ASSEMBLY BUDGET SUBCOMMITTEE NO. 1 ON HEALTH AND HUMAN SERVICES

Assembly Member Jerry Hill, Chair

THURSDAY, FEBRUARY 11, 2010
STATE CAPITOL, ROOM 4202
1PM

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4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Eliminate Use of AIDS Drug Assistance (ADAP) in County Jails

The Governor proposes legislation to amend Section 120955 of Health & Safety Code regarding ADAP which would make an inmate residing in a city or county jail ineligible to receive HIV/AIDS medications under ADAP effective July 1, 2010. The Administration states that $9.5 million (GF) would be saved from this action and would be invested within the ADAP to assist in meeting state expenditures in 2010-11. The Administration states that local health jurisdictions are legally responsible for inmate care in jails.

ADAP contracts with a Pharmacy Benefit Manager (PBM) which reimburses pharmacies for dispensed medications. ADAP began serving inmates in county jails in 1994 due to the increasing fiscal impact on local health jurisdictions in meeting their mandate to provide medical services to their incarcerated populations. The ADAP's PBM contracts with either the in-house county jail pharmacy, or with the county's pharmacy service provider, to provide reimbursement for medications. Thirty-six counties receive reimbursement for medications from ADAP to serve individuals in 44 jails. About 2,027 incarcerated individuals would be affected by this proposal. Existing statutes in both the Government and Penal Codes state the responsibility of local governments to provide medical care to inmates in local jails.

STAFF COMMENT

This proposal can be viewed as a cost shift from the state to counties, as compared to a reduction in services.

Is it significantly more costly for county jails to purchase AIDS drugs than it is for the state through the ADAP program?

Issue 2: Technical Federal Fund Shift

The Administration states that a current year shift of $3.5 million (federal funds) from state support to local assistance is needed in order to maximize federal funds for HIV/AIDS services. These federal funds are available due to the elimination of 21 positions in the current-year which were previously supported with these funds. This transfer would fund HIV/AIDS prevention and testing activities, and care and support services. Using these federal funds for local assistance is consistent with the Office of AIDS plan for HIV/AIDS services released in the fall of 2009. There is no General Fund impact.

The DPH re-crafted its HIV/AIDS services in 2009 as a result of the loss of General Fund support for direct HIV care and support services, including prevention and testing activities, due to the Governor's veto. This included a reduction of state staff and the need to re-craft the expenditure of federal funds. The $3.5 million (federal funds) consists of $2.4 million in federal Centers for Disease Control grants, and $1.1 million in Ryan White CARE Act, Part B funds. The Administration notes that if this shift does not occur, these federal funds will likely remain unspent in the current-year. Consequently, this could result in the loss of future federal supplemental allocations for HIV/AIDS services since the federal government has historically reallocated unspent federal dollars to other states.

STAFF COMMENT

Legislative authorization is required for the Administration to shift these funds from state support to local assistance. There is no GF impact and not shifting these funds could result in future loss of federal funds.

4280 MANAGED RISK MEDICAL INSURANCE BOARD

Issue 1: Reduce Children's Eligibility in Healthy Families from 250 percent to 200 percent of poverty

The Governor proposes legislation to reduce eligibility in Healthy Families from 250 percent to 200 percent of the federal poverty level (FPL) for a reduction of $41.9 million ($10.5 million GF) in 2009-10, and $252.4 million ($63.9 million GF) in 2010-11. This would result in 203,300 children immediately losing their health, dental and vision coverage as of May 1, 2010. In addition to the 203,300 children dropped from coverage, it is estimated that 5,670 children each month (21 percent of new enrollment) would be denied enrollment from this income change.

Healthy Families provides subsidized health, dental and vision coverage through managed care arrangements for children (up to age 19) in families with incomes up to 250 percent of poverty, who are *not* eligible for Medi-Cal but meet citizenship or immigration requirements. A 65 percent federal match is obtained through a federal allotment. Over 900,000 children are presently enrolled. It is likely the estimated 203,300 children dropped from coverage under this proposal would receive only episodic health care services. Emergency room visits would likely increase, as well as absences from school. Infants in the Access for Infants and Mothers (AIM) Program (200 percent of poverty to 300 percent of poverty) are immediately enrolled into Healthy Families and can remain until age two. AIM would *not* be impacted by this proposal and therefore an estimated 14,900 AIM-linked infants would continue to be eligible for Healthy Families under this proposal. However, infants (0-2 years) who are enrolled in Healthy Families who are not AIM-linked, and whose family incomes are above 200 percent of FPL, would lose coverage.

CHIP Programs in other states:

- 18 other states provide coverage to kids up to 200 percent of FPL or less;
- 9 other states provide coverage to kids up to between 200 and 250 percent of FPL;
- 12 other states provide coverage to kids at or above 250 percent of FPL;
- 7 out of 10 "highest cost of living" states provide coverage to kids up to 300 percent of FPL; and
- New York provides coverage to kids up to 400 percent of FPL.

2009 Solutions

Two stop-gap funding mechanisms were agreed to last year and are currently supporting the program: 1) First 5 California contributed $81 million to cover the costs of children ages 0-5; and 2) AB 1422 (Bass, Statutes of 2009) expanded a tax on managed care plans. AB 1422 sunsets on December 31, 2010. The Governor's proposed 2010-11 budget for this program assumes that the First 5

Commissions, as they did last year, will contribute $81 million to the program (assuming coverage up to 250 percent of FPL) and some amount less than $81 million if eligibility is restricted.

STAFF COMMENT

The Legislature rejected this proposal last year, in favor of an unspecified budget reduction to the program. Over 200,000 children would lose access to health care as a result of this eligibility reduction, including over 5,000 children with significant "CCS-eligible" medical conditions. As described above, the Legislature, Governor and First 5 California negotiated solutions last year just in time to avert disenrollments of children from the program. More time is needed this year for similar deliberations and negotiations.

Issue 2: Eliminate Vision Benefit & Increase Premiums Paid by Families

The Governor proposes legislation to eliminate vision coverage and increase monthly premiums for families with incomes from 151 percent to 200 percent of the poverty level effective July 1, 2010 for a combined reduction of $65.8 million ($21.7 million GF).

Vision Benefit

An elimination of vision coverage would result in over 900,000 children no longer having access to eye exams and glasses. Elimination of vision coverage in Healthy Families would mean that only medically necessary vision-related services, such as eye surgery and treatment for eye injuries, would be covered. Eye exams and glasses would not be covered.

Premium Increase

All families pay a monthly premium and co-payments. The amount paid varies according to a family's income and the health plan selected. Certain premium discount options can offset some costs. Monthly premiums for families from 151 percent to 200 percent of poverty would be increased by $14 per child (to $30 for one child; $60 for two; and a family maximum of $90 for three or more). Families under 150 percent would not have a premium increase. A state plan amendment would be required. Premiums and co-payments were increased as of November 1, 2009, except for families under 150 percent. Families at 150 to 200 percent had premiums increased by $4 per child (to $16 for one; $32 for two; and a family maximum of $48 for three or more). The Governor's proposal increases it further. Premiums and co-payments were also increased for families from 201 percent to 250 percent as of November 1, 2009. This category is not proposed to be increased due to its assumed elimination. The chart below, provided by MRMIB, shows recent and proposed premium increases.

Premium Increase		**Before Feb 1, 2009**	**After Feb 1, 2009**	**After Nov 1, 2009**	**After July 1, 2010**
Category A (134% FPL – 150% FPL)	1 Child	$7	$7	$7	$7
	2+ Children	$14	$14	$14	$14
Category B (151% FPL – 200% FPL)	1 Child	$9	$12	$16	$30
	2 Children	$18	$24	$32	$60
	3+ Children	$27	$36	$48	$90
Category C (201% FPL – 250% FPL)	1 Child	$14	$17	$24	No premium due to proposal to reduce eligibility to 200% of FPL
	2 Children	$28	$34	$48	
	3+ Children	$42	$51	$72	

Note: Community Provider Plan (CPP) subscribers will receive a $3 discount on premiums, maximum of $9 discount per family per month.

The Governor's savings estimate on the premium increase assumes that no families will decline to enroll or drop coverage as a result of the higher premiums. This is consistent with the state's experience with the last two significant premium increases.

STAFF COMMENT

The Committee may wish to ask the Administration for alternative premium and co-payment increase proposals, including savings estimates for increasing premiums for the 200-250 percent category. As with the prior Healthy Families proposal, these policies should be considered over a longer period of time in order to explore all possible means for keeping this program whole.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Obtain Federal Approval to Establish Limits on Benefits, Expand Cost Sharing & Other Program Changes

The Governor proposes legislation to authorize the Department of Health Care Services (DHCS) to negotiate with the federal government to implement various changes to Medi-Cal for a reduction of $2.388 billion (total funds). This proposal would require federal law changes and other federal approvals. The amount of GF savings attributed to this action is contingent upon the Federal Medical Assistance Percentage (FMAP) provided for California. The budget assumes a GF savings of $750 million. A July 1, 2010 implementation date is assumed. The Governor also assumes: 1) continuation of the federal American Recovery and Reinvestment Act from December 30, 2010 to June 30, 2011 at 61.59% FMAP; and 2) an overall increase in the FMAP base from 50 percent to 57 percent.

This proposal is under development and is one of the Governor's federal government requests. The reduction amount is an *initial* estimate. The level of General Fund savings is also contingent upon the amount of FMAP provided to California. Broadly crafted legislation from DHCS states that cost-containment methods shall achieve $2.388 billion ($750 million GF) annually and may include:

1) Increased utilization controls, including limits on particular services and benefits (examples include: Texas limits prescription drugs to 3/mo; some states limit hospital days);

2) Increased cost-sharing through co-payments and premiums (Medi-Cal currently has voluntary co-payments and this would make them, and potentially new premiums, mandatory); and

3) Flexibility in adjusting provider rates (the Administration intends to explore making provider rates consistent with either Medicare or other private payers).

DHCS would affect these changes based on federal approval. Per the Governor's proposed legislation, the Legislature would only receive notification of these changes through the Joint Legislative Budget Committee within 30-days prior to implementation; no legislative approval would be required for potentially significant changes to the Medi-Cal program. The LAO assumes savings of $917.1 million (GF) by assuming continuation of ARRA but not assuming the permanent 7 percent increase in the FMAP base.

STAFF COMMENT

The Administration has yet to provide the Legislature with sufficient detail on this proposal and, through proposed trailer bill language, has requested authority to make significant changes to the Medi-Cal program autonomously without legislative input or authorization. A longer and more detailed conversation will need to take place on this proposal, based on a more detailed proposal from the Administration.

Issue 2: Newly-Qualified Legal Immigrant Adults

The Governor proposes legislation to eliminate full-scope Medi-Cal for newly-qualified legal immigrant adults in the U.S. for less than five years for a net reduction to Medi-Cal of $433,000 (GF savings of $697,000 and an increase of $264,000 federal funds) in 2009-10, and a reduction to Medi-Cal of $33.4 million (GF savings of $53.8 million and an increase of $20.4 million federal funds) in 2010-11. Effective June 1, 2010, these individuals (48,600 adults) would only receive emergency services, prenatal care, state-only breast and cervical cancer treatment, long-term care, and tuberculosis services. The DHCS estimates that 56 percent of the cost for services would shift to emergency services and therefore would be partially reimbursed by the federal government (per the state's FMAP).

California has always provided legal immigrant adults with full-scope services in Medi-Cal if they otherwise meet all other eligibility requirements. Due to federal law changes enacted in 1996, federal matching funds are not provided for non-emergency services for this category of individual and therefore Medi-Cal uses 100 percent GF funding for this purpose. Federal law does require states to provide emergency services and will reimburse for these services if they are identified as being an emergency medical service. California has incorporated the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) option to obtain federal funds for legal immigrant children and pregnant women by eliminating the previous five-year waiting period; as such, federal funds are now obtained for this population.

STAFF COMMENT

Defer action on this item to the regular budget. The Legislature has rejected this proposal several times already in light of the fact that it would deny access to health care for over 48,000 legal residents.

Issue 3: Permanently Residing Under Color of Law (PRUCOL individuals)

The Governor proposes legislation to eliminate full-scope Medi-Cal for individuals designated as PRUCOL for a net reduction to Medi-Cal of $289,000 (GF savings of $465,000 and increase of $176,000 federal funds) in 2009-10, and a $39.6 million reduction to Medi-Cal (GF savings of $63.8 million and an increase of $24.2 million federal funds) in 2010-11. Effective June 1, 2010, these individuals (17,000 people) would only receive emergency services, prenatal care, state-only breast and cervical cancer treatment, long-term care, and tuberculosis services. The DHCS states that 56 percent of the cost for services would shift to emergency services and would be partially reimbursed by the federal government.

PRUCOL generally means that the immigration authorities are aware of a person's presence and have no plans to deport or remove them from the country. Medi-Cal lists several immigration statuses that are considered PRUCOL. The various PRUCOL categories are permitted by the Department of Homeland Security to remain in the U.S. There are 17,000 people whom Medi-Cal considers to be PRUCOL; most of these individuals have sought the PRUCOL status because of an existing medical condition. Medi-Cal uses 100 percent GF funding for this purpose. California has always provided full-scope services to these individuals if they otherwise meet all other eligibility requirements. Due to federal law changes enacted in 1996, federal matching funds are not provided for non-emergency services for this category of individual. Federal law does require states to provide emergency services and will reimburse for these services if they are identified as being an emergency medical service.

STAFF COMMENT

Defer action on this item to the regular budget. These 17,000 people have significant health needs, no access to other insurance, and are living here legally. There could be significant cost shifts to emergency care. The Legislature has rejected this proposal several times already.

Issue 4: Eliminate Adult Day Health Care

The Governor proposes legislation to eliminate Adult Day Health Care (ADHC) services for a savings of $3.9 million ($1.5 million GF) in 2009-10, and $350.7 million ($134.7 million GF) in 2010-11. A June 1, 2010 implementation date is assumed. ADHC services are a community-based day program providing health, therapeutic, and social services designed to serve those at risk of being placed in a nursing home, thereby enabling these individuals to live outside of institutional care, decreasing costs, and increasing their quality of life. There are 320 active ADHC providers in Medi-Cal who serve about 37,000 average monthly Medi-Cal enrollees. Under federal Medicaid law, ADHC services are “optional” for states to provide.

There are 37,000 average monthly Medi-Cal enrollees in ADHC services and the average monthly cost per user is estimated to be $978 (all inclusive/bundled rate) in 2010-11. Several cost-containment actions have occurred. In 2004 the DHCS placed a moratorium on the expansion of ADHC providers which is still in place. In 2009, a rate freeze was enacted which is proposed for continuation into 2010-11, assuming ADHC is not eliminated. Onsite treatment authorization reviews (TARs) were implemented in November 2009 and are estimated to reduce expenditures by 20 percent. Medical acuity eligibility criteria were placed into statute in 2009 and are to be implemented as of March 2010. DHCS estimates this will reduce expenditures by another 20 percent.

The implementation of reducing ADHC benefits to a maximum of three days per week, as enacted in 2009, was enjoined in September 2009 in the case of *Brantwell v. Maxwell-Jolly*. The court found the 3-day cap to be a form of discrimination against these individuals based upon their disability, in violation of the "integration mandate" under the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. It would be a violation because the reductions would increase the likelihood of nursing home placement and hospitalizations for the 800 program participants attending four and five days per week; the "integration mandate" specifies that persons with disabilities receive services in the "most integrated setting appropriate to their needs."

DHCS states that 1,500 people with developmental disabilities utilize ADHC services, making up $23 million in costs. Individuals with developmental disabilities would still be guaranteed services under the Lanterman Act, through the state's "DD" system, however it is unknown whether these services would actually be available if no longer covered by Medi-Cal.

STAFF COMMENT

Defer action on this item to the regular budget. In 2009, the Governor proposed elimination of ADHC which was rejected by the Legislature in favor of the cost-control measures described above. In response to last year's proposal, the LAO opposed this proposal, stating that if 20 percent of ADHC consumers enter skilled nursing facilities (SNF) as a result of the elimination of ADHC, given the high cost of SNF care, there would be no savings for the state. Any percentage higher than that would lead to increased costs for the state. In addition to these increased costs, eliminating ADHC services could be expected to result in increased costs resulting from increased emergency room visits and hospitalizations. The Administration has not provided the Legislature with a savings estimate that accounts for all of these increased costs.

Issue 5: Delay Medi-Cal Checkwrite for Institutional Providers

The Governor proposes to delay the June 17, 2010 Medi-Cal checkwrite for institutional providers for a one-time only reduction of $256.9 million ($94.3 million GF) in 2009-10, with a corresponding cost of $38.5 million GF in 2010-11 for a net GF savings of $56.1 million. No statutory change is proposed. The increase of $38.5 million GF for 2010-11 is the estimated penalty California would need to pay for violating "prompt payment" provisions contained in the federal American Recovery and Reinvestment Act (ARRA) of 2009.

This proposal would shift the June 17, 2010 checkwrite for institutional providers to the first week of July, and the new fiscal year. Since 2004-05, the last Medi-Cal checkwrite in June has been delayed until the start of the next fiscal year. This proposal would make it two checkwrites at the end of each fiscal year. The federal ARRA penalty of $38.5 million is applicable to this new, additional shift. Institutional providers include hospitals, long-term care facilities, various types of clinics, Adult Day Health Care, Home Health Agencies, Mental Health Inpatient and others. Other fee-for-service providers would not be affected by this new proposal.

Issue 6: Reduce Reimbursement Paid for Eight Family Planning Service Codes

The Governor proposes a reduction of $343,000 ($74,000 GF) in 2009-10, and $88.7 million ($15.3 million GF) in 2010-11 by reducing Medi-Cal rates for eight specified office codes billed for family planning services. The State receives a 90 percent federal match for family planning services, including these eight family planning office visits. Senate Bill 94, Statutes of 2007, provided an increase for these eight specified family planning office visits equal to the weighted average of at least 80 percent of the amount that the federal Medicare Program reimburses for these same or similar services. The rate became effective as of January 1, 2008. The Governor's proposal would restore the rates to the level they were prior to January 1, 2008. The proposed reduction includes fee-for-service providers, such as physicians and clinics, and managed care health plans. The Governor's proposal assumes that rate adjustments for managed care health plans will occur in 2010-11, including any needed adjustment for 2009-10. Prior to SB 94 in 2007, the rates for these services had been stagnant for approximately 20 years. These funds do not pay for abortions.

STAFF COMMENT

Defer action on this item to the regular budget. According to community clinics throughout the state that offer family planning services, the demand for such services far exceeds their capacity. Prior to the rate increase in 2008, California's clinics were turning away an estimated 10,000 people every month for lack of resources and capacity to serve them. Family planning services save the state money by preventing unwanted pregnancies. According to a 2002 UCSF evaluation of the Family PACT program, within which a substantial portion of the state's family planning services are provided, 205,000 unintended pregnancies were averted which, collectively, would have cost the public $1.1 billion up to two years and $2.2 billion up to five years after birth.

Issue 7: Medi-Cal Anti-Fraud on Physician Services & Pharmacy

The Governor proposes *net* savings of $51.5 million ($26.4 million GF) in 2010-11 through various anti-fraud activities conducted by 38 new staff. Local assistance savings of $56.6 million ($28.3 million GF) assumes staff to:

1) Conduct compliance-focused sweeps of physicians ($12 million);

2) Implement utilization controls and sanctions on physicians ($26.6 million);

3) Conduct physician education functions ($2.8 million);

4) Implement utilization controls and sanctions on pharmacy and medical supply providers ($8.7 million);

5) Target incontinent and durable medical providers for re-enrollment ($3.4 million); and

6) Implement "beneficiary lock-in" to deter drug-seeking behavior ($3 million).

The DHCS Medi-Cal Payment Error Study of 2007, released in May 2009, identifies Physician Services and Pharmacies at highest risk for payment error and potential fraud. The DHCS Audits & Investigations Branch has 712 existing positions. They identify 373 of these positions as focused on Medi-Cal anti-fraud and abuse efforts. They contend existing staff cannot be redirected for this newly proposed effort. An increase of $5.1 million ($1.9 million GF) is requested for 38 new positions which would be hired by July 1, 2010. No legislation is proposed.

STAFF COMMENT

The Subcommittee may wish to ask DHCS for additional explanation on how it is that the existing 373 existing positions on Medi-Cal fraud and abuse cannot complete this work, and what the equivalent number of lost positions is as a result of three furlough days for all 712 Audits and Investigations positions.

Issue 8: Reduce Funding for CCS to Conform to Healthy Families Program Eligibility Reduction from 250 to 200 percent FPL

The Governor includes this conforming proposal related to his proposal to reduce eligibility within the Healthy Families program from 250 percent to 200 percent of poverty for a *net* reduction of $25.8 million ($4.2 million GF) in the CCS Program. About 5,000 children would lose eligibility for CCS services under this proposal. This assumes that 556 children shift to CCS-only due to their medical condition and family income. The federal government provides a 65 percent match for Healthy Families-linked children.

The CCS program provides specialized, pediatric health care services to low-income children who have CCS-eligible medical conditions. CCS services are available to children:

1) Enrolled in the Healthy Families Program;
2) Enrolled in Medi-Cal; and
3) "CCS-Only" for families with incomes below $40,000 (regardless of family size) or with medical costs greater than 20 percent of family income (regardless of income). Per federal poverty level guidelines: A family of 4 with an annual income of $44,100 is at 200 percent FPL; a family of 3 with an annual income of $45,775 is at 250 percent FPL.

According to DHCS, about 20 percent, or 5,560 CCS-enrolled children have family incomes between 200 percent and 250 percent of poverty. DHCS assumes that 556 of these children, currently enrolled in Healthy Families, would become CCS-only linked and still receive services at a state-only cost of $1.1 million (GF).

STAFF COMMENT

Defer action on this item to the regular budget. Recognizing that this is a conforming item to a Healthy Families program proposal, that proposal would need to be acted upon first.

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

Issue 1: Extension of 3% reduction to Regional Centers

The Governor's Budget proposes to extend, by one-year, a three percent reduction to Regional Center funding, both for the Purchase of Services and for operations. This identical proposal passed last year and is set to sunset June 30, 2010. The proposal includes the suspension of existing statutory requirements, such as caseload ratios of 1:66 and the regional center reporting of employee salary and administrative expenditure data.

The State contracts with 21 independent Regional Centers who are responsible for providing case management, intake and assessment, community resource development and individual program planning (IPP) for consumers. This reduction would reduce reimbursement of certain providers by 3 percent and reduce regional center operations funding. Just as last year, SSI and SSP consumers are exempt and regional centers may demonstrate that a non-reduced payment is necessary to protect the health and safety of a consumer. Upon review and approval from the department, the regional center would not be obligated to reduce the provider payment.

This proposal estimates a reduction of $115.7 million, with $60.9 million in General Fund expenditure savings in 2010-11.

	General Fund	**Federal Funds**
Purchase of Service	$49.7 million	$49.8 million
Regional Center Operations	$11.2 million	$5 million
TOTAL:	**$60.9 million**	**$54.8 million**

If approved, the new sunset deadline would become June 30, 2011.

STAFF COMMENT

The impact of the continuation of this reduction includes a decrease in Purchase of Services which may result in the consolidation of programs and therefore limit consumer choices. On the regional center operations side, it is difficult to identify the impact when you have 21 independent regional centers, but it is noted that higher caseloads per case worker will be a direct result and arguably impact quality of service.

4440 DEPARTMENT OF MENTAL HEALTH

Issue 1: Use Mental Health Services Act (MHSA) Funds to Backfill for GF

The Governor proposes legislation to redirect $904.6 million in MHSA Funds to backfill the General Fund during the period of July 1, 2010 through June 30, 2012. This requires amending the MHSA Act (Proposition 63, Statues of 2004) and voter approval (June 2010 ballot). A total of $452.3 million in MHSA Funds would be appropriated in lieu of GF for each fiscal year. Of this amount, $391.2 million is for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program, and $61.2 million is for the Mental Health Managed Care Program. As part of the Governor's "trigger" proposal, he is also proposing to redirect $847 million in MHSA Funds for 2010-11 if $6.9 billion in federal funds is not achieved.

The Governor's legislation amends the nonsupplantation and maintenance-of-effort provisions of the MHSA Act (Act) in order to redirect funds. This proposal is very similar to Proposition 1E of 2009 (May 2009) which was rejected by voters, except this proposal is redirecting over twice as much in MHSA Funding for the GF backfill. The Act imposes a one percent tax on personal income in excess of $1 million. It provides for a continuous appropriation of funds which are deposited on a percentage basis into six different components: 1) community planning; 2) community services and supports; 3) prevention and early intervention; 4) innovative programs; 5) capital facilities and technology; and 6) work force education and training. The Act requires each County Mental Health Plan to submit a three year plan, with annual updates, to DMH for approval after review and comment by the MHSA Oversight & Accountability Commission. Funding is provided to Counties based on their approved plans. The purpose of these plans is to expand the provision of mental health services.

EPSDT is a federal requirement and Mental Health Managed Care is part of Medi-Cal and therefore is an entitlement program. Therefore, should the Legislature reject these proposals, or if the voters reject the proposals, these programs still must be funded, likely with GF dollars. At this time, the Governor has proposed only this fund shift and no reduction in services or cost controls.

The Administration estimates a $1.1 billion reserve in the MHSA fund at the end of 2010-11, after the initial proposed funding shift of $452 million. Accordingly, the Administration believes that there would be no delay or reduction in the allocations to counties as a result of this fund shift. If, however, the trigger proposals are implemented and an additional $847 million in Prop 63 dollars are shifted to DMH programs, counties may experience deferred (delayed) allocations in 2011-12 and 2012-13 leading to significant disruptions in their mental health services.