

**AGENDA
SUBCOMMITTEE No. 1
ON HEALTH AND HUMAN SERVICES**

ASSEMBLYMEMBER JERRY HILL, CHAIR

**WEDNESDAY, APRIL 22, 2009
STATE CAPITOL, ROOM 4202 (PLEASE NOTE ROOM CHANGE)
1:30 P.M.**

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VOTE-ONLY ITEMS

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

ISSUE 1: EXTEND SB 962 HOME PILOT AND EVALUATION - TBL

BACKGROUND

The Administration has proposed trailer bill language requesting a one-year extension of the sunset date for the Adults with Special Health Care Needs Pilot Program and its associated report.

The language extends the independent evaluation of the Adult with Special Health Care needs Pilot Program until January 1, 2010 and extends the sunset date of the pilot until January 1, 2011. The extension provides the time period needed to conduct the thorough evaluation contemplated in statute which includes the participation of all former Agnews residents residing in this model of care, as well as their families.

SB 962 (Chesbro) Chapter 558, Statutes of 2005, established the Adult Residential Facilities for Persons with Special Health Care Needs (ARFPSHN) pilot project that would operate through January 1, 2010 and required the Department of Developmental Services (DDS) to contract with an independent contractor to evaluate the project and submit a report to the Legislature by January 1, 2009.

Staff Recommendation

Adopt the Administration's requested trailer bill language to extend the sunset date of the pilot and the report, both by one year, to allow for proper evaluation of this model of care.

4440 DEPARTMENT OF MENTAL HEALTH

<p>ISSUE 1: EXTEND THE PATIENT POPULATION CAP AT PATTON STATE HOSPITAL – TBL</p>

<p>BACKGROUND</p>

Forensic patients in the state hospitals must be housed in a “secure facility.” However, the state hospital system has only a limited number of secure facilities able to house forensic patients. Since the early 1990s, the Department of Mental Health (DMH) has experienced substantial growth in its forensic patient population, leading to an increased demand for housing at the Department’s secure facilities and maintenance of patient populations above anticipated levels. For example, while Patton State Hospital (PSH) is licensed to house 1,287 patients, the hospital currently houses 1,506 patients (as of August 2008).

DMH expects continued growth in its forensic patient population to result in an overall patient population that exceeds the state hospital system’s legally defined capacity. To accommodate this population growth, the Department will need to overpopulate most of its state hospitals, including PSH, a secure facility capable of housing forensic patients.

Under current law, DMH will need to reduce its patient population at PSH to 1,336 by September 6, 2009, or be in violation of the law. Due to pressures to make more beds available to accommodate those on the Incompetent to Stand Trial (IST) waiting list, respond to the number of orders to show cause, and the recent joint Coleman/Valdivia court order to take in parolees, DMH expects continued growth in its forensic patient population. This will require maintenance of a patient population at PSH in excess of 1,336 until other options can be explored. It is anticipated that this will take three more years beyond the current sunset of September 6, 2009.

No resources or funding is required for this proposal.

Staff Recommendation

Adopt the Administration's requested trailer bill language to extend by three years, from September 2009 to September 2012, their ability to house up to 1,530 penal-code patients at Patton State Hospital. Secure beds are needed and this facility has the capacity for this purpose.

ISSUE 2: APRIL 1 LETTER – MHSA FUNDS (ISSUES 003 AND 319)**BACKGROUND**

California Health Information Survey, Mental Health Component (Issue 003). The Administration requests Mental Health Services Funds (MHSF) of \$1.264 million for development and dissemination of the mental health questions included in the California Health Information Survey (CHIS) of 2009. In addition to existing CHIS authority of \$304,000 MHSF, the augmentation will fully fund the mental health component of the CHIS (\$1,568,000 MHSF). The CHIS is a biennial telephone survey of more than 50,000 individuals, to gather data on the health status, behaviors, and mental health of Californians. The survey is used by researchers to develop training and professional presentations by counties to estimate need for and range of services, and to assess matters of mental health services stigma and utilization.

Technical Adjustment to Accurately Reflect Program Reimbursement Source (Issue 319). It is requested that the Mental Health Services Act (MHSA) local assistance program Schedule (5) of Item 4440-101-0001 be eliminated, and Reimbursements be decreased by \$40.0 million, with an offsetting and corresponding change in 4440-101-3085. This technical adjustment is to accurately reflect Reimbursements from county MHSA funds to the DMH. These funds are provided by counties to augment a variety of statewide programs, including student mental health and suicide prevention.

Staff Recommendation

Staff sees no issues with these requests and recommends approval of the two items in the DMH Spring Finance Letter.

ITEMS TO BE HEARD

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

ISSUE 1: BUDGET OVERVIEW

BACKGROUND

The Department of Developmental Services (Department) is responsible under the Lanterman Developmental Disabilities Services Act (Lanterman Act) for ensuring that more than 230,000 persons with developmental disabilities receive the services and support they require to lead more independent and productive lives and to make choices and decisions about their lives.

The Governor's Budget, as introduced in early January, included \$4.65 billion (\$2.78 billion General Fund) for the Department in 2008-09, and \$4.57 billion (\$2.75 billion General Fund) for 2009-10. This is \$75 million (\$33 million General Fund) below the revised 2008-09 budget.

**DEPARTMENT OF DEVELOPMENTAL SERVICES
2009-10 GOVERNOR'S BUDGET
FUNDING SUMMARY
(Dollars in Thousands)**

	2008-09 Estimated Expenditures	2009-10 Governor's Budget	Difference	Percent Change
BUDGET SUMMARY				
COMMUNITY SERVICES	\$3,888,239	\$4,226,878 *	\$338,639	8.7%
DEVELOPMENTAL CENTERS	719,485	689,457	-30,028	-4.2%
HEADQUARTERS SUPPORT	37,992	38,265	273	0.7%
TOTALS, ALL PROGRAMS	\$4,645,716	\$4,954,600	\$308,884	6.6%
FUND SOURCES				
General Fund	\$2,778,543	\$3,079,338 *	\$300,795	10.8%
Reimbursements: Totals All	1,634,525	1,679,861	45,336	2.8%
<i>Home & Community Based Serv. (HCBS) Waiver</i>	878,147	883,924	5,777	0.7%
<i>HCBS Waiver Administration</i>	7,674	7,728	54	0.7%
<i>Medicaid</i>	44,000	44,000	0	0.0%
<i>Medicaid Administration</i>	14,271	14,530	259	1.8%
<i>Targeted Case Management</i>	133,037	155,131	22,094	16.6%
<i>Targeted Case Management Administration</i>	4,351	4,572	221	5.1%
<i>Medi-Cal</i>	310,558	298,553	-12,005	-3.9%
<i>Title XX Social Services Block Grant</i>	203,903	228,173	24,270	11.9%
<i>Self-Directed HCBS Waiver</i>	4,999	9,759	4,760	95.2%
<i>Self-Directed HCBS Waiver Administration</i>	1,453	1,714	261	18.0%
<i>Vocational Rehabilitation</i>	588	300	-288	-49.0%
<i>All Other</i>	31,544	31,477	-67	-0.2%

	2008-09 Estimated Expenditures	2009-10 Governor's Budget	Difference	Percent Change
Public Transportation Account (PTA)	138,275	138,275	0	0.0%
Federal Trust Fund	90,829	54,093	-36,736	-40.4%
Lottery Education Fund	495	0	-495	-100.0%
Program Development Fund (PDF)	1,855	1,912	57	3.1%
Mental Health Services Fund	1,119	1,121	2	0.2%
Developmental Disabilities Svs Acct	75	0	-75	-100.0%
AVERAGE CASELOAD				
Developmental Centers	2,404	2,404	0	0.0%
Regional Centers	229,675	242,520	12,845	5.6%
AUTHORIZED POSITIONS				
Developmental Centers	6,899.1	6,899.1	0.0	0.0%
Headquarters	382.5	382.5	0.0	0.0%

* The General Fund amount is reduced in this display to reflect the 2009-10 Governor's proposed budget by \$334 million as a savings target.

The Department's Community Services Program Estimates show growth in the 2009-2010 budget year. In response to the state's significant fiscal situation, the Governor's Budget established a \$334 million reduction target for the Community Services Program and directed the Department to work with stakeholders to develop strategies to mitigate the growth. Ultimately, as a product of the Special Session producing the 17-month budget package (SB X3 1), the Legislature approved \$100 million in reductions versus the \$334 million original, proposed amount. This was adopted in addition to the Governor's Special Session proposal to reduce Regional Center purchase of services and operations funds by three percent.

PANELISTS

- Department of Developmental Services
*Please present briefly on recent trends and cost drivers in DDS.
Please present briefly on the impacts of the three percent reduction to Regional Centers implemented in the current year.
Please provide a brief update on the Agnews closure and warm shut-down.*
 - Department of Finance
 - Legislative Analyst's Office
- No Public Comment – Informational Item -

ISSUE 2: REGIONAL CENTER GENERAL FUND REDUCTION**BACKGROUND**

In lieu of the Governor's proposed \$334 million General Fund proposed reduction to Regional Centers, the 2009-10 Budget Act included a \$100 million General Fund reduction. The associated trailer bill (Assembly Bill X3 5, Chapter 20, Statutes of 2009) required DDS to work with stakeholders to submit a plan to the Legislature that identified specific cost containment measures to achieve \$100 million in General Fund on-going reductions starting in 2009-10. In the absence of statutory changes to enact this reduction more specifically and by September 1, 2009, Regional Centers will experience a 7.1 percent reduction for services and supports paid from purchase of service funds.

Responding to this requirement and an April 1, 2009 deadline for submission of proposals to the Legislature for consideration, the DDS held three public forums in Sacramento, Oakland, and Los Angeles. In total, approximately 1,400 stakeholders attended these forums. Additionally, the DDS participated in a California Disability Community Action Network town hall meeting and DDS received over 1,350 written recommendations outlining budget suggestions. The Department also convened workgroup meetings to discuss proposals with representatives from statewide stakeholder groups impacted by the reductions.

DDS states that of importance to stakeholders generally were proposals with the least adverse impact on the consumer while still ensuring program and service integrity. Other goals included maximizing the use of generic resources pursuant to the Lanterman Developmental Disabilities Services Act, and maximizing receipt of federal funds.

PROPOSALS

In total, there are 15 cost containment proposals that are the outcome of the DDS stakeholder process. Each of these proposals but one requires trailer bill language to effectuate the change. The Administration continues to work on developing trailer bill language and circulating it to members of the stakeholder group for review and input. Subcommittee staff has received a majority of these drafts and input sent to the group thus far and will continue to track the proposals and how they change given feedback and adjustments.

The proposals are listed here in sets. For each set of proposals, the Subcommittee asks that first the Department briefly present individually on the proposals listed, with LAO and Finance offering comment, and then after each set is discussed, public comment will be taken on that set, so as to allow for the most fair and efficient hearing

of both the Administration's view and the public's response to and questions about the proposals.

The sets are intended to logically link related proposals or proposals that affect similar populations. The sets in general start with the largest proposals, those that allow for the strongest savings and have the widest impact, to the smaller of the proposals with less General Fund impact.

All proposals are implemented in the 2009-10 budget year, some taking effect immediately presuming a July 1, 2009 effective date and others phased-in at some point during the fiscal year due to ramp-up needs or seeking of federal approvals, where necessary. Full, annualized savings are displayed in the chart below as well. This agenda summarizes each of the 15 proposals and full details on each are available at www.dds.ca.gov/Director/BudgetProposals.cfm.

Sets of Proposals for Purposes of Public Comment.

Set A – Service Redirections

1. Maximize Cost Effective Transportation Services
2. Reduce Costs for In-Home Behavior Intervention Services

Set B – Proposals Related to Supported Living, Day Programs, and Employment

3. Amend Supported Living Services Regulations
4. Implement Uniform 14 Hour Holiday Schedule
5. Increased Consumer Employment and Volunteerism

Set C - Proposals Impacting Children

6. Neighborhood Preschools
7. Use of Private Insurance for Early Start Consumers
8. Restrict Eligibility for Early Start

Set D – Proposals With Savings of Less Than \$5 Million

9. New Service for Seniors at Reduced Rate
10. Access to IHSS Services and Hours
11. Expansion of In-Home Respite Agency Worker Duties
12. Reduction in One Time Regional Center Funding
13. Eliminate Triennial Quality Assurance Review
14. Parental Fee Program
15. Quality Assessment Consolidation

PANELISTS

(For Overview and Each Set)

- Department of Developmental Services
- Department of Finance
- Legislative Analyst's Office
- Public Comment

SUMMARY	09-10 Savings		Annual Savings		
	Dollars in Millions	TF	GF	TF	GF
1. Maximize Cost Effective Transportation Services	18.4	16.9	39.9	36.6	
<p>Effective July 1, 2009, at the time of development, scheduled review, or modification of a consumer's IPP or IFSP, regional centers: shall not fund specialized transportation services for adults who can access and utilize public transportation; shall only fund the least expensive transportation modality that meets the consumer's need; fund transportation to the nearest program that can meet a consumer's needs as identified on the IPP/IFSP; and shall only fund transportation services for minor children when the family provides documentation that they can not provide transportation.</p> <p>Regional centers purchase transportation services for consumers of all ages. Transportation is provided so consumers can get to work, day and infant programs, social-recreation activities, therapies and medical care, etc. Regional center funded transportation services include specialized transportation, vouchers, taxis, bus passes for public transportation systems, and services provided by day and residential programs as an additional component of their vendored service. In FY 2007-08, regional centers spent \$114.8 million purchasing transportation services for nearly 56,000 consumers. An additional \$100 million was expended on contract transportation services.</p>					
2. Reduce Costs for In-Home Behavior Intervention Services	8.1	6.4	16.2	12.8	
<p>Reduce POS costs for in-home behavior intervention services by refining Service Code (Client/Parent Support Behavior Intervention Training) and Service Code 077 (Parent Coordinated Home Based Behavior Intervention Program for Autistic Children). These service codes will refine the two services such that group instruction on behavior intervention for parents (and/or guardians) must be completed prior to receipt of in-home behavioral services. Training would include the basics of behavior intervention, how to manage less severe behavioral challenges, and the role and responsibilities of parents (and/or guardians) in the provision of in-home behavioral services.</p> <p>In fiscal year 2007/08, regional centers spent at least \$44,527,003 on in-home behavior services for consumers residing in their families' homes. These costs include those billed to Service Code 048 (Client/Parent Support Behavior Intervention Training) and Service Code 077 (Parent Coordinated Home Based Behavior Intervention Program for Autistic Children).</p> <p>Behavior intervention services are a proven model and often critical to a consumer remaining with their family at home. Currently, at least three regional centers (Valley Mountain Regional Center, North Los Angeles Regional Center, and Frank D. Lanterman Regional Center) provide group training to parents on behavior intervention. In-home behavioral interventions require a significant time commitment on the part of family members. Some family members are not aware of the time commitment and/or could benefit from group training in lieu of in-home behavioral services. Training would be provided by a Board Certified Behavior Analyst with teaching experience and costs approximately \$1,200 per training. For an average size regional center, the assessed need is about 24 trainings per year.</p>					
3. Amend Supported Living Services (SLS) Regulations	10.5	6.9	21.0	13.8	
<p>Regulations would be amended to (1) require regional centers to review and renegotiate contracts to specify allowable administrative costs; (2) restrict the conditions under which a regional center can supplement a consumer's rent; and (3) require regional centers, to the extent feasible and appropriate, to utilize the same SLS</p>					

SUMMARY	09-10 Savings		Annual Savings		
	Dollars in Millions	TF	GF	TF	GF
<p>provider for consumers who share a home. The proposal requires SLS agencies to develop and promote the use of natural or generic resources (such as housing subsidies and SSI/SSP).</p> <p>SLS consist of a broad range of services to adults with developmental disabilities who, through the Individual Program Plan (IPP) process, live in homes they themselves own, rent, or lease in the community. In FY 2007/08, approximately 9,500 individuals used SLS at a cost of approximately \$300 million. Each of the proposals is reflected in pending draft regulations the stakeholder community has already reviewed.</p>					
4. Implement Uniform 14 Hour Holiday Schedule	22.0	16.3	22.0	16.3	
<p>Implement a 14 day Uniform Holiday Schedule for day programs, look-alike day programs, and work activity programs. Eighteen regional centers currently establish a uniform holiday schedule varying from six to twelve days annually. The other three regional centers estimate that, on average, service providers have nine to ten holidays annually. DDS sets the uniform holiday schedule for work activity programs at ten holidays per year. By increasing the number of mandatory holidays to a uniform number statewide, savings to the general fund would be achieved. To add four days and minimize the impact on residential services, it is proposed that those additional days be during the week between December 25th and January 1st.</p> <p>The savings would be achieved both through the closure of day programs, look-alike day programs, and work activity programs, and all the associated transportation costs to and from those programs. Should a program elect to remain open it would not be funded by the regional centers for services and regional centers would not fund transportation on the specified days.</p>					
5. Increased Consumer Employment and Volunteerism or Custom Endeavors Option	17.1	12.7	17.1	12.7	
<p>Custom Endeavors Option (CEO) will offer the opportunity to develop a customized employment or volunteer option with support from existing providers for 5% of current population. Participating providers would not be able to increase their current program capacity, as reflected in their program designs and/or by licensing requirements.</p> <p>Currently over 51,000 adults are served by day program and look-alike day program providers. Consumers currently served by day programs and look-alike day programs often want to work, volunteer, or become self-employed. Some of these consumers are utilizing day programs because the supports needed to help them achieve their goals are not available. Utilizing existing service providers, five percent of existing consumers could be supported to develop and maintain their employment or volunteer activities.</p>					
6. Neighborhood Preschools	8.9	8.9	17.8	17.8	
<p>Expand the availability and use of neighborhood preschools as a natural environment service setting which may be less costly than segregated center-based infant development programs. In some areas of the state, regional center funds social/recreational programs (525) at \$13.12 to \$24.74 per hour or preschool using the Child Day Care (851) service code at a "usual and customary" or negotiated rate. These programs are used to enhance social/emotional or language development. However, they do not meet the description for specialized instruction or therapeutic services. Occasionally, individually vendored early interventionists and therapists are funded to provide EI services in a preschool setting at the "usual and customary" or Medi-cal rate.</p> <p>Neighborhood preschools provide a variety of child care and development programs to young children and youth up to 12 years of age. Preschools may include public and private programs. Specific services and age ranges offered are based on program design. Preschool programs under California Department of Education's Child Development Division serve three to five year olds and are state and federally funded. Their rates are based on "usual and customary rates" in each region of the state. In order for preschool services to be comparable to an IDP, an EI provider must be funded to provide specialized instruction in addition to preschool services.</p> <p>It is estimated that a preschool program funded at \$19 per hour for 3 hours 3 times per week would result in a cost of \$171 per week. Add an additional cost for an early interventionist or speech therapist to provide specialized EI services at a cost of \$136 for 1 hour of intervention 3 times a week for a total cost of \$307 per week for preschool and therapy services. IDP center-based services would be approximately \$549 for 3 hours 3 times per week whereas neighborhood preschool services would be an estimated \$242 less than the cost for the IDP.</p> <p>Based on DDS' Expenditure Information Report by Budget Category for 2007-08, there were 30,700 children served by IDPs. It is estimated that 5% of those children (1,535), 18 months of age or older, could be served in a</p>					

SUMMARY	09-10 Savings		Annual Savings		
	Dollars in Millions	TF	GF	TF	GF
neighborhood preschool program at a savings of \$242 per week for six months resulting in a total savings of \$8,915,280 for six months.					
7. Use of Private Insurance for Early Start Consumers	6.5	6.5	13.0	13.0	
<p>Requires families to access private insurance for all identified medical services, other than evaluation and assessment, for service provision or denial prior to service provision by the regional center as payer of last resort (already required for children age three years and older).</p> <p>Assumptions include:</p> <ul style="list-style-type: none"> • \$89,391,372 estimated medical-related expenditures in FY 2009/10 not related to evaluation and assessment and for which regional centers are paying. • Partial year implementation (\$89.4M / 2 = \$44.7M). • 25% of medical-related costs for families with insurance are covered by insurance (\$44.7M / 4 = \$11.18M). • 58.1% of families have private insurance (California Health Survey, 2005) and medical costs are equally distributed across families (\$11.18 x .581 = \$6.5M). 					
8. Restrict Eligibility for Early Start	15.5	15.5	15.5	15.5	
<p>Prospectively limit eligibility for Early Start services to only those infants/toddlers at the highest risk of a developmental disability in most need of program services entering Early Start at 24 months of age or older.</p> <p><u>Current:</u> Those who are determined 'at risk' can enter the Early Start Program at any age.</p> <p><u>Proposed:</u> Those who are determined 'at risk' and are aged 24 months or older would not be eligible for the Early Start Program.</p> <p><u>Current:</u> Those who have a 'developmental delay' of 33% or greater in one of five domains can enter the Early Start Program at any age.</p> <p><u>Proposed:</u> Those who have a 'developmental delay' in only one domain and are aged 24 months or older would need to have a 'developmental delay' of 50% or greater.</p>					
9. New Service for Seniors at Reduced Rate	1.4	1.0	1.4	1.0	
<p>Create a new service for seniors at a reduced rate and with a corresponding increase in the staffing ratio. The new service is to be provided by the consumer's existing provider. While the service is designed with consumers over the age of 50 in mind, it will be available to any consumer desiring a less rigorous day program. Participating providers would not be able to increase their current program capacity, as reflected in their program designs and/or by licensing requirements.</p> <p>This proposal assumes that consumers currently served by day programs, look-alike day programs, and work activity programs would want to "retire" and receive different services from the same providers at a reduced rate and increased staffing ratio. The current day program model is based on a staff to consumer ratio grounded in providing specific activities and services. A consumer participating in a day program must participate in these activities and services. Individuals with developmental disabilities, similar to their counterparts without disabilities, may enjoy a less intense level of activity. This service is intended enhance the quality of life of seniors with developmental disabilities who would be no longer interested in the current level of activities and services in their day program.</p> <p>This proposal hinges on being able to decrease the amount of support from 1:3, 1:4, and 1:6 down to 1:8 for many of the seniors. To achieve savings, the rate of reimbursement would be reduced from as high as \$72.42/day and as low as \$35.34/day down to \$35/day. Current service providers would not be able to increase their current program capacity. There are three service codes that would not have any rate change.</p>					
10. Access to IHSS Services and Hours	1.9	1.3	1.9	1.3	
<p>Regional centers will be prohibited from purchasing personal care services for consumers who are Medi-Cal beneficiaries. All Supported Living Service (SLS) Agencies will be required to assist a consumer to apply for IHSS within five days of moving into a Supported Living arrangement. That component of the SLS rate that covers personal care services provided during the lag period for IHSS approval shall not exceed the IHSS standard rate. By April 1, 2010, DDS will collaborate with CDSS to develop processes to allow: 1) preliminary assessment for IHSS services to be conducted in CDSS and CDPH licensed facilities and the family home; and 2) reimbursement for regional center costs for personal care services provided during the lag period (time between IHSS application to</p>					

SUMMARY

approval). It is estimated that 10,909 regional center consumers currently receive IHSS Services.

From the time a consumer applies for IHSS services to the time their application is approved; domestic personal care services are purchased through regional center funding in order for consumers to maintain living in a supported living arrangement. The amount of time between application to approval (lag period) varies from one to three months. Reimbursements for these services should be made from the IHSS program at the local county level. Currently, during this lag period, the State is paying a higher rate to the SLS provider (and not benefiting from the county share of cost) than it would if the consumer were enrolled in IHSS. Payment for these services for the lag period to regional centers is at issue. California Department of Social Services' (DSS) policy is that county IHSS offices will reimburse only "out of pocket expenses" incurred in this period, referring to what is paid directly by the consumer for "like" services. In actuality, the consumer does not pay out of pocket for services due to California's service delivery model with funding for all services coming through the regional center. This results in regional centers not getting reimbursed for the waiting period. To remedy this structural discrepancy, DDS proposes that "like services" during consumers' eligibility waiting periods should only be paid at the local IHSS rate for the support their staff provides, not the SLS rate, until a consumer's IHSS eligibility is finally determined.

Further, DDS estimates that a small number of consumers do not apply for IHSS. This is because of either the potential for a share of cost or because of the additional responsibility of being an IHSS employer. This proposal would prohibit regional centers from paying for services that are the responsibility of IHSS. A hardship exemption process would be developed.

Expand the scope of duties performed by In-Home Respite Agency workers to include routine skilled services, consistent with those allowed to be provided by licensed day program staff per Title 22, Division 6, Chapter 3, (Adult Day Program Regulations, Article 8, Section 82092), with the exception of tracheostomy care. Compensate in-home respite workers by providing a \$.50/hour wage increase for hours they are providing the increased skill services (and cover the employer's social security, unemployment, workers' compensation costs associated with the wage increase).

Reduce funding for regional center costs associated with moving and/or expansion. Funding for one time costs associated with relocation and/or expansion is provided to regional centers through the budget process. This unique, one time funding is provided, for instance, to assist a regional center in opening a new branch office in an outlying county with rapid population growth. Funding may also be provided for office expansion (e.g. communication system) to accommodate increased staffing needs associated with caseload growth and/or new mandates.

Eliminate Regional Center funding and requirement for conducting a Triennial Quality Assurance Review of vendored Community Care Facilities. Funding is provided through the core staffing formula to regional centers to meet this regulatory mandate. Current regulations require a quality assurance evaluation be conducted a minimum of once every three years. This evaluation includes record reviews, consumer observation and interviews to determine satisfaction with facility services, and an assessment of the facility in assisting consumers in achieving the individual life quality outcomes. A written report is issued with regional center follow up as needed which may include the provision of technical assistance. This proposal would eliminate this requirement and associated funding.

Update the Parental Fee Program fee that applies to parents of children under the age of 18 who live in any out-of-home care arrangement, whether community or Developmental Center. The current fee was last fully adjusted in 1989. The Parental Fee Program applies to parents of children under the age of 18 who live in any out-of-home care arrangement, whether in the community or a Developmental Center. Parents are assessed a fee based on a sliding scale that varies by family size and income. The fee is the same regardless of where the child is placed out of home. The Department determines the parents' ability to pay, assesses the fee, and bills the parents monthly until the child turns 18. Revenues produced by this program are deposited in the Program Development Fund and

SUMMARY

used for developing expanded community resources.

In order for this proposal to be considered, the increase in parental fees would need to be deposited into the General Fund, rather than the Program Development Fund.

Redirect funding for the Life Quality Assessment (LQA) and the Evaluation of People with Developmental Disabilities Moving from Developmental Centers into the Community (Movers Study) into a single quality assessment tool and data collection effort. The tool will be nationally recognized and programmatically up-to-date. DDS will contract for administration of the tool with the State Council on Developmental Disabilities.

In consultation with stakeholders, DDS will establish a set of nationally recognized quality assurance performance and outcome indicators that will:

- Provide consistent and measurable data for DDS' Quality Management System;
- Enable DDS, regional centers (RCs), and policy makers to benchmark the performance of California against that of other states, as well as a comparison of quality measures across all 21 California regional centers;
- Provide a stratified, random sample of surveys among the entire DDS consumer population; and
- Avoid the duplicative data collection of personal outcome elements (e.g. school, work, health, safety), currently generated by the Client Development and Evaluation Report (CDER).

LAO

LAO has two related recommendations that the Subcommittee has asked for them to present briefly on at the end of this item. These involve the following (taken from the LAO's 2009-10 Budget Analysis Series on Health):

“Cost-Effective” Services Should Be Clearly Defined. We recommend that the Legislature (1) define the term cost-effective with clear elements that generally require RCs to choose the least costly services that are appropriate for an RC consumer, (2) insert the term into additional key sections of the Lanterman Act, and (3) clarify how the requirements for providing cost-effectiveness are to be balanced with a consumer's preference in the services they receive.

Definition of Cost-Effective Should Contain Certain Elements. We believe the term cost-effective should be defined in the Lanterman Act in a way that is meaningful and ensures that it can be applied in a practical way to the decisions that RC staff must make about their purchase of services or supports needed to implement a consumer's IPP. We recommend that the definition clarify that cost-effective services and supports are those that are: (1) either evidence-based or consistent with the current standard of practice, (2) purchased at an economical rate or price, and/or (3) the least costly appropriate option that results in the desired measurable outcome for the consumer. Generally, a definition of cost-effective that contains the elements described above should require RCs to choose the least costly option when choosing between two or more appropriate options.

Cost-Effectiveness Requirement Should Be Applied More Broadly. We also recommend the term cost-effective be inserted into some additional key sections of the Lanterman Act. For example, the Legislature could modify a provision of the Lanterman Act that provides that persons with developmental disabilities and their families are to be assisted in securing services and supports which maximize opportunities and choices in living, working, learning, and recreating in the community. The language could be changed to ensure that *cost-effective* services and supports are to be provided for these purposes. Our review of the Lanterman Act indicates that there are other sections where the term cost-effective could be inserted to clarify legislative intent.

Clarify Relation Between Cost-Effectiveness and Consumer Preference. The Legislature should also clarify how a consumer's choices and preferences in their services are to be balanced against the requirement that cost-effective services be provided to them. State law should specify that when two equally cost-effective and appropriate services are available, consumer preference should generally be the deciding factor, but that the more cost-effective services must be the ones provided if the services preferred by a consumer are a less cost-effective alternative.

Savings Would Grow Over Time. In the report cited above, DDS estimated that codifying the definition of the term cost-effective in the Lanterman Act would result in General Fund savings of approximately \$29 million annually. This estimate was based on the assumption that RC costs for purchases of services would be reduced by 1 percent. It would take about three years to implement such a change as new IPPs are developed for consumers. Accordingly, we estimate that the changes we propose would result in roughly \$5 million in General Fund savings in the first year. These savings could grow to as much as the low tens of millions of dollars annually after three years of implementation.

Implement Regulations to Govern RC Expenditures. The DDS estimate for community services projects that expenditures for the miscellaneous services category will grow from \$338 million in the current year to \$452 million in the budget year, or by about 34 percent. (We note that the Governor's 2009-10 budget plan proposes to reduce overall General Fund spending for the RCs by \$344 million relative to the DDS estimate. However, the budget plan does not allocate this reduction among the various service categories, leaving it unclear how miscellaneous services would be affected by the reduction.) Between 2004-05 and 2007-08, for example, the service expenditure code for special therapy services for children less than three years old almost doubled from \$18.8 million to \$37.2 million, according to DDS data. On a per-person basis during this same time period, spending increased from \$1,699 to \$2,399 or by \$700 per person for these services. A number of other service expenditure codes, such as client and parent behavior intervention training and socialization training program services, have experienced similar growth.

This rate of growth is out of line with other categories of RC services. As shown above in Figure 9, the adjusted total growth rate is 11.8 percent. In comparison, miscellaneous services have been growing at an average annual rate of almost 34 percent. If expenditures for miscellaneous services had grown at the same rate as the adjusted total growth rate of 11.8 percent the proposed 2009-10 level of expenditures would be \$74 million lower.

Regulation of Miscellaneous Services Would Slow RC Spending. State agencies frequently adopt regulations to clarify state law and to help ensure that it is applied consistently. In a number of cases, the adoption of regulations has helped to ensure that expenditures of state funds are properly controlled. Given the rapid rate of growth in the miscellaneous services category, we believe the promulgation of regulations governing the use of these expenditure codes is warranted. Notably, the nine other categories of services that are not growing as quickly as miscellaneous services are generally subject to DDS regulations. We believe it is likely that the adoption of regulations to more carefully limit expenditures for these services would slow the dramatic growth of RC spending for these services.

[LAO recommends] that the Legislature direct DDS to adopt emergency regulations governing miscellaneous services. The promulgation of regulations defining miscellaneous services would clarify what services may be purchased under individual service expenditure codes, thereby limiting expenditures in this service category. We recommend that the department begin with adopting regulations for the miscellaneous services expenditure codes that have seen the largest growth in overall cost, caseloads, and per-person spending.

Possible Questions

Department, what responses have you heard from stakeholders thus far? What have they said about the real client impact?

Department, what is your process for finalization of the proposed trailer bill language?

Department and Finance, what would be the effects of a late budget on the timeline for federal approvals for these proposals?

LAO, what is your view of the fiscal methodology associated with the proposals?

Staff Recommendation

Staff will continue to monitor the development of these proposals from DDS and take stakeholder input in anticipation of more information on the DDS budget and the overall budget situation at May Revision. No action is required at this time.

4440 DEPARTMENT OF MENTAL HEALTH

ISSUE 1: BUDGET OVERVIEW

The Department of Mental Health (DMH) administers state and federal statutes pertaining to mental health treatment programs, including programs that serve Medi-Cal enrollees. The Department also directly administers the operation of five State Hospitals including Atascadero, Coalinga, Metropolitan, Napa, and Patton, in addition to two acute psychiatric programs at the California Medical Facility in Vacaville and the Salinas Valley State Prison.

Though the Department oversees policy for the delivery of mental health services, counties (i.e., County Mental Health Plans) have the primary funding and programmatic responsibility for the majority of local mental health programs as prescribed by State-Local Realignment statutes enacted in 1991 and 1992. Furthermore, counties also have an integral role in the Mental Health Services Act. Specifically counties are responsible for: (1) all mental health treatment services provided to low-income, uninsured individuals with severe mental illness, within the resources made available, (2) the Medi-Cal Mental Health Managed Care Program, (3) the Early Periodic Screening Diagnosis and Treatment (EPSDT) Program for children and adolescents, (4) mental health treatment services for individuals enrolled in other programs, including special education, CalWORKs, and Healthy Families, and (5) programs associated with the Mental Health Services Act of 2004 (known as Proposition 63).

Medi-Cal enrollees may receive mental health services through the Medi-Cal Mental Health Managed Care system or through the Medi-Cal Fee-For-Service system. The Mental Health Managed Care system is administered by the DMH through contracts with counties (County Mental Health Plans). County Mental Health Plans may directly provide services and/or contract with local providers to provide services. If the County Mental Health Plans contract with local providers, it selects and credentials its provider network, negotiates rates, authorizes services and provides payment for services rendered. Services provided through the Fee-For-Service system are general mental health services offered through individual providers who contract with the Department of Health Care Services or service provided through managed care health plans.

The February budget package provides expenditures of \$5.231 billion (\$1.9 billion General Fund) for mental health services. This is an increase of almost \$49 million (total funds) from the revised current-year. It should be noted that \$226.7 million (Mental Health Services Act Funds) of this appropriation is contingent upon passage of Proposition 1E in the May 19th, Special Election. Of the total amount, \$1.384 billion is proposed for long-term care services, mainly to operate the State Hospital system. The remaining \$3.8 billion is for community-based mental health programs.

Summary of Expenditures (dollars in thousands)	2008-09	2009-10	\$ Change
Program Source			
Community Services Program	\$3,814,187	\$3,842,455	\$28,268
Long Term Care Services	1,364,288	1,384,063	19,775
Mental Health Services Oversight and Accountability Commission	4,089	4,739	650
Total, Program Source	\$5,182,564	\$5,231,257	\$48,693
Funding Source			
General Fund	\$2,101,992	\$1,940,084	-\$161,908
General Fund, Proposition 98	15,000	15,153	153
Mental Health Services Fund (Prop. 63)	1,545,216	1,771,064	225,848
Federal Funds	66,262	62,963	-3,299
Reimbursements	1,452,384	1,440,424	-11,960
Traumatic Brain Injury Fund	1,165	1,172	7
CA State Lottery Education Fund	153	--	-153
Licensing & Certification Fund	392	397	5
Total Department	\$5,182,564	\$5,231,257	\$48,693

PANELISTS

- Department of Mental Health
*Please present briefly on recent trends and cost drivers in DMH.
Please present briefly on the impacts of reductions taken in the 2008-09 Budget.*
 - Department of Finance
 - Legislative Analyst's Office
- No Public Comment – Informational Item -

ISSUE 2: MENTAL HEALTH MANAGED CARE AND DHCS SPRING LETTER

The February budget package provides a total of \$226.7 million (General Fund), and corresponding federal funds, for the Mental Health Managed Care Program. This reflects an increase of about \$3 million (\$1.5 million General Fund). The increase of \$3 million primarily includes adjustments for an increase in the number of individuals served in the Disabled Aid category of Medi-Cal, and for increases in the need for Psychiatric Inpatient Services. Individuals in the Disabled Aid category of Medi-Cal increased by 25,000 people for a total of 1.1 million. These individuals require more intensive services.

Under Medi-Cal Mental Health Managed Care psychiatric inpatient hospital services and outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, are the responsibility of a single entity, the Mental Health Plan (MHP) in each county.

Full consolidation was completed in June 1998. This consolidation required a Medicaid Waiver (“freedom of choice”) and as such, the approval of the federal government. Medi-Cal recipients must obtain their mental health services through the County MHP. The Waiver promotes plan improvement in three significant areas—access, quality and cost-effectiveness/neutrality. The DMH is responsible for monitoring and oversight activities of the County MHPs to ensure quality of care and to comply with federal and state requirements. This Waiver expires as of June 30, 2009 and must be renewed with the federal CMS. Under this model, County Mental Health Plans (County MHPs) generally are at risk for the state matching funds for services provided to Medi-Cal recipients and claim federal matching funds on a cost or negotiated rate basis. County MHPs access County Realignment Funds (Mental Health Subaccount) for this purpose.

An annual state General Fund allocation is also provided to the County MHP’s. The state General Fund allocation is usually updated each fiscal year to reflect adjustments as contained in Chapter 633, Statutes of 1994 (AB 757, Polanco). These adjustments have included changes in the number of eligibles served, factors pertaining to changes to the consumer price index (CPI) for medical services, and other relevant cost items. The state’s allocation is contingent upon appropriation through the annual Budget Act. Based on the most recent estimate of expenditure data for Mental Health Managed Care, County MHPs provided a 48 percent match while the state provided a 52 percent match. (Adding these two funding sources together equates to 100 percent of the state’s match in order to draw down the federal Medicaid funds.)

DHCS SPRING LETTER

Spring Letter - Development and Implement a Mental Health Services Supplemental Payment Program (Issue 309). The administration requests expenditure authority and the establishment of 1.0 permanent, full-time position to develop and implement the Mental Health Services Supplemental Payment Program.

The program would authorize County Mental Health Plans to submit certified public expenditures (CPEs) to the Department of Health Care Services (DHCS) for purposes of claiming federal financial participation to reimburse and supplement counties for their costs of mental health services to Medi-Cal beneficiaries. The supplemental payment will consist of the difference between the current fee-for-service rate being paid for these services and the actual costs to the counties to provide mental health services. Trailer bill language is proposed to authorize DHCS to implement the program and to seek federal approval to provide supplemental reimbursement to County Mental Health Plans.

Questions have arisen from advocates on the intent and effect of this language, particularly for private providers under contract with the county.

PANELISTS

- Department of Health Care Services
- Department of Mental Health
- Department of Finance
- LAO
- Public Comment

STAFF COMMENT

The budget for this program will need to be modified at the May Revision to reflect caseload updates, and most importantly, the enhanced FMAP for the program. The enhanced FMAP (at 61.59 percent versus 50 percent) will result in state General Fund savings, as well as in County Realignment Fund savings.

The DMH estimate also includes \$485,000 (General Fund) for supporting certain ancillary services (physical health services) within Institutes for Mental Disease (IMD) which is no longer applicable. This would save \$485,000 (General Fund).

Possible Questions

What is the status of the federal waiver for the program? What is the timeline for the renewal package? Will the program change in any way as a result of this renewal?

How has DHCS and DMH responded to the questions raised from stakeholders on the Spring Letter and the associated TBL regarding the Supplemental Payment?

Staff Recommendation

Staff recommends holding these issues and the Spring Letter open pending the May Revision and additional discussions between stakeholders and the administration.

ISSUE 3: COMMUNITY MENTAL HEALTH FISCAL OVERSIGHT AND RELATED BCP

State Fiscal Integrity and Federal CMS Audits. Significant fiscal management issues have continued to be raised regarding the state's administration of the overall Medi-Cal mental health system (including the Early and Periodic Screening and Treatment Program, and Mental Health Managed Care). There are several aspects to this concern, but first and foremost are fiscal audits by the federal Centers for Medicare and Medicaid (CMS), coupled with the need for continued work to "restructure" the payment process for the state to reimburse counties and other providers within a 30-day period, versus the 90-day to 120-day timeframe that exists today.

The DMH acknowledges that a "restructuring" of their payment process to shorten their current claiming, mainly for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, to pay claims within 30-days is necessary. They have been working diligently with the DHCS to craft such a process. The Administration states that a new computer system—the "Short-Doyle/Medi-Cal Phase II" will, among other things, provide adjudicate claims and appropriately reimburse counties and providers for services rendered. However, the DMH needs to implement considerable accounting system changes to interface with this system. Further, the Short-Doyle/Medi-Cal Phase II system will not be ready for beta testing until February 2010.

The Legislature has discussed fiscal integrity issues regarding the operation of state mental health programs for the past three years, including five reports prepared by the Office of Statewide Audits and Evaluations (OSAE), Department of Finance. Though progress has been made to more comprehensively monitor, track and coordinate claims processing functions, considerably more work needs to be done.

Federal CMS audits and the need to quickly restructure the claims processing system, will require a concerted effort on the part of the Administration. The federal CMS has recently released two audits with findings and presently has three more audits that are in process. All of these audits and reviews pertain to concerns regarding lack of fiscal controls, overpayments, and lack of coordination with the Department of Health Care Services regarding the management of reimbursements made under Medicaid.

Key findings and outcomes from the two released audits (in September 2008 and December 2008) include the following:

- The DHCS and DMH systems are not adequate to comply with federal reporting requirements, resulting in the total mental health program expenditures reported to the federal CMS (using form 64) likely to be significantly misstated.
- DMH transferred a total of almost \$21 million in federal funds back to the federal CMS as repayment for "excess" federal funds it had claimed incorrectly, due to overpayments in the EPSDT Program (for 2003-04), and claims the DMH made for programs not operated under Medi-Cal (i.e., certain state-only programs and other federal programs).

- The DHCS does not appear to provide adequate oversight over the Medicaid mental health program, specifically over the processing of DMH invoices (such as for the EPSDT Program and Mental Health Managed Care Program).
- California's existing reimbursement methods, processes and policies are not fully consistent with federal law, particularly regarding interim payment, reconciliation and cost-settlement processes. Therefore, the state must provide the federal CMS with a "State Plan Amendment" by July 1, 2009 that articulates all of these practices.
- By July 1, 2009, California must implement controls to ensure that the process used to count County Realignment Funds (i.e., "certified public expenditures") towards the federal match, meets federal requirements.
- California needs to implement procedures to ensure adequate oversight of amounts claimed as Medicaid mental health costs.

The three remaining federal CMS audits which are presently underway are described below:

- **Audit #3—Financial Management Review.** The federal CMS has completed field work at five counties, including San Francisco, Los Angeles, San Diego, Orange, and Sacramento to examine how counties utilize their County Realignment Funds to draw federal matching funds, and other aspects of the reimbursement process. Outcomes from this review are still pending.
- **Audit #4—Payment Error Rate Measurement Audit.** The federal CMS conducts this audit to identify program vulnerabilities that result in improper payments and to promote efficient Medicaid (Medi-Cal in California) programs. The state is presently working with the federal CMS regarding a "Post Project Review" document and a "Corrective Action Plan"; this information is due to the federal government by April 1, 2009.
- **Audit #5—Program Integrity Audit.** The federal CMS conducts this audit to determine overall program integrity to policies and procedures, and to learn how states receive and use information about potential fraud and abuse involving Medicaid providers. It is anticipated that the federal CMS will release the results of this audit in 60-days or so.

Enhanced Federal Funds through ARRA. According to the DHCS, California is to receive an increase in the Federal Medicaid Assistance Percentage (FMAP) of 11.59 percent which would provide for a 61.59 percent FMAP for the overall Medi-Cal Program from October 1, 2008 through December 2010. Specifically, this enhanced FMAP would provide California with at least \$10.112 billion in additional federal funds for the 27-month period.

This enhanced federal funding is also applicable to the Medi-Cal program components administered by the DMH, including the EPSDT Program and Mental Health Managed Care Program because they serve Medi-Cal enrollees. However, the FMAP increases apply only if a state conforms to certain specified requirements, including the timely reimbursement of claims based on period of service.

**Specialty Mental Health Waiver
BCP**

The Department of Health Care Services requests resources to correct significant fiscal integrity, accounting, reimbursement, and electronic claims processing issues identified by the federal government and OSAE in the Specialty Mental Health Services Waiver. This was a BCP that was removed from the 2009-10 Budget Act without prejudice to allow for further consideration.

The BCP requests to convert one limited-term (LT) manager to a permanent position, correct the funding source of the LT manager position, and establish two new specialist positions on a permanent basis. The Administration states that the proposal will allow the State to correct deficiencies identified by CMS and OSAE and to comply with federal Medicaid requirements for the waiver and DHCS' role as the Medicaid Single State Agency. With the addition of these staff, the administration says that the State may face budget deficiencies, overpayments, and interest penalties for late payments to county Mental Health Plans. In addition, the federal government could cancel the Medi-Cal Specialty Mental Health Services Waiver program, resulting in the loss of more than \$1 billion per year in Federal Financial Participation (FFP) for California.

PANELISTS

- Department of Health Care Services
- Department of Mental Health
- Department of Finance
- LAO
- Public Comment

Possible Questions

How will the Administration restructure the payment process for the state to reimburse counties and other providers within a 30-day period to ensure timely payment and the receipt of federal funds?

Department, please provide an update on the implementation of the Short Doyle/Medi-Cal computer system? To what extent have you collaborated with counties on this automation project?

Staff Recommendation

In line with pending action in the Senate, adopt placeholder trailer bill language to require the DHCS to provide the results of any federal audits, including federal CMS or any other federal agency, regarding the Medi-Cal Program to the fiscal and policy committees of the Legislature.

ISSUE 4: EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM

The February budget package appropriates a total of \$1.1 billion (\$283.7 million General Fund, \$226.7 million Mental Health Services Act Funds, \$166.4 million County Realignment Funds, and corresponding federal funds). It should be noted the \$226.7 million in Mental Health Services Act funds assumes passage of Proposition 1E in the May 19th Special Election.

Most children receive Medi-Cal services through the EPSDT Program. Specifically, EPSDT is a federally mandated program that requires states to provide Medicaid (Medi-Cal) recipients under age 21 any health or mental health service that is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition identified by an assessment, including services not otherwise included in a state's Medicaid (Medi-Cal) Plan. Examples of mental health services include family therapy, crisis intervention, medication monitoring, and behavioral management modeling.

Though the Department of Health Care Services (DHCS) is the "single state agency" responsible for the Medi-Cal Program, mental health services including those provided under the EPSDT, have been delegated to be the responsibility of the Department of Mental Health (DMH). Further, County MHPs are responsible for the delivery of EPSDT mental health services to children.

The 2009-10 estimate assumes a \$43.1 million (General Fund) increase over the Budget Act of 2008. The DMH states this increase is based on 70-months of historic data, and is weighted using 13 independent services used within the program, such as Mental Health Services; Psychiatric Health Facility; Crisis Stabilization; Day Treatment; Therapeutic Behavioral Services; Medication Support; and Targeted Case Management. The DMH notes the EPSDT service that reflects the most growth is in the Mental Health Services category, which increased by 11 percent over the revised current-year. This category is for expenditures that pertain to individual or group therapies and interventions that are designed to provide a reduction of mental disability and restoration. Service activities may include assessment, plan development, therapy rehabilitation, and family services. This is a very broad category of service and reflects about 80 percent of the EPSDT Program's expenditures.

The DMH does not provide analysis as to why this category is increasing nor do they provide any other key fiscal information, such as the basis for the expenditures or related assumptions. Further, the DMH provides no discussion regarding changes to the program that were implemented in the Third Extraordinary Special Session of 2008 (February 2008) or the Budget Act of 2008. In addition, a Special Master's Nine Point Plan (Plan) for the provision of Therapeutic Behavioral Services (i.e., Emily Q. Settlement), approved by the court on November 14, 2008 is not referenced as a policy issue in the estimate package. Though this Plan will be phased-in over time, it should

have been discussed in the estimate package and it will likely require some funding in 2009-10.

Instead of more drastic reductions proposed in the Special Session, the Legislature enacted statutory changes to require the DMH to implement a "Performance Improvement Project (PIP)" for the EPSDT Program. This action was taken in lieu of yet other reductions proposed by the Governor that would have potentially eliminated some children from treatment. The PIP was assumed to save \$12.1 million General Fund in 2008-09 by targeting coordination and integration of care for children through case management, and by achieving certain administrative efficiencies.

PANELISTS

- Department of Mental Health
- Department of Finance
- LAO
- Public Comment

STAFF COMMENT

The budget for this program will need to be modified at the May Revision to reflect caseload updates, the enhanced FMAP for the program, and potentially, the Special Master's Nine Point Plan for Therapeutic Behavioral Services. DMH should provide status updates enacted through last year's budget process, including their monitoring of the EPSDT Program, implementation of the PIP, and the effects of any other changes.

Possible Questions

How is the DMH planning to provide a more detailed estimate for EPSDT at May Revision?

Department, what information can you share on the reasons for increased utilization in EPSDT?

Staff Recommendation

Hold these issues open pending the May Revision.

ISSUE 5: STATE HOSPITALS – OVERVIEW AND ISSUES**OVERVIEW**

The Budget Act of 2009 provides an appropriation of \$1.384 billion (\$1.289 billion General Fund, and \$95.1 million in Reimbursements) for the State Hospital system, including the operation of five State Hospitals—Atascadero, Metropolitan, Napa, Patton, and Coalinga-- and two acute psychiatric programs at the California Medical Facility in Vacaville, and Salinas Valley State Prison. This amount also includes state administrative support.

The budget reflects an increase of \$19.8 million (increase of \$42.5 million General Fund). These increases are primarily due to: (1) continued implementation of a settlement agreement with the federal government regarding the Civil Rights for Institutionalized Persons Act (CRIPA); (2) continued activation of Coalinga State Hospital; and (3) increases for “Non-Level of Care” support at Salinas Valley State Prison. Each of these issues, along with patient population adjustments will be discussed further below.

Overall Classifications of Patient Population & Funding Sources. Patients admitted to the State Hospitals are generally either (1) civilly committed, or (2) judicially committed. These referrals come from County Mental Health departments, the courts, and the CA Department of Corrections and Rehabilitation (CDCR). As structured through the State-Local Realignment statutes of 1991/92, County Mental Health Plans contract with the state to purchase State Hospital beds for civilly-committed individuals when appropriate (versus using community-based services). Counties reimburse the state for these beds using County Realignment Funds.

Civil Rights for Institutionalized Persons Act (CRIPA). In July 2002, the U.S. DOJ completed an on-site review of conditions at Metropolitan State Hospital. Recommendations for improvements at Metropolitan in the areas of patient assessment, treatment, and medication were then provided to the DMH. Since this time, the U.S. DOJ identified similar conditions at Napa, Patton, and Atascadero (Coalinga was not involved). The Administration and US DOJ finally reached a Consent Judgment on May 2, 2006.

Based on recent fiscal data, the Legislature has approved about \$31 million (General Fund) to enhance care at the four hospitals under the Consent Judgment (Coalinga State Hospital has not been formally included by the DOJ) to meet CRIPA requirements. According to the Consent Judgment, the DMH has until November 2009 to fully comply. The Legislature receives periodic updates from the DMH regarding compliance.

ISSUES

State Hospital Estimate. Due to increasing expenditures at the State Hospitals and the need for budget accuracy, the Legislature required the DMH to submit a comprehensive budget “estimate” package with the Governor’s budget (i.e., annually in January and at the May Revision). This estimate package has evolved over time but the need for more detail has become evident. The DMH has been open to making changes to their estimate package. Each year more information has been provided, and further clarity has been achieved. However, with the tremendous growth in the program—a 20 percent annual increase in the past three years—compacted with high vacancy rates in clinical positions, increasing operating costs, and the need to meet CRIPA compliance—more information needs to be provided. There are several components to this discussion, including both short-term and longer-term considerations.

The OSAE conducted an audit of the DMH’s State Hospital budget estimate process (dated December 2008). This audit came forth as efforts to provide more detailed information to the Legislature evolved, and concerns emerged as cost increases and patient caseload at the State Hospitals became more difficult to project (due to statutory changes, lawsuits, and interactions with the CA Department of Corrections and Rehabilitation).

The OSAE made the following observations in their audit report (which were within the scope of their audit):

- The DMH methodology for estimating patient caseload and Level-of-Care staff appears
- to be reasonable and adequately supported;
- The DMH methodology for estimating operating expenditures appears to be reasonable
- and adequately supported;
- Coalinga State Hospital operating expenditures were not included in the Budget Act of 2008 projection (note—DMH has corrected for this.); and
- Hospital expenditures are adequately monitored.

The OSAE also noted several other matters in their report which were outside the scope of this particular audit but came to their attention. As such, OSAE stated that the following issues should be considered to improve State Hospital operations:

- The current staffing model may not adequately reflect hospital work load;
- The equity pay increases resulting from lawsuits (such as Coleman, Plata and Perez) have not been incorporated into the budgeted overtime allocations; and
- Funding is insufficient for annual operating expenditures.

OSAE generally noted that DMH’s calculations and expenditures information supporting their budget estimate are accurate. Moreover, OSAE stated that the State Hospitals and DMH headquarters monitor operating expenditures to prioritize spending and

prevent deficits. As a result of the OSAE audit, the DMH must provide a “corrective action plan” to OSAE in response to the specific items which need to be modified, including a schedule of work products to be completed and timelines.

LAO

The LAO is seeking several changes to both the Governor’s budget display for the State Hospitals, as well as considerable changes to the DMH Estimate Package for the State Hospitals. Specifically they are recommending the following:

- Require the DOF to display in the Governor’s budget summary (January document) a breakout of expenditures by State Hospital.
- Require the DMH to provide funding for the OSAE to contract with an independent consultant to identify what, if any, improvements are necessary to the current staffing model for the State Hospitals, including both Level-of-Care and Non-Level-of Care. The consultant should provide an evaluation of workload distribution issues, all staffing ratios, and overtime. In addition, the LAO states that said consultant should also review whether the staffing levels established to meet federal CRIPA requirements are appropriate.
- Require the DMH to include additional information in the Estimate Package, including the status of CRIPA compliance, waiting lists for State Hospital admissions, staffing vacancies and related recruitments, and various performance measures (such as average length of stay for patients broken out according to their hospital, commitment category, and major diagnosis).
- Finally, the LAO is requesting the Legislature to direct the Administration to participate in a workgroup with legislative staff to develop an improved budget format for its January and May Revision packages.

STAFF COMMENT

The OSAE generally noted that DMH’s calculations and expenditures information supporting their budget estimate are accurate. OSAE also noted that DMH adequately monitors their State Hospital expenditures. However, the State Hospital Estimate Package has evolved over time and indeed needs to be modified to more comprehensively reflect various cost factors. In light of the OSAE findings, the DMH recognizes the need for changes and desires to take constructive steps over time.

Specifically, DMH has informed the Legislature that it intends to take the following actions in time for the May Revision:

- (1) Include Level-of-Care and Non-Level-of Care charts to display personnel at the State Hospitals more comprehensively.
- (2) Include prior-year expenditure charts for comparison purposes.
- (3) Provide key program updates including a statement of change, if any, from the last estimate. For example, information regarding the activation of new beds.

(4) Provide information regarding future fiscal issues, if any. Further, the DMH is willing to convene a workgroup in Fall to further discuss potential changes in its methodology and Estimate Package process.

Possible Questions

What is the outlook for meeting the compliance deadline for CRIPA?

What are the most immediate pressures in the state hospitals for budget year?

What are the dynamics around the hiring and retention of Level of Care and Non-Level of Care staff?

Staff Recommendation

No action is recommended at this time and review of the State Hospitals budget will continue at May Revision.