developmentally disabled, consumers who have the means should shoulder a greater financial responsibility for the cost of their care.

The existing law requires the provision of services and supports for the persons with developmental disabilities by Regional centers, pursuant to contracts with the Department of Developmental Services. Regional Centers are required to identify and pursue all possible sources of funding for clients receiving Regional Center Services, including governmental and private funding sources. The SACCO proposes trailer bill language be adopted that would include funds held for the benefit of a regional center consumer, including, but not limited to, funds held in a special needs trust, as a possible funding source for Regional Center Service.

Also, the language would make conforming changes to require related notices to be delivered to the Regional Centers.

Alternatively, the Administration has proposed trailer bill language that would affect special needs trusts in the Medi-Cal program. Currently there is a substantial difference in liability for payment for the cost of services between consumers of Developmental Centers (DC) and consumers receiving services through Regional Centers. While DC residents have a liability for the cost of services provided to them, Regional Center consumers have no such statutory liability. The Department will assess the ability to access Special Needs Trusts (SNT) for consumers in the community as part of its cost containment efforts for 2005-06 and propose separate trailer bill language if the decision is made to go forward. At this point, the Department has not determined the approach it will pursue in accessing SNTs for these individuals, therefore, the specific impact of the Department of Health Services trailer bill language on the 2005-06 SNT proposal cannot be determined at this time. This assessment has been postponed to 2005-06 because of the focus on the co-payment assessment program issue.

Department of Developmental Services does not have existing data on the number of consumers in DCs or being served in the community having SNTs that would assist in developing a DDS fiscal estimate resulting from the DHS TBL proposal, however, the Department believes the numbers are relatively small and therefore the potential loss in Federal Funds would be minor.

**COMMENTS:**

Department of Developmental Services, please provide the Subcommittee your assessment of the proposal and how it fits in with the future plans of the Department.

**ITEM 4300 DEPARTMENT OF DEVELOPMENTAL SERVICES****ISSUE 3: COST CONTAINMENT TRAILER BILL LANGUAGE****BACKGROUND:**

The Legislature adopted various budgetary actions in the 2003-2004 Fiscal Year Budget and the appropriate trailer bill language to provide the Department the authority to achieve the cost savings. The Department has proposed amending the various provisions. Only one change is problematical and that is for the unallocated reduction. The language would change from 30 days to 60 days for the Department of Developmental Services to decide an allocation method for the unallocated reduction. Regional Centers are required to adopt a plan 60 days after enactment of the Budget Act. Therefore, the Department must inform each Regional Center of the amount of unallocated it needs to absorb within the shorter time frame of 30 days.

**ITEM 4300 DEPARTMENT OF DEVELOPMENTAL SERVICES****ISSUE 4 REGIONAL CENTER REPORTING LANGUAGE – FINANCE LETTER****BACKGROUND:**

The Administration is proposing trailer bill language to limit the amount of reporting of data by Regional Centers. Existing statute requires each Regional Center to report to the Department of Developmental Services complete current salary schedule for all personnel classifications used by the regional center and from the regional center operations budget all administrative services, including managerial, consultant, accounting, personnel, labor relations, and legal services, whether procured under a written contract or otherwise must be reported. The reporting is for two purposes: accountability, the Legislature and the Department have detailed data regarding the expenditure of funds for Regional Center Operations; and, the language plays a role in serving as a mechanism to dissuade utilizing funds for other purposes than Operations.

The Department proposes to modify the requirement as follows:

**Section 4639.5 of Welfare and Institutions Code**

(a) By December 1 of each year, each regional center shall provide a listing to the state department of developmental services a complete current salary schedule for all personnel classifications used by the regional center. The information shall be provided in a format prescribed by the department. The department shall provide this information to the public upon request.

(b) ~~By December 1 of each year~~ At the request of the Department of Developmental Services, each regional center shall report information ~~to the State Department of Developmental Services~~ on all prior fiscal year expenditures from the regional center operations budget for all administrative services, including managerial, consultant, accounting, personnel, labor relations, and legal services, whether procured under a written contract or otherwise. Expenditures for the maintenance, repair or purchase of equipment or property shall not be required to be reported for purposes of this subdivision. The report shall be prepared in a format prescribed by the department and shall include, at a minimum, for each recipient the amount of funds expended, the type of service, and purpose of the expenditure. The department shall provide this information to the public upon request.

**COMMENTS:**

Department of Developmental Services, what is the need for the change in reporting requirements? How much staff time is required by the Regional Centers to comply with the current reporting requirement?