

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

Assemblymember Hector De La Torre, Chair

MONDAY MAY 9, 2005, 2PM
STATE CAPITOL, ROOM 444

VOTE ONLY CALENDAR

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VOTE ONLY ITEMS

ITEM 4260 DEPARTMENT OF HEALTH SERVICE - PUBLIC HEALTH

ISSUE 1: ELECTRONIC DEATH REGISTRATION SYSTEM

The budget proposal is to expend \$225,000 from the Health Statistics Special Fund to deploy the Electronic Death Registration System (EDRS) and to train system users to ensure the successful integration of EDRS into local registration/business processes. The funding comes from the Health Statistics Fund and no fee increase is required to implement the program. The program will contract with the University of California – Davis for the deployment of the system and for training the local government users of the system.

ISSUE 2: OFFICE OF BI-NATIONAL BORDER HEALTH

The budget proposes to eliminate General Fund support, \$604,000, for the California Office of Bi-national Border Health. The Office of Bi-national Border Health contractor would be given at least 30 days notice of the contract termination.

ISSUE 3: CALIFORNIA ASTHMA PUBLIC HEALTH INITIATIVE

Funding for both the California Asthma Public Health Initiative programs, Childhood Asthma Initiative and the California Asthma Among the School Aged will expire on June 30, 2005. The programs received approximately \$13 million in fiscal year 2004-2005.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – PUBLIC HEALTH**ISSUE 4: IMPACT PROGRAM**

The Prostrate Cancer Coalition requests the Legislature appropriate \$6.5 million for the IMPACT (Improving Access, Counseling and Treatment for Californians with Prostate Cancer) Program.

ISSUE 5: BETTER STATE OF HEALTH

The number of overweight people in California has been increasing over time. Being overweight is a significant factor in disease, disability, premature death, and creates a burden to the state for increasing health care costs. To address the health care aspects of the problem the Governor's budget includes approximately \$6 million in General Fund resources to implement a variety of proposals to promote healthy nutrition, increased physical activity, and obesity prevention. The Governor's initiative is outlined in the table from the Legislative Analyst Office below.

Figure 4		
Proposed Components of Anti-Obesity Initiative		
<i>(Dollars in Thousands)</i>		
	DHS Positions	General Fund
DHS coordinating office	1	\$371
Community action grants	1	3,029
Training and technical assistance	—	500
Enhanced health services for Medi-Cal children	—	1,408
Surveillance, evaluation, and research	—	500
Public relations	—	150
Miscellaneous OE&E expenses	—	76
Totals	2	\$6,034

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL**ISSUE 1: DENTAL BENEFIT MODIFICATION**

Commencing in the 2005-2006 fiscal year, the Governor's budget proposes to limit Adult Dental Services to \$1,000 per rolling 12-month period. The budget projects a savings of \$48.2 million (\$24.6 million General Fund) in 2005-06. An implementation date of August 1, 2005 is assumed. This proposal requires trailer bill legislation to enact. There are nearly 3 million adults in the Medi-Cal program. Approximately 95,000 Medi-Cal beneficiaries would be subject to the cap.

The Department projects there will be no savings in the budget year from the proposal.

ISSUE 2: BENEFICIARY COST SHARING

The Department of Health Services is authorized to collect insurance premiums. The proposal would add 3.5 positions to the Department and the initiative would cost \$2.282 million, \$650,000 General Fund. The proposal would increase Local Assistance payments by a total of \$12.394 million, \$6.197 million General Fund.

The 2005-2006 Budget proposes to establish monthly premiums for certain families, children, elderly individuals, and persons with disabilities. Effective January 1, 2007, Medi-Cal enrollees with incomes above 100 percent of the federal poverty level would pay a monthly premium to maintain their Medi-Cal coverage. The 100 percent of poverty threshold represents \$1,306 per month for a family of three, \$812 a month for a senior, or disabled individual, and \$1,437 a month for a couple receiving SSI/SSP. Exempted from the premium requirement are share-of-cost beneficiaries, 1931 (b) families enrolled in CalWORKS, infants under one year of age, American Indians, and Alaskan Natives.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES MEDI-CAL**ISSUE 3: EASING ENROLLMENT FOR CHILDREN**

The proposed budget's purpose is to improve the Medi-Cal eligibility determination process for children that apply through the Single Point of Entry (SPE) application. The SPE would become a centralized, one-stop center to make preliminary eligibility determinations for Medi-Cal applications submitted through SPE. Final eligibility determination for children-only Medi-Cal applications would shift from the counties to the State.

ISSUE 4: ESTABLISH AND MONITOR COUNTY PERFORMANCE STANDARDS

The Governor's Budget provides resources (2.5 positions and \$297,000, \$148,000 General Fund) for the establishment of performance standards in the Medi-Cal/Healthy Families Bridge Program. Also, the Governor's Budget provides resources, (\$995,000 total funds and \$312,000 General Fund) for county performance standard verification, contract monitoring staff, and follow-up services to monitor counties and impose sanctions for not meeting performance standards. Currently, counties submit reports to the Department of Health Services annually to certify if they met all of the performance standards. There is no verification of the self-reported certifications from the counties.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES - MEDI-CAL**ISSUE 5: INTERMEDIATE CARE FACILITIES STAFFING**

The Intermediate Care Facility for Persons with Developmental Disabilities – Continuous Nursing (ICF/DD-CN) was established by AB 359 (Aroner, Chapter 845, Statutes of 1999). The program is a pilot that requires the Department to explore more flexible models of health care facility licensure to provide continuous skilled nursing care to medically fragile developmentally disabled individuals in the least restrictive setting. The budget proposes to extend four limited-term positions that are currently scheduled to expire January 1, 2006. The positions would be extended to January 1, 2008, the sunset date of AB 359.

ISSUE 6: DISPROPORTIONATE SHARE HOSPITAL OVERSIGHT

The budget proposes to add two fulltime, permanent positions in the Medi-Cal Operations Division (MCO) of the Department of Health Services. In addition, the budget proposes to add two limited term positions for 18 months in the Medi-Cal Policy Division.

ISSUE 7: STAFFING FOR MEDI-CAL ADMINISTRATIVE ACTIVITIES AND TARGETED CASE MANAGEMENT

The Governor's Budget provides resources to address the increased workload within the Medi-Cal Administrative Activities (MAA) and the auditing requirements in the Targeted Case Management (TCM) program. The funding is through the Local Governmental Agencies (LGA) reimbursement contract and matched with federal funds, \$938,000, \$469,000 in reimbursements from Local Government Agencies and \$469,000 in federal funds. No general funds are required.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES**ISSUE 8: PACE**

PACE, Program of All-inclusive Care for the Elderly (PACE), serves seniors in need of nursing home care. With broad range and intense coordination of services provided by PACE, these seniors are able to remain at home and in their communities. PACE provides comprehensive medical and long-term care services, with the program's interdisciplinary team fully coordinating these services. Two-thirds of the program's funding comes from the federal government, through Medicare and Medicaid capitation payments.

ISSUE 9: DISEASE MANAGEMENT (DM)

The Governor's proposed budget includes \$4 million in 2005-06 (\$2 million from the General Fund) for two contracts to establish disease management services. This funding is in addition to the three staff previously provided for implementation of the pilot project. The Governor's budget plan does not assume any Medi-Cal savings from the implementation of the pilot program in 2005-06. According to the LAO, the Department of Health Services has indicated that this is because it is not yet certain that the pilot projects will result in savings. Notably, some Medicaid programs in other states have encountered difficulties in trying to quantify the savings, if any, that have resulted from their DM program.

The Legislative Analyst Office recommends the Legislature approve the \$4 million (\$2 million General Fund) requested by the administration in the 2005-06 budget proposal. This will enable Department of Health Services to continue with implementation of the pilot program. Also, the LAO recommends that the Legislature direct Department of Health Services to report at budget hearings on the potential fiscal and programmatic interaction between the DM pilot project and the proposed Medi-Cal Redesign. The department should explain how it will ensure that it does not pay twice for the same DM services for aged, blind, and disabled Medi-Cal beneficiaries who would be shifted into managed care.

ITEM 4300 DEPARTMENT OF DEVELOPMENTAL SERVICES**ISSUE 1: REGIONAL CENTER COST CONTAINMENT**

The budget proposed for the fiscal year 2005-2006 will continue several cost containment measures enacted as part of the 2003-2004 and 2004-2005 fiscal year Budgets. The actions of the Legislature are projected to save \$71.8 million General Fund in fiscal year 2004-2005. For fiscal year 2005-2006 the Department projects the state will save \$84.363 million in General Fund.

ISSUE 2: EMPLOYMENT SERVICES FUNDING

The California Rehabilitation Association states that the only programs that suffered rate reductions in the past two budgets were employment programs. The affected programs are those that enable people with disabilities to work, earn wages, pay taxes and become more independent. The Association requests the five percent Work Activity Program rate reduction and the two-one-half percent Supported Employment Program rate reduction be restored. The Department estimates the restorations for a full year would increase expenditures \$4.664 million Total Funds, \$3.592 million General Fund.

ISSUE 3: CAPPED EMPLOYMENT PROGRAM RATES

The California Rehabilitation Association requests the Legislature authorize community based day services programs on temporary rates to submit the necessary data to determine permanent rates and to receive permanent rates. The Association projects the expenditures of the state would increase by \$14-15 million.

ITEM 4300 DEPARTMENT OF DEVELOPMENTAL SERVICES**ISSUE 4: DIRECT CARE STAFF WAGE INCREASE**

The California Rehabilitation Association requests the Legislature increase the wages of direct care staff. The Association estimates a one percent increase in wages would cost between \$8 million and \$16 million. A five percent wage rate increase would, therefore, increase the state's expenditures by \$40 million to \$80 million.

ITEM 4440 DEPARTMENT OF MENTAL HEALTH**ISSUE 1: HEALTHY FAMILIES PROGRAM ADJUSTMENT**

The budget proposes a decrease in local assistance reimbursements of \$1.952 million in the current year and an increase of \$352,000 in the budget year to reflect adjustments to the Healthy Families Program. The current year decrease includes a net decrease of \$1,775 million for caseload adjustments and \$177,000 for county administrative costs. The budget year includes a net increase of \$320,000 for caseload adjustments and \$32,000 for county administration.

ISSUE 2: DISASTER PREPAREDNESS - LIMITED TERM POSITION

The Department of Mental Health is requesting a two-year limited term position to allow the Department to participate in state-level bioterrorism planning, preparedness and capacity building. The budget proposes to increase reimbursements to the Department from the Department of Health Services. The Department of Health Services will reimburse the Department of Mental Health \$94,000 from funds provided by the federal government through the Center for Disease Control and the National Bioterrorism Hospital Preparedness Program.

ITEM 4440 DEPARTMENT OF MENTAL HEALTH**ISSUE 3: MANAGED CARE PROGRAM ADJUSTMENTS**

The Department of Mental Health requests a General Fund augmentation of \$5.717 million to reflect adjustments in the Managed Care Program. The adjustments are: an increase of \$5.764 million for an increase in the number of Medi-Cal eligibles in the program; a reduction of \$134,000 to reflect a one percent adjustment for inpatient growth; a reduction of \$2,000 for a decrease in the number of eligibles in the Breast and Cervical Cancer Treatment Program; and an increase of \$89,000 to reflect the implementation of the federal Medicaid Managed Care regulations for Solano County.

ISSUE 4: APRIL 1 FINANCE LETTER – FEDERAL FUNDING FOR PATH

In an April 1st Finance Letter the Department is requesting a \$750,000 increase in local assistance Federal Trust Fund appropriation to reflect additional funds from the Projects for Assistance in Transition from Homelessness (PATH) formula grant. The additional funds will be allocated to the counties based on the Cigarette and Tobacco Surtax formula.

**ISSUE 5: SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES
ADMINISTRATION BLOCK GRANT – APRIL 1 FINANCE LETTER**

The Department requests a \$303,000 increase in its local assistance Federal Trust Fund appropriation. The increase reflects the receipt of additional funds from the SAMHSA Block Grant. The funds will be allocated to the counties based on the Cigarette and Tobacco Products Surtax.

ITEM 4440 DEPARTMENT OF MENTAL HEALTH**ISSUE 6: TRANSFER OF GENERAL FUND APPROPRIATION FROM DEPARTMENT OF CORRECTIONS TO DEPARTMENT OF MENTAL HEALTH – APRIL 1 FINANCE LETTER**

The Administration proposes to make a permanent transfer of \$61.034 million from the General Fund Budget of the California Department of Corrections (CDC) to the state hospital appropriation for the Department of Mental Health to reflect a mutually agreed to decision by both departments. The transfer decision will shift the CDC dollars currently reimbursed to the Department for costs associated with the care and treatment of CDC inmates.

ISSUE 7: EXPANSION OF INTERMEDIATE CARE AND DAY TREATMENT PROGRAMS AT VACAVILLE INPATIENT PSYCHIATRIC PROGRAM

The budget proposes a \$2.330 million increase in reimbursements in the state hospital appropriation in the Budget Year from the CDC. The increase in-reimbursements is to support an increase of 61 intermediate care and day treatment program beds for the Inpatient Psychiatric Program at the California Medical Facility in Vacaville. The funding will support the increase of 22.5 level-of-care positions and 1 non-level-of-care position that will be required when the number of beds increase from 83 to 144. Also, it will provide overtime funding to allow for immediate implementation of the program expansion while recruitment is ongoing for Registered Nurses and Medical Technical Assistants.

ISSUE 8: SAN MATEO PHARMACY AND LABORATORY SERVICES – FUNDING ADJUSTMENTS

The budget proposes to increase expenditures for the San Mateo Field Test Project by \$1.136 million from reimbursements to the Department of Mental Health from the Department of Health Services.

ITEM 4440 DEPARTMENT OF MENTAL HEALTH**ISSUE 9: METROPOPLITAN STATE HOSPITAL – REMODEL OF SATELLITE SERVING KITCHEN**

The Administration proposes to shift funding for a portion of this approved project from lease revenue bond funding to the General Fund. The portion of the project being shifted will renovate all existing Satellite Kitchens and Dining Facilities to meet the requirements of licensing and the cook/chill system.

ISSUE 10: COALINGA STATE HOSPITAL

The budget proposes a continued activation of the Coalinga State Hospital in the Department of Mental Health. The augmentation would be \$74.169 million, \$65.694 General Fund, and \$8.475 million in reimbursements from the CDC. In addition, the Department would receive 893.0 non-level-of-care and level-of-care positions (708.7 PYs) and funding for operating expenses and equipment, workforce recruitment efforts and relocation costs. Also included in the provision of a 50-bed intermediate level is care unit for the CDC.

ISSUE 11: STAFFING FOR YOUTH AND SKILLED NURSING FACILITIES AT METROPOLITAN AND NAPA STATE HOSPITALS

The budget proposes to increase the budget by \$3.6 million for staffing increases at the Youth and Skilled Nursing Facility Programs at Metropolitan State Hospital and the Napa State Hospital. The funding is from realignment reimbursements from counties and has no effect on the General Fund.

ITEM 4440 DEPARTMENT OF MENTAL HEALTH

ISSUE 12: EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT PROGRAM - FUNDING ADJUSTMENTS

The budget proposes a decrease of \$29.164 million in local assistance reimbursements from the Department of Health Services in the current year to reflect adjustments from updated paid claims information to the funding level for the Early and Periodic Screening, Diagnosis and Treatment Program. In addition, the budget proposes an increase in the budget year of \$47.487 million to reflect additional program costs. This includes a State General Fund (SGF) increase of \$27,232,000 and an increase of \$20,255,000 in Federal Financial Participation (FFP). The increase also reflects a slowdown in the rate of growth of the program, which reflects for a total savings for the General Fund of \$15.8 million, and a reduction in Federal Funds of \$13.35 million.

ITEMS TO BE HEARD

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 1: BABYBIG

The mission of the Infant Botulism Treatment and Prevention Program (IBTPP) is to provide and improve the treatment of infant botulism, and to prevent infant botulism and related diseases. The Program became permanently effective in May 1997 when its multi-year clinical trial of the Orphan Drug human Botulism Immune Globulin (BIG) demonstrated its apparent safety and efficacy as the first specific treatment for infant botulism. BIG was officially licensed by the U.S. Food and Drug Administration on October 23, 2003 for the treatment of infant botulism types A and B under the proprietary name of BabyBIG®.

The IBTPP is statutorily established (H&SC Sect. 123700-123709) as a fee-supported, Special Fund activity that is required 1) to produce and distribute BabyBIG® statewide and nationwide, 2) to provide diagnostic and consultative medical services for infant botulism, 3) to investigate all cases of infant botulism in California, 4) to develop and implement prevention and control measures for infant botulism and related illnesses (e.g., some cases of SIDS, crib death), and 5) to carry out applied research into improving the prevention and treatment of infant botulism and related illnesses.

BabyBIG® represents the "standard-of-care" for all patients hospitalized with infant botulism. The high national profile of the program is also a consequence of its interactions with the U.S. Food and Drug Administration (FDA), the U.S. Centers for Disease Control and Prevention (CDC), the Massachusetts Public Health Biologic Laboratories, all California local Health Departments and approximately 200 major university, children's, and community hospitals statewide and nationwide.

Through the development phase the program was funded by loans from the State's General Fund. The loan from the General Fund is approximately \$3.5 million and it is to be repaid from the fees charged providers. At the current rate of utilization it will take three to four years to repay the loan. There is only one alternative to BabBIG and that is a horse derived serum that has significant side effects. The Department of Health Services projects 80 to 100 cases per year nationally will utilize the serum. In addition to the repayment of the loan, the Fund has to accumulate a sufficient reserve to use for paying for the manufacturing of the next round BabyBIG. The General Fund may well not be available to fund the production of BabyBIG.

Each dose of BabyBIG costs \$45,300 to purchase. California averages somewhere near forty cases per year. There is no specific reimbursement mechanism to reimburse the hospitals that provide the medical care to young children stricken with the potentially lethal disease. To address the reimbursement of providers the following placeholder trailer bill language would require the California Medical Assistance Commission to specifically consider the costs of BabyBIG in its reimbursement rate contract negotiation with hospitals.

Placeholder Trailer Bill

Welfare and Institutions Code Section 14085.6(g)(4)

Be able to demonstrate a purpose for additional funding under the selective provider contracting program including proposals relating to emergency services and other health care services, including infrequent, yet high-cost services such as anti-AB human antitoxin treatment for infant botulism (HBIG - human botulinum immune globulin, commonly referred to as "Baby-BIG"), that are made available, or will be made available, to Medi-Cal beneficiaries.

ISSUE 2: MEDI-CAL MANAGED CARE

The Administration, in its 2005-2006 fiscal year budget proposal, is proposing to redesign the Medi-Cal program in order to maintain health care coverage to eligible Californians while containing costs and maximizing operating efficiencies.

Medi-Cal provides medical services for 6.6 million low-income individuals. In addition to providing services to these individuals, Medi-Cal is a critical funding source for hospitals and clinics serving Medi-Cal beneficiaries and the uninsured. Program expenditures for 2005-06 will exceed \$34 billion (\$12.9 billion in State General Fund). Medi-Cal is the second largest expenditure in the State budget behind K-12 education.

While Medi-Cal is one of the most cost-effective Medicaid programs in the nation, continuing and increasing fiscal demands threaten the program's the long-term financial viability and while jeopardize the State's ability to fund other programs.

Since 1998-99, General Fund expenditures in Medi-Cal have grown by 60 percent (\$4.5 billion). These costs are the result of several factors, including:

- Program expansions and reforms have added 1.2 of the 1.6 million new beneficiaries since 1998-99, a 32 percent increase in the number of people receiving health care services through the Medi-Cal program.
- Demographic trends have increased the number of people eligible for Medi-Cal.
- Health care costs have risen at rates above the general inflation rate.
- Medical advances have improved outcomes and increased the cost of treatment.
- Medi-Cal provides beneficiaries with a comprehensive range of benefits, exceeding the scope of benefits of other states and employer-based programs.

California provides Medi-Cal benefits via managed care in 22 counties to 3.2 million beneficiaries including families, children, seniors and people with disabilities. Managed care delivers better quality care and greater beneficiary access at a lower cost than the Medi-Cal fee-for-service program. Redesign seeks to build upon this success by:

- Enrolling 262,000 parents and children in managed care in 13 additional counties. The expansion will involve beneficiaries in El Dorado, Imperial, Kings, Lake, Madera, Marin, Mendocino, Merced, San Benito, San Luis Obispo, Sonoma, Placer and Ventura counties.
- Enrolling 554,000 seniors and disabled individuals into managed care in all counties in which managed care is available (these population groups are already enrolled in managed care in the 8 counties with an existing County Organized Health System).
- Implementing Acute and Long Term Care Integration projects in Contra Costa, Orange and San Diego counties to test innovative approaches for enabling more individuals to receive care in settings that maximize community integration.

The managed care expansion will be achieved through a phased-in process over a twelve-to eighteen-month period commencing in January 2007.

Other elements of the Medi-Cal Redesign proposal include:

- Hospital Financing to strengthen the state's health care safety net, a new five-year hospital financing waiver is being negotiated with the federal government. This new waiver will allow California to continue contracts with selected hospitals serving low-income and vulnerable populations and will replace current funding methods with new systems that create opportunities to draw down additional federal dollars.
- Modify the Medi-Cal Benefit Package The Medi-Cal dental benefit package provided to approximately 3 million adults will be aligned with private employer-based and public sector health coverage programs by placing an annual limit of \$1,000 on dental services provided to adults. The majority of the dental needs of the approximately 3 million Medi-Cal adult beneficiaries, including the cost of dentures, is expected to be covered by the \$1,000 benefit limit. The limit will not apply to federally mandated dental services provided by a physician, emergency dental services, and hospital costs associated with dental treatment.
- Beneficiary Cost Sharing Medi-Cal beneficiaries with incomes above the federal poverty level will pay a small premium to maintain their Medi-Cal coverage. These beneficiaries include 460,000 families and children in households with incomes above 100 percent of the Federal Poverty Level and 90,000 seniors and persons with disabilities with incomes above the Supplemental Security Income/State Supplemental Payment level. Premiums will be \$4 per month for each child under the age of 21 and \$10 per month for adults, with a maximum of \$27 per month per family. The required premium payments represent approximately 1-2 percent of the total annual income for affected individuals.

Realization:

Experience with Medi-Cal's shifting people to Managed Care in the mid 1990s underscores the importance of a deliberate and gradual implementation so that systems and providers are ready and beneficiaries fully informed to understand the changes that will occur. For these reasons the Department proposed a multi-year timeline to realize its Medi-Cal Redesign goals.

When fully implemented, Medi-Cal Redesign is expected to maintain and improve Medi-Cal coverage for eligible individuals and will reduce annual Medi-Cal expenditures by \$287,180,000 (\$144,902,000 GF). Savings over the first 5 years are expected to total \$332,000,000 (\$171,000,000 GF).

The rationale for expanding managed care in the Medi-Cal Program has been founded on the expectation that when implemented in a careful, deliberate manner, can increase access to services, improve patient outcomes, increase accountability for health care dollars, and be more cost effective than an unmanaged fee-for-service program has recently been challenged by research published by the Robert Wood Johnson Foundation. In an article published in March 2005 that focused on how mandatory enrollment in managed care has affected both spending and health outcomes for California Medicaid recipients. The author found that despite a dramatic increase in Medicaid managed care enrollment – from less than 12 percent in 1993 to 51 percent in 1999- there was neither a significant reduction in spending nor improved health outcomes. Specifically the author found "In fact, Medicaid spending appeared to increase by almost 20 percent following a shift to managed care and persisted long after the mandates first took effect."

Questions for Department of Health Services:

1. Are you familiar with this study? If so, can you reconcile the study conclusions with the current proposal to expand Medi-Cal managed care?
2. It would be helpful if the department could provide HEDIS results of HMOs that operate in the Geographic Managed Care and Two Plan counties. How do the results compare to the County Organized Health Systems which provide care to the ABDs and the national averages?
3. What are the profit margins of HMOs that contract with the State for MediCal? How does this compare with the commercial sector?
4. Does the State have any requirements on how much profit a plan can make? (Maryland and other states have limits) Is there a minimum threshold for medical/loss ratio?
5. Historically HMO's have resisted taking the Aged, Blind and Disabled (ABD) population. Why is there interest now? What has changed? And, since the HMOs haven't historically treated the ABDs, are they prepared to do so? Do they have the networks and programs in place; networks/programs designed for ABD rather than TANF?

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL**ISSUE 3: IMPLEMENTATION OF SKILLED NURSING FACILITY SPECIFIC RATES**

The proposed budget for the 2005-2006 fiscal year presumes the implementation of AB 1629, Chapter 875 of the Statutes of 2004. The statute would institute a Quality Improvement Fee to be effective by August 1, 2004, require the Department of Health Services to provide a cost-of-living-adjustment to nursing homes, effective August 1st and provide for the establishment of a facility specific rate methodology by August 1, 2005.

To implement the Statute, the Department of Health Services has to obtain federal approval for a State Plan Amendment for the August 1, 2004 Cost of Living Adjustment (COLA). The State Plan Amendment was filed as of September 30, 2004. The Department of Health Services also has to secure federal approval to waive the federal requirement regarding “uniformity” of the Quality Improvement Fee. Finally, the Department must acquire federal approval for a State Plan Amendment for establishing a facility specific rate methodology in lieu of the peer group process presently used for rate setting. The Department filed the State Plan Amendment as of February 2, 2005.

The Quality Improvement Fee is 3 percent for the current-year and 6 percent for the budget year and thereafter. The three percent for the current year is because the timing in the fiscal year. Revenues from the fee are deposited into the General Fund. It is assumed that General Fund savings of \$120 million for the 2004-2005 fiscal year and \$257 million for the 2005-2006 fiscal year will be achieved from the fee.

Costs to the Medi-Cal Program for the COLA-adjustment and new rate methodology are expected to be \$99 million General Fund in the 2004-2005 fiscal year and \$259.5 million General Fund in the 2005-2006 fiscal year. For the current year these dollars reflect about a 5.7 percent COLA, and for the budget year it is 8 percent, the capped level established in the legislation.

All components necessary to proceed with the implementation have been filed with the Centers for Medicare and Medicaid Services (CMS). The CMS has responded to the state and posed eight general questions and 12 specific questions. CMS approval is required for the State Plan Amendments and the Quality Improvement Fee for the new facility specific rate methodology to go into effect. Also, the Quality Improvement Fee ends then the new facility specific rate methodology ceases.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL**ISSUE 4: REIMBURSEMENT INCREASE FOR NON-EMERGENCY MEDICAL TRANSPORTATION**

The California Medical Transportation Association requests the Legislature increase, on a one-time basis, the reimbursement rate for providers of non-emergency medical transportation. The Association asserts that a one time rate increase of ten percent would cost the state \$7.5 million, \$3.75 million General Fund. If the rates are not increased to accommodate the dramatically higher gasoline rates, some if not all of the providers might have to discontinue the service because the costs of operation will exceed the reimbursement received.

Non-emergency medical transportation plays an important role in the Medi-Cal Program. The Medi-Cal beneficiaries that utilize the service are mostly dialysis and they are too sick, frail or disabled to ride in a bus or car to and from medical complications. Kidney dialysis is the only treatment that keeps End Stage Renal Disease patients alive and functioning since there is no cure except a kidney transplant. If the Non-Emergency Medical Transportation providers were to close their doors, the Medi-cal program would have to resort to the much more expensive emergency forms of transportation, emergency vehicles.

According to the Association an analysis of the financial condition of several Non-Emergency Medical Transportation providers found that annual average loss was 9.2 percent. The Association states that some of the Non-Emergency Medical Transportation providers are decreasing their Medi-Cal participation while others are going out of business.

Non-Emergency Medical Transportation is more fuel dependent than other Medi-Cal benefits. The companies' vans are on the road for as much as 16 hours per day. Dialysis clinics operate 3 to 4 cycles per day. Each cycle lasts the four hours necessary to provide the treatment. The last Medi-Cal rate increase for the providers was in 2000. Since that time fuel costs have increased 71 percent, according to the Association.

ITEM 4280 MANAGED RISK MEDICAL INSURANCE BOARD**ISSUE 1: HEALTHY FAMILIES AND MEDI-CAL PROGRAMS EDUCATION AND OUTREACH ACTIVITES**

The budget proposes an increase in expenditures of \$14.5 million, \$5.9 million General Fund, \$5.9 million federal funds, and \$2.7 million in Reimbursements for state support and local assistance to re-establish application assistance fees to support individuals and organizations working to maximize success enrollment of children into the Healthy Families and Medi-Cal Programs.

The components of the expenditures are:

- Application Assistance Fees in the budget year - \$11.7 million – The funding provides a \$50 fee for each successfully enrolled Health Families or Medi-Cal application upon request by the Certified Application Assister. The funding also provides \$25 fee for each successful Annual Eligibility Re-determinations application that results in ongoing Healthy Families coverage for an eligible subscriber. The requested funding also provides a much needed incentive for more local entities to obtain Certified Application Assister training and install application assistance programs.
- State Administrative and Operational Support in the budget year - Three positions and \$263,000. Two technical staff will provide expertise in the development of business rules, testing the administrative vendor system for operational readiness and accuracy of payments; oversee implementation and ongoing monitoring of the administrative vendor functions. The technical staff will also be responsible for the review and approval of all outreach activities to notify community partners of the restoration of application assistance reimbursement and promotional material for Certified Application Assisters. One position is proposed in order to provide administrative support to the technical staff.
- Effect on Healthy Families Caseload – budget year \$2.4 million. The funding provides for increased enrollment in the Healthy Families Program of approximately 15,000 children by June 30, 2006 resulting from application assistance.

When the Healthy Families Program was started in July, 1998, it contained a sizable outreach program. Program funding peaked at \$50 million in the 2001-2002 fiscal year, \$20 million General Fund and \$30 million federal funds. The program consisted of media campaigns, public relations, application assistance fees, Community Based Organizations and school grants and Certified Application Assister training and certification for many community based organizations.

Beginning in the 2001-2002 fiscal year, all funding for education and outreach, except for Certified Application Assister payments, was eliminated as a cost saving measure despite its highly affective role in achieving California children's health goals. Funding for Certified Application Assister payments was eliminated in the 2003-2004 fiscal year.

By the end of July 2003, the number of applications coming in with assistance had dropped from 62 percent to about 50 percent. By September 2003, the assistance rate had dropped to 42

percent and by March 2004, it had dropped 19 percent leaving 81 percent of the applications unassisted. This has created major problems:

- The number of incomplete applications has risen from 40 percent in 2003 to approximately;
- The length of time it takes a child to be enrolled is much longer, about two months, because the administrative vendor must contact the applicant and collect information that is missing.
- The number of families that the administrative vendor must contact by telephone and mail has increased dramatically.
- There are a limited number of Certified Application Assisters. At the program's peak there were over 22,000 and now there only are 1,600.
- There has been a dramatic increase in appeals (130 per month to over 600 per month) since the Certified Application assister funding was eliminated.

Certified Application Assisters also helped families responding to Healthy Families Program Annual Eligibility Re-determinations AER). The effort helped ensure that qualified children did not get dis-enrolled because the AER process was not completed properly. The number of children not returning their AER started to increase in November 2003.

- Just prior to the Certified Application Assisters funding being eliminated the monthly average for not returning the AER or not following up on an incomplete application was 8,000 children;
- As of October 2004, the monthly average dis-enrollment was over 12,000, a 50 percent increase. The increase is continuing at a rate of 300 children a month despite the fact that total Healthy Families Program enrollment growth has slowed significantly.

ISSUE 2: HEALTHY KIDS PROGRAM LINKAGE WITH HEALTHY FAMILIES PROGRAM

The 2005-2006 budget proposal includes trailer bill legislation to develop a Healthy Families Program (HFP) "buy-in" option and an increase of \$261,000, (\$91,000 Proposition 10 Funds and \$170,000, federal funds) to fund three two-year limited-term positions at Managed Risk Medical Insurance Board.

Several counties have established or are planning to establish programs to provide coverage to uninsured children who are not eligible for full-scope coverage under Medi-Cal or the Healthy Families Program. Funding for existing county coverage has come from a variety of sources, including local Proposition 10 funds, county Tobacco Settlement Funds, grants from foundations, and federal funds obtained from the Managed Risk Medical Insurance Board through the County Health Initiative Matching Fund (CHIM) Program established by AB 495, Statutes of 2001. Counties with Healthy Kids programs include Santa Clara, Alameda, San Francisco, San Mateo, San Joaquin, San Bernardino, Riverside, Santa Cruz, Tulare, and Los Angeles.

The California Children and Families First Commission has approved funding for the Managed Risk Medical Insurance Board to work with the counties to develop the "buy-in" option. The "buy-in" would enable counties to utilize the advantages of the HFP marketplace and it would provide comprehensive health care to children in need of medical services. Under the "buy-in" the Managed Risk Medical Insurance Board would direct the new staff to provide technical assistance and support to local counties in the development and expansion of their locally funded "Healthy Kids Programs". In essence, the "buy-in" proposal is a subset of the overall existing County Health Initiative Matching Fund Program. The proposed staff would determine how the "buy-in" concept should be designed and would work with county staff to implement any of the approved "buy-in" programs.

ISSUE 3: HEALTHY FAMILIES PROGRAM OVERSIGHT OF CONTRACTOR AND CUSTOMER SERVICE

The budget proposes 24.5 position and \$2.215 million Total Funds. \$775,000 General Fund in the budget year for state support costs to enable the Managed Risk Medical Insurance Board (MRMIB) to enhance Healthy Families oversight of contractor and customer services. MRMIB has one of the lowest state support/local assistance ratios in state government (less than one percent), the lack of sufficient positions and funding has impaired MRMIB's ability to provide services to the public and maintain adequate oversight of the contracted vendor.

MRMIB's organizational model is rare among state agencies. Both by statutorily and by administrative design, MRMIB's state support budget provides resources for essential core functions only. Day to day eligibility, benefits and enrollment functions are contracted out to administrative vendors that operate under the policy, operational direction and oversight of MRMIB's state staff. The core functions staffed at MRMIB only are those necessary to ensure that, in delivering the services and meeting its obligations, the State's health policy and fiduciary responsibilities, citizen access to government and health advocacy are not delegated or subject to interests other than the state's own.

To reach targeted savings goals set by the Legislature, 13.4 positions were eliminated from MRMIB's budget over the two year period beginning in 2002-2003. The combination of hiring freezes and the subsequent reductions coinciding with significant program growth have affected MRMIB's ability to keep up with ongoing workload like applicant appeals, coordination with the federal government on federal grants and SCHIP funding, state and federal legislation and the continued implementation of administration of several program changes.

Due to inadequate staff resources, program growth and changes in the Healthy Families Program, Access for Infants and Mothers and Managed Risk Medical Insurance Program and the addition of the County Health Initiatives Program and the Major Risk Medical Insurance Pilot Project; core functions in all areas are experiencing delays or backlogs. The MRMIB requests the Legislature add 24.5 position to address the delays and backlogs and to provide the resources needed to adequately staff core functions to any program growth or change.

ISSUE 4: S-CHIP FUNDING

The 2004-2005 and the 2005-2006 fiscal; years recognize recent federal regulations under the State's Children Health Insurance Program (S-CHIP) (Healthy Families in California) that declare an unborn child (from conception) may be considered an eligible child under the program. Under the federal regulations a state may elect to extend eligibility to unborn children using federal S-CHIP funds (a 65 percent federal match rate) for health benefits coverage, including prenatal care and delivery.

California would need to submit an S-CHIP State Plan Amendment (SPA) to the federal CMS for approval in order to obtain the 65 percent federal match. In order to capture the proposed current-year General Fund savings, the SPA must be submitted to the federal CMS by no later than June 30, 2005.

The budget proposal would achieve state savings in the General Fund and Proposition 99 Funds—through the use of the 65 percent federal match. The federal match would be used for both the Medi-Cal Prenatal Care Program for Undocumented Women which is 100 percent General Fund supported, and the Access for Infants and Mothers (AIM) Program which is supported by Proposition 99 Fund supported.

The Governor's proposal would save a net total of about \$259 million General Fund across the two fiscal years. The savings presume: approval by the federal CMS of the S-CHIP State Plan Amendment. The approval of SPA would allow the state to receive federal funds for the AIM and the Medi-Cal Prenatal Care services for Undocumented Women Programs. Therefore, the state will be able to use \$120.5 million in unencumbered Proposition 99 Funds from AIM to backfill for General Fund support of programs such as; State Hospitals that serve individuals with a mental illness; the Expanded Access to Primary Care Clinic Program; Medi-Cal services provided to legal immigrants; as well as other programs. Finally, the SPA would permit General Fund support to AIM to draw the new federal match of 65 percent.

The proposal has fiscal merit by its use of S-CHIP funds to save General Fund moneys. However, concerns have been raised regarding the need to articulate that receipt of these federal funds for unborn children does not erode or jeopardize existing California law regarding the provision of prenatal care services to women, or existing Supreme Court rulings regarding a woman's right to privacy.

Both the Prenatal Care Program for Undocumented Women and the AIM Program provide comprehensive prenatal care services, including post-partum care, to eligible pregnant women. Though the Administration has not proposed to change existing state statute regarding these comprehensive prenatal care services, the language contained in the federal guidelines is narrower in its interpretation of services. For example, the federal regulations address pregnancy-related services provided to unborn children and does not reference post-partum care.

The Administration contends that since California uses a "bundled" rate of global fee method for our prenatal care programs including post-partum care, in lieu of individual services, the federal CMS will not likely raise concerns. However the federal CMS could raise concerns once they review the S-CHIP State Plan Amendment.

With respect to a woman's right to privacy, concerns have been raised that accepting the S-CHIP funds under the federal regulation's definition of eligible child may place into question Supreme Court rulings regarding a woman's reproductive rights.

The California Health & Human Services Agency is in the process of working with constituency groups to potentially craft language regarding these two concerns. At this time, consensus has not been fully attained.

ISSUE 5: HEALTHY FAMILIES PROGRAM HEALTH PLAN ENROLLMENT ASSISTANCE

As part of the 2001-2002 Budget, the Legislature added to the Health Trailer Bill that authorized health plans to partner with schools to do outreach and enrollment activities. A sunset was added to the legislation and the program will be sunset this year if it is not repealed. The attached language would repeal the sunset and the successful enrollment programs that have taken place in school districts over the last few years will be able to continue.

Following the adoption of the provision, the California Association of Health Plans and the California Teachers Association jointly approached the California Endowment to fund activities in the schools that would enroll children into Healthy Families, Medi-Cal or local programs for the uninsured. Funding was granted for the program which is known as Teachers for Healthy Kids (THK). The objective was to make teachers conduits of information about these programs since they were trusted messengers to parents. What the THK program initially found after surveying teachers that 89 percent had never heard of Healthy Families and that 85 percent thought that a family must be eligible for cash welfare assistance in order to qualify for Medi-Cal.

THK started an education program for teachers with the slogan, "You Can't Teach to an Empty Desk." After two years, 68 percent of teachers are familiar with these programs. Several programs have been initiated in over 70 schools districts to reach out to parents. The most successful programs employ a survey model or efforts where teachers distribute information to parents and health plans and community based organizations follow up with the parents to enroll the children. For example in Los Angeles, LAUSD has been split up by Board of Education Districts with a health plan assigned by the District to each district. Forms indicating a parent's interest are electronically transferred to plans that contact parents or work with CBOs who contact parents to assist with enrollment. Over 19,000 forms were processed last year by plans in LAUSD alone. In Long Beach, THK is working with 14 of the schools of greatest need to systematically work with each school and enroll children without coverage.

All of these activities take place under the auspices of the Managed Risk Medical Insurance Board. Health Plans that participate sign Memorandums of Agreements with the Board. There

have been no reported problems with the Program. Referrals from school districts have increased greatly since the programs inception making the schools the greatest source of information that leads to enrollment. Schools want to participate, teachers are willing to provide information and the availability of needed resources provided by this program make this a viable model.

These efforts will not be possible if the language is allowed to sunset at the end of this year. The California Association of Health Plans request the Budget Subcommittee to adopt the following placeholder trailer bill language. (See next page)

12693.325. (a) (1) Notwithstanding any provision of this chapter, a participating health, dental, or vision plan that is licensed and in good standing as required by subdivision (b) of Section **12693.36** may provide application assistance directly to an applicant acting on behalf of an eligible person who telephones, writes, or contacts the plan in person at the plan's place of business, or at a community public awareness event that is open to all participating plans in the county, or at any other site approved by the board, and who requests application assistance.

(2) ~~Until January 1, 2006,~~ a participating health, dental, or vision plan may also provide application assistance directly to an applicant only under the following conditions:

(A) The assistance is provided upon referral from a government agency, school, or school district.

(B) The applicant has authorized the government agency, school, or school district to allow a health, dental, or vision plan to contact the applicant with additional information on enrolling in free or low-cost health care.

(C) The State Department of Health Services approves the applicant authorization form in consultation with the board.

(D) The plan may not actively solicit referrals and may not provide compensation for the referrals.

(E) If a family is already enrolled in a health plan, the plan that contacts the family cannot encourage the family to change health plans.

(F) The board amends its marketing guidelines to require that when a government agency, school, or school district requests assistance from a participating health, dental, or vision plan to provide application assistance, that all plans in the area shall be invited to participate.

(G) The plan abides by the board's marketing guidelines.

(b) A participating health, dental, or vision plan may provide application assistance to an applicant who is acting on behalf of an eligible or potentially eligible child in any of the following situations:

(1) The child is enrolled in a Medi-Cal managed care plan and the participating plan becomes aware that the child's eligibility status has or will change and that the child will no longer be eligible for Medi-Cal. In those instances, the plan shall inform the applicant of the differences in benefits and requirements between the Healthy Families Program and the Medi-Cal program.

(2) The child is enrolled in a Healthy Families Program managed care plan and the participating plan becomes aware that the child's eligibility status has changed or will change and that the child will no longer be eligible for the Healthy Families Program. When it appears a child may be eligible for Medi-Cal benefits, the plan shall inform the applicant of the differences in benefits and requirements between the Medi-Cal program and the Healthy Families Program.

(3) The participating plan provides employer-sponsored coverage through an employer and an employee of that employer who is the parent or legal guardian of the eligible or potentially eligible child.

(4) The child and his or her family are participating through the participating plan in COBRA continuation coverage or other group continuation coverage required by either state or federal law and the group continuation coverage will expire within 60 days, or has

expired within the past 60 days.

(5) The child's family, but not the child, is participating through the participating plan in COBRA continuation coverage or other group continuation coverage required by either state or federal law, and the group continuation coverage will expire within 60 days, or has expired within the past 60 days.

(c) A participating health, dental, or vision plan employee or other representative that provides application assistance shall complete a certified application assistant training class approved by the State Department of Health Services in consultation with the board. The employee or other representative shall in all cases inform an applicant verbally of his or her relationship with the participating health plan. In the case of an in-person contact, the employee or other representative shall provide in writing to the applicant the nature of his or her relationship with the participating health plan and obtain written acknowledgment from the applicant that the information was provided.

(d) A participating health, dental, or vision plan that provides application assistance may not do any of the following:

(1) Directly, indirectly, or through its agents, conduct door-to-door marketing or telephone solicitation.

(2) Directly, indirectly, or through its agents, select a health plan or provider for a potential applicant. Instead, the plan shall inform a potential applicant of the choice of plans available within the applicant's county of residence and specifically name those plans and provide the most recent version of the program handbook.

(3) Directly, indirectly, or through its agents, conduct mail or in-person solicitation of applicants for enrollment, except as specified in subdivision (b), using materials approved by the board.

(e) A participating health, dental, or vision plan that provides application assistance pursuant to this section is not eligible for an application assistance fee otherwise available pursuant to Section 12693.32, and may not sponsor a person eligible for the program by paying his or her family contribution amounts or copayments, and may not offer applicants any inducements to enroll, including, but not limited to, gifts or monetary payments.

(f) A participating health, dental, or vision plan may assist applicants acting on behalf of subscribers who are enrolled with the participating plan in completing the program's annual eligibility review package in order to allow those applicants to retain health care coverage.

(g) Each participating health, dental, or vision plan shall submit to the board a plan for application assistance. All scripts and materials to be used during application assistance sessions shall be approved by the board and the State Department of Health Services.

(h) Each participating health, dental, or vision plan shall provide each applicant with the toll-free telephone number for the Healthy Families Program.

(i) When deemed appropriate by the board, the board may refer a participating health, dental, or vision plan to the Department of Managed Health Care or the State Department of Health Services, as applicable, for the review or investigation of its application assistance practices.

(j) The board shall evaluate the impact of the changes required by this section and shall provide a biennial report to the Legislature on or before March 1 of every other year. To prepare these reports,

*the State Department of Health Services, in cooperation with the board, shall **code** all the application packets used by a managed care plan to record the number of applications received that originated from managed care plans. The number of applications received that originated from managed care plans shall also be reported on the board's Web site. In addition, the board shall periodically survey those families assisted by plans to determine if the plans are meeting the requirements of this section, and if families are being given ample information about the choice of health, dental, or vision plans available to them.*

*(k) Nothing in this section shall be seen as mitigating a participating health, dental, or vision plan's responsibility to comply with all federal and state laws, including, but not limited to, Section 1320a-7b of Title 42 of the United States **Code**.*

(l) Paragraph (2) of subdivision (a) shall become inoperative on January 1, 2006.

ITEM 4440 DEPARTMENT OF MENTAL HEALTH

ISSUE 1: PROPOSITION 63 IMPLEMENTATION

The Department of Finance submitted a letter requesting the implementation of Proposition 63, the Mental Health Services Act which became effective on January 1, 2005. The initiative established a state personal income tax surcharge on the one percent of taxpayers with an annual taxable income of more than \$1.0 million. The funds from the surcharge are deposited into the new state Mental Health Services Fund and will be used for state and county planning and implementation consistent with the Act's provisions. The Act provides for the expansion of mental health services and includes specific provisions related to education and training of the mental health workforce, development of innovative programs and integrated plans for prevention, intervention and system of care services, investment in capital facilities and technology needs and enhanced oversight and accountability.

The estimated revenues in the Fund in the current fiscal year will total \$254 million and \$683 million in the budget year. While most of the revenues will be available to county mental health programs, the Act authorizes up to five percent of the revenues in the Fund annually for state administration. Funding available for state administration is projected to \$12.7 million in the current fiscal year and \$34.2 million in the budget year.

The Act provides a continuous appropriation from the Fund for state and county expenditures, the Administration proposes to establish in-lieu appropriations for state administrative costs during the first several years of implementation.

The Finance Letter request the position authority be increased by 109.0 positions, including 20.0 positions effective January 2006. The positions include 55.0 permanent positions and 54.0 three-year limited term positions. The proposed resources will enable the Department of Mental Health to provide leadership and oversight to county mental health departments in the development of education and training programs, capital facilities and technology, prevention and early intervention programs and Children's System of Care and Adult and Older Adult System of Care Programs, consistent with the Act's provisions. The request includes \$6.151 million for contracts in variety of areas, including but not limited to, the stakeholder input process, policy design, outreach and training, data support and information technology support.

The Finance Letter also proposes budget bill language be added to provide and in-lieu appropriation for the Department of Mental Health's administrative cost. Also, the Finance Letter proposes provisional language is requested to allow the Director of Finance to increase the funding no sooner than 30 days after providing the specified legislative notification. The flexibility is to accommodate additional Department of Mental Health needs that may be identified as the department progresses in its planning efforts.

For the current year the Department of Mental Health spend \$4.991 million from the continuous appropriation for immediate planning and implementation efforts. This includes \$3.271 million for various contracts. The Administration has also approved administrative establishment of 20.0 positions effective February 1, 2005 and an additional 31.0 positions effective April 1, 2005.

The Legislative Analyst Office has proposed an alternative to the plan proposed by the Administration. The proposal is as follows:

- 1) Approve the proposed reduction in DMH positions and dollars identified on the attached spreadsheet.
- 2) Approve an increase in oversight commission positions and dollars, modified to include minor technical adjustments on the dollar amounts calculated by DMH, and as shown on the attached spreadsheet.
- 3) Limit all limited term positions to two years, instead of the proposal for three years, for all departments with Prop. 63 requests. DADP, DHS and DOE would also be affected by this recommendation.
- 4) Recognize \$1 million in General Fund revenues in 2005-06 to reflect the initial results of the expansion of audit activity made possible with some of the new positions.
- 5) Adopt Budget Bill language, modified for the appropriation level, as proposed by the administration.
- 6) Adopt placeholder trailer bill language to provide information to the Legislature in the future about local assistance expenditures of Prop. 63 funding.

In addition the Department proposes in a Finance Letter the following Budget Bill Language:

4440-001-3085—For Support of Department of Mental Health, for payment to Item 4440-001-0001, payable from the Mental Health Services Fund

Provisions:

1. Funds appropriate in this item are in lieu of the amounts that otherwise would have been appropriate for administration pursuant to Section 5892(d) of the Welfare and Institutions Code.
2. Notwithstanding any other provision of law, the Director of Finance may increase the funding provided in this item to further the implementation of Mental Health Services Act. Any increase would occur no sooner than 30 days after written notification has been provided to the chairperson of the committee in each house of the Legislature that considers appropriations, the chairpersons

of the committees, and the appropriate subcommittees, in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee identifying the need for such increase and the expenditure plan for the additional funds.

LAO analysis of DMH Proposition 63 budget request — Summary - Including DMH Proposed Adjustments

Version: 4/21/05 Revised 5/04/05 Revised 5/5/05

UNIT Classification	Prop 63 BCP (positions)	LAO position adjustments to Prop 63 BCP	Fiscal effect of adjustment proposed by LAO	LAO rationale (see footnotes below)	DMH position adjustment to Prop 63 BCP	Fiscal effect of adjustment proposed by DMH
Directors Office						
350 Mental Health Planning Council:						
Assoc Mental Hlth Spec	2	0	\$0	(a)	0	\$0
550 Mental Health Services Oversight & Acct. Comm						
Staff Mental Hlth Spec	2	1	\$94,369	(b)	1	\$93,340
Assoc Mental Hlth Spec	1	2	\$171,794	(b)	2	\$169,921
Program Compliance (Prop 63 pos eff 1/1/06)						
610 Licensing and Certification:						
Staff Mental Health Spec (1 Prop 63 pos eff 7/05)	3	-2	-\$94,369	(e)	-2	-\$93,340
Assoc Mental Health Spec	3	-3	-\$128,845	(c) (e)	-3	-\$127,441
Office Techn-Typing	1	-1	-\$26,222	(e)	-1	-\$25,936
632 Medi-Cal Oversight - South:						
Staff Mental Health Spec	1	-1	-\$47,185	(c) (d)	-1	-\$46,670
Assoc Mental Health Spec	1	-1	-\$42,948	(c) (d)	-1	-\$42,480
640 Audits:						
Supvng Govtl Auditor II						
Gen Auditor III	4	0	\$0	(c) (f)	0	
Gen Auditor II	2	0	\$0	(c) (f)	0	
Systems of Care						
734 County Operations-North/Bay:						
Assoc Mental Health Spec	2	-1	-\$85,897	(c)	0	
735 County Operations-South/Central:						
Assoc Mental Health Spec	2	-1	-\$85,897	(c) (g)	0	
737 Children and Family Program Policy:						
<u>Staff Mental Health Spec</u>	3	0			-1	-\$93,340
Assoc Mental Health Spec	3	-1	-\$85,897	(c) (d) (g)	-1	-\$84,961
751 Statistics and Data Analysis:						
Research Analyst II-Soc/Behavioral	3	-1	-\$90,180	(c)	0	
755 Epidemiology, Allocation & Support:						
<u>Research Manager II</u>	1	0			-1	-\$107,700
<u>Research Program Spec II</u>	2	0			-1	-\$102,508
Research Analyst II-Soc/Behavioral	3	-1	-\$90,180	(e)	-3	-\$267,592
752 Perf Outcomes & Quality Improve:						
Research Prog Spec I-Soc/Behavioral	2	-1	-\$94,369	(c)	0	
Administrative Services						
912 Personnel:						

Pers Svcs Spec I	1	-1	-\$50,795	(c)	0	
Office Techn-Typing	1	-1	-\$52,444	(c)	-1	-\$51,872
<u>913 Business Services:</u>						
<u>Business Services Assistant</u>	1	0			-1	-\$98,083
933 Accounting:						
Acctg Techn	1	-1	-\$51,515	(c)	-1	-\$50,954
950 Information Technology:						
Staff Programmer Analyst - Spec	2	-2	-\$197,760	(c)	-1	-\$97,802
						-
Total proposed adjustments		-16	-\$958,342		-16	\$1,027,419

Footnotes:

- (a) Position was vacant 4/7 but has since been filled.
- (b) Insufficient staff resources available for independent review of county plans.
- (c) Workload could be handled by filling existing vacancies.
- (d) AB 3632 workload largely unrelated to Prop 63. Also, the administration is proposing to suspend AB 3632.
- (e) Request premature; workload increase not yet demonstrated.
- (f) Productivity of existing auditing staff not yet documented.
- (g) Position reduction adjusted to reflect vacancies caused by recent shift of staff into new administratively established Prop 63 positions.
- (h) Vacancy count excludes 20 additional positions established administratively for Prop. 63 implementation, nine of which had been filled as of 4/7.