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

Assemblymember Hector De La Torre, Chair

MONDAY, MAY 8, 2006, 4 PM
STATE CAPITOL, ROOM 127

ITEMS TO BE HEARD

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ITEM4120 EMERGENCY MEDICAL SERVICES AUTHORITY

ISSUE 1: POISON CONTROL CENTERS

The Poison Control System of the Emergency Medical Services Authority is requesting a $1.36 million General Fund augmentation. The Poison Control System states that it responds to over 900 poisoning calls per day. This translates to 300,000 annually. The Poison Control System states that over half of the calls are for children 5 and under. The System says it saves the state $70 million annually by averting and estimated 61,000 emergency department visits each year.

The System states that it needs, at a minimum, $8.26 million from the state in the 2006-07 fiscal year. The Poison Control System is budget from the Administration at $6.9 million, leaving a $1.36 million gap. The Poison Control System will receive $.41 million from other sources in the 2006-07 fiscal year.

ITEM 4120 EMERGENCY MEDICAL SERVICES AUTHORITY

ISSUE 2: TRAUMA CENTER FUNDING

The Legislature appropriated $27.5 million for Trauma Care in 2001-02. It was the first time trauma center funds were included in the budget. The Legislature appropriated $20 million in 2002-03. The Legislature further appropriated $10 million in 2005-06. The Trauma Centers are requesting $15 million for the 2006-07 fiscal year.

In 2001-02 six percent of the trauma fund was held in reserve for new trauma hospitals ($1.5 million) and EMSA withheld the allowable administrative costs ($280,000). The funding available for distribution through the Local Emergency Medical Services Agencies (LEMSA) for designated trauma centers was $23,220,000. LEMSAs that did not have designated trauma hospitals within their geographic boundaries did not receive funding, even though they had EMSA approved Trauma Plan. These plans required transport of trauma patients to trauma hospitals located within other EMSAs. LEMSA's were permitted to withhold one percent of their available funding for administrative costs. Not all LEMSAs utilized this option; some distributed all funds to designated trauma hospitals.

The 2001-02 fiscal year Trauma Care Fund also provided one-time funding plan for the preparation and implementation of trauma care system plans in those LEMSAs that did not have an approved trauma plan. The California Trauma Care Fund included $2.5 million for planning another major milestone in the effort to develop a statewide trauma hospital system. In fiscal year 2002-03 the Legislature appropriated $20 million to the Trauma Care Fund. After withholding six percent reserve fund of $1.2 million and EMSA's allowable administrative costs, $280,000, $18,520,000 became available to distribute to LEMSAs.

The Legislature intended that trauma funds be spent on trauma services. EMSAs directed the LEMSAs to take several factors into consideration for distributing the funds.

The formula for distribution of funds included data for the following variables:

- Volume of uninsured trauma patients;
- High number of unindured trauma patients compared to the total number of trauma patients.

The Legislature appropriated $10,000,000 for trauma centers for the 2005-06 fiscal year. The distribution of the fund was done on a competitive bid basis. The following table summarizes how the funds have been used to date.

2005/06 Trauma Care Fund Expenditures as of March 7, 2012

LEMSA	LEMSA Allocation	Status of Funds	Distribution
Alameda County EMS	$441,069		
Central California EMS	$430,325		
Coastal Valley EMS	$275,959	RFP process will be complete by April 1, 2006	Anticipate that trauma centers will use funds for specialty on call panels
Contra Costa EMS	$239,606	Contract with trauma center is being finalized.	John Muir Medical Center will use the funds for preservation or restoration of specialty physician and surgeon on- call panels.
Imperial County EMS	$48,710	Board of Supervisors has approved contracts.	Funds will be used to purchase computer equipment for trauma registry and for specialty on call panels.
Inland Counties EMS	$700,195	RFP process complete.	**Arrowhead Regional Medical Center** Preservation of Specialty On-call: $214,790 Cameras/installation/trauma bays: $13,000 Collector Outcomes Program (Trauma Registry): $4,700 Equipment: $114,106 **TOTAL** $346,596 **Loma Linda University Medical Center** Preservation of Specialty On-Call: $310,000 Equipment: $36,597 **TOTAL** $346,597
Kern County	$252,142	Contract has been approved for local trauma center.	Kern Medical Center will use the money to purchase portable monitors. Trauma center is frequently overloaded, and portable monitors will allow for expansion of patient capacity.
Los Angeles County EMS	$2,194,423	RFP in preparation	All trauma centers will use these funds to maintain physician on-call panels.
Marin County EMS	$67,602	RFP process complete.	Pending LEMSA decision.
Mountain-Valley EMS	$196,449	Contracts have been awarded to two local trauma centers.	**Doctor's Medical Center $60,000** Will use the money for equipment such as: gurneys, transport monitors, Level I Infusers **Memorial Medical Center $132,000** Will purchase: Spinal Care Injury Equipment: Roto-Rest beds, C-Spine Skin care initiative, splints Advanced Trauma Life Support mannequin to facilitate training and education in trauma life support
Northern California EMS	$227,996	RFP process complete.	Pending LEMSA decision.
Orange County			

EMS	$723, 117	RFP process complete.	Pending LEMSA decision.
Riverside County EMS	$633,220	RFP process complete.	Grant proposal for funds is as follows: **Desert Regional** – specialty on-call panels and indigent care **Riverside Community** – specialty on-call panels and indigent care **Inland Valley** – specialty on-call panels **Riverside County Regional** – indigent care
Sacramento County EMS	$693,569		
San Diego County EMS	$1,418,836	RFP process will be complete 3/17/06.	Pending LEMSA decision.
San Francisco County EMS	$240,860	Nearing completion of "accept and expend" procedures with local government.	Funds will be used to support trauma center's specialty on-call panel.
Santa Barbara County EMS	$212,387		
Santa Clara County EMS	$511,984		
Sierra-Sacramento EMS	$211,491	RFP process complete.	The following equipment will be purchased: **Rideout Memorial Hospital** 4 designated trauma gurneys - $32,000; Trauma One Registry Software and Training - $9,000; Specialty Physician and surgeon on-call for trauma services - $68,491 **Sutter Roseville Hospital** Minimally Invasive Reduction and Plate Insertion Equipment - $28,000; Basic Percutaneous Instrumentation and Aiming Arm - $22,000; Vital signs monitor for the trauma OR room - $7,000; PrismaFlex System - $45,000

The trauma centers have requested $15 million for the 2006-07 fiscal year.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 1: COUNTY ADMINISTRATION

The Department has proposed a reduction to county eligibility operations. The California Welfare Directors Association have several concerns about the proposed elimination of cost-of-doing-business increases for county Medi-Cal eligibility operations. First, the Administration linked full funding for Medi-Cal operations to the establishment of performance standards back in 2003-04. Additional performance standards were adopted in 2004-05 and 2005-06, and CWDA supported the standards because the Administration continued full funding of the program. CWDA contends counties are not spending an untoward amount to administer the program, and the increases that have occurred over time can be directly linked to program eligibility expansions, legislatively required workload, or court cases that required additional eligibility work. The proposal to eliminate full funding for the program, but to leave the performance standards in place, is both unfair and unrealistic. The practice would, according to CWDA, place counties in a situation where they could be fiscally penalized for failing to meet statutory requirements that they're not appropriately funded to actually meet. The Department, however, counters the issue with the fact the costs per worker have been growing. Total cost has been increasing at a faster rate than have eligibility workers. The costs could be increasing for two reasons, labor costs and non-labor cost.

A determination of which costs are increasing is important to the Development of policy for the recommendations.

The CWDA prepared a chart (see below) which traces increases in county administrative expenditures over the past several years. The administrative expenditure document shows that the increase in county administrative expenditures over time has been very closely tied to program eligibility expansions, legislative requirements and court settlements that have required additional work in order to determine eligibility for clients. The major changes for each year are highlighted with bullet points.

County Medi-Cal Administrative Funding: A Brief History

1998-99 Budget

Spending increased from $468 million to $562 million. This increase was primarily due to: (1) the shift of an estimated $27 million from CalWORKs to Medi-Cal to reflect a new policy of allocating to Medi-Cal a portion of the eligibility determination costs for CalWORKs applicants, in order to maximize federal funding; and (2) new costs to implement the Medi-Cal changes enacted as part of the Healthy Families program.[i]

Major components of Medi-Cal operations budget during this year:

- Implementation of 1931(b), requiring counties to determine if families leaving CalWORKs were still eligible for Medi-Cal. Cases stayed in Medi-Cal until their eligibility was determined.
- Implementation of transitional benefits for those leaving aid due to increased earnings.
- Adoption of a one-month bridge from Medi-Cal to Healthy Families for children.
- Implementation of mail-in applications for pregnant women and children.
- Creation of joint Medi-Cal/Healthy Families application.

1999-00 Budget

Spending increased from $562 million to $661 million. This increase was primarily due to: (1) Staff time required to process a large backlog of cases leaving CalWORKs and being held in Medi-Cal until their eligibility could be redetermined using 1931(b) rules; (2) eligibility increases due to the 1931(b) expansion to 100% of poverty enacted as part of the 1998-99 budget, which took effect in March 2000 and added an estimated 83,000 to the rolls in 1999-00; (3) other increases to non-welfare-linked caseloads and (4) continued shift of funding for eligibility determination from CalWORKs to Medi-Cal.[ii]

Major components of Medi-Cal operations budget during this year:

- Implementation of the asset test waiver for children in the "percentage programs."
- Expansion of 1931(b) program to 100% of federal poverty limits (FPL).
- Expansion of 1931(b) asset limit from $2,000 to $3,300.

2000-01 Budget

Spending grew from $661 million to $736 million. This was the last year that the Proposed County Administrative Budget (PCAB) process was in place for county-administered health and human services programs, including Medi-Cal. Growth in spending was due primarily to increased caseloads associated with: (1) the 1931(b) expansions; (2) the creation of 12-month continuous eligibility for children; and (3) elimination of the quarterly status report.[iii]

Major components of Medi-Cal operations budget during this year:

- Extension of coverage to aged, blind and disabled up to 133% FPL.
- Establishment of coverage for working persons with disabilities, up to 250% FPL.
- Elimination of the quarterly report for beneficiaries as of January 1, 2001.
- Creation of 12-months continuous eligibility for children.
- Implementation of SB 87 began, requiring redetermination of eligibility prior to termination of benefits for former CalWORKs recipients leaving aid.

2001-02 Budget

Spending increased from $736 million to $793 million primarily due to caseload increases. Overall, caseloads grew an estimated 17% over the prior year due to eligibility expansions enacted in prior years, reflecting an additional 900,000 eligibles. The expansions particularly noted by the LAO included continuous eligibility for children, transitional benefits for those leaving CalWORKs, elimination of quarterly status reports, the 1931(b) expansion to 100% of FPL, and the aged, blind and disabled expansion to 133% FPL.[iv]

Note that Governor Davis decided during this fiscal year not to allocate $107.7 million to the counties that had been budgeted by the Legislature and included in the final, signed budget.

Major components of Medi-Cal operations budget during this year:

- $91.5 million was appropriated for growth in eligibles.
- Implementation of coverage for aged, blind, and disabled individuals up to 133% FPL.
- Continued implementation of quarterly reporting elimination and SB 87 redeterminations.
- Implementation of extended eligibility for former foster children.

2002-03 Budget

Spending increased from $793 million to $855 million. Caseloads grew by an additional 546,000 eligibles, about a 10 percent increase over the prior year. The LAO cited the same reasons for this growth as in 2001-02, with the addition of increased caseload due to the *Craig v. Bonta* lawsuit.[v]

Note that Governor Davis had vetoed $58 million in county operations funding when he signed the 2002-03 budget. Subsequently, the November 2003 estimate proposed a mid-year increase of $36 million to reflect actual county costs, offset by a projected savings of $194 million in the budget year due to counties being able to complete annual redeterminations in a timely manner.

Major components of Medi-Cal operations budget during this year:

- $105.2 million was appropriated for growth in eligibles.
- Implementation of the *Craig v. Bonta* lawsuit extending SB 87 protections to SSI-linked beneficiaries leaving assistance. Counties were required to process eligibility for a backlog of cases that had been moved into a holding aid code during the court case ($2.4 million was appropriated).
- Creation of the CHDP Gateway for children seeking Medi-Cal or Healthy Families coverage through a doctor's office.
- Implementation of accelerated enrollment for children applying for Medi-Cal through the Single Point of Entry and changes to enable counties to report the results of eligibility determinations for applications that came through SPE ($3.1 million was appropriated).
- Implementation of eligibility redeterminations for families reaching their 60-month CalWORKs time limits ($21.7 million was appropriated).

2003-04 Budget

Spending increased from $855 million to $974 million, primarily due to (1) caseload increases; (2) the Craig v. Bonta lawsuit; and (3) restoration of the cost-of-doing-business increase for county Medi-Cal operations. Restoring the cost-of-doing-business increase was tied to the establishment of performance standards related to county eligibility processing and annual redeterminations of eligibility. The budget projected $194 million in savings due to full county funding and the establishment of performance standards.

Major components of Medi-Cal operations budget during this year:

- $206.4 million was appropriated for growth in eligibles.
- Continued implementation of Craig v. Bonta ($51.2 million was appropriated).
- Continued redeterminations for families timing out of CalWORKs ($44.8 million was appropriated).
- Continued implementation of CHDP Gateway ($7.9 million was appropriated).
- Institution of semi-annual status reporting. (Counties claim expenditures for this workload to their base funding.)

2004-05 Budget

Spending increased from $974 million to $1.088 billion. The growth was primarily due to (1) caseload growth, especially in the aged, blind and disabled cases and CHDP Gateway cases; (2) continuation of past program expansions; and (3) continued provision of the cost-of-doing-business increase. Note that the cost-of-doing-business increase cannot be separately projected as it is rolled into the base in the DHS May Revise estimate (the November estimate contains a placeholder number, but it is not based on actual data from counties).

Major components of Medi-Cal operations budget during this year:

- $49.8 million was appropriated for growth in eligibles.
- Continued implementation of *Craig v. Bonta* ($40.5 million was appropriated).
- Expansion of Express Lane Eligibility to additional sites ($4.8 million was appropriated).
- Increased funds for CHDP Gateway ($48.7 million was appropriated).
- New requirements for county Medi-Cal staff to determine eligibility for In-Home Supportive Services (IHSS) recipients ($7.5 million was appropriated).

2005-06 Budget

Counties were allocated $1.175 billion, though historic spending patterns indicate that actual spending will be below this amount.

Major components of Medi-Cal operations budget during this year:

- $31.8 million was appropriated for growth in eligibles.
- Continued funding for county Medi-Cal staff to determine eligibility for IHSS ($10.8 million was appropriated).
- Continued implementation of *Craig v. Bonta* lawsuit/appeals and the CHDP Gateway (a total of $77.7 million was appropriated for these two items).
- Implementation of Medicare Part D prescription drug coverage (counties were given no funding for services related to Part D).

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 2: COUNTY ADMINISTRATION

In addition to the salary and overhead freeze, the Governor's budget also proposes to hold counties financially responsible for any federal penalties or disallowances that result from the failure of the counties to comply with the requirements of the Medi-Cal Program. The penalty would be imposed by reducing the allocation of state funds to the county for eligibility determinations. There has been no explanation of the rationale for the proposal. The county allocation for salaries benefits and overhead were frozen indefinitely and it is possible that the counties' ability to make eligibility determinations in accordance with federal requirements might be repaired. The LAO states the liability proposal warrants examination by the policy committee.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 3: DENTAL SEALANT

A proposal for a $5.5 million augmentation to the California Dental Disease Prevention Program (DDPP) budget. The purpose of the augmentation is to increase the use of sealants (at least 10 percent) and introduce the use of fluoride varnish to eligible schoolchildren. Sealants are permanent and applied on permanent teeth, usually the molars. DDPP is a school-based oral health program, serving pre-school through sixth grade in schools with 50% or greater student participation in the National Free or Reduced School Lunch Program. Approximately 4,000 schools are eligible but because of limited funding (currently at $3.3 million (GF)), only 1, 400 schools are served. (Existing law that authorizes the program is Health and Safety Code Section 104770-104825).

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ISSUE 4: CERTIFIED APPLICATION ASSISTERS

The Certified Application Assisters (CAA) receive a fee of $50 for every person successfully enrolled in the Medi-Cal and Healthy Families Programs. Also, a fee of $25 is paid for each enrollment for annual eligibility re-determinations the fees were stopped because budgetary constraints in 2001 and were restored in 2005. The CAA approach ended in 2001 due to fiscal constraints; however, this funding was restored through the Budget Act of 2005. By all accounts, the Certified Assistance Program has been a big success in getting children in Medi-Cal and Healthy Families.

The budget proposes $11.8 million ($4.9 million General Fund) for the program in the budget year, $5.4 million more than the current year, for the application assistance. The $50 and $25 reimbursements levels will continue unchanged. The estimate assumes that approximately 60 percent of the program enrollees will be enrolled by an application assister. The 60 percent translate into approximately 35,000 children. The budget also reflects an increase of $26.7 million, $9.7 million General Fund for services to the children who are enrolled in Healthy Families through the auspices of a CAA.

Also, the budget proposes incentive payments for CAAs if they increase the number of their assisted applications by 20 percent over their prior quarterly applications. The budget proposes $2.5 million, $1 million General Fund. The incentive payment would be 40 percent of the total payments made in the qualifying quarter.

CAA payments are also provided under the Medi-Cal Program in the same manner as in the HFP. The General Fund amount for these payments is budgeted under the HFP, as noted above, and a portion of the federal funds for these payments is budgeted within the Medi-Cal Program. The Medi-Cal program also utilizes the services of the CAAs. Medi-Cal receives $3 million for the enrollment of children by Application Assister.

The Legislative Analyst Office recommends the Incentive Proposal be rejected. The LAO notes the state doesn't have the experience to know whether the base program will be effective or not. However, given economic theory it is reasonable to assume the incentive payments will in fact induce greater efforts.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 5: COUNTY OUTREACH

The budget proposes a county-based outreach, enrollment, and retention program. The proposed budget would implement two adjustments to local assistance expenditures to implement a county-based outreach, enrollment, and retention program. The proposal has two compliments, trailer bill language and an increase of $19.7 million ($8.5 million General Fund) for local assistance to allocate to counties to partner with public and private community organizations for outreach, streamlined enrollment, and retention efforts.

Most of the $17.0 million would be allocated to the counties via a formula. The formula would be based on the number of eligible but not insured kids residing in the Medi-Cal/Healthy Families caseload for children residing in the county.

The other $2.5 million would be allocated by the Department of Health Services to the remaining counties who have applied for the funding, and can demonstrate they have an established coalition for children's outreach and enrollment that has been in place for at least 12 months. The Department of Health Services expects to fund five to ten counties. The maximum grant would not exceed $250,000 to $300,000. Under the DHS proposal, counties are to partner with a broad range of public and private community organizations to perform outreach, streamlined enrollment, retention of health care coverage, and appropriate utilization of health care.

Trailer bill language has been proposed for implementation of the program. The language has concerns with the medical information released on the Child Health and Disabilities Prevention Program and imposes requirements on counties to participate in the program.

The proposal would provide an increase of $250,000 ($125,000 General Fund) for the existing toll-free telephone line to handle the expected volume of calls generated by the county outreach grants. Total expenditures for the toll-free telephone line would be $1.550 million ($775,000 General Fund).

The LAO recommends the trailer bill language that relates to the CHDP program be rejected.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 6: MEDIA CAMPAIGN

The 2006-07 budget proposes a media campaign; the first year's budget would be $3.4 million, $1.4 million General Fund. The ongoing expenses of the Proposal would $11.9 million, $4.9 General Fund. The ostensible purpose of the campaign is to work in co-ordination with county outreach to target families which have children with no health coverage and are likely to be eligible for one of the state programs. Neither Medi-Cal nor Healthy Families are projecting an increase in enrollment as a result of the campaign. In fact it is unclear what the results from the prior campaign had the effect of increasing enrollment in the program.

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ISSUE 7: MEDICARE PART D: CO-PAYMENTS

An interest has been expressed in appropriating $75 million in the 2006-07 fiscal year to cover the cost of co-payments for prescription drugs that Medicare Part D requires people dually eligible for Medicare and Medi-Cal to pay.

On January 1, 2006, nearly one million California dual eligibles whose prescription drug costs were previously paid by Medi-Cal had their drug coverage transferred to the new Medicare Part D. Under Part D, dual eligibles are required to pay co-payments ranging from $1 to $5. If a beneficiary fails to make that co-payment, a pharmacy can refuse to dispense the drug.

Imposing co-payments on poor elderly patients who take multiple medicines and who live at or below the poverty level is an unfair penalty against the neediest and sickest members of our society, whether imposed by the federal or state government. In the past, the Legislature has rejected proposals to impose cost-sharing burdens on Medi-Cal beneficiaries. The state follows the previous policy of the Legislature and prevented federally imposed co-payments.

While co-payments of $1 to $5 would not place a burden on many Medicare beneficiaries, especially those who are prescribed a limited number of drugs, dual eligibles are sicker and poorer than the general Medicare population. According to the Kaiser Family Foundation, dual eligibles use an average of 10 more prescription drugs than non-dual eligible Medicare beneficiaries do do do. It is not uncommon for these individuals to take 20 or more medications everyday. Most dual eligible's have monthly incomes of $825 or less. The high number of medications they take, combined with their low incomes, make it impossible for most dual eligibles to afford their new Medicare Part D co-payments unless they spend less on food or rent.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 8: CYCSTIC FIBROSIS

Each year 100 Californians are born with cystic fibrosis. Approximately 60 are white, 30 are Latino, and 2 are African Americans, with the remainder in other ethnic groups. Children with cystic fibrosis may not show distinguishing signs of disease for weeks, months, or even years. Only half will be diagnosed by six months of age and at least 10% will not be diagnosed until age 18 or older. Doctors often misdiagnose cystic fibrosis and wrongly treat it, resulting in slowed physical and mental development**,** recurrent illness, and hospitalizations, and in some cases, death. Newborn screening can prevent hardships on these children and families and the waste of large amounts of health care dollars trying to reach a correct diagnosis. Currently the California Newborn Screening Program screens all newborns for 86 distinct genetic conditions; however, the program does not yet screen for cystic fibrosis.

Cystic fibrosis (CF) is the second most common serious inherited childhood disorder, occurring in one in 3500 births. Approximately 3,000 children and adults live with CF in California. A defective gene causes the body to produce abnormally thick, sticky mucus that clogs the lungs and leads to life-threatening lung infections. It also obstructs the pancreas and prevents digestive enzymes from reaching the intestines to help break down and absorb food, leading to impaired growth and development. To have CF, a child must inherit two defective cystic fibrosis genes, one from each parent. More than 1 million Californians are unknowing, symptom-free carriers of the defective cystic fibrosis gene.

Early diagnosis through newborn screening allows a child to receive appropriate medical treatments before irreversible disease processes have begun. Early treatment improves growth and development and reduces the cost of medications and expensive hospitalizations in children. Studies suggest that early intervention makes a big difference in babies with CF, including improved nutritional status and cognitive development, decreased hospitalizations, better quality of life and decreased mortality. One study found an increase of 7-10 IQ points in children with CF who were diagnosed early through newborn screening versus those diagnosed later. The U.S. Centers for Disease Control and Prevention recommend CF screening; 21 states and the District of Columbia already screen for CF.

Biotinidase Deficiency (BTD) is caused by the lack of an enzyme called biotinidase. Without treatment, this disorder can lead to seizures, developmental delay, eczema, and hearing loss. Problems can be prevented with biotin treatment.

The gene defect for biotinidase deficiency is unknowingly passed down from generation to generation. This faulty gene only emerges when two carriers have children together and pass it to their offspring. For each pregnancy of two such carriers, there is a 25% chance that the child will be born with the disease and a 50% chance the child will be a carrier for the gene defect. Studies show that 1 of every 60,000 live births will have biotinidase deficiency.

Infants with biotinidase deficiency appear normal at birth, but develop critical symptoms after the first weeks or months of life. Symptoms include hypotonia, ataxia, seizures, developmental delay, alopecia, seborrheic dermatitis, hearing loss and optic nerve atrophy. Metabolic acidosis can result in coma and death. With early diagnosis and treatment, all symptoms can be prevented.

Biotinidase deficiency is treated with free biotin, or biotin that is not bound to protein or other molecules. In patients diagnosed through screening, treatment will clear the skin rash and alopecia and improve the neurological status. It is necessary that treatment be managed by the doctor to be sure that the biotin is in the free form and in sufficient amounts

Interesting Facts About Newborn Screening:

- Less than 10% of babies born in the US currently get comprehensive screening for all metabolic, endocrine, and hematologic disorders already detectable through existing routine newborn screening programs.
- Six babies are born everyday in the US alone that have disorders detectable through newborn screening, but go undetected because they aren't screened.
- Newborn screening can detect more than 35 disorders.
- Most disorders detectable through newborn screening are treated by diet restrictions.

The California State Genetic Disease Branch estimates that the CF test will require a $12 increase in the state Newborn Screening fee per birth (approximately 560,000 births per year). Adding CF to the state's Newborn Screening Program would bring the total fee to $90 per newborn to screen for 76 conditions.

The State Genetic Disease Branch estimates that if a test for Biotinidase is added at the same time the CF test is added, an additional fee increase of $5.75 would be necessary, making the total fee increase $17.75 for the two conditions. Adding Biotinidase and CF to the state's Newborn Screening Program would bring the total newborn screening fee to $95.75 per newborn to screen for 77 conditions.

The total fee increase would be a $17.75 increase in the existing fee.

BUDGET YEAR (2006/2007) COSTS

TO DEVELOP NEWBORN SCREEN FOR CYSTIC FIBROSIS (CF)

Reagents: 6 months supply for pilot tests x 50%	$ 1,584,800 ($3,169,600
State personnel: 9 months salary for 5 FTE (5 FTE x $90,000) x 75%	$ 337,500
Contracts for Testing Services: (Includes Laboratories, Follow-up, Diagnostic services) 6 months for pilot tests ($1,820,000 x 50%)	$ 910,000
System Development ($2,500,000 x 90%)	$ 2,250,000
Oversight (External Project Manager, IV&V, IPOC) ($600,000 x 100%)	$ 600,000
End User Training ($250,000 x 100%)	$ 250,000
Total Budget Year Costs Of Adding CF	**$ 5,932,300**

BUDGET YEAR (2006/2007) COSTS

TO DEVELOP NEWBORN SCREEN FOR BIOTINIDASE (BD)

Reagents:	$ 1,005,200	
6 months supply for pilot tests x 50%		($2,010,400
State personnel:	$ 202,500	
9 months salary for 3 FTE (3 FTE x $90,000) x 75%		
Contracts for Testing Services: (Includes Laboratories, Follow-up, Diagnostic services)		
6 months for pilot tests ($607,000 x 50%)	$ 303,500	
System Development ($825,000 x 90%)	$ 742,500	
End User Training ($300,000 x 100%)	$ 300,000	
Total Budget Year Costs of Adding BD	**$ 2,553,700**	

ITEM 4260 DEPARTMENT OF HEALTH SERVICES

ISSUE 9: ALZHEIMER'S RESEARCH

The Alzheimer's Disease Program and the Alzheimer's Research Centers of California (ARCCs) request a $2 million General Fund augmentation to its current $4.9 million budget for the Alzheimer's Disease Program. The augmentation would supplement the funding of the Alzheimer's Research Centers of California. It would also fund the management of the Alzheimer's Research Centers of California data and the program evaluation component at the UCSF Institute of Health and Aging.

The accomplishments of the ARCCs include:

1. Made California the leader in the field of Alzheimer's research
2. Generated leveraged resources: 4:1 ratio ($120 million+)
3. Made great progress in multicultural diagnosis and research (e.g. Cross-Cultural Assessment Battery (CCNB)
4. Advanced the field of collaborative research (the ARCCs have 10 translational studies awaiting start-up funding)
5. Built and maintain a unique database on AD and related dementias (The Feds are only now doing this – the ARCCs are 20 years ahead), and
6. Lead the national field in translational research (getting results of bench research into mainstream medicine and to the consumer)

The ten ARCCs are located at university medical centers throughout the state (UC Davis/Sacramento, UC Davis/Martinez, UC San Francisco, UC San Francisco/Fresno, UC Irvine, UC Los Angeles, UC San Diego, USC/Los Angeles, USC/Rancho Los Amigos, and Stanford University**)** shall receive an augmentation of $185,000. Each ARCC will maintain flexibility to distribute and manage its augmented funds as directed under ADP program policies and procedures.

Each ARCC would use its augmentation to:

1. Support existing 'state-of-the-art' diagnostic services and academic & community education
2. Expand unique clinical research and education projects according to the expertise and needs of individual centers
3. Participate in and expand the ARCCs' program of cutting edge collaborative translation research**.**

Translation of important research findings into treatment, disease management, and the general knowledge base of professionals and the community at large maximizes the benefit of research discoveries, no matter where in the world they are made. Research into effective methods of translation is imperative to ensure appropriate use of fiscal resources for health care and maintenance of as high a level of academic knowledge and clinical skills for up-and-coming health care professionals as possible.

The Institute for Health and Aging (IHA) shall receive an augmentation of $150,000. The IHA has worked collaboratively with the ARCCs and DHS since the inception of the Alzheimer's Disease program in the creation, updating, and maintenance of the ARCC Minimum Uniform Data Set (MUDS). The MUDS is an extremely rich resource, which contains more than 20 years worth of data, and adds more each year. As additional research, questions arise related to advances in our understanding of AD and related disorders, the IHA works with the ARCCs to design and develop studies to answer new questions and move research in the field forward. These data are used to examine scientific questions related to AD and related disorders, as well as provide the DHS with administrative information for program evaluation purposes. The IHA works with the DHS to evaluate the performance of each ARCC in meeting program goals.

ITEM 4280 MANAGED RISK MEDICAL INSURANCE BOARD

ISSUE 1: UNIVERSAL HEALTH CARE COVERAGE IN FAMILIES WITH INCOMES UNDER 300 % OF THE FEDERAL POVERTY LEVEL

OBJECTIVE: Health Care Insurance Coverage for all children living in families with income less than 300 percent of the federal poverty level.

1. The program would increase the income ceiling for both the Healthy Families and Medi-Cal

    - The Healthy Families income ceiling would increase from 250 percent to 300 percent.
    - Medi-Cal income ceiling would increase to 133 percent of the Federal Poverty Level for all eligible ages, thereby standardizing program.
    - Immigrant children enrollment in a program would be dependent on the family's income, even if there are no matching federal funds.
    - The Program would be administered by the Department of Health Services.

2. The projected enrollment of children in the program would be July 2008.

Local Children Coverage known as Healthy Kids Programs

- 17 counties are offering Healthy Kids Program, it is an add-to the existing Healthy Families Program
- 14 are being planned
- Small counties that do not have a program would have the option of buying into the Healthy Families Program
- The Healthy Kids Program is at the discretion of the counties, county funds are used to provide the federal match for the programs
- Enrolled children in the Healthy Kids Program

- Several Counties have capped the eligibility in their programs:

    i. The state would provide matching funds for the counties to lift their caps
    ii. The funding only would be for those counties that had an operational Healthy Kids program
    iii. The proposal would provide $40 million for Healthy Kids Program on annual basis,
    iv. The funding would end when the Health Insurance for Kids Program is enrolling children
    v. There would be county match required, participating counties would have to match the states $1 with $1 of county funding

Population: Medi-Cal, Healthy Families Programs provide health insurance significant number of California's children.

1. The California Health Information Survey at UCLA provides the following estimates:

2. The estimates are from the UCLA Center for Health Policy Research and are for families with income greater than 250 percent of the Federal Poverty Level

    - There are 207,000 children who qualify for Medi-Cal but are not enrolled
    - There are 224,000 children who qualify for Healthy Families who are not enrolled
    - There are 148,000 children who would qualify income wise but are not eligible because of their immigration status
    - Each child would enroll in the program that is commensurate with the family income.
    - Enrolling kids in families with incomes between 250 percent of Federal Poverty Level would not increase the cost of the program significantly.
    - Increasing the income level for the Medi-Cal to 133 percent of the Federal Poverty Level would significantly increase the cost to the Medi-Cal Program.
    - Undocumented kids' emergency services shall be included in the programs development

Administration of the Program

1. **The Managed Risk Medical Insurance Board would be appropriated $750,000 and the Department of Health Services would be appropriated $4.25 million in the budget year** for the purposes of developing and implementing the myriad of technical and administrative duties necessary to establish the program and begin enrollment of eligible children. **It is expected the efforts of the Board to establish the program will require the Board to finish by January 2008 and additional funds will be needed in the 2007-2008 Fiscal Year.**

2. In addition to developing and implementing the Program, duties the Department would also be responsible for implementing several simplifications. The program would be improved on current efforts in the areas of Outreach and Enrollment, Retention and assistance to local efforts to cover all kids.

    - Outreach and Enrollment would include the design and development of a unified electronic gateway system expediting enrollments, it is multi year project will need less than $250,000 General Fund in the budget year and a $300,000 General Fund in budget year plus 1 in the 2007-08 fiscal year, enrolling children would commence in the 2008-09 fiscal year, among other issues.

    - Additional amendments to the system include expanding existing Medi-Cal to Healthy Families Program accelerated enrolment making it effective on January 1, 2008. Also, improve the bridge programs between Healthy Families to Medi-Cal effective January 1, 2008. Finally,

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ISSUE 2: STREAMLINE ENROLLMENT PROCESSES FOR CHILDREN'S HEALTH PROGRAMS

The Managed Risk Medical Insurance Board requests $91,000 ($32,000) General Fund and one Associate Government Program Analyst (two year limited term) to implement changes in the Healthy Families eligibility and enrollment processes that will:

1. Increase Healthy Families Program enrollment;
2. Eliminate barriers to applying for Healthy Families and Medi-Cal;
3. Make application processing and enrollment into the Health Families Program easier without relaxing program requirements;
4. Promote the use of the Health-e-App; and Reduce enrollment administrative costs.

An estimated 173,000 applications submitted per year either do not include the premium payment with the application or fail to specify the plans in which the child should be enrolled. The applications represent approximately 311,000 children. Under present practice, the Administrative Vendor will terminate the application if the premium payment is not provided or plan choice is not made within 20 days. The Administrative Vendor expends a significant amount of resources attempting to get the missing information to complete applications, but nearly half of the applications with missing critical information do not become enrolled because the information is not received with in 20-day termination period. Thus, during the review period approximately 140,000 children either never get enrolled or experience a delay in enrollment.

Of all the initial applications filed on the web-base Health-e-App, 64 percent are successfully enrolled in the Healthy Families Program versus 50 percent for those filed on the mail-in application. The reasons for this are: the data are already typed in so there is no problem with readability of information; and the format of the electronic application requires that all fields be filled in before the application can be submitted.

To address these enrollment barriers, the Managed Risk will be making the following changes:

1. Discontinue requiring applicants to make a plan selection as a pre-condition of enrollment. Instead, encourage plan selection at the time of application but, if not selected, enroll the child in the local Community Provider Plan health plan and randomly assign dental and vision plans. Enrollees will be able to change plans in the first three months if they wish as is currently the case under existing policy, necessitating a regulatory change;

2. Discontinue requiring a Healthy Families Program applicant to pre-pay premiums when submitting a HFP. Premium will still be owed, but the applicant will not be billed until they are successfully enrolled. The change would require changes in regulations and is contingent on enactment of Trailer Bill Language; and

3. Expanding the availability of the web-based application to the general public. Currently, the Health-e-App is available to Certified Application Assistants and some counties. The state has long contemplated making the electronic application available to the public and doing so was approved as part of the feasibility report originally conducted for Health-e-App. The Administrative Vendor is required to absorb any systems costs associated with making the electronic application available in the public under terms of its existing contract.

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ISSUE 3: ELIMINATE DUPLICATE ENROLLMENTS IN HEALTHY FAMILIES AND MEDI-CAL

The Managed Risk Medical Insurance Board requests $300,000 ($105,000 General Fund) for systems changes at MAXIMUS to eliminate the potential for duplicate enrollment and to expedite enrollment for eligible infants born to mothers in the Access for Infants and Mothers (AIM) program. The proposal requires trailer bill language changes and regulatory changes in the Healthy Families Program and AIM programs. Once implemented the proposal is projected to produce net savings to the state.

The goal of the request is:

1. Reduce costs by eliminating duplicative Health Families Program enrollment of AIM-linked infants who already have no cost Medi-Cal or private insurance;
2. Expedite the automatic enrollment of AIM infants into the Healthy Families Program by requiring pre-payment of a portion of the Healthy Families Premium in conjunction with collection of the mother's AIM premium; and
3. Reduce the number of AIM linked infants disenrolled during the first year of enrollment in the Healthy Families Program for non-payment of premiums by requiring pre-payment of a portion of the Healthy Families Program premium in conjunction with collection of the mother's AIM premium.

The Trailer Bill Language to amend the Healthy Families Program and AIM would:

1. Determine an AIM-linked infant ineligible for the Healthy Families Program if the infant is enrolled in no-cost Medi-Cal or employer-sponsored insurance, beginning July 1, 2007; and

2. Permit the Managed Risk Medical Insurance to assess an additional Healthy Families subscriber contribution as part of the AIM subscriber contribution; require that this portion of the AIM subscriber contribution be uses as a pre-payment of the Healthy Families Program premium for an AIM linked infant's initial enrollment in the program; and authorize transfer of these funds from the mother's AIM account to the child's Healthy Families Program account.

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ISSUE 4: STAFF TO ADDRESS WORKLOAD

The Managed Risk Medical Insurance Board requests 10 positions and $983,000 (248,000 General Fund) in the budget year for state support costs to enable MRMIB to address anticipated workload. The staff would be dedicated too:

- Applicant and Plan Subscriber Customer Service
- Policy and Legislation Coordination
- Legal Research and Review
- Health Plan Services Research and Quality Improvement
- Rural Health Demonstration Program

MRMIB indicates for its size, complexity, and visibility of its health insurance program, MRMIB has a small number of staff to perform all of the functions needed to properly administer them. MRMIB spends about one percent of its total budget on support.

MRMIB has responsibility for the Major Risk Medical Insurance Program, Access for Infants and Mothers Program, the Healthy Families Program and the County Health Initiative. The programs have a combined budget of over $1 billion and provide coverage to 1 million. Since the 2002 fiscal year the Healthy Families program has grown more than 50 percent.

The MRMIB indicates that an analysis of its Eligibility Division shows that there is a need for 11 full-time positions. The Board believes that the positions are essential to maintain the core appeals processing functionality without having to redirect staff resources from other functions The MRMIB received several positions in the current year. The staff positions did not address the issue of program growth, emerging policy challenges and new functions such as health plan services research and quality improvement.

A new study by the Managed Risk Medical Insurance Board of the workload indicate the Managed Risk Medical Insurance Board could satisfy it's staffing needs with the addition of three staff to the Board.

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ISSUE 5: ACCEPTANCE OF FOUNDATION AND GRANT FUNDING

MRMIB will be withdrawing this item

The Managed Risk Medical Insurance Board's authority to allow the Department of Finance to change expenditure authority and/or establish permanent positions to the extent that foundation and grant funding are available to fully offset any increases. The Board requests the following language be added to 4280-001-0001 and 4280-001-0890.

Augmentations to reimbursements in this item are exempt from Section 28.50 of this act. The Managed Risk Medical Insurance Board shall provide written notification within 30 days to the Joint Legislative Budget Committee describing the nature and planned expenditure of these augmentations when the amount received exceeds $200,000. Federal funds may be increase to allow for the matching of augmentations or reimbursements and the Department of Finance authorize the establishment of positions if the costs are fully offset by the augmentations to reimbursements.

The current process for accepting grants or foundation endowments involves submitting a request to the General Fund State Operations item (4280-001-0001 and the federal fund state operations item 4280-001-0890). The request is pursuant to Section 28.00 and Section 28.50, which require a 30-day notification to the Legislature in the form of a Section letter. MRMIB prepares the Section letter and submits it to DOF for approval. Once approved, the Department of Finance, submits the letter to the Legislature. Once the 30-day notification period has ended and the Legislature has not denied the request, then a budget revision can be processed which gives MRMIB the authority to spend the grant and matching funds. The process can take from one to four months.

ITEM 4280 MANAGED RISK MEDICAL INSURANCE BOARD

ISSUE 6: OVERSIGHT OF MENTAL HEALTH SERVICES FOR HEALTHY FAMILIES PROGRAM ENROLLEES

The Medical Managed Risk Medical Insurance Board requests $432,000 ($151,000 from the Mental Health Services Fund and $281,000 in federal funds) in budget year funding authority to secure resources necessary to increase oversight in the delivery of mental health services for Healthy Families Program enrollees with serious emotional disturbances.

The funding would provide $166,000 for two additional staff (1 Research Program Specialist I and 1 Staff Services Analyst) and $266,000 in one-time costs for a customer survey and independent evaluation of the Healthy Families Program Mental Health Delivery System. The $266,000 in one-time budget year funding will provide for Phase II and Phase III of an independent evaluation of the Healthy Families Program Mental Health Delivery System. The independent evaluation will focus on delivery systems and coordination efforts used to provide mental health and substance abuse treatment services to children enrolled in the Healthy Families Program and a strategy for monitoring outcomes,

Over the last few years, the Healthy Families Program has experienced low utilization fates for Seriously Emotionally Disturbed treatment and has received feedback from counties, health plans, and families regarding the inadequate coordination of services and problems with access to Seriously Emotionally Disturbed treatment.

The Board has collected information on the utilization of mental health and SED services as reported by the counties and health plans. The data collected includes:

1. The number of Healthy Families Program subscribers being referred by health plans to a county mental health department for SED assessment and treatment;
2. The number of active Healthy Families Program SED cases as reported by the counties; and
3. The number of children receiving outpatient follow-up care after and inpatient psychiatric admission.

National estimates indicate that up to five percent of children require mental health intervention. Data collected on mental health referrals and the number of active SED cases based on the approved claims data from county mental health departments suggests the Healthy Families Program subscribers are under utilizing mental health services.

Health Plan utilization data also indicate under utilization. HEDIS scores for mental health services have not reflected the actual need for services.

The low incidence of mental health referrals and treatment may be due to several factors:

1. Inadequate screening of Healthy Families Program children for mental health needs;
2. Lack of coordinated oversight by the Department Mental Health and the Managed Risk Medical Insurance Board; and barriers to communication between counties and plans; and
3. Ineffective data collection and reporting by health plans and counties.

The Board proposes that Proposition 63 fund be used to establish two new MRMIB positions: a Staff Services Analyst and a Research Program Specialist I. The positions would be used to assure the level of State coordination/collaboration and to facilitate increased Department of Mental Health oversight role in the delivery of services to Healthy Families Program enrollees who are SED.

There are ongoing concerns about the ongoing evaluation of SED services in the Healthy Families Program. MRMIB proposes to evaluate the current system of providing SED treatment to Healthy Family Program subscribers. MRMIB proposes the utilization of Proposition 63 funds to support Phase II and Phase III of the University of California San Francisco independent evaluation of the delivery system used to provide mental health and substance treatment services to children enrolled in the Healthy Families Program and strategy for monitoring outcomes. The study MRMIB proposes would include the following:

1. Researching, developing and piloting a screening tool that plans can use for the early detection of Healthy Families Program Children who may have an SED condition or substance abuse problem, and, when applicable, increasing access to care by making appropriate referrals to the county mental health department for increasing treatment;

2. Conducting a follow-up survey to identify outcomes from use of the piloted screening tool, and related assessment and treatment results; and

3. Preparing a written report of findings and recommendations on steps that can be taken to improve SED services for Healthy Family Program enrollees with potential action items for system change.

ITEM 4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

ISSUE 1: MEDICARE PART D: FEASIBILITY STUDY REPORT AND BACKFILL FOR LOST MEDI-CAL REIMBURSEMENTS

It is requested that Item 4300-001-0001 be increased by $694,000 and Reimbursements be reduced by $314,000. This augmentation will backfill $314,000 in Medi-Cal reimbursements lost due to the implementation of Medicare Part D (Part D). Under Part D, the Department of Developmental Services will no longer be reimbursed for administrative costs associated with providing prescription drugs to Developmental Center clients. This request will also provide $380,000 in one-time funding for a Feasibility Study Report to examine long-term solutions for implementing Part D.

ITEM 4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

ISSUE 2: DELAY OF AGNEWS CLOSURE: BUDGET BILL LANGUAGE TO EXTEND LIQUIDATION OF PRE-DEVELOPMENT FUNDS

It is requested that Item 4300-491 be added to extend the liquidation period of pre-development funds for the Bay Area Housing Plan to June 30, 2010. This extension is necessary due to the need for additional time to develop and finance community residential facilities. The lack of housing will result in the closure of Agnews Developmental Center being delayed until June 30, 2008. Extending the liquidation period would eliminate the need to annually reappropriate the funds.

4300-491-Reappropriation, Department of Developmental Services. Notwithstanding any other provision of law, the period to liquidate encumbrances of the following citations is extended to June 30, 2010.

0001-General Fund
(1) Item 4300-105-0001, Budget Act of 2004 (Ch. 208, Stats. 2004), as reappropriated by Item 4300-490, Budget Act of 2005 (Ch. 38, Stats. 2005).

ITEM 4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

ISSUE 3: COST RECOVERY SYSTEM FEASIBILITY STUDY

The Department of Developmental Services is requesting a $380,000 one-time increase in General Fund authority for the implementation of, and compliance with, requirements of Medicare Part D. In addition, the requirement will need an ongoing appropriation of $314,000 to offset the loss of Medi-Cal Reimbursements that will result from the implementation Of Medicare Part D. The $380,000 in one-time General Fund authority will fund a contract for services to perform an assessment of the Department's Cost Recovery System. The funds will also fund a formal Feasibility Study Report that documents the findings of the assessment and makes recommendations for improved system operations that are consistent with federal mandates for billing.

The LAO notes this issue should be talked about with the Mental Health Issue, Re-appropriation of Medicare Part D below.

ITEM 4440 DEPARTMENT OF MENTAL HEALTH

ISSUE 1: RE-APPROPRIATION OF MEDICARE PART D

The Department of Mental Health is requesting the re-appropriation of $330,000 General Fund from the 2005 Budget Act to the 2006 Budget Act that was appropriated to implement Medicare Part D. The appropriation was in the state hospital appropriation to implement changes in the DMH billing systems to allow state hospitals to claim Medicare Part reimbursement from the Prescription Drug Plans. When the Department of Developmental Service and the Department of Mental were established, DDS was made responsible for all clients billing for both agencies. DMH operates computer systems that must interface with DDS' systems and provide the information that DDS needs to bill third parties.

The Administration proposed a solution to Medicare Part D issues in state hospitals. The federal guidance on Medicare was not published and the Prescription Drug Plans were not designated.

The lack of guidance delayed the state preparation. As information was released by the federal government, it became evident that the number and extent of systems changes were much greater than expected. DDS only announced its revised requirements to DMH to allow the DMH to draft a Feasibility Study Report.

The LAO notes it withholds recommendation on the administration's proposal to re-appropriate $330,000 from the 2005 Budget Act to implement Medicare Part D. Also, the LAO recommends that the Legislature require DMH to report at budget hearings on how DMH is coordinating its Medicare Part D related billing systems changes with the Department of Developmental Services (DDS). It is not clear how effectively DMH and DDS are coordinating their efforts.

According to DMH, DDS is responsible for all clients billing for drugs for both departments. The DMH operates systems that must interface with DDS' systems and provide the information that DDS needs to bill third parties for patient care.

The LAO notes that DDS submitted a Spring Finance Letter requesting $380,000 in one-time General Fund authority to fund a contract for an assessment of DDS' cost recovery system and a Feasibility Study Report (FSR) to document the findings of the assessment and to make recommendations for improved system operations. There are no concerns about the proposed FSR. Given that DDS's proposal contemplates changes to their cost recovery system and it may have, an effect on how DMH's systems would interface with DDS', the LAO believes that these two issues should be considered jointly.

The issue for the Department of Developmental Services the LAO recommends to be discussed this Mental Health Issue is the Cost Recovery System Feasibility Study.

ITEM 4440 DEPARTMENT OF MENTAL HEALTH

ISSUE 2: STAFFING FOR STATE AND FEDERAL LAWSUITS

The Department of Mental Health requests the Legislature augment Item 4440-491 by $513,000 and Item 4440-011-0001 be decreased by $513,000 to reflect the redirection of workers compensation to fund 5.0 permanent headquarters position for support of the activities related to state and federal lawsuits. Of the 5.0 positions requested, 4.0 positions will address the workload needs associated with all California Department of Corrections and Rehabilitation related lawsuits/activities and 1.0 position will serve as the Civil Rights for Institutionalized Persons Act (CRIPA) Business Manger.

The LAO recommends the proposal to redirect existing resources to establish a "Business Manager" in support of the state hospitals' implementation of the United States Department of Justice (USDOJ) consent decree pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). When the Finance Letters were released the LAO noted it was premature to approve resources to address this issue until a final agreement to resolve federal findings of deficiencies in state hospitals has been finalized and until documents detailing a remediation plan for the hospitals have been provided to the Legislature.

The LAO has no concerns regarding the redirection of funds to support four positions to manage expanding inpatient treatment programs operated by DMH for the California Department of Corrections and Rehabilitation (CDCR) in response to the Coleman Court Decision. We note that on April 28, 2006, U.S. District Court Judge Lawrence Karlton approved a long-range administration plan to add 695 new beds for mentally ill inmates. Karlton also ordered CDCR to immediately implement measures to alleviate the lack of mental health services in state prisons.

ITEM 4440 DEPARTMENT OF MENTAL HEALTH

ISSUE 3: CONTINUED IMPLEMENTATION OF THE MENTAL HEALTH SERVICES ACT (PROPOSITION 63)

The Department requests that Item 4440-001-3085 be increased by $10,637,000, Reimbursements be increased by $50,000, and that Item 4440-001-0001 be amended to reflect this change for continued implementation of the Mental Health Services Act. This request includes funding for 11.0 positions (3.0 two-year limited term positions) to address the impact of the Mental Health Services Act on administrative functions and regulations development, while the balance of the funding requested for new or existing contracts.

ITEM 4440 DEPARTMENT OF MENTAL HEALTH

ISSUE 4: PHASE IN OF POSITIONS FOR THE CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS ACT (CRIPA) FINANCE LETTER

The Department of Mental Health requests a savings of $19,619,000 ($16,895,000 General Fund $2,724,000 in realignment reimbursement for state hospitals) for the Budget Proposal contained in the January 10 budget submitted to the Legislature. The reduction implements a phased in approach of the needed positions.

ITEM 4260 DEPARTMENT OF MENTAL HEALTH

ISSUE 5: IMPLEMENTATION OF THE WELLNESS AND RECOVERY MODEL SUPPORT SYSTEM (WARMSS)

The Department requests that Item 4440-001-0001 be increased by $1,842,000 and five positions and 4440-011-0001be increased by $706,000 and 10 positions (3.0 positions half-year initial funding) to support the implementation of the WaRMSS. The WaRMSS is the information technology support system requested to meet the US Department of Justice Consent decree pursuant to the Civil Rights for Institutionalized Persons Act (CRIPA)

The LAO generally concurs with the Wellness and Recovery Model Support System (WaRMSS) proposal but recommends the department report at budget hearings on these two issues:

- User trainer acceptance is too late in system development. There is little discussion of user involvement in system requirements definition and design phase, which is critical to ensure it meets the user needs in the business process workflow relative to screen and data presentation.

- The project schedule does not reflect contract tasks. The requirements definition and design phases are planned for December 2006 completion. Oversight vendor should be on board to help validate that requirements are adequately documented and traceable. Technical vendor staff will need to be on board during design phase. The schedule may be too aggressive to allow for this.

[i] LAO Analysis of the 1999-00 Budget Bill
[ii] LAO Analysis of the 2000-01 Budget Bill
[iii] LAO Analysis of the 2001-02 Budget Bill
[iv] LAO Analysis of the 2002-03 Budget Bill
[v] LAO Analysis of the 2003-04 Budget Bill