Senate Budget and Fiscal Review—Holly J. Mitchell, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, M.D., Chair
Senator William W. Monning
Senator Jeff Stone

Thursday, March 9, 2017
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Scott Ogus

PUBLIC COMMENT

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0530 OFFICE OF SYSTEMS INTEGRATION
4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Overview

Background. In 2005, the Office of Systems Integration (OSI) was established within the California Health and Human Services Agency to manage a portfolio of large, complex health and human services information technology (IT) projects. The OSI provides project management, oversight, procurement and support services for these high criticality projects and coordinates communication, collaboration and decision-making among project stakeholders and program sponsors. After the procurement phase, OSI oversees the design, development, governance and implementation of IT systems which serve health and human services programs.

OSI currently oversees the following projects:

1. Appeals Case Management System (ACMS)—Sponsored by the California Department of Social Services (DSS) State Hearings Division (SHD), OSI will help procure system integration services to assist the design, development and implementation of a hearings appeals system that will assist the recipients of public social service programs seeking fair hearings, DSS stakeholders, and state and local government entities. The ACMS will create a single case management system that will combine intake, scheduling and reporting functions into a single workflow; streamline current manual processes and reduce errors caused by data entry. The ACMS will also allow SHD to meet Health Insurance Portability and Accountability Act and language requirements, and provide a public portal for a person or authorized party to request a new hearing or check the status of an existing case.

2. California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS)—Sponsored by Covered California, the Department of Health Care Services (DHCS), and 13 program partners, CalHEERS serves as the consolidated system support for eligibility, enrollment, and retention for the Covered California health benefits exchange and the Medi-Cal program. The system streamlines resources from which individuals and small businesses are able to research, compare, check their eligibility for, and purchase health coverage. CalHEERS supports the maintenance, operations, and on-going business of both Covered California and DHCS by supporting account creation, consumer application, eligibility rules, and health plan selection for insurance affordability programs. CalHEERS also interfaces via the Electronic Health Information Transfer (eHIT) with the Statewide Automated Welfare Systems (SAWS) for Modified Adjusted Gross Income (MAGI) Medi-Cal eligibility, enrollment, and reporting; and provides data for potential eligibility to other programs, such as non-MAGI Medi-Cal, CalFresh, and California Work Opportunities and Responsibility for Kids (CalWORKs).

3. Case Management Information and Payrolling Systems (CMIPS II)—Welfare & Institutions Code 12302.2 requires a payroll and payment system for the In-Home Supportive Services (IHSS) program administered by DSS. This mandate resulted in the development of the Case Management, Information and Payrolling System (CMIPS). DSS contracted with OSI to

manage the contract to design, develop, maintain, and operate the system for CMIPS, which is used to support the following IHSS-related programs: Personal Care Services Program (PCSP), IHSS Plus Option Program (IPO), IHSS Residual (IHSS-R) Program, Community First Choice Option (CFCO), and Medi-Cal Waiver Personal Care Services (WPCS). CMIPS provides a statewide database and central processing for the programs to support three primary functions: 1) case management, 2) payroll, and 3) reports. CMIPS is used by social workers to track nearly 495,000 active cases statewide and processes over $5.5 billion in gross annual payroll for services provided to Californians. After successful statewide transition in 2013 from the legacy CMIPS system to a new system, CMIPS II, the project is currently in the maintenance and operations phase.

4. Child Welfare Services-New System (CWS-NS) Project—The CWS-NS provides an automated child welfare system with capabilities that include mobile and web-based technology to support the current and future business practice needs of the counties and the state. The new system will support child welfare programs, business processes and legislated improvements focused on protecting the safety of children and families. CDSS, working collaboratively with OSI and the County Welfare Directors Association (CWDA), developed the CWS-NS Project to replace the current Child Welfare Services/Case Management System (CWS/CMS).

5. Child Welfare Services/Case Management System (CWS/CMS)—The CWS/CMS is a statewide tool that supports the Child Welfare System of services. The CWS/CMS provides information to service workers to improve case work services, reduces repetitive manual workload, provides policy makers with information to design and manage services, and fulfills state and federal legislative requirements.

6. Electronic Benefit Transfer (EBT) Project—EBT is the system used in California for the delivery, redemption, and reconciliation of public assistance benefits, such as CalFresh, California Food Assistance Program, and cash aid benefits. Recipients of public assistance in California access their benefits with the Golden State Advantage EBT card. California EBT cards can be used at more than 15,000 businesses and over 54,000 ATMs in California.

7. Statewide Fingerprint Imaging System (SFIS)—Based on stakeholder input, SFIS utilizes biometric technology to detect and deter multiple aid fraud in public assistance programs managed and operated by the state. The Los Angeles Automated Finger Image Report and Match (AFIRM) system was the first finger imaging system to be used for a welfare application. Based upon the success of AFIRM, the California Legislature enacted the SFIS.

8. Statewide Automated Welfare System (SAWS)— The SAWS project is the automation of county welfare business processes for the following programs: CalWORKs, CalFresh, Medi-Cal, Foster Care, Refugee, and County Medical Services. SAWS is being implemented through three consortia: the Los Angeles Eligibility, Automated Determination, Evaluation and Reporting (LEADER) Consortium, the Welfare Client Data System (WCDS) Consortium, and Consortium IV (C-IV). OSI is responsible for state-level project management and oversight. The Consortia are responsible for local project management.

9. Welfare Data Tracking Implementation Project—The Welfare Data Tracking Implementation Project (WDTIP) is a statewide welfare time-on-aid tracking and reporting system which is accessible to the county welfare eligibility workers through DHCS' Medi-Cal Eligibility Data System (MEDS). WDTIP eliminates the need for counties to manually contact other counties outside their respective consortia system and/or other states to obtain information relative to the TANF 60-month and CalWORKs 48-month time limitations for time-on-aid by providing eligibility workers an automated tool from which they can obtain up-to-date information for Temporary Assistance to Needy Families (TANF) and CalWORKs applicants and recipients. WDTIP is the interface system within the existing county SAWS consortia.

Subcommittee Staff Comment and Recommendation. This is an informational item.

Questions. The subcommittee has requested OSI to respond to the following:

1. Please provide a brief overview of OSI's mission and the projects it oversees.

Issue 2: Medi-Cal Eligibility Data System (MEDS) Modernization

Budget Issue. OSI and DHCS request $6.6 million ($727,000 General Fund and $5.9 million federal funds) to extend support of 16 positions and other resources approved in the 2016 Budget Act for two additional years. If approved, these resources would continue the agency-wide planning effort to replace the Medi-Cal Eligibility Data System (MEDS). These staffing and other resources would support completion of activities required by the Department of Technology's Project Approval Lifecycle (PAL) Stage Gate requirements.

Program Funding Request Summary (DHCS)			
Fund Source	**Program**	**2016-17**	**2017-18**
0001 – General Fund	3960010 – Medical Care Services (Medi-Cal)	$-	$727,000
Total Fund 0001 – General Fund		**$-**	**$727,000**
0890 – Federal Trust Fund	3960010 – Medical Care Services (Medi-Cal)	$-	$5,903,000
Total Fund 0890 – Federal Trust Fund		**$-**	**$5,903,000**
Total Funding Request – All Funds		**$-**	**$6,630,000**
Total Positions Requested[1]:		**0.0**	
[1] ***DHCS is requesting resources equivalent to 3.0 positions, but no permanent position authority.***			

Program Funding Request Summary (OSI)			
Fund Source	**Program**	**2016-17**	**2017-18**
9745 – California Health and Human Services (CHHS) Automation Fund	0290 – Office of Systems Integration	$-	$5,473,000
Total Fund 9745 – CHHS Automation Fund[2]		**$-**	**$5,473,000**
Total Positions Requested:		**13.0**	
[2] ***CHHS Automation Fund receives transfers from the DHCS budget (see above) to fund all OSI expenditures contained in this budget request.***			

Background. DHCS serves as the single state agency responsible for the administration of Medi-Cal, California's state Medicaid program. Medi-Cal provides medical, dental, mental health, substance use disorder services, and long-term care to more than 14 million low-income Californians. Eligibility for Medi-Cal is determined by local county welfare and public health agencies. Since 1983, DHCS has used the current MEDS system for a variety of eligibility and reporting functions for the Medi-Cal program. Specifically, MEDS captures beneficiary information from the three county Statewide Automated Welfare System (SAWS) consortia (LEADER, Consortium IV and CalWORKs Information Network), state and federal partners, and Covered California.

In addition to its role maintaining eligibility information for Medi-Cal, MEDS serves as the "system of record" to determine eligibility for many of the state's health and human services programs. DHCS utilizes MEDS data for determinations regarding its Every Woman Counts, Child Health and Disability Prevention, Breast and Cervical Cancer Treatment, and Family Planning Access Care and Treatment programs. The Department of Social Services (DSS) leverages MEDS data for eligibility determinations and administration of CalWORKs, CalFresh, Cash Aid Program for Immigrants, In-Home Supportive Services, and Refugee Cash Assistance. Local governments also use MEDS data, specifically for the County Medical Services Program and the County Welfare and Tribal Temporary Assistance for Needy Families. Access to MEDS is provided to more than 35,000 end users and DHCS must ensure that the system and its end users protect confidential beneficiary information in accordance with state and federal security and privacy requirements.

Although MEDS is currently providing support to a diverse array of state and local health and human services programs, a multi-year, multi-agency process has been underway to modernize MEDS to address system issues, meet current and future operational needs, and fulfill requirements of state and federal guidance. The primary programming language of MEDS is COBOL. The number of qualified programmers familiar with COBOL is limited and is declining over time. This limitation presents challenges for making appropriate system changes to preserve the stability of MEDS and allow flexibility to continue supporting the system's many end users.

The Medicaid Information Technology Architecture (MITA) is an initiative of the federal Center for Medicaid & State Operations (CMSO). MITA is intended to foster integrated business and IT transformation across the Medicaid enterprise to improve the administration of the Medicaid program. Its common business and technology vision for state Medicaid organizations emphasize: 1) a patient-centric view not constrained by organizational barriers; 2) Common standards with, but not limited to, Medicare; 3) Interoperability between state Medicaid organizations within and across states, as well as with other agencies involved in healthcare; 4) Web-based access and integration; 5) Software reusability; 6) Use of commercial off the shelf (COTS) software; and 7) Integration of public health data.

In 2011 the federal Centers for Medicare and Medicaid Services (CMS) released regulations to provide enhanced federal funding for design, development and installation (DDI) or maintenance and operations (M&O) of Medicaid eligibility systems, such as MEDS. These regulations were meant to allow states to modernize eligibility systems to account for the new eligibility determination policies implemented by the Affordable Care Act. Prior to these regulations, eligibility systems had not been eligible for enhanced funding since 1986. Under the new rule, DDI activities receive 90 percent federal match and M&O activities receive 75 percent match. To receive the enhanced match, states must submit and CMS must approve an advanced planning document (APD), which demonstrates that the system will, among other provisions, meet the standards and conditions of the MITA initiative.

DHCS began the process of modernizing MEDS in 2014 with its initial request for 16 positions for two years. These positions and resources were reauthorized for an additional year in the 2016 Budget Act and management of the project was transferred to OSI. According to OSI, the following activities have been completed in each of the three years of the project:

2014-15

- Procured Project Management Support consultant services
- Performed initial business rules extraction
- Purchased and installed business rules extraction software
- Procured Business, Information, and Technology Enterprise Architects consulting services
- On-boarded 16 new state staff
- Obtained approval of Planning Advanced Planning Document Update (PAPDU) for federal year 2015 funding participation

2015-16

- Established formal Project Steering and Executive Steering Committees
- Implemented stakeholder engagement activities
- Procured new Project Planning consultant
- Executed departmental interagency agreement between the DHCS and the Department of Social Services.
- Completed core transition activities to move the MEDS Modernization planning effort from DHCS to OSI
- Restructured project to align with State PAL Stage Gate requirements
- Obtained approval of PAPDU for federal year 2016 funding participation
- Completed business rules extraction and annotation
- Completed As-Is Assessment of MEDS Business, Information and Technology Architecture

2016-17

- Procured consultant services and began a multi-agency alternatives analysis
- Began PAL Stage 2 Alternatives Analysis (S2AA)
- Obtained Department of Technology (CDT) approval of PAL Stage 1 Business Analysis (S1BA)
- Obtained approval of PAPDU for federal year 2017 funding participation
- Executed departmental interagency agreement between OSI and DHCS

OSI and DHCS report that a vendor was hired in September 2016 to manage the Stage 2 Alternatives Analysis, which is expected to be completed by the second half of 2017. If the requested extension of resources is approved, OSI and DHCS plan to focus over the next two years on approval of the Stage 2 analysis and completion of the PAL Stage 3 Solution Development and Stage 4 Project Readiness and Approval requirements. These requirements are as follows:

Stage 3 Solution Development

- Refinement of approved Stage 2 Mid-Level solution requirements and developing the detailed solution requirements; including Functional, Non-Functional, Project/Transition, Mandatory/Optional, and Administrative
- Documentation of To-Be Process Workflows
- Determining the specific types of vendor procurements (both primary and secondary solicitations) needed to support the modernized solution's subsequent detailed design, development and implementation (DD&I) phases
- Developing the DD&I procurement(s) Statement of Work
- Developing the proposed Procurement Planning and Development dates
- Solicitation(s) development
- Developing evaluation team(s) procedures

Stage 4 Project Readiness and Approval

- Releasing solicitation(s)
- Selecting vendor(s)
- Contract management readiness
- Baseline DD&I project cost and schedule
- Develop risk register
- Obtain DOF/Legislature approvals

The following is a detailed description, provided by OSI and DHCS, of the allocation of positions and resources contained in this budget request:

MEDS FY 2017-18 BCP Request			Department	
Line Items	**PYs**	**Total Project**	**DHCS**	**OSI**
Total Staffing (includes Staff OE&E)	**16.0**	**$2,318,021**	**$2,318,021**	**$1,961,021**
Core Planning Staff (1.0 PY, 1.0 existing redirected)	1.0	$349,165	$349,165	$349,165
Project Mgmt Staff (5.0 PY, include 1.0 DHCS transfer)	5.0	$669,675	$669,675	$669,675
Technical Project Mgmt Staff (4.0 PY)	4.0	$568,506	$568,506	$568,506
Program/Stakeholder Staff (4.0 PY)	4.0	$496,448	$496,448	$139,448
DHCS (3.0 PY)		$357,000	$357,000	$0
OSI (1.0 PY)		$139,448	$139,448	$139,448
Direct Administrative Services (2.0 PY)	2.0	$234,227	$234,227	$234,227
Total Other OE&E		**$1,172,787**	**$1,172,787**	**$597,000**
Indirect Administrative Services		$575,787	$575,787	$0
Facilities		$597,000	$597,000	$597,000
Subtotal (BCP Requests)			**$3,490,808** [2]	**$2,558,021**
Consultant Contracts		$3,138,665	$3,138,665	$2,914,665
Subtotal (Consultant Contracts)		**$3,138,665** [4]	**$3,138,665**	**$2,914,665**
Total Project Costs	**16.0**	**$6,629,473** [1]	**$6,629,473**	**$5,472,686** [3]

[1] Total Project Funding of $6,629,473 for FY 2017-18 and FY 2018-19.

[2] BCP amount requested for DHCS.

[3] BCP amount requested for OSI. Expenditure Authority only.

[4] DHCS Consultant Contracts amount $3,138,665 (includes $2,914,665 in OSI Consulting Contracts).

Subcommittee Staff Comment and Recommendation—Hold Open. While no concerns have been raised with this proposal, subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested OSI and DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

2. What major new features will enhance the end-user's ability to navigate MEDS for eligibility and other determinations?

3. How will the new system interface with other IT systems for public programs at the state and local levels?

4. Given the central role MEDS plays in administration of health and human services programs, please describe how OSI and DHCS plan to implement the new system while preserving the continuity of eligibility processing during the implementation process.

5. Recent IT procurements have suffered delays at a minimum and even material breach at the worst. Please describe the planned safeguards that will be utilized to prevent or minimize these possibilities.

0530 OFFICE OF PATIENT ADVOCATE

Issue 1: Overview

Office of Patient Advocate Funding Overview.

Fund Source	2015-16	2016-17	2017-18
	Actual	**Revised**	**Proposed**
Fund 3209 – Office of Patient Advocate Trust Fund	$1,955,000	$2,063,000	$2,063,000
Positions	6.2	10.2	10.2

Background. The Office of Patient Advocate (OPA) coordinates, provides assistance to, and collects data from state health care consumer assistance call centers. According to OPA, the goal of these efforts is to better enable health care consumers to access the health care services for which they are eligible. OPA produces the following: 1) Health Care Quality Report Cards with clinical performance and patient experience data for the state's largest health plans and over 200 medical groups; 2) Complaint Data Reports and Baseline Review of State Consumer Assistance Call Centers with data findings based on health care consumer complaint data and call center information submitted to OPA from the Department of Managed Health Care, Department of Insurance, Department of Health Care Services, and Covered California; and 3) Model Protocols for State Consumer Assistance Call Centers with recommendations for responding to and referring calls outside of a call center's jurisdiction.

OPA was originally established as part of the Department of Managed Health Care (DMHC) to represent the interests of enrollees served by health care service plans regulated by the department. AB 922 (Monning), Chapter 522, Statutes of 2011, transferred the office to the Health and Human Services Agency, and established the Office of Patient Advocate Trust Fund to provide ongoing funding for the office's activities. The fund receives, upon appropriation by the Legislature, transfers from the Insurance Fund and Managed Care Fund proportionate to the number of covered lives regulated by the California Department of Insurance (CDI) and DMHC, respectively. AB 922 also required OPA to operate a toll-free telephone line to act as a single point of entry for consumer assistance with their health benefits.

The 2014 Budget Act revised the role of OPA to remove its direct consumer assistance responsibilities and clarify its directive to track, analyze, and produce reports about problems, complaints, and questions received by other state departments from health care consumers. The Administration's rationale for elimination of OPA as a single point of entry was that existing consumer assistance programs were sufficient for consumers' needs. The OPA was instead tasked with creating a series of reports on complaint data received by four reporting entities: 1) DMHC, 2) CDI, 3) DHCS, and 4) Covered California. The goal of these reports is to collect and analyze data to identify trends and make recommendations to improve the consumer assistance protocols for these four reporting agencies.

In addition to its complaint reporting role, OPA produces Health Care Quality Report Cards. Each year, a random sample of members from the ten largest health maintenance organizations (HMOs) and the five largest preferred provider organizations (PPOs) is selected and their records are reviewed to determine if their medical care meets national standards for care and treatments proven to be effective. Information from health plans' records are collected and scored based on standards for quality of care set by the Healthcare Effectiveness Data and Information Set (HEDIS) performance measurement system to make sure that health plans are offering quality care and service to their members. OPA sorts more than 41 HEDIS quality care measures into nine health topics, like 'Heart Care' and 'Maternity Care', which are used to rate health plans on how well the plan and its doctors make sure that members get the right care for each health condition or topic and that they do not receive unnecessary care or services. OPA also produces report cards for medical groups that serve the commercial market, as well as publicly funded programs such as Medicare.

Subcommittee Staff Comment. This is an informational item.

Questions. The subcommittee has requested OPA to respond to the following:

1. Please provide a brief overview of OPA's mission and programs.

Issue 2: Complaint Data Reporting Update

Background. SB 857 (Committee on Budget and Fiscal Review), Chapter 31, Statutes of 2014, requires OPA to produce a baseline review and annual report of health care consumer or patient assistance help centers, call centers, ombudspersons, or other assistance centers operated by the Department of Managed Health Care (DMHC), the Department of Health Care Services (DHCS), the Department of Insurance (CDI), and Covered California. The first report was required to be submitted by July 1, 2015, and include the types of calls received; the number of calls; the call center's role with regard to each type of call, question, complaint or grievance; the protocol for referring or transferring calls outside the jurisdiction of the call center; and the call center's methodology of tracking calls, complaints, grievances, or inquiries.

Baseline Review of Health Care Complaint Data. OPA published its initial Baseline Review of Health Care Complaint Data in May 2016, describing and analyzing information received from the four reporting entities for calendar year 2014. The choice of 2014 as the baseline year is significant as it was the first year of implementation of the federal Affordable Care Act, including the establishment of the Covered California health benefit exchange and the expansion of Medi-Cal. The baseline review reported 27,028 consumer health care complaints closed in 2014 from the following sources:

- DMHC received 13,994 complaints from its 61,813,050 enrollees (0.02 percent rate)
- DHCS received 4,589 complaints from its 21,376,642 enrollees (0.02 percent rate)
- CDI received 4,079 complaints from its 2,574,181 enrollees (0.16 percent rate)
- Covered California received 4,366 complaints from its 1,395,929 enrollees (0.31 percent rate)

The top five statewide complaint reasons were: 1) Claim denial (18 percent); 2) Quality of care (11 percent); 3) Medical necessity denial (10 percent); 4) Co-pay, deductible, and co-insurance issues (7 percent); and 5) Enrollment or disenrollment issues (6 percent). The top five statewide complaint results were: 1) Compromise settlement/resolution (24 percent); 2) Complaint withdrawn (19 percent); 3) Health plan position substantiated (14 percent); 4) Insufficient information (9 percent); and 5) Health plan position overturned (7 percent). The range of time to resolve complaints by entity was: 1) DMHC – 6 to 37 days; 2) DHCS – 12 to 150 days; 3) CDI – 21 to 157 days; and 4) Covered California – 39 to 50 days.

The baseline report also identified four "Next Steps" based on its analysis of the 2014 data. These included the following recommended actions:

- Improvement and standardization of data definitions and coding across the four reporting entities to allow for better collection, tracking, and analysis of data on problems and complaints by consumers.
- Continued reporting by OPA of findings and trends from its collected data to improve best practices for consumer assistance.
- Expanded collection of demographic and language data from the reporting entities to allow further study of the low rate of non-English speaking consumers filing complaints. Collected data indicates only three percent of complaints were received from callers speaking a language other than English.
- Evaluation of strategies to expand access to consumer assistance resources across various modes of communications, such as smart phone applications.

While the baseline report included the entities of referral for non-jurisdictional inquiries, the report did not specify whether the reporting entities connected consumers directly, or simply provided contact information.

Calendar Year 2015 Complaint Data Report. OPA published its Complaint Data Report for calendar year 2015 in January 2017, providing its first annual data comparison to the 2014 baseline review. In 2015 the four reporting entities received 33,836 consumer health care complaints from the following sources:

- DMHC received 17,737 complaints from its 55,925,968 enrollees (0.03 percent rate)
- DHCS received 6,740 complaints from its 13,439,444 enrollees (0.05 percent rate)
- CDI received 3,209 complaints from its 2,158,334 enrollees (0.15 percent rate)
- Covered California received 6,150 complaints from its 1,318,193 enrollees (0.47 percent rate)

Compared to the 2014 baseline review, these figures represent an increase of 27 percent for DMHC, an increase of 47 percent for DHCS, a decrease of 21 percent for CDI, and an increase of 41 percent for Covered California.

The top five statewide complaint reasons were: 1) Medical necessity denial; 2) Denial of coverage; 3) Cancellation; 4) Pharmacy benefits; and 5) Co-pay, deductible, and co-insurance issues. The top five statewide complaint results were: 1) Health plan position substantiated; 2) Complaint withdrawn; 3) Compromise settlement/resolution; 4) Insufficient information; and 5) Health plan position overturned (7%). The range of time to resolve complaints by entity was: 1) DMHC – 6 to 56 days; 2) DHCS – 0 to 200 days; 3) CDI – 68 to 95 days; and 4) Covered California – 49 to 60 days.

Instead of next steps, OPA provided a section on "Conclusions" from the 2015 data. These conclusions included the following:

- Observation of the increase in complaints received by all reporting entities except CDI. OPA suggests this may be due to increased efficiency of data collection from the reporting entities, rather than a significant increase in complaints.
- Observation of an increase in complaints about pharmacy benefits and cancellations, suggesting these may be particular areas of concern to consumers. However, OPA cautions that additional data is necessary to establish any trends or conclusions about improvements that can be made regarding these complaints.
- Despite improvements in data reporting, there are still significant data limitations and lack of uniformity among reporting entities. OPA committed to continue working with the reporting entities on improving standardization of data reporting.
- Encouraging consumer participation in the complaint process to help regulators and oversight programs identify and address systemic issues.

OPA reports that data submissions for calendar year 2016 are still underway and the 2016 Complaint Data Report should be available some time in 2017.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions. The subcommittee has requested OPA to respond to the following:

1. Briefly describe interim conclusions, if any, that OPA has made based on its collected data regarding how DMHC, CDI, Medi-Cal and Covered California can improve their consumer assistance activities.

2. Please provide a status update on the reporting entities' data submission and preparation for the 2016 complaint data report.

3. Please describe the improvements reporting entities have made based on the information and conclusions of the baseline and 2015 reports. What progress have the reporting entities made towards achieving a more uniform tracking methodology for complaint data?

4. How does each of the reporting entities manage non-jurisdictional referrals to other reporting entities?

5. What is the status of the reporting entities' outreach to non-English speaking health care consumers to address the low rate of complaints relative to the state's proportion of non-English speaking residents?

6. Do you have any suggestions on how to increase the visibility and usefulness of the Complaint Data Report?

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Overview

Background. The Department of Public Health (DPH) delivers a broad range of public health programs. Some of these programs complement and support the activities of local health agencies in controlling environmental hazards, preventing and controlling disease, and providing health services to populations who have special needs. Others are solely state-operated programs, such as those that license health care facilities.

According to DPH, their goals include the following:

- Achieve health equities and eliminate health disparities.
- Eliminate preventable disease, disability, injury, and premature death.
- Promote social and physical environments that support good health for all.
- Prepare for, respond to, and recover from emerging public health threats and emergencies.
- Improve the quality of the workforce and workplace.

The department is composed of seven major program areas:

(1) Center for Chronic Disease Prevention and Health Promotion – This center works to prevent and control chronic diseases, such as cancer, cardiovascular diseases, asthma, adverse pregnancy outcomes, and diabetes; to reduce the prevalence of obesity; to provide training programs for the public health workforce; to prevent and control injuries, violence, deaths, and diseases related to behavioral, environmental, and occupational factors; to promote and support safe and healthy environments in all communities and workplaces; and to prevent and treat problem gambling.

(2) Center for Environmental Health – This center works to protect and improve the health of all California residents by ensuring the safety of drinking water, food, drugs, and medical devices; conducting environmental management programs; and overseeing the use of radiation through investigation, inspection, laboratory testing, and regulatory activities.

(3) Center for Family Health – This center works to improve health outcomes and reduce disparities in access to health care for low-income families, including women of reproductive age, pregnant and breastfeeding women, and infants, children, and adolescents and their families.

(4) Center for Health Care Quality – This center regulates the quality of care in approximately 8,000 public and private health facilities, clinics, and agencies throughout the state; licenses nursing home administrators, and certifies nurse assistants, home health aids, hemodialysis technicians, and other direct care staff.

(5) Center for Infectious Disease – This center works to prevent and control infectious diseases, such as HIV/AIDS, viral hepatitis, influenza and other vaccine preventable illnesses, tuberculosis, emerging infections, and foodborne illnesses.

(6) Center for Health Statistics and Informatics – This center works to improve public health by developing data systems and facilitating the collection, validation, analysis, and dissemination of health information.

(7) Public Health Emergency Preparedness – This program coordinates preparedness and response activities for all public health emergencies, including natural disasters, acts of terrorism, and pandemic diseases. The program plans and supports surge capacity in the medical

care and public health systems to meet the needs during emergencies. The program also administers federal and state funds the support DPH emergency preparedness activities.

Summary of Funding for the Department of Public Health. The budget proposes expenditures of about $3.3 billion ($132.2 million General Fund) for DPH as noted in the table below and 3,632.0 positions. Most of the funding for the programs administered by DPH comes from a variety of federal funds, including grants and subventions for specified areas (such as emergency preparedness, and Ryan White Program funds). Many programs are also funded through the collection of fees for specified functions, such as for health facility licensing and certification activities. Several programs are funded through multiple sources, including General Fund support, federal funds, and fee collections.

Department of Public Health Funding Overview.

Fund Source	**2015-16**	**2016-17**	**2017-18**	**BY to CY**
	Actual	**Revised**	**Proposed**	**Change**
General Fund	$128,330,000	$148,211,000	$132,221,000	($15,990,000)
Federal Trust Fund	$1,592,872,000	$1,696,107,000	$1,727,858,000	$31,751,000
Special Funds & Reimbursements	$990,877,000	$1,169,250,000	$1,442,748,000	$273,498,000
Total Expenditures	**$2,712,079,000**	**$3,013,568,000**	**$3,302,827,000**	**$289,259,000**
Positions	**3352.0**	**3468.2**	**3632.0**	**163.8**

Subcommittee Staff Comment and Recommendation. This is an informational item.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of DPH's programs and budget.

Issue 2: Childhood Lead Poisoning Prevention Program IT Project Planning

Budget Issue. DPH requests one position and expenditure authority from the Childhood Lead Poisoning Prevention (CLPP) Fund of $480,000 in 2017-18 and $158,000 annually thereafter. If approved, these resources would allow the CLPP Program to conduct required Project Approval Lifecycle analyses to upgrade its electronic blood lead testing information system.

Program Funding Request Summary			
Fund Source	**Program**	**2016-17**	**2017-18**
0080 – Childhood Lead Poisoning Prevention (CLPP) Fund	4045010 – Chronic Disease Prevention and Health Promotion	$-	$480,000
Total Fund 0080 – CLPP Fund		**$-**	**$480,000**
Total Positions Requested:		**1.0**	

Background. The CLPP program was established in 1986 to take steps necessary to reduce the incidence of childhood lead exposure in California. The program focuses on young children considered at increased risk for lead exposure, particularly those receiving publicly-funded services such as Medi-Cal and WIC, or those living in older housing stock with lead-based paint or lead-contaminated dust and soil. Children at high risk of exposure are required to be blood tested for lead and children with high blood lead levels are eligible for CLPP services.

There are 43 local CLPP programs in 40 counties and three cities that provide services to eligible children under a contract with DPH. The state CLPP program provides services to eligible children in the remaining 18 counties. These services include outreach to populations at high risk of lead exposure, educational and other services for children with high blood lead levels, full public health nursing and environmental services to children with lead poisoning, and follow-up to ensure sources of lead exposure are removed. The state CLPP program also provides information on laboratory reported lead tests to local CLPP programs; and statewide surveillance, data analysis, oversight, outreach and technical assistance for all counties.

The CLPP program's current electronic information system, RASSCLE 2, supports the receipt of laboratory lead testing results and the management and monitoring of lead-exposed children. According to DPH, RASSCLE 2, which was activated in 2006, suffers from several limitations that may not allow it to provide continued functionality to the CLPP program as testing caseload grows and program complexity increases. Some of these limitations include: 1) inability to handle the volume of testing information without reduced performance; 2) limitations in changing or adding data fields; 3) incompatibility with other electronic lab reporting formats; 4) reliance on data entry of paper records for family visit information; and 5) inadequate data security.

DPH proposes to begin planning for the design of a new childhood lead data system, SHIELD, which will upgrade CLPP's testing, reporting, and security capabilities and address the limitations of RASSCLE 2. According to DPH, current measures to maintain and upgrade RASSCLE 2 are no longer sufficient to ensure long-term stability of the system and to meet program needs and public expectations for timely and accessible information.

Some of the proposed design components of SHIELD include:

1) Ability to handle the larger volume of reported blood lead tests, as well as the matching functions needed to track repeat blood tests for children receiving services.
2) Flexibility to add new data fields as program needs change
3) Compatibility with standardized laboratory reporting formats and the centralized Health Information Exchange (HIE) Gateway
4) Ability to link to other public program's databases to ensure all high-risk children are being screened for blood lead levels
5) Allow for initial electronic data entry, particularly from the field, which could reduce or eliminate the use of paper-based records
6) Automation of tracking, monitoring, and reporting functions

DPH also reports that SHIELD will be able to handle twice the blood lead test workload of RASSCLE 2 and will be implemented as an enterprise solution that will continue to be upgraded and expanded to meet the needs of the program.

According to DPH, the Stage 1 Business Analysis and preliminary activities for the Stage 2 Alternatives Analysis are currently underway using existing departmental resources. These are the first two steps in the Department of Technology's Project Approval Lifecycle Stage Gate process. DPH requests one Research Scientist III to serve as the project's technical consultant and liaison during the proposed continuation of project planning. DPH intends to complete the Stage 2 Alternatives Analysis by October 2017, the Stage 3 Solution Development by July 2018, and the Stage 4 Project Readiness and Approval by May 2019. The Research Scientist III will work with the department's IT staff to ensure the new system meets the specifications needed by program staff and appropriately plans for future needs. DPH indicates that some of the workload may be performed as part of an IT services contract, depending on whether additional expertise is needed. After completion of the Stage 4 process, DPH expects to make a resource request for procurement and implementation of the new system.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 3: Tobacco Tax Initiative (Prop 56) Public Health Program Funding

Budget Issue. DPH requests 57 positions and expenditure authority of $223.5 million annually from the State Dental Program Account, Tobacco Law Enforcement Account, and Tobacco Prevention and Control Programs Account of the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) Fund. If approved, these resources would fund oral health, tobacco law enforcement, and tobacco prevention programs as required by voter approval of Proposition 56.

Program Funding Request Summary			
Fund Source	**Program(s)**	**2016-17**	**2017-18[1]**
0001 – General Fund	4045010 – Chronic Disease Prevention and Health Promotion	$-	($774,000) – SO ($2,880,000) – LA
Total Fund 0001 – General Fund		**$-**	**($3,654,000)**
3307 – State Dental Program Account (Prop. 56 Fund)	4045010 – Chronic Disease Prevention and Health Promotion	$-	$1,875,000 – SO $35,625,000 - LA
Total Fund 3307 – State Dental Program Acct		**$-**	**$37,500,000**
3308 – Tobacco Law Enforcement Account (Prop. 56 Fund)	4045010 – Chronic Disease Prevention and Health Promotion 4045059 – Environmental Health	$-	$2,875,000 – SO $4,625,000 – LA
Total Fund 3308 – Tobacco Law Enforcement Acct		**$-**	**$7,500,000**
3309 – Tobacco Prevention and Control Programs Account (Prop. 56 Fund)	4045010 – Chronic Disease Prevention and Health Promotion	$-	$8,923,000 – SO $169,532,000 - LA
Total Fund 3309 – Tobacco Prev/Control Prog Acct		**$-**	**$178,455,000**
Total Funding Request – All Funds		**$-**	**$219,801,000**
Total Positions Requested:		**57.0**	
[1] ***SO = State Operations; LA = Local Assistance***			

Background. Proposition 56, approved by voters in November 2016, increases excise taxes on cigarettes by $2.00 and imposes equivalent taxes on other tobacco products, such as electronic cigarettes. The Governor's Budget assumes revenue from these new taxes in 2017-18 of approximately $1.7 billion, allocated to the Department of Justice, the Board of Equalization, the Department of Public Health, the University of California, the State Department of Education, the Department of Health Care Services, and the State Auditor. In addition, Proposition 56 revenue must backfill expected reductions in sales and use tax revenue, as well as Proposition 10 and Proposition 99 tobacco tax revenue, as a

result of the expected decline in tobacco sales resulting from the higher tax rate. The Governor's Budget assumes the following allocations of Proposition 56 revenue:

Proposition 56 Allocations
(Dollars in Millions)

Investment Category	*Department*	*Program*	*2017-18 Amount* [1/]
Enforcement	Department of Justice	Local Law Enforcement Grants [2/]	$37.5
	Department of Justice	Distribution and Retail Sale Enforcement [2/]	$7.5
	Board of Equalization	Distribution and Retail Sales Tax Enforcement [2/]	$5.8
	Department of Public Health	Law Enforcement [2/]	$7.5
Education, Prevention, and Research	University of California	Cigarette and Tobacco Products Surtax Medical Research Program	$80.7
	University of California	Graduate Medical Education [2/]	$50.0
	Department of Public Health	State Dental Program [2/]	$37.5
	Department of Public Health	Tobacco Prevention and Control	$178.5
	State Department of Education	School Programs	$31.5
Health Care	Department of Health Care Services	Health Care Treatment	$1,237.4
Administration and Oversight	State Auditor	Financial Audits	$0.4
	Board of Equalization	Sales and Use Tax	$1.1
Revenue Backfills	Proposition 99, Breast Cancer Research Fund, and Proposition 10		$37.1
Total			**$1,712.5**

[1/] 2017-18 figures include one quarter of 2016-17 revenue and four quarters of 2017-18 revenue.
[2/] Annual amount specified in statute.

Oral Health Program. DPH requests 11 positions and expenditure authority from the State Dental Program Account of the Proposition 56 Fund (Fund 3307) of $37.5 million in 2017-18 and $30 million annually thereafter for DPH's Oral Health Program. The Oral Health Program was established by the 2014 Budget Act, which included General Fund and reimbursement resources to establish a State Dental Director, hire an epidemiologist, and provide consulting services to re-establish a statewide oral health program. DPH proposed that this program would: 1) offer surveillance and evaluation capacity to determine the burden of dental disease; 2) evaluate dental health infrastructure capacity and assess the impact of interventions; 3) provide vision and leadership to engage partners in an advisory committee to guide program priorities; and 4) develop a state dental plan to identify strategies to reduce the burden of dental disease. While DPH initially proposed publication of an Oral Disease Burden Report by February 2015 and a State Oral Health Plan by 2015, difficulties in hiring a State Dental Director delayed development and publication of these reports. In August 2015, Dr. Jay Kumar was appointed as the State Dental Director.

According to DPH, the Oral Disease Burden Report and State Oral Health Plan are currently in development. The department expects the Oral Disease Burden Report to be published in March 2017. In addition, the Oral Health Program is working on the following initiatives: 1) Community Water Fluoridation Implementation Project; 2) Oral Health Workforce Expansion Program; 3) Perinatal Infant Oral Health Quality Improvement Program; and 4) California Children's Dental Disease Prevention Program. These initiatives are currently funded by a combination of state and federal funds.

Proposition 56 allocates $30 million annually to the Oral Health Program ($37.5 million in 2017-18 to account for collection of the tax beginning in the final quarter of 2016-17). According to the text of the initiative, this allocation is "for the purpose and goal of educating about, preventing and treating dental disease, including dental disease caused by use of cigarettes and other tobacco products. This goal shall be achieved by the program providing this funding to activities that support the state dental plan based on demonstrated oral health needs, prioritizing serving underserved areas and populations. Funded program activities shall include, but not be limited to, the following: education, disease prevention, disease treatment, surveillance, and case management."

DPH proposes to use these additional resources to create a comprehensive public health infrastructure to support oral health education, prevention, surveillance, and treatment of dental disease. This funding would expand the capacity of the Oral Health Program, local jurisdictions, and Denti-Cal to implement the goals, objectives, strategies, and activities of the forthcoming State Oral Health Plan, Healthy People 2020 Oral Health Objectives, Denti-Cal and Maternal and Child and Health Services Block Grant performance measures, and the California Wellness Plan. The impact of the expanded program activities would be evaluated through analysis of: 1) oral health survey of kindergarten and 3rd grade children; 2) Denti-Cal utilization reported in the annual Denti-Cal performance report; 3) the Maternal and Infant Health Assessment; 4) the Behavioral Risk Factor Surveillance System; 5) the Youth Risk Behavior Surveillance System; 6) the California Health Interview Survey; 7) the National Survey of Children's Health; 8) the California Cancer Registry; and 9) survey of dental practitioners.

The state operations request for the Oral Health Program includes one Dental Hygienist Consultant, one Dental Program Consultant, one Staff Services Manager I, one Health Program Manager II, three Health Program Specialist I, one Health Program Specialist II, one Research Scientist III, one Associate Governmental Program Analyst, and one Office Assistant. The local assistance request for the Oral Health Program includes funding for: 1) Local health department allocations; 2) community-focused competitive contract awards to non-profit organizations to promote oral health and tobacco prevention programs; 3) statewide-focused competitive grants, contracts, and interagency agreements for training and technical assistance; 4) a statewide-focused competitive grant, contract, or interagency agreement for an oral health literacy and media campaign; and 5) evaluation and surveillance contracts and interagency agreements. This budget request also reduces existing General Fund expenditures of approximately $3.7 million currently dedicated to the Oral Health Program. According to the Administration, the allocation for the Oral Health Program is not subject to the initiative's provisions prohibiting supplantation of existing General Fund expenditures with Proposition 56 revenue.

Tobacco Control Branch. The department's Tobacco Control Branch was established after the passage in 1988 of Proposition 99, which added a 25 cent excise tax on each pack of cigarettes sold in California and an equivalent tax on other tobacco products. The Tobacco Control Branch administers funds to local health departments and competitively selected community-based organizations, runs a statewide

tobacco prevention media campaign, and completes comprehensive evaluation efforts. Proposition 56 allocates a percentage of collected excise tax revenue to the Tobacco Control Branch ($178.5 million in 2017-18) to "award funds to state and local governmental agencies, tribes, universities and colleges, community-based organizations, and other qualified agencies for the implementation, evaluation, and dissemination of evidence-based health promotion and health communication activities in order to monitor, evaluate, and reduce tobacco and nicotine use, tobacco-related disease rates, and tobacco-related health disparities, and develop a stronger evidence base of effective prevention programming with not less than 15 percent of health promotion, health communication activities, and evaluation and tobacco use surveillance funds being awarded to accelerate and monitor the rate of decline in tobacco-related disparities with the goal of eliminating tobacco-related disparities."

The state operations request for the Tobacco Control Branch includes one C.E.A. – Level A, eight Associate Governmental Program Analysts, one Staff Services Analyst, one Office Technician, six Health Program Specialist I, one Health Program Specialist II, one Research Scientist I, one Research Scientist II, one Research Scientist III, one Research Analyst I, one Staff Services Manager II, one Associate Health Program Adviser, and two Associate Accounting Analysts. The local assistance request for the Tobacco Control Branch includes funding for: 1) advertising and public relations contracts; 2) evaluation and surveillance contracts and interagency agreements; 3) local health department allocations; 4) community-focused competitive grants awarded to non-profit organizations to conduct tobacco prevention programs; and 5) statewide-focused competitive grants, contracts, and interagency agreements awarded for training and technical assistance, Helpline services, and support services.

Stop Tobacco Access to Kids Enforcement (STAKE) Act Enforcement. The department's STAKE Act Unit in the Food and Drug Branch enforces the provisions of California's STAKE Act, which created a statewide enforcement program to prevent illegal sales of tobacco to minors. Specifically, the STAKE Act requires DPH to:

- Implement an enforcement program to reduce the illegal sale of tobacco products to minors and conduct sting operations using minors granted immunity
- Operate a toll-free number for the public to report illegal tobacco sales to minors
- Require tobacco retailers to post warning signs which include the toll-free number to report violations
- Require clerks check the identification of youthful-appearing persons prior to a sale
- Assess civil penalties ranging from $200 to $6,000 against store owners for violations
- Comply with the federal SYNAR Amendment aimed at reducing youth access to tobacco
- Prepare an annual report regarding enforcement activities and their effectiveness for the federal government, Legislature, and Governor

Proposition 56 allocates $6 million annually to DPH for tobacco law enforcement activities ($7.5 million in 2017-18 to account for collection of the tax beginning in the final quarter of 2016-17). According to the initiative text, this allocation is intended "to support programs, including, but not limited to, providing grants and contracts to local law enforcement agencies to provide training and funding for the enforcement of state and local laws related to the illegal sales of tobacco to minors, increasing investigative activities, and compliance checks, and other appropriate activities to reduce illegal sales of tobacco products to minors, including, but not limited to, the Stop Tobacco Access to Kids Enforcement (STAKE) Act, pursuant to Section 22952 of the Business and Professions Code."

The state operations request for the STAKE Act Unit includes one Section Chief, two Food and Drug Program Specialists, two Supervising Food and Drug Investigators, twelve Investigators, one Attorney, and two Associate Governmental Program Analysts. The local assistance request for the STAKE Act Unit includes funding for local law enforcement agencies for training and increased retailer compliance checks.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open pending further discussions regarding the projects funded by these resources, as well as updates to Proposition 56 allocations at May Revision.

Questions. The Subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of this proposal.

2. What are the expected publication dates for the Oral Disease Burden Report and State Oral Health Plan?

3. Please describe local programs that will be funded by the local health department allocations and contracts awarded to local non-profits by the Oral Health Program. Are the funds from the California Department of Education sufficient to fund all school districts? Could they be supplemented with these funds?

4. Please describe local programs that will be funded by the local health department allocations and contracts awarded to local non-profits by the Tobacco Control Branch.

Issue 4: California Electronic Violent Death Reporting System (SB 877)

Implementation Update. SB 877 (Pan), Chapter 712, Statutes of 2016, requires DPH, to the extent funding is available, to establish and maintain the California Electronic Violent Death Reporting System (CalEVDRS). The system will collect and report data on violent deaths in California so that state and local policymakers can identify and implement appropriate prevention programs and strategies.

Background. According to the Centers for Disease Control, more than 42,000 people died by suicide and 16,000 by homicide in the United States in 2014. In 2002, the National Violent Death Reporting System (NVDRS) was established by the CDC as a surveillance system to collects data on violent deaths from participating states. NVDRS provides states and communities with a clearer understanding of violent deaths to guide local decisions about efforts to prevent violence and track progress over time. NVDRS collects data from state and local medical examiners, coroners, law enforcement, toxicology and vital statistics records and compiles them into a usable, anonymous database. NVDRS covers all types of violent deaths—including homicides and suicides—in all settings and for all age groups. NVDRS may include additional data on the circumstances or potential problems related to the violent death, including physical health, mental health, financial or relationship problems.

According to DPH, from 2005 through 2008, California was one of 17 states participating in the NVDRS. Under NVDRS, DPH contracted with county health departments to collect data on violent deaths from four data sources – death certificates, coroner/medical examiner records, police reports, and crime laboratory records. During its four years of data collection, DPH compiled detailed information on circumstances of more than 10,000 violent deaths, including homicides and suicides, in Alameda, Los Angeles, Riverside, San Francisco, Santa Clara, and Shasta counties. This information represented approximately half the violent deaths in California. During this period, California was unable to obtain law enforcement records required by NVDRS and could not reapply for funding from the CDC.

DPH secured funding from the David and Lucile Packard Foundation to develop CalEVDRS, which takes advantage of California's Electronic Death Registration System (CA-EDRS), created in 2005 to allow counties to file death certificates online instead of mailing paper forms. CalEVDRS data elements were created according to NVDRS specifications and law enforcement data for homicides are linked using Supplementary Homicide Reports (SHR) from the California Department of Justice. Additional funding from the California Wellness Foundation (TCWF) allows DPH to pay coroners to complete this supplement. As of 2010, fourteen counties are contributing data to this system, accounting for about 57 percent of the violent deaths and two-thirds of all homicides in California.

The 2014 federal budget included increased funding for the CDC to expand NVDRS to all 50 states. DPH applied to the CDC for grant funding to continue participation in NVDRS. According to DPH, the CDC approved grant funding of $347,000 annually for five years, which will be sufficient to implement the requirements of SB 877 and the CDC grant. The department expects to post the summary and analysis required by SB 877 within one to two years, and may provide fact sheets on data collected in the interim.

Subcommittee Staff Comment and Recommendation. This is an informational item.

Questions. The Subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of the status of this program

2. Please describe the violent death data collection efforts currently underway and any plans to expand to additional jurisdictions.

3. Please describe the elements DPH plans to include in the required analysis of violent deaths in California.

Issue 5: AIDS Drug Assistance Program (ADAP)

ADAP Local Assistance Funding Summary			
Fund Source	**Program**	**2016-17**	**2017-18**
0890 – Federal Trust Fund	4045023 – Infectious Diseases	$121,800,000	$117,400,000
Total Fund 0890 – Federal Trust Fund		**$121,800,000**	**$117,400,000**
Change from 2016 Budget Act		**($5,100,000)**	**($9,500,000)**
3080 – AIDS Drug Assistance Program (ADAP) Rebate Fund	4045023 – Infectious Diseases	$240,700,000	$264,800,000
Total Fund 3080 – ADAP Rebate Fund		**$240,700,000**	**$264,800,000**
Change from 2016 Budget Act		**$34,600,000**	**$58,600,000**
Total ADAP Local Assistance Funding – All Funds		**$362,500,000**	**$382,200,000**

Background. The Office of AIDS within DPH administers the AIDS Drug Assistance Program (ADAP), which provides access to life-saving medications for Californians living with HIV and assistance with costs related to HIV pre-exposure prophylaxis (PrEP) for Californians at risk for acquiring HIV. Clients are eligible for ADAP services if they meet the following criteria:

1. are HIV infected;
2. are a resident of California;
3. are 18 years of age or older;
4. have a Modified Adjusted Gross Income that does not exceed 500 percent of the Federal Poverty Level; and
5. are not fully covered by or eligible for Medi-Cal or any other third-party payer.

ADAP provides services to its clients through support for medications, health insurance premiums and out-of-pocket costs. Clients participate in three main programs:

1. Medication Program – This program pays prescription costs for medications on the ADAP formulary for the following coverage groups (either the full cost of medications or deductibles and co-pays):
   a. *ADAP-only clients* – These clients are people living with HIV who are uninsured. ADAP pays 100 percent of the cost of prescription medications on the ADAP formulary
   b. *Medi-Cal Share of Cost clients* – These clients are people living with HIV enrolled in Medi-Cal, but who have a share of cost. ADAP pays 100 percent of the cost of prescription medications on the ADAP formulary up to the client's Medi-Cal share of cost amount
   c. *Private insurance clients* – These clients are people living with HIV enrolled in private health insurance. ADAP pays prescription drug deductibles and co-pays for these clients
   d. *Medicare Part D clients* – These clients are people living with HIV enrolled in Medicare and who have purchased Medicare Part D. ADAP pays the Medicare Part D drug deductibles and copays for these clients

2. Office of AIDS-Health Insurance Premium Payment (OA-HIPP) Program – This program pays for private health insurance premiums or Medicare Part D premiums for clients co-enrolled in the ADAP medication program. ADAP pays health insurance premiums for eligible clients with one of three different types of health insurance:
   a. *Non-Covered California private insurance* (OA-HIPP/non-Covered California)
   b. *Private insurance through Covered California* (OA-HIPP/Covered California)
   c. *Medicare Part D* (OA/Medicare Part D)
3. Pre-Exposure Prophylaxis (PrEP) Assistance Program – This program, which is scheduled to begin in spring 2017 covers medication costs and out-of-pocket costs for PrEP for individuals at risk for, but not infected with HIV. PrEP is a daily medication taken by HIV-negative individuals that significantly reduces the risk of HIV infection.

ADAP is funded by federal funds and the ADAP Rebate Fund (Fund 3080). The federal government began funding state programs to assist people living with HIV to purchase antiretroviral medications in 1987. Since 1990 with the passage of the Ryan White Comprehensive AIDS Resources Emergency Act, now known as the Ryan White Program, the federal Health Resources and Services Administration (HRSA) provides funding to states for ADAP programs. In addition to federal funds, ADAP receives significant funding from mandatory and voluntary manufacturer rebates for ADAP drug expenditures.

ADAP Local Assistance Estimate. The November 2016 ADAP Local Assistance Estimate reflects revised 2016-17 expenditures of $362.5 million, which is an increase of $29.5 million or 8.8 percent compared to the 2016 Budget Act. According to DPH, this increase is primarily due to growth in medication-only clients and continuing increases in medication prices. For 2017-18, DPH estimates ADAP expenditures of $382.2 million, an increase of $49.2 million or 14.8 percent compared to the 2016 Budget Act. According to DPH, this increase is primarily due to a resumption of the growth rate of new ADAP clients consistent with the program's pre-ACA levels, as clients eligible for the Medi-Cal expansion have completed the transition to the program. In addition, medication prices continue to increase. However, ADAP expects medication-only clients to decrease as these clients are transitioned into private insurance pursuant to the program's proposal to implement case management services.

ADAP tracks caseload and expenditures by client group. DPH estimates ADAP caseload and expenditures for 2016-17 and 2017-18 will be as follows:

Caseload by Client Group	**2016-17**	**2017-18**
Medication-Only	12,892	11,819
Medi-Cal Share of Cost	152	155
Private Insurance	7,735	10,059
Medicare Part D	8,462	8,462
PrEP Assistance Program	50	500

Expenditures by Client Group	2016-17	2017-18
Medication-Only	$299,933,593	$297,842,202
Medi-Cal Share of Cost	$728,786	$792,993
Private Insurance	$29,889,234	$50,782,005
Medicare Part D	$19,429,180	$21,678,722
PrEP Assistance Program	$4,782	$401,701

Enrollment and Case Management. In addition to expenditures for services to clients, the ADAP Local Assistance Estimate also includes funds for a variety of enrollment, case management, and quality improvement efforts to support the program.

- Local ADAP enrollment sites will receive approximately $4 million in 2016-17 and 2017-18 for costs associated with enrolling and maintaining clients in ADAP.
- Local ADAP enrollment sites will also receive approximately $2.3 million of federal ADAP Earmark funds from the 2017 Ryan White Part B grant application to provide outreach and case management services. These services would assist uninsured, medication-only ADAP clients to transition into comprehensive healthcare coverage available through Medi-Cal, private insurance, or other programs. Provision of these services is consistent with recommendations of a recent HRSA site visit to evaluate the state's Ryan White program.
- A Pharmacy Quality Incentive Program (QIP) will use approximately $2.3 million of ADAP Earmark funds to provide incentives to pharmacies performing tasks related to ensuring medication adherence, providing HIV testing, selling syringes without a prescription, and/or linking patients to medication and co-pay assistance programs for HIV pre- and post-exposure prophylaxis.
- ADAP entered into an agreement with a new Enrollment Benefits Manager, A.J. Boggs, to provide an enrollment portal to simplify enrollment and access to Ryan White programs. The Estimate includes costs of approximately $3.9 million in 2016-17 and $2.2 million in 2017-18 for this contract. However, the implementation of the enrollment portal was halted in March 2017 and the contract terminated (see discussion below).

Enrollment Benefits Manager Contract Terminated. Prior to July 2016, ADAP's pharmacy benefits manager (PBM) contract included both pharmaceutical and enrollment services. After the expiration of the PBM contract, the 2016 Budget Act approved contract resources to separate these functions into two contracts: a PBM contract with Magellan and a new enrollment benefits manager (EBM) contract with A.J. Boggs & Company. A.J. Boggs, under the terms of the contract, was required to provide a web-based eligibility portal that would allow local enrollment sites and other Ryan White programs to simplify enrollment and access to services.

In November 2016, the enrollment portal was unexpectedly unavailable for enrollment worker and client use. DPH identified security vulnerabilities in the new system and identified two breaches of

confidential client information. After the portal became unavailable, DPH took several actions to address the problems with enrollments and eligibility determinations:

- Enrollment workers were instructed to faxed client applications directly to A.J. Boggs for processing
- Client eligibility was extended until the next reenrollment or recertification period after June 30, 2017
- Paper applications were shortened to streamline the faxed application process
- DPH staff actively worked with enrollment sites, clients, and advocates to monitor problems and ensure continued access to medications and health insurance
- DPH provided semi-weekly updates on the issue with enrollment workers and stakeholders
- ADAP ceased secondary, state-level review of new applications to expedite access to medications.

DPH staff also engaged consultants at Deloitte to provide an independent assessment of the security issues and future viability of the enrollment portal.

On March 1, 2017, DPH announced it was terminating its EBM vendor relationship with A.J. Boggs, citing material breach of contract as the portal does not allow for the secure exchange of data. A.J. Boggs ceased processing applications on Friday, March 3, 2017. Beginning Monday, March 6, 2017, DPH will process applications received by fax. On Monday, March 13, 2017, DPH will begin implementation of a new enrollment system developed in consultation with Deloitte since the failure of the A.J. Boggs enrollment portal. At that time, DPH staff will provide training and access to the new system for enrollment workers and will redirect 20 staff positions from other divisions to support these efforts. The department has not yet provided information on the disposition of its financial relationship with A.J. Boggs or any potential sanctions or penalties due to the security breach and failure to implement a secure, functional enrollment portal.

Enrollment Worker Funding Request. The California HIV Alliance requests a $4 million augmentation from federal and ADAP Rebate funds. If approved, these resources would support local enrollment workers' increased workload related to the failure of the enrollment portal and the assumption of new responsibilities for enrolling individuals in the new PrEP Assistance Program.

PrEP Assistance Program Limitations. The California HIV Alliance also reports the department's new PrEP Assistance Program will limit enrollment of HIV-negative individuals to those who currently have health care coverage and will not provide PrEP medications to the uninsured. The 2016 trailer bill language authorizing the program provides that "*the director may expend funding from the AIDS Drug Assistance Program Rebate Fund for this HIV infection prevention program to cover the costs of prescribed ADAP formulary medications for the prevention of HIV infection and related medical copays, coinsurance, and deductibles.*" DPH is interpreting the statutory reference to "*copays, coinsurance, and deductibles*" to require enrollment only of individuals with health care coverage. It is neither clear that the statute must be interpreted in this manner nor that exclusion of uninsured individuals was an intended result of adoption of this language in the 2016 Budget Act. The Office of AIDS indicates that, for each HIV infection prevented, $367,000 of lifetime treatment costs are avoided. Given the potential public health benefits and avoidance of future treatment and medication costs, the subcommittee may wish to consider clarifying the statutory authority for this program to ensure access to PrEP medications for the uninsured.

ADAP Data Sharing Trailer Bill Proposal. DPH proposes trailer bill language to allow information sharing between ADAP and other entities. This information sharing is intended to streamline the enrollment and case management activities that require partnership between ADAP and local entities. According to DPH, enhancing case management capabilities would result in program savings due to increased enrollment of medication-only ADAP clients in comprehensive health care coverage. However, the subcommittee should evaluate whether the client privacy implications of this proposal would be more appropriately considered in the relevant policy committees of the Legislature.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open. The challenges with the program's enrollment portal merit further monitoring to ensure the transition of enrollment processing from the EBM contractor to DPH occurs smoothly and ADAP clients can maintain access to these life-saving medications and health care coverage. In addition, there will likely be updated estimates of caseload and expenditures, as well as changes to contract funding, included in the May Revision Estimate. The subcommittee should revisit the status of enrollment, the workload of enrollment workers, eligibility concerns for the PrEP Assistance Program, and the appropriate venue for consideration of the ADAP data sharing trailer bill proposal at that time.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of the major changes to the ADAP Estimate.

2. Please provide an update regarding the enrollment portal transition from A.J. Boggs to the department, actions taken regarding the breach of client information, and the expected timeline for implementation of enrollment system functionality.

3. Please describe the department's interpretation of its authority to provide PrEP medications to individuals pursuant to the trailer bill proposal approved in the 2016 Budget Act. What would be the fiscal impact of providing PrEP to uninsured individuals?

Issue 6: Ryan White Program Compliance with Standards, Quality, and Timeliness

Budget Issue. DPH is requesting seven positions and annual expenditure authority of $1,239,000, comprised of $740,000 from the Federal Trust Fund and $499,000 from the AIDS Drug Assistance Program (ADAP) Rebate Fund. If approved, these resources would allow the department's Office of AIDS to address findings from a federal Health Resources and Services Administration (HRSA) site visit, improve client health outcomes, and reduce health disparities through implementation of Standards of Care and a Clinical Quality Management Program. DPH also plans to redirect two positions from other departmental divisions for this purpose.

Program Funding Request Summary			
Fund Source	**Program**	**2016-17**	**2017-18**
0890 – Federal Trust Fund	4045023 – Infectious Diseases	$-	$740,000
Total Fund 0890 – Federal Trust Fund		**$-**	**$740,000**
3080 – AIDS Drug Assistance Program (ADAP) Rebate Fund	4045023 – Infectious Diseases	$-	$499,000
Total Fund 3080 – ADAP Rebate Fund		**$-**	**$499,000**
Total Funding Request – All Funds		**$-**	**$1,239,000**
Total Positions Requested:		**7.0**	

Background. DPH's HIV Care Program and AIDS Drug Assistance Program (ADAP) receive federal funds from the U.S. Health Resources and Services Administration (HRSA) through grants, which are provided by Part B of the Ryan White Program. These Part B grants are used to fund the provision of medication and assistance with insurance premiums for people living with HIV. Other Ryan White Program provisions fund medical care and supportive services through grants to local health departments and community based organizations. Specifically, Ryan White Program provides funding for the following California programs:

- The HIV Care Program is solely funded by the federal Ryan White Program grant. The program funds 42 contractors, which provide up to 12 types of core medical services and 16 types of supportive services to about 15,500 low-income HIV-positive clients.

- ADAP is funded by both the federal Ryan White Program grant and the ADAP Rebate Fund. As reported in the November 2016 ADAP Local Assistance Estimate, ADAP is expected to provide medication and health insurance assistance to 30,496 HIV-positive clients enrolled in the program in 2017-18 through contracted ADAP enrollment sites.

During a comprehensive site visit in March 2016, HRSA found that DPH was out of compliance with three federal mandates for the Ryan White Program:

- *Standards of Care* – The Ryan White Program requires grantees to establish service standards for each of the 28 funded services to define the basic level of service. According to DPH, the HIV Care Program has never established Standards of Care due to insufficient resources. HRSA is requiring the program to develop standards of care and service for every funded service category for all regions of the state.

  DPH is requesting one Health Program Specialist I, one Research Program Specialist II, and one redirected Associate Governmental Program Analyst (AGPA) to: 1) create the Standards of Care for the 28 funded service categories; 2) integrate the Standards of Care into the 42 HIV Care Program contracts and monitor compliance annually; 3) ensure the Standards of Care are evidence-based, data-driven, and can be routinely monitored; and 4) provide routine reports on how well contractors and providers implement the Standards of Care.

- *Clinical Quality Management Program* – The Ryan White Program requires grantees to establish Clinical Quality Management Programs to assess whether services are consistent with federal guidelines for the treatment of HIV and related opportunistic infections. HRSA found the current staff level dedicated to quality management was insufficient to implement the Clinical Quality Management Program and corresponding activities.

  DPH is requesting one Public Health Medical Officer III, one Research Scientist I, and one Research Program Specialist II to: 1) compile, analyze, and evaluate data on Clinical Quality Management; 2) provide medical expertise to ensure the Clinical Quality Management activities and Standards of Care are consistent with evidence-based clinical practices; and 3) coordinate data sharing to conduct effective clinical quality management for clients transitioning between public programs and ensure ADAP clients are receiving adequate care.

- *Timely Payment of Invoices* – HRSA noted the long timeframe for the HIV Care Program to pay some invoices. The California Prompt Payment Act requires that state agencies pay properly submitted invoices within 45 days of receipt. Beginning in FY 2013-14, DPH instituted a 100 percent review of all invoices and backup documentation to ensure that expenditures were accurate and allowable. According to DPH, this accountability measure is considered a best practice by HRSA, but has increased staff workload and increased processing time from an average of 36 days in 2013-14 to an average of 51 days in 2015-16.

  DPH is requesting one redirected AGPA) to: 1) review and process invoices from 42 HIV Care Program contractors for compliance with the California Prompt Payment Act; 2) conduct activities related to the collection and monitoring of contractors' audits; and 3) provide reports on timeliness of payments and other fiscal performance indicators.

- *ADAP Case Management Services* – HRSA recommended that DPH consider utilizing a portion of ADAP Rebate Funds "to enhance services to engage people in care, including linkage and retention in health care services, and to support transitioning activities to secure comprehensive health care coverage for people living with HIV and AIDS in the state including case management." ADAP is requesting local assistance expenditure authority to support case management services in the November 2016 ADAP Local Assistance Estimate.

DPH is requesting one Health Program Specialist I and one AGPA to: 1) support and coordinate outreach and case management services to transition ADAP-only clients to comprehensive health coverage; 2) process, manage, and provide oversight for ADAP enrollment site contract compliance; 3) ensure contracts adhere to Health Insurance Portability and Accountability Act (HIPAA) privacy and security regulations.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of this proposal.

2. Is there a requirement or process to report these corrective actions to HRSA?

Issue 7: Preventing Healthcare-Associated Infections in Facilities

Budget Issue. DPH requests six positions and expenditure authority from the Licensing and Certification Program Fund of $991,000 annually. If approved, these resources would allow the department's Healthcare-Associated Infections (HAI) Program to increase public education, track strategic performance measures, and support the HAI Advisory Committee.

Program Funding Request Summary			
Fund Source	**Program**	**2016-17**	**2017-18**
3098 – Licensing & Certification Program Fund	4050010 – Health Facilities	$-	$991,000
Total Fund 3098 – Licensing & Cert. Program Fund		**$-**	**$991,000**
Total Positions Requested:		**6.0**	

Background. According to the U.S. Centers for Disease Control (CDC), Healthcare-Associated infections (HAIs), infections patients get while receiving medical treatment in a healthcare facility, are a major, yet often preventable, threat to patient safety. Approximately 7,500 to 9,000 patients with HAIs die during their hospitalizations each year in California and direct medical costs of HAIs in California hospitals are approximately $3.1 billion to $3.7 billion annually. Research shows that when healthcare facilities, care teams, and individual doctors and nurses, are aware of infection problems and take specific steps to prevent them, rates of some targeted HAIs can decrease by more than 70 percent.

Established in 2009, the department's HAI Program collects, analyzes, interprets, and publishes HAI data from 392 California hospitals. The program produces an annual statewide report on the incidence certain HAIs including *Clostridium difficile* diarrheal infections (CDI), central-line-associated bloodstream infections (CLABSI), bloodstream infections due to methicillin-resistant *Staphylococcus aureau* (MRSA BSI) and vancomycin-resistant enterococci (VRE BSI), and surgical site infections (SSI) following 29 types of surgical procedures. The data in the annual report is compared to national baselines.

The HAI Program is supported by a HAI Advisory Committee composed of experts in the surveillance, prevention and control of HAIs, including state and local health department officials, infection control professionals, hospital administrators, health care providers, health care consumers, experts in infectious disease and hospital epidemiology, and experts in integrated health care systems. The committee is tasked with making recommendations related to methods of reporting HAIs, use of national guidelines and public reporting of process measures for preventing the spread of HAIs. The committee also reviews the impacts of federal, state and regulatory mandates; recommends assessment, educational curricula, and training methods for infection prevention professionals; and recommends methods for auditing hospital data and reporting compliance for HAIs.

DPH is requesting 6.0 positions and expenditure authority from the Licensing and Certification Program Fund of $991,000 annually. 4.0 Nurse Consultant III will serve as liaison infection preventionists and work directly with hospitals and other health care facilities to identify and improve problems that may cause HAIs. 1.0 Public Health Medical Administrator I will serve as the program's Medical Director

and collaborate with local health department officials and provide guidance and clinical expertise. 1.0 Health Program Manager I will supervise existing staff working on public education and social media outreach, as well as support for the HAI Advisory Committee.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of this proposal.

2. Please describe the progress California hospitals have made in reducing the incidence of HAIs since implementation of the HAI Program.

3. Based on data reported to the HAI Program, what major areas of improvement are needed by hospitals and other facilities to reduce the incidence of HAIs?

Issue 8: Oversight: Licensing and Certification (L&C) Division

Background. DPH's Licensing and Certification Division (L&C) is responsible for administering the licensure, regulation, inspection, and certification of health care facilities and certain health care professionals in California. The division is organized into 14 district offices and Los Angeles County, which operates under a contract with the division. L&C staff conduct periodic inspections and investigation of complaints to ensure health care facilities comply with state and federal laws and regulations, conducting roughly 27,000 complaint investigations annually. L&C also contracts with the federal Centers for Medicare and Medicaid Services (CMS), which provides federal funding to ensure that facilities accepting Medicare and Medi-Cal payments comply with federal laws and regulatory requirements. In addition to facility oversight, L&C oversees the certification of nurse assistants, home health aides, hemodialysis technicians, and the licensing of nursing home administrators.

History of Problems with Health Facility Oversight. L&C's regulatory oversight of health care facilities has raised concerns from the federal government, the Legislature, the California State Auditor, stakeholders, and the media for more than ten years. In particular, L&C has demonstrated a consistently poor record of completing investigations of health care facility complaints of abuse and neglect of residents in a timely manner.

California State Auditor (2007) - The division was the subject of a 2007 state audit that found that investigations were promptly initiated for only 51 percent of its 15,275 complaints and promptly completed only 39 percent of the time. The audit noted that, despite efforts to increase staffing, the reliance on nurses to conduct complaint investigations resulted in struggles to fill vacant facility evaluation staff positions due to low salaries and a shortage of available nurses.

Federal Office of Inspector General (2011, 2012, 2014) – The division was the subject of three separate reports from the federal Office of Inspector General for the U.S. Department of Health and Human Services. These reports found that L&C was not meeting its federal oversight requirements for health care facilities pursuant to Medicare and Medicaid laws and regulations. In particular, L&C investigators were not properly identifying unmet federal requirements in its surveys and inspections of health care facilities.

California State Auditor (2014) – The division was the subject of a second audit in 2014 that found systemic problems completing health care facility complaint investigations timely that were substantially similar to the problems identified by the Auditor in 2007. The new audit found that, as of April 2014, the division had more than 10,000 open complaints and entity-reported incidents (ERIs) against long-term care facilities and nearly 1,000 open complaints against individuals. Many of these complaints, including those indicating a safety risk to one or more facility residents, had remained open for nearly a year.

Los Angeles County Investigation, Audit (2014) – In 2014, an investigative report published in the *Los Angeles Daily News* discovered that the Los Angeles County Department of Public Health was administratively closing health care facility complaints of abuse and neglect that were submitted anonymously without completing an investigation. In response, the county's Board of Supervisors ordered an audit of the county department's Health Facilities Inspection Division (HFID). This review found more than 30% of complaint investigations had been open for more than two years, there was no

central state or county monitoring of complaint investigation completion or timeliness, and HFID could neither identify the number of staff devoted to investigations nor the number of staff it would need to complete investigations timely.

Hubbert Systems Consulting Assessment and Gap Analysis (2014) – In response to concerns expressed by the Legislature, L&C contracted with Hubbert Systems Consulting to perform an organizational assessment and evaluate areas where L&C was experiencing challenges and barriers contributing to less than optimal performance. Hubbert released its report in 2014 identifying issues with completing state and federal survey and licensing workload, facility and professional complaint investigations, oversight of the Los Angeles County contract, staff vacancy and retention, and other organizational management challenges. The report also provided 21 separate recommendations for remediating these issues including improvements in leadership, performance data monitoring, workforce development and retention, and operational management.

Budget Augmentations, Oversight and Legislative Reporting Mandates. The Legislature has sought to address the ongoing issues with L&C through a variety of budget actions and reporting requirements.

2014-15 Budget – The 2014-15 Budget included trailer bill language requiring L&C to:

- Report metrics quarterly on: (1) investigations of paraprofessional complaints; (2) long-term care health facility complaints, investigations, state relicensing, and federal recertification surveys; and (3) vacancy rates and hiring within L&C.
- Report by October 2016 the above information for all facility types.
- Assess the possibilities of using professional position classifications other than health facility evaluator nurses to perform licensing and certification survey or complaint workload.
- Hold semiannual meetings for all interested stakeholders to provide feedback on improving the L&C program.

2015-16 Budget – The 2015-16 Budget included*:*

- Approval of 237 positions over two years to address the licensing and certification workload.
- $2 million from the Internal Departmental Quality Improvement Account to implement quality improvement projects.
- $14.8 million from the L&C Program Fund to augment the Los Angeles County contract to perform licensing and certification activities in Los Angeles County.
- $378,000 from the L&C Program Fund and 3 positions to provide on-site oversight and perform workload management, training, and quality improvement activities to improve the efficiency and effectiveness of the Los Angeles County contract licensing and certification activities.
- Trailer bill language to establish timeframes to complete complaint investigations at long-term care facilities, as follows:
    - For immediate jeopardy complaints the department must complete the investigation within 90 days of receipt, with an additional extension of 60 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department must notify the facility and the complainant in writing of this extension and the extenuating circumstances and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation must be issued and served within thirty days of the completion of the complaint investigation.

- For all other categories of complaints received on or after July 1, 2017, the department must complete the investigation within 90 days of receipt, with an additional extension of 90 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department must notify the facility and the complainant in writing of this extension and the extenuating circumstances and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation must be issued and served within thirty days of the completion of the complaint investigation.
- For all complaints received on or after July 1, 2018, the department must complete the investigation within 60 days of receipt, with an additional extension of 60 days if the investigation cannot be completed due to extenuating circumstances. If there is an extension, the department must notify the facility and the complainant in writing of this extension and the extenuating circumstances and document the extenuating circumstances in its final determination. Any citation issued as a result of the complaint investigation must be issued and served within thirty days of the completion of the complaint investigation.
- Report on an annual basis (in the Licensing and Certification Fee report) data on the department's compliance with these new timelines.
- Beginning with the 2018-19 Licensing and Certification November Program budget estimate, the department must evaluate the feasibility of reducing investigation timelines based on experience implementing the timeframes described above.
- States the intent of the Legislature that the department continues to seek to reduce long-term care complaint investigation timelines to less than 60 days with a goal of meeting a 45-day timeline.

2016-17 Budget – The 2016-17 Budget included*:*

- $2 million from the Internal Departmental Quality Improvement Account to execute two contracts to redesign the Centralized Applications Unit information technology systems, and the Health Facilities Consumer Information System.
- $2.5 million in expenditure authority from the L&C Program Fund to convert 18 existing two-year limited-term positions to permanent positions, and fund two additional positions for the Office of Legal Services, for a total of 20 positions to improve the timeliness of investigations of complaints against caregivers.
- One-time $1 million augmentation to the Long-Term Care Ombudsman Program using funds from the State Health Facilities Citation Account.
- $2.1 million from the L&C Program Fund to augment the Los Angeles County contract to account for two, three percent salary increases effective October 2015 and October 2016, an increase to the employee benefit rate from 55.1 to 57.8 percent, and a decrease in the indirect cost rate from 33.2 to 31.4 percent.

Vacancy Rates: Center for Health Care Quality and HFEN Classification. According to DPH's latest annual Position and Vacancy Report, the Center for Health Care Quality, which oversees the L&C Division, had a 13.54% vacancy rate for all positions reported. However, many of district offices had vacancy rates that were much higher, including San Francisco (25.93%), San Diego South (24.32%), Orange (21.88%), and the East Bay (20.00%). The department-wide vacancy rate for the Health Facilities Evaluator Nurse (HFEN) classification, the primary classification conducting health facility

oversight and investigation, was 16.64%. According to DPH, the HFEN vacancy rate for the L&C Division was approximately 18%.

DPH reports it hired two contractors to help remedy the high vacancy rates for HFENs in the L&C Division. An onboarding and retention contractor will assist hiring candidates to navigate the state civil service process and help improve retention of hired staff. In addition, a recruitment contractor will seek candidates for these positions at job fairs, conduct outreach to registered nurses in California, develop marketing materials and attempt to meet recruitment targets. Funding for these contracts was approved as part of the 2015-16 Budget from the Internal Departmental Quality Improvement Account. These activities represent two of the recommendations from the Hubbert assessment.

Los Angeles County Contract Oversight. Ongoing concerns about facility oversight and management practices in LA County's Department of Public Health led DPH to request resources in the 2015-16 Budget for monitoring and quality improvement of the county's contract. These resources were meant to improve efficiency and effectiveness of the county's licensing and certification activities. DPH reports that it is taking the following actions to meet this goal:

- Established an LA County Monitoring Unit staffed by a Branch Chief, a HFEN supervisor, two HFEN surveyors, and a retired annuitant to provide oversight and monitoring of performance, including on-site review, observation, data analysis, and audits.
- Providing focused training to LA County HFID staff.
- Implementing a review tool to provide correct processing of deficiency findings and citations by HFID supervisors and managers.
- Performing concurrent on-site quality reviews of surveys with HFID staff using a state observation survey analysis process and providing targeted training to address identified issues.
- Performing quarterly audits of quality, prioritization, and principles of documentation.
- Creating a performance metrics worksheet for effective tracking of contracted workload.
- Establishing biweekly conference calls with HFID management to review performance metrics, discuss workload management, solve problems, and build collaboration.
- Providing written feedback to HFID management regarding identified concerns and requiring corrective action plans when appropriate.

Based on the implementation of these measures, CMS has released $390,000 of federal funds that were previously withheld pending DPH performing improvement activities for the LA County contract.

Persistent Complaint Investigation Backlog. Beginning in 2014, L&C has produced quarterly reports on the number, investigation, completion and other details about health care facility complaints and ERIs. In its first quarterly report, for July through September 2014, L&C reported 4,320 open complaints and 6,792 open ERIs. In its most recent quarterly report, for April through June 2016, L&C reported 5,001 open complaints and 9,374 open ERIs. The backlog of open complaints and ERIs continues to grow despite the approval of significant staff resources for the division and contract resources for the Los Angeles County contract. DPH reports that it is attempting to utilize enhanced data tools, such as dashboards and metrics in its district offices, to better manage its complaint and ERI investigation workload.

Long-Term Care Ombudsman Funding Proposal. The Long-Term Care Ombudsman Program is a federally authorized program administered by the California Department of Aging that monitors and assists residents in skilled nursing facilities and residential care facilities for the elderly. There are 35 local Long-Term Care Ombudsman programs throughout the state that work to resolve complaints or problems of care by working directly with facility administrators and care providers.

The Long-Term Care Ombudsman Program receives $1.1 million annually from the State Health Facility Citation Penalties Account, which receives funds from penalties imposed upon health facilities for violations of state laws and regulations. The Program received an additional $1 million augmentation on a one-time basis in both the 2015-16 and 2016-17 Budgets. The California Long-Term Care Ombudsman Association is requesting the $1 million augmentation be provided on an ongoing basis to allow the local programs to make sustainable infrastructure improvements and increase resident access to the programs' services.

CalQualityCare.org Proposal. CalQualityCare.org is a website administered by the University of California, San Francisco that provides important, objective information to consumers about the quality of about 20,000 LTSS providers including skilled nursing facilities, congregate living health facilities, hospice, home health, residential care facilities, continuing care retirement communities, adult day care, adult day health care, and intermediate care for the developmentally disabled (ICF/DD). Depending on available data, the following information is included for these providers: Provider characteristics (e.g. location, size, ownership), ratings (for skilled nursing facilities, home health, hospice, ICF/DD), staffing (number and type), quality of facility (deficiencies, complaints), quality of care (e.g. pressure ulcers, infections), cost and finances.

The CalQualityCare.org website was launched through a partnership between the California Health Care Foundation (CHCF) and the University of California, San Francisco (UCSF) in 2002. The website has almost 400,000 hits annually and gives consumers access to publicly available data to help them make placement decisions. According to the administrators of the website, public funding is needed to continue the website in the future, as the grants that previously funded the project have expired. The administrator's, as well as the Alzheimer's Association of Greater Los Angeles, request revenue transfer from the State Health Facility Citation Penalties Account of $500,000 annually to the University of California to continue administering CalQualityCare.org.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending further discussions about the performance of the L&C Division's oversight of health care facilities, particularly the timeliness of complaint investigations.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of the L&C Division, including regulatory responsibilities, organizational structure, and funding.

2. What is the status of the department's annual L&C Fee report, including the required data on compliance with the immediate jeopardy complaint investigation timelines established in the 2015-16 Budget?

3. What is the status of the department's September 2016 and December 2016 metrics reporting on complaints, ERIs, recertification, re-licensure, professional certification, and position vacancies?

4. Does L&C see a viable pathway for the division to clear its complaint backlog and consistently meet its investigation and other workload in the future? What steps still need to be taken to achieve this goal?

Issue 9: L&C: Performance Measurement and Quality Improvement

Budget Issue. DPH requests expenditure authority from the Internal Departmental Quality Improvement Account (IDQIA) of $2 million in 2017-18, 2018-19, and 2019-20. If approved, these resources would allow DPH to execute quality improvement projects and contracts to improve facility, agency and professional regulation and oversight.

Program Funding Request Summary			
Fund Source	**Program**	**2016-17**	**2017-18**
0942 – Internal Departmental Quality Improvement Account	4050010 – Health Facilities	$-	$2,000,000
Total Fund 0942 – Internal Dept. Qual. Improve. Acct.		**$-**	**$2,000,000**
Total Positions Requested:		**0.0**	

Background. Health and Safety Code Section 1280.15(f) establishes the IDQIA and provides that "moneys in the account shall be expended for internal quality improvement activities in the Licensing and Certification Program." The account is funded by administrative penalties DPH imposes against health facilities for violations that meet the definition of immediate jeopardy of death or serious harm to a patient or administrative penalties associated with breaches of medical information. In 2014-15, IDQIA funding was used to conduct a federally-required assessment of DPH's survey and certification operations by Hubbert Systems Consulting, which issued a final report containing 21 recommendations for improvement. In 2015-16, IDQIA funding was used to develop performance dashboards, automate key business practices, and streamline data collection from regulated entities. In 2016-17, IDQIA funds were authorized to redesign the program's Centralized Applications Unit IT systems and the Health Facilities Consumer Information System, an online system that provides quality and other information about licensed long-term care facilities and hospitals in California.

DPH requests $2 million annually from the IDQIA for 2017-18, 2018-19, and 2019-20, to complete the following quality improvement activities:

1. Information Technology Assessment: DPH will contract with an IT contractor to assess the status and long-term viability of CHCQ's many IT systems and develop an "IT road map" to identify, guide, and prioritize CHCQ's IT procurement needs.
2. Performance Dashboards: DPH expects ongoing costs to create, publish, and maintain internal and external facing dashboards and other visual displays of data.
3. Improve Survey and Investigation Quality, Timeliness, and Consistency by Optimizing the Use of Tablets through Business Process Redesign: DPH will contract with a consultant to identify strategies to optimize the use of surveyors' existing tablets.
4. Automate Certified Care-Giver Application Forms in the Professional Certification Branch: DPH will execute a contract to further expand the use of automated form technology to automate key business practices and provide better service to certified health care providers.
5. Innovative Applications: In collaboration with the California Health and Human Services Agency's Innovation Initiative, DPH is engaged in a pilot project to explore innovative ways to facilitate investigation of adverse events related to retained foreign objects.

6. Outcomes and Effectiveness Evaluation: DPH will execute a contract to have a consultant annually evaluate the effectiveness of enforcement actions. Health and Safety Code Section 1438 requires CDPH to produce an annual report to the Legislature to "review the effectiveness of the enforcement system in maintaining the quality of care provided by long-term health care facilities."
7. Quality Improvement Facilitation: DPH will engage the services of a quality improvement facilitator who is trained in process mapping, performance measurement, and the "Plan-Do-Check-Act" (PDCA) quality improvement process that the department has adopted. In addition, the facilitators will help address media responses more timely, and the scheduling of periodic surveys and unpredictable complaint activities.
8. Staff Development, Leadership and Quality Improvement Training: DPH will provide training on leadership and quality improvement principles for all staff.
9. Onboarding, Retention, and Recruitment Contract: DPH anticipates completing work on the onboarding and retention, and recruitment contracts that were initiated in 2015-16.
10. Centralized Applications Unit and Health Facilities Consumer Information System redesign: Continuation of the redesign of the Centralized Applications Unit information technology systems and the Health Facilities Consumer Information System.
11. Emerging Quality Improvement Needs: Prior quality improvement projects or the department's focus on continuous quality improvement may require DPH to respond to emerging and unforeseen quality improvement needs.

Funding for each of these proposed activities by fiscal year is as follows:

Project	FY 2017-18	FY 2018-19	FY 2019-20
IT Assessment	$ 250,000	$ -	$ -
IT Assessment follow-up		$ 250,000	$ 250,000
Dashboards	$ 250,000	$ 50,000	$ 50,000
Tablet Optimization	$ 100,000	$ 100,000	$ 25,000
Automate Forms (PCB)	$ 125,000	$ 125,000	$ 50,000
Innovation Projects	$ 250,000	$ 500,000	$ 500,000
Outcomes research	$ 200,000	$ 200,000	$ 200,000
QI Facilitation	$ 200,000	$ 200,000	$ 200,000
Staff Training		$ 400,000	$ 500,000
Recruitment and Retention	$ 125,000	$ -	$ -
CAU/HFCIS	$ 500,000	$ -	$ -
Emerging Needs	$ -	$ 175,000	$ 225,000
Total	**$ 2,000,000**	**$ 2,000,000**	**$ 2,000,000**

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 10: L&C: Los Angeles County Contract

Budget Issue. DPH requests expenditure authority from the Licensing and Certification Program Fund of $1.1 million annually. If approved, these resources would augment the state's licensing and certification contract with Los Angeles County to account for general salary increases approved by the county's Board of Supervisors of three percent in October 2016, two percent in October 2017, and two percent in April 2018.

Program Funding Request Summary			
Fund Source	**Program**	**2016-17**	**2017-18**
3098 – Licensing & Certification Program Fund	4050010 – Health Facilities	$-	$1,100,000
Total Fund 3098 – Licensing & Cert. Program Fund		**$-**	**$1,100,000**
Total Positions Requested:		**0.0**	

Background. For over 30 years, DPH has contracted with LA County to perform federal certification and state licensing surveys and investigate complaints and entity-reported incidents for approximately 2,500 health care facilities in the LA County area. Roughly one third of licensed and certified health care facilities in California are located in LA County, and 18.7 percent of the long-term care complaints and entity-reported incidents received statewide each year are generated in LA County.

In July 2015, DPH and LA County renewed the contract for a three-year term, ending June 30, 2018, for an annual budget of $41.8 million to fund 224 positions. The 2016 Budget Act authorized an additional $2.1 million in expenditure authority to fully fund LA County to conduct tier 1 and tier 2 federal workload, long-term care complaints and entity-reported incidents, and pending complaints and entity-reported incidents. According to DPH, the LA County Board of Supervisors approved general salary increases for employees covered by the LA County contract in December 2015, after the negotiation of the contract renewal.

DPH is requesting expenditure authority of $1.1 million to account for these salary increases. DPH and LA County indicate these resources are necessary to fully fund the 224 positions in the contract and complete the required workload. If approved, this proposal would increase the total annual budget of the contract to $45 million.

As previously discussed, the LA County contract has long been the subject of increased scrutiny due to its performance on regulatory oversight of health care facilities, including timeliness and management of complaint investigations. As a result, the terms of the contract renewal included several metrics and deliverables the county would be required to meet. DPH and LA County both report that the county is meeting the first year deliverables contained in the contract. However, DPH is continuing its monitoring activities to ensure effectiveness and efficiencies of the licensing and certification activities in LA County.

Los Angeles County Additional Augmentation Proposal. LA County, while supportive of the augmentation contained in this proposal, is requesting additional funding to support the contract. The

county reports it has experienced other increases in program costs due to cost-of-living adjustments, increased lease costs, and changes in the indirect and fringe benefit rates. LA County is requesting an additional $1.5 million of expenditure authority from the Licensing and Certification Program Fund for DPH to augment the county's contract.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended this issue be held open pending further discussions about the appropriate level of funding needed for the LA County contract, as well as ongoing monitoring of the county's performance of its contracted responsibilities.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 11: Improved Access to Vital Statistics Data

Budget Issue. DPH requests expenditure authority from the Health Statistics Special Fund of $75,000 in 2017-18 and $325,000 in 2018-19. If approved, these resources would fund replacement of the California Vital Statistics Query (CA-VSQ), a web-based interactive system that allows access to medical and demographic data collected by the department.

Program Funding Request Summary			
Fund Source	**Program**	**2016-17**	**2017-18**
0099 – Health Statistics Special Fund	4045041 – Health Statistics and Informatics	$-	$75,000
Total Fund 0099 – Health Statistics Special Fund		**$-**	**$75,000**
Total Positions Requested:		**0.0**	

Background. The department's Center for Health Statistics and Information (CHSI) is responsible for the registration of vital events, the issuance of legal vital records documents, and the collection and management of public health and vital statistics data. This responsibility falls under the duties of the director of DPH, designated by statute as the State Registrar, to register each live birth, fetal death, and marriage, and to report every judgment of dissolution of marriage, legal separation, or nullity decree. According to DPH, CHSI annually compiles vital statistics data from birth, death, and fetal death certificates for more than 750,000 Californians, which is used by federal, state, and local government agencies, policy makers, and researchers for measuring population health, for research on health outcomes, and for state and local public health reporting and surveillance.

CHSI uses CA-VSQ, a web-based interactive system, to provide access to medical and demographic data collected by the department. According to DPH, CA-VSQ is 20 years old and has several important functional limitations. For example, the system only contains birth and death data for the years 1994 to 2013, has limited reporting functionality, and is unable to apply small cell size repression to avoid the risk of re-identification of individuals based on reported data. CA-VSQ also cannot currently accept data files from CHSI's new Vital Records Business Intelligence System (VRBIS). DPH proposes to update CA-VSQ to improve functionality and be more responsive to public demands for more timely availability of data.

DPH is requesting expenditure authority from the Health Statistics Special Fund of $75,000 in 2017-18 and $325,000 in 2018-19, and $15,000 annually thereafter. If approved, these resources would fund one or more vendor contracts to develop and implement the new system. According to DPH, a Stage 1 Business Analysis and Stage 2 Alternatives Analysis have been completed pursuant to the Department of Technology's new Project Approval Lifecycle process. DPH reports it is currently beginning the Stage 3 Procurement Analysis and expects the new system would be operational by June 2019.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 12: Demographic Data - Asian, Native Hawaiian, Pacific Islander (AB 1726)

Budget Issue. DPH requests 2.5 positions and expenditure authority from the Health Statistics Special Fund of $326,000 in 2017-18, $316,000 in 2018-19, and $314,000 annually thereafter. If approved, these resources would allow DPH to include additional separate data collection categories and other tabulations for specified Asian American, Native Hawaiian, and other Pacific Islander subgroups pursuant to the requirements of AB 1726 (Bonta), Chapter 607, Statutes of 2016.

Program Funding Request Summary			
Fund Source	**Program**	**2016-17**	**2017-18**
0099 – Health Statistics Special Fund	4045010 – Chronic Disease Prevention & Health Promotion	$-	$82,000
0099 – Health Statistics Special Fund	4045041 – Health Statistics and Informatics	$-	$244,000
Total Fund 0099 – Health Statistics Special Fund		**$-**	**$326,000**
Total Positions Requested:		**2.5**	

Background. AB 1726 requires, on or after July 1, 2022, DPH to use additional separate data collection categories and other tabulations for specified Asian American, Native Hawaiian, and other Pacific Islander (AANHPI) sub-groups including, but not limited to, Bangladeshi, Hmong, Indonesian, Malaysian, Pakistani, Sri Lankan, Taiwanese, Thai, Fijian, and Tongan. In addition, AB 1726 requires DPH to make any data collected publicly available, except for personal identifying information, by posting the data on DPH's website and updating the data annually. Existing law requires state agencies, boards, and commissions that directly, or by contract, collect demographic data as to the ancestry or ethnic origin of Californians to use separate collection categories and tabulations for each major Asian Pacific Islander group, including, but not limited to, Chinese, Japanese, Filipino, Korean, Vietnamese, Asian Indian, Laotian, Cambodian, Hawaiian, Guamanian, and Samoan.

AB 1726 was intended to identify and address potential health disparities within certain Asian Pacific Islander subgroups that are masked when aggregated data is collected for broader population categories. According to the Southeast Asia Resource Action Center, the sponsor of AB 1726:

> "Certain AANHPI subgroups have fallen behind in important measurements of health and education. For example, although aggregate data shows the average AANHPI individual tends to have health insurance and is on track to obtaining a four-year degree, disaggregated data demonstrates that Koreans, Cambodians, Thais, Tongans, and Fijians have a higher percentage of being uninsured, and that Vietnamese, Laotian, Cambodian, and Hmong Americans have the lowest educational attainment of Asian American ethnic groups nationwide. Samoans, Fijians, and Tongans have a bachelor's degree attainment rate significantly lower than the statewide average."

The department's Center for Health Statistics and Information (CHSI) is responsible for the registration of vital events, the issuance of legal vital records documents, and the collection and management of public health and vital statistics data. This responsibility falls under the duties of the director of DPH, designated by statute as the State Registrar, to register each live birth, fetal death, and marriage, and to

report every judgment of dissolution of marriage, legal separation, or nullity decree. According to DPH, data on over 99 percent of these vital events is captured electronically at the time of registration and includes all of the AANHPI categories specified in AB 1726. DPH is requesting two Research Program Specialist I positions in CHSI to determine the statistical reliability of data and ensure that re-identification of individuals is not possible from any data reporting. In addition, DPH is requesting 0.5 Research Scientist III position in its Childhood Lead Poisoning Prevention Branch to modify the branch's electronic blood lead reporting system to capture and report the required demographic data elements for incidence of childhood lead poisoning.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 13: Certified Copies of Vital Records: Electronic Application (AB 2636)

Budget Issue. DPH requests two permanent positions and expenditure authority from the Health Statistics Special Fund of $257,000 in 2017-18, $253,000 in 2018-19 and 2019-20, and $127,000 in 2020-21. If approved, these resources would allow DPH to implement acceptance of electronic acknowledgments for requests for certified copies of birth, death, or marriage records, pursuant to AB 2636 (Linder), Chapter 527, Statutes of 2016.

Program Funding Request Summary			
Fund Source	**Program**	**2016-17**	**2017-18**
0099 – Health Statistics Special Fund	4045041 – Health Statistics and Informatics	$-	$257,000
Total Fund 0099 – Health Statistics Special Fund		**$-**	**$257,000**
Total Positions Requested:		**2.0**	

Background. The department's Center for Health Statistics and Information (CHSI) is responsible for the registration of vital events, the issuance of legal vital records documents, and the collection and management of public health and vital statistics data. This responsibility falls under the duties of the director of DPH, designated by statute as the State Registrar, to register each live birth, fetal death, and marriage, and to report every judgment of dissolution of marriage, legal separation, or nullity decree. According to DPH, CHSI annually compiles vital statistics data from birth, death, and fetal death certificates for more than 750,000 Californians, which is used by federal, state, and local government agencies, policy makers, and researchers for measuring population health, for research on health outcomes, and for state and local public health reporting and surveillance.

The State Registrar, local registrars, and county recorders may only provide certified copies of vital records to authorized persons, as defined by state law. Since 2001, in response to reports the state had sold the birth records of 24 million Californians, the Legislature has enacted several measures to protect against unauthorized release of vital records. Until passage of AB 2636, individuals submitting a written request for certified copies of vital records were required to provide a notarized statement that the requester was authorized to receive the records. Individuals requesting vital records in person were required to swear under penalty of perjury in the presence of a state or local government official that they were an authorized person.

AB 2636 authorizes, until 2021, state and local government officials to accept an electronic acknowledgment sworn under penalty of perjury when a request for a certified copy of a birth, death, or marriage record is made electronically. The electronic acknowledgment must use a multilayered remote identity proofing process that: 1) Meets or exceeds National Institute of Standards and Technology electronic authentication guidelines; 2) Verifies through record checks with state or local governments, or credit reporting agencies, a valid government-issued identification number, and a financial or utility account number; 3) Meets or exceeds information security requirements contained in state and federal laws and regulations; and 4) Retains a record of the applicant and steps taken to verify the applicant's identity. AB 2636 was intended to reduce the time an applicant must wait to receive a certified copy of a vital record, often needed to verify identity for official purposes, as well as to reduce the associated costs imposed on an applicant's request by the necessary notary fees.

Upon approval of the requested resources, DPH proposes to implement the provisions of AB 2636 as follows:

- DPH's Information Technology Services Division (ITSD) staff would modify the existing electronic submission interface with the Center Request Tracking System (CRTS) to accept electronic requests for certified copies of vital records. The existing interface currently only accepts electronic submission of requests for informational copies of vital records. DPH requests one Systems Software Specialist II to manage the modification and ongoing maintenance of the interface.
- DPH would contract with multiple vendors to modify its website and provide for data and payment transmission to implement electronic submission services. DPH requests one Associate Governmental Program Analyst (AGPA) to manage development, review, and compliance for these contracts, as well as payment processing and reconciliation. The subcommittee notes that DPH has not included expenditure authority for the vendor contracts in this request.

The department's request does not include contract funding for the website, data and payment transmission vendors. According to DPH, the contracts would be no-cost, with vendors providing services to the public and charging consumers directly for services rendered. No charges will be billed to DPH. However, the department indicates that it will continue to receive the full amount of the fee authorized in statute for requests of birth certificates, death certificates and marriage records.

Consumer Protections. AB 2636 eliminates the notarization requirement for individuals to verify they are authorized to receive vital records. Consumer privacy groups, such as the Privacy Rights Clearinghouse, noted during consideration of AB 2636 that "the substitution of an electronic acknowledgment for a notarized affidavit will facilitate the ability of identity thieves and other fraudsters to obtain vital records that can then be used to engage in criminal acts against Californians". The legislation included requirements that cities and counties report to the Attorney General and legislative policy committees, among other information, a description of the mechanism and process, if any, by which consumers who have been victims of identity theft may temporarily limit electronic access to certified vital records. The implementation of such a process is not required by AB 2636. However, DPH has indicated that they expect to include a process for consumers to limit electronic access to their records during the implementation of the electronic submission capabilities.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of this proposal.

2. Please describe the implementation plan and required resources for the website, data transmission, and payment transmission vendor contracts.

3. What electronic resources are currently available for consumers to request informational copies of records?

4. Please describe the expected consumer interface for the new system for certified copies of vital records. Are there any additional fees consumers will be required to pay in excess of the current vital records fee structure?

5. To the extent that planning is sufficiently developed, please describe how the process for consumers to protect their records from electronic release would be implemented operationally.

Issue 14: Youth Tobacco Enforcement Staffing

Budget Issue. DPH requests conversion of nine expiring, limited-term positions to permanent and $1.1 million reimbursement expenditure authority. If approved, these resources would allow DPH to continue tobacco retailer inspections and other activities to prevent tobacco sales to children, pursuant to a contract with the U.S. Food and Drug Administration (FDA).

Program Funding Request Summary			
Fund Source	**Program**	**2016-17**	**2017-18**
0995 - Reimbursements	4045059 - Environmental Health	$-	$1,130,000
Total Fund 0995 – Reimbursements		**$-**	**$1,130,000**
Total Positions Requested:		**9.0**	

Background. The federal Family Smoking Prevention and Tobacco Control Act (known as the "Tobacco Control Act") was signed into law on June 22, 2009, authorizing the FDA to regulate the manufacture, distribution, and marketing of tobacco products. The Tobacco Control Act imposes significant restrictions on the sale and marketing of tobacco products to children, including: 1) a ban on sales to minors; 2) a ban on vending machine sales (except in adult-only facilities); 3) a ban on packages with fewer than 20 cigarettes; 4) prohibition of tobacco-brand sponsorship of sports, entertainment, social, or cultural events; and 5) restrictions on promotional giveaways of tobacco products. The FDA is required to develop an enforcement plan for these sale and marketing restrictions and contracts with states to carry out inspections of retailers to ensure compliance. The contracts and other programmatic activities of the Tobacco Control Act are funded by user fees from manufacturers and importers of cigarettes, snuff, chewing tobacco, roll-your-own tobacco, cigar, and pipe tobacco.

Beginning September 2011, the FDA has contracted with DPH to conduct tobacco retailer inspections to ensure compliance with the regulatory requirements of the Tobacco Control Act. The current three-year contract, which was last renewed in 2014, requires DPH to inspect at least 20 percent of the state's tobacco retailers annually, or approximately 8,000 inspections. Of these inspections, 75 percent are required to be undercover buys (UB) and 25 percent are required to be advertising and labeling inspections. The department's Stop Tobacco Access to Kids Enforcement (STAKE) Act Unit, which enforces similar California restrictions on tobacco sales and marketing since 1995, conducts retailer inspections pursuant to the FDA contract.

The 2015 Budget Act approved nine limited-term positions, comprised of one Investigator and eight Associate Governmental Program Analysts (AGPAs), to achieve the FDA contract's requirements to inspect 20 percent of retailers. The federally required UB inspections are conducted with eight two-person teams (one Investigator and one AGPA) that supervise a youth operative and process evidence for submission to the FDA. AGPAs conduct advertising and labeling activities that do not require a youth operative under the contract.

The nine positions approved in the 2015 Budget Act are scheduled to expire in September 2017, concurrent with the expiration of the FDA contract. DPH expects the FDA to approve a new, three-year contract to continue tobacco retailer inspections in the spring of 2017. DPH is requesting conversion of

the nine expiring, limited-term positions to permanent and $1.1 million of reimbursement authority for expenditure of federal Tobacco Control Act funding expected from the renewal of the FDA contract.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open pending further discussion about renewal of the FDA contract.

Questions. The subcommittee has requested DPH to respond to the following:

1. Please provide a brief overview of this proposal.

2. What are the differences in tobacco retailer enforcement between the federal Tobacco Control Act and the state's STAKE Act?

3. How frequently are retailers cited for violations of the Tobacco Control Act or the STAKE Act? What is the penalty?