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

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, M.D., Chair
Senator Melissa Hurtado
Senator Jeff Stone

Thursday, May 2, 2019
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

PART B

Consultant: Scott Ogus

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0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
4260 DEPARTMENT OF HEALTH CARE SERVICES
4265 DEPARTMENT OF PUBLIC HEALTH
4300 DEPARTMENT OF DEVELOPMENTAL SERVICES
5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: CalHEERS System Integrator Contract Transition Activities

Spring Finance Letter and Budget Bill Language. CHHSA's Office of Systems Integration (OSI) and DHCS request expenditure authority from the California Health and Human Services (CHHS) Automation Fund of $17.6 million in 2019-20. If approved, these resources would allow OSI to fund anticipated contract costs for transition to a new system integrator for the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) project. Included as part of this request, funding for the CHHS Automation Fund would be provided by increased expenditure authority for DHCS of $15.4 million ($3.7 million General Fund and $11.7 million federal funds) and budget bill language that would provide for the funds to be transferred upon finalization of the vendor selection, as determined by the Department of Finance. The remaining $2.2 million for the project would be provided from the California Health Trust Fund by Covered California.

Program Funding Request Summary (CHHSA-OSI)		
Fund Source	**2019-20**	**2020-21**
9745 – CHHS Automation Fund	$17,627,000	$-
Total Funding Request:	**$17,627,000**	**$-**

Program Funding Request Summary (DHCS)		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$3,743,000	$-
0890 – Federal Trust Fund	$11,702,000	$-
Total Funding Request:	**$15,445,000**	**$-**

Program Funding Request Summary (Covered California)		
Fund Source	**2019-20**	**2020-21**
3175 – California Health Trust Fund	$2,182,000	$-
Total Funding Request:	**$2,182,000**	**$-**

Background. The California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) is an automated system that provides eligibility determination, enrollment, and retention services for California's health insurance affordability programs including Covered California and Medi-Cal. Covered California health benefit exchange consumer use CalHEERS to shop for coverage, allowing for comparison across plans for price, benefits, services, and quality, as well as net costs after determination of eligibility for federal premium subsidies. CalHEERS also can determine whether a consumer is eligible for Medi-Cal, with applications transmitted to the appropriate county office for enrollment processing.

In 2012, the California Health Benefit Exchange awarded a contract to Accenture LLC to implement CalHEERS. The contract included a total of $359 million, with $183 million provided for the initial development and implementation of the system for five years and $176 million provided for continued development and operating costs three years after implementation. According to OSI, the project is currently in the second year of the three year development and operation phase, which expires on June 21, 2020.

OSI released a pre-solicitation Request for Proposal in March 2018. According to OSI, this RFP would be the CalHEERS project's first effort to procure a new system integrator (SI) contract. When the incumbent SI contract expires, the existing Systems Development, Management and Operations (SDMO) activities would be assumed by the new SI vendor. These activities include system development, ongoing maintenance, operation, enhancement of the CalHEERS system, reporting, and customer service. The transition is expected to last 12 months, beginning in July 2019, and run through the end of the existing SI contract term in 2020.

If OSI selects a new vendor, during the 12 month transition period OSI would incur costs for both the existing SI contract and the new SI contract. During this overlapping period, OSI would work with both contractors to execute the transition of responsibilities and transfer of knowledge from the existing vendor to the new vendor to ensure a successful transition.

OSI and DHCS request expenditure authority from the California Health and Human Services (CHHS) Automation Fund of $17.6 million in 2019-20 to allow OSI to fund the anticipated contract costs for both contracts during the transition. According to OSI, the total transition costs for funding both contracts is $25.1 million, but the project has excess expenditure authority of $7.4 million due to lower than expected costs. As a result, the project would require an additional $17.6 million of expenditure authority.

In addition to the expenditure authority in the CHHS Automation Fund, DHCS requests increased expenditure authority of $15.4 million ($3.7 million General Fund and $11.7 million federal funds). This increased authority would include budget bill language that would provide for the funds to be transferred to the CHHS Automation Fund upon finalization of the vendor selection, as determined by the Department of Finance. The proposed budget bill language is as follows:

Item 4260-001-0001:
8. Of the amount appropriated in this item, up to $3,743,000 shall be available to the Department of Health Care Services to reimburse the Office of Systems Integration Item 0530-001-9745 for the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) Project system integrator contract transition activities upon determination of the Department of Finance that the Office of Systems Integration has finalized the vendor selection.

Item 4260-001-0890:
3. Of the amount appropriated in this item, up to $11,702,000 shall be available to the Department of Health Care Services to reimburse the Office of Systems Integration Item 0530-001-9745 for the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) Project system integrator contract transition activities upon determination of the Department of Finance that the Office of Systems Integration has finalized the vendor selection.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

2. What is the status of the Request for Proposal for the new SI contract?

Issue 2: Medi-Cal Eligibility Data System Modernization Project Multi-Departmental Team

Spring Finance Letter. CHHSA's Office of Systems Integration (OSI), DHCS, and DSS request combined expenditure authority of $21.2 million in 2019-20 and $4.6 million in 2020-21 through 2022-23. If approved, these resources would continue the multi-departmental planning effort to replace the Medi-Cal Eligibility Data System (MEDS) and support completion of the next phase of activities required by the Department of Technology's Project Approval Lifecycle (PAL) Stage Gate requirements.

Program Funding Request Summary (CHHSA-OSI)		
Fund Source	**2019-20**	**2020-21****
9745 – CHHS Automation Fund	$18,647,000	$3,432,000
Total Funding Request:	**$18,647,000**	**$3,432,000**

Program Funding Request Summary (DHCS)		
Fund Source	**2019-20**	**2020-21****
0001 – General Fund	$2,066,000	$402,000
0890 – Federal Trust Fund	$19,134,000	$4,160,000
Total Funding Request:	**$21,200,000**	**$4,562,000**

Program Funding Request Summary (DSS)		
Fund Source	**2019-20**	**2020-21****
0001 – General Fund	$60,000	$60,000
0995 – Reimbursements*	$555,000	$541,000
Total Funding Request:	**$615,000**	**$601,000**

* Reimbursements for DSS are funded from federal fund transfers from DHCS expenditure authority.
** Resources ongoing until 2022-23.

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 13 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, DHCS, and DSS, the following activities have been completed in each of the five 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

2017-18

- Submission and approval of Stage 2 Alternatives Analysis documentation
- Submission and approval of a PAPDU for federal year 2018 funding participation
- Completion of Stage 3 Solution Development for the Health Insurance System component
- Submission of an Implementation Advance Planning Documents (IAPD) for detailed design, development and implementation activities to begin in 2018-19.

2018-19

- Obtaining CDT approval of Stage 3 Solution Development documentation
- Obtaining CMS approval for the IAPD for detailed design, development and implementation.
- Procuring vendor development and related services
- Beginning first phase of modernization activities related to the Health Insurance System (HIS)

The 2017 Budget Act extended 16 positions for a two-year period for project activities related to the requirements of completing Stages 3 and 4 of the PAL process. OSI, DHCS, and DSS report the 2017-18 activities focused primarily on the first planned conversion of existing MEDS data, which consists of three HIS data files currently maintained using outdated Virtual Storage Access Method (VSAM) technology. The HIS data component currently stores information about other health coverage, ensuring Medi-Cal is the payer of last resort. Utilizing this approach provided the opportunity to pilot the proposed use of modern Identity Access Management (IdAM), Application Programming Interface (API), and Master Data Management (MDM) principles, methods, and tools as part of the modernization solution.

The 2018 Budget Act authorized an additional seven positions and expenditure authority of $7.9 million ($787,000 General Fund, $6.6 million federal funds, and $426,000 reimbursements) for administrative, project management and IT workload at OSI, subject matter and technical expertise at DSS, and contract resources for hardware and software services, technical support, and software customization

OSI reports the project sponsors, stakeholders, and control agencies agreed to rearrange the organizing approach to the project, shifting from a ten module phase-in to a four-phased approach focusing on major areas of the MEDS database and application enterprise. Phase 1 would focus on full conversion of HIS data to the new infrastructure and database. Phase 2 would focus on converting the Statewide Client Index (SCI). Phase 3 would focus on converting the MEDS VSAM data files and MEDS Alerts. Phase 4 would focus on converting other MEDS VSAM and other databases. According to OSI, this phased approach is not a change to the overall scope of the project, but to the order and timing of work efforts. These changes were intended to focus initial development efforts on modernization of the limited-scope HIS database to prove the effectiveness of the project's modernization methods prior to engaging in modernization of other larger and more complex components.

OSI, DHCS, and DSS request combined expenditure authority of $21.2 million in 2019-20 and $4.6 million in 2020-21 through 2022-23 to continue with scheduled modernization activities for MEDS. Specifically, these resources would fund the completion of Phase 1 of implementation, related to conversion of HIS data, and the beginning of Phase 2, related to conversion of the SCI. According to OSI, the Phase 2 activities require increased resources as SCI is a much larger and more complex component of the modernization project. The requested resources would fund the following new and existing limited term positions and contract resources:

OSI Project Team – Four-year limited-term funding of $3 million equivalent to 19 positions

- **18 existing OSI positions** approved in previous budgets for the MEDS Modernization project would be funded through 2022-23.
- **One Information Technology Supervisor II** position would be added to the OSI Project Team for MEDS Modernization to supervise procurement and fiscal staff, provide management and expert guidance for contractual obligations, acquisition activities, procurement strategy, evaluation approach, contract negotiation, and vendor conferences.

DHCS – Four-year limited-term funding of $501,000 equivalent to four positions

- **Three existing DHCS positions** approved in previous budgets for the MEDS Modernization project would be funded through 2022-23.
- **One Information Technology Supervisor II** position would be added to the Enterprise Innovation Technology Services (EITS) division at DHCS to maintain operational security of the system, perform ongoing risk analysis of design and system changes, maintain system security and technology recovery plans, perform continuous security monitoring, respond to security incidents and threats, implement and support security controls, and lead security improvement initiatives.

CDSS – Four-year limited-term funding of $527,000 equivalent to four positions

- **Three existing CDSS positions** approved in previous budgets for the MEDS Modernization project would be funded through 2022-23.
- **One Information Technology Supervisor I** position would be added to the Innovative Technology Solutions Branch at CDSS to review system functions and business flow, ensure compliance with state and federal information security and privacy laws and regulations.

Non-contract services - $5 million

- **Hardware and Software** - $2.4 million would support purchase of cloud-based hardware and software services, including cloud fees, architecture modeling, project and system environment management, database, conversion and extraction transformation and load, application development, and API management identity, and access management, and security tools.
- **Other Operating Expenses and Equipment** - $2.1 million would support general expenses, printing, communications, travel, training, and office equipment for the 27 limited-term positions.
- **Facilities** - $597,000 would support facilities costs for the 27 limited-term positions.

Contract services - $12.2 million

- **Project Management Support Services** - $1.7 million would support a contract to provide assistance with overall project planning, project management, scheduling, transition planning, and strategies and support of the project's modular and iterative procurement approach. These services also include agile coaching, stakeholder liaison and organizational change management.
- **Technical Support Services** - $10.2 million would support the following technical consulting services: infrastructure and application development, data conversion, technical support, system integration support, business analysis, testing, security technology support, and penetration testing
- **Project Oversight Services** - $302,000 would support independent project oversight functions provided by CDT, independent verification and validation (IV&V) consultants to verify and validate adherence to industry standards and that all delivered products meet requirements and specifications.

The following is a detailed description, provided by OSI, DHCS, and DSS, of the total allocation of ongoing positions and resources approved in the 2018 Budget Act for 2018-19 and the requested positions and resources contained in this budget request for 2019-20:

BUDGET	2018-19 2018 Budget Act	2019-20 Budget Request
OSI Costs		
Personnel Services	$2,332,000	$2,991,000
OE&E	$1,685,000	$1,884,000
Consultant Services	$7,092,000	$10,811,000
Facilities	$597,000	$597,000
Hardware/Software	$1,166,000	$1,166,000
OSI MEDS Project Total	**$12,872,000**	**$18,657,000**
CDSS Costs		
Personnel Services	$371,000	$527,000
OE&E	$102,000	$88,000
CDSS MEDS Project Total	**$473,000**	**$615,000**
DHCS Costs		
Personnel Services	$321,000	$501,000
OE&E	$65,000	$97,000
Consultant Services	$824,000	$1,400,000
Transfer to CDSS*	[$426,000]	[$555,000]
Transfer to OSI	[$12,872,000]	[$18,647,000]
DHCS MEDS Project Total	**$1,210,000**	**$1,998,000**
Total Project Budget	**$14,555,000**	**$21,260,000**
TOTAL DHCS REQUEST		**$21,200,000**

* CDSS receives federal funds transferred from DHCS and reflected as reimbursements in the CDSS budget.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

Issue 3: Electronic Visit Verification Phase II Planning

Spring Finance Letter. The Agency has submitted an April finance letter requesting a one-time augmentation of $3.5 million ($351,000 General Fund) for seven positions for the EVV phase II planning efforts across multiple departments within the agency. The tables below provide a breakdown of the request by department.

Table 1 - BCP Resource Request

	Departments				
Type	DHCS[1]	DDS[2]	OSI	CDPH	Line Item Total
Positions	0.0	3.0	3.0	1.0	7.0
Personal Services	$0	$350,000	$404,000	$114,000	$868,000
Consultant Contracts	$500,000	$0	$1,170,000	$0	$1,670,000
Facilities	$0	$0	$664,000	$0	$664,000
Other OE&E	$0	$66,000	$202,000	$33,000	$301,000
Total	**$500,000**	**$416,000**	**$2,440,000**	**$147,000**	**$3,503,000**

[1] DHCS received 2.0 PYs in 2018-19 for this effort and will be redirecting 2.5 additional PYs.

[2] DDS received 2.0 PYs in 2018-19 for this effort.

Table 2 - BCP Funding Request

Funding[3]	Federal Fund (FF) 90%	General Fund (GF) 10%	Total
DHCS	$1,548,000	$172,000	$1,720,000
DDS[4]	$1,472,000	$164,000	$1,636,000
CDPH	$132,000	$15,000	$147,000
Total	**$3,152,000**	**$351,000**	**$3,503,000**

[3] Funding requested is for CDPH, DHCS and DDS. The OSI request is Expenditure Authority Only.

[4] Funding allocation for OSI costs has been assumed to be 50/50 between DDS and DHCS, pending a determination of the cost allocation methodology.

Background. Federal legislation (H.R. 2646) signed in December of 2016, contains provisions that would require states to implement EVV systems for Medicaid-funded personal care and home health care services, such as IHSS. Electronic Visit Verification is a telephone and computer-based method that electronically verifies in-home service visits. The bill stipulates that the electronic system must verify (1) the service performed, (2) the date and time of service, (3) the location of the service, and (4) the identities of the provider and consumer. California has until January 2020 to comply for personal care services, and until January 2023 for home care services, or escalating penalties will be incurred.

The state is subject to incremental Federal Medical Assistance Percentage (FMAP) reductions of up to 1 percent unless the state has both made a "good faith effort" to comply and has encountered "unavoidable delays." In 2019, the Department of Health Care Services (DHCS) intends to submit a Good Faith Extension letter to the federal Centers for Medicare and Medicaid Services (CMS) to request an additional year for implementation. Pending CMS approval, this would allow California to avoid a federal penalty.

In California, EVV will impact service provided under the Medi-Cal State Plan and under several Medicaid waiver programs. These services are provided through programs managed by the DHCS, the

Department of Developmental Services (DDS), the Department of Social Services (DSS), the Department of Public Health (CDPH), and the Department Aging (CDA). EVV is being implemented in two phases in California. Phase I is the self-directed model for the In-Home Supportive Services (IHSS) program and Waiver Personal Care Services program. Phase II is for planning, developing, and implementing EVV for other individual providers and agencies that provide personal care services and/or home care services to Medi-Cal beneficiaries. The table below provides a list of the phase II programs.

Electronic Visit Verification Phase II Programs

Department	Program	Self-Directed Model	Agency Model	Personal Care Service	Home Health Care Services
DDS	1915 (c) Waiver	✔	✔	✔	✔
DDS	1915 (i) State Plan	✔	✔	✔	✔
DDS	1915 (c) Waiver Self-Determination Program	✔	✔	✔	✔
DHCS	1915 (c) Home and Community-Based Alternatives Waiver	✔	✔	✔	✔
DHCS	Home Health Care Services		✔		✔
DHCS	Waiver Personal Care Services Agency Model (Self-Directed in Phase I)		✔	✔	
CDA/DHCS	Multipurpose Senior Services Program 1915 (c) and 1115 Waivers		✔	✔	
CDPH/DHCS	1915 (c) AIDS Medi-Cal Waiver		✔	✔	✔
CDSS	In-Home Supportive Services Agency Model (Self-Directed in Phase I)		✔	✔	

In February 2019, California submitted an advanced planning document to request enhanced federal resources for phase II multi-departmental planning activities. OSI will use the requested state and consultant resources for project management of the planning activities, including managing the federal certification and state PAL activities. The stage one business analysis, outlining the business need and objectives, was approved by the Agency on March 20, 2019. The sponsor departments will conduct the business analysis necessary to define business requirements and explore information technology (IT) solution options. The project intends to complete the PAL stage two alternatives analysis in 2019-20. Upon completion of this analysis and identification of a preferred solution for Phase II, California will submit an Implementation Advance Planning Document for enhanced federal resources to support the cost of the design, development, and implementation activities of the proposed solution.

The requested positions, by department, are described below.

- **OSI**. The department is requesting resources for one project director, one procurement and contract management analyst, and one budget analyst. The project director will be responsible for management of the project planning team, also serving as an advisor and liaison to the project steering committee. The procurement and contract management analyst will be responsible for the management and tracking of consultant contract deliverables. The budget analyst will develop fiscal and budget related documents and monitor the project budget.

- **DDS.** The department is requesting resources for one lead technical architect/analyst, and two program analyst. The lead technical architect/analyst will document systems architecture and all

interfaces with the EVV system, as well as provide technical subject matter expertise and guidance. The program analysts will be responsible for coordinating with DDS technical and budgetary staff, regional center staff, service providers, service recipients, other stakeholders, and with the contactor. Additionally, they will research regulations, polices, and procedures impacted by EVV.

- **CDPH.** The department is requesting resource for one health program specialist. The specialist will be responsible for the development of EVV specific policies and procedures, providing updates to management and staff and acting as a liaison to other state agencies and stakeholders.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

2. Has the state received word from CMS on the good faith extension letter it submitted earlier this year?

Issue 4: Statewide Automated Welfare System Consolidation

Spring Finance Letter. The Agency has submitted an April finance letter requesting $1.3 million ($393,000 General Fund) on a four-year limited-term basis for eight positions to support the consolidation and implementation of a single SAWS. A breakdown of the funding request for each department is provided below.

Table 1 - BCP Resource Request

	Departments			
	DHCS	CDSS	OSI	Line Item Total
Positions	3.0	4.0	1.0	**8.0**
Personal Services	$ 381,000	$ 512,000	$ 102,000	**$ 995,000**
Other OE&E	$ 93,000	$ 145,000	$ 34,000	**$ 272,000**
Total	**$ 474,000**	**$ 657,000**	**$ 136,000**	**$ 1,267,000**

Table 2 - BCP Funding Request

Funding[1]	Federal Fund	General Fund	Reimbursement	Total
DHCS	$ 426,000	$ 48,000	$ 0	$ 474,000
CDSS	$ 401,000	$ 345,000	$ 47,000	$ 793,000
Total	**$ 827,000**	**$ 393,000**	**$ 47,000**	**$ 1,267,000**

[1] The funding requested for CDSS includes funds for reimbursement of 9745-California Health and Human Services Fund. The $136,000 ($66,000 General Fund) will be included in the CDSS Local Assistance Estimate. The OSI request is Expenditure Authority Only.

Background. The SAWS Consortia is made up of multiple systems which support such functions as eligibility and benefit determination, enrollment, and case maintenance at the county level for some of the state's major health and human services programs. Currently, there are three separate systems that include the following:

- The LEADER Replacement System (LRS), which supports Los Angeles County;
- The Welfare Client Data System (CalWIN), which supports 18 counties;
- And the Consortium IV (C-IV) system, which supports 30 counties

In December 2016, the federal government issued a requirement for SAWS to be a single system by 2023 in order to continue to receive federal funds. Going forward, the state will work to implement this single system, to be known as CalSAWS. The California Automated Consortium Eligibility System (CalACES) is a joint powers authority that maintains and operates the LRS and C-IV systems. The LRS is the base system for CalSAWS that C-IV counties are currently being migrated to. The Office of Systems Integration (OSI) is responsible for state-level project management and oversight of CalSAWS. The Departments of Health Care Services (DHCS) and Social Services (DSS) partner with OSI to verify

project activities are conducted in accordance with contracted standards and adhere to accepted best practices.

The specific requests, by department, are outlined below

- **DHCS**. The department is requesting limited-term funding for two positions (through 2022-23) for the Medi-Cal Eligibility Division (MCED) and one position for the Enterprise Innovation Technology Services (EITS) Division. The direct involvement of the MCED will ensure business continuity from the Medi-Cal program administration perspective and will help to minimize integration challenges. The direct involvement of the EITS Division will provide SAWS' access and interfaces to the Medi-Cal Eligibility System (MEDS) throughout this transition and provide proactive and dedicated support for testing and connectivity.

- **DSS.** The department is requesting limited-term funding for four positions (through 2022-23) for the Family Engagement and Empowerment Division to direct, govern, and oversee planning and implementation of SAWS. The positions will create a new CalSAWS unit within the division.

- **OSI.** The office is requesting limited-term funding for one position through 2022-23 for the SAWS Consortium Management Unit. The position will work directly with the SAWS liaisons in the analysis of consortium processes and governance, project management plans, and contracts. Additionally, they will assist with acquiring consultant services for project management, and the identification of technical issues and impact to stakeholders.

The requested resources within both DHCS and DSS will support the oversight and coordination of information sharing, development, testing, and releases. On February 1 of each year, the OSI in partnership with DHCS and CDSS shall provide an annual report to the appropriate committees of the Legislature on the statewide automated welfare system implemented under this section. The report shall address the progress of state and consortia activities and any significant schedule, budget, or functionality changes in the project.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

Issue 5: Healthy California For All Commission

Spring Finance Letter and Trailer Bill Language Proposal. CHHSA requests General Fund expenditure authority of $5 million, available for encumbrance or expenditure until July 31, 2021. If approved, these resources would fund the Healthy California for All Commission, which would submit two reports to the Legislature and the Governor that would analyze California's existing health care delivery system and key design options for a single-payer financing system. CHHSA also requests reversion of General Fund expenditure authority of $5 million included in the 2018 Budget Act for the Council on Health Care Delivery Systems and trailer bill language to amend the title and responsibilities for the Council to align with the new title and single-payer-oriented responsibilities of the Healthy California for All Commission.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	($5,000,000)	$5,000,000
Total Funding Request:	**($5,000,000)**	**$5,000,000**

***** Resources available for encumbrance or expenditure until July 31, 2021.

Background. The 2018 Budget Act included General Fund expenditure authority of $5 million to establish the Council on Health Care Delivery Systems, with three members appointed by the Governor and one each from the Senate Rules Committee and Speaker of the Assembly. The council, on or before October 1, 2021, will submit a plan to the Legislature and Governor with options to implement changes to health care delivery, including steps necessary to achieve a unified financing system.

The Administration has submitted a spring finance letter to adjust the title and responsibilities of the Council, renaming it the Healthy California for All Commission and refocusing its mission on preparations for a transition to a single-payer financing system for health care in California. CHHSA requests reversion of the $5 million General Fund expenditure authority approved in the 2018 Budget Act and new General Fund expenditure authority of $5 million, available for encumbrance or expenditure until July 31, 2021, to fund the Commission. CHHSA also proposes trailer bill language to amend the statutory authority and responsibilities for the Council with the following provisions related to the new title and responsibilities for the Commission:

- Establishes the Healthy California for All Commission, changing the title from the Council on Health Care Delivery Systems.
- The commission would be comprised of 13 members, as follows:
  - The Secretary of CHHSA
  - Six members appointed by the Governor
  - Three members appointed by the Senate Committee on Rules
  - Three members appointed by the Speaker of the Assembly
  - Three ex officio nonvoting members including the Executive Director of Covered California, the Director of DHCS, and the Chief Executive Officer of the Public Employees' Retirement System
- The commission would submit a report by July 1, 2020, with the following components:
  - An analysis of California's existing health care delivery system

  - Options for additional steps California can take to prepare for transition to a single-payer financing system
  - Options for coverage expansions, including potential funding sources.
- The commission would submit a second report, by February 1, 2021, with options for key design considerations for a single-payer financing system including the following components:
  - Eligibility and enrollment
  - Covered benefits and services
  - Provider participation
  - Purchasing arrangements
  - Provider payments, including consideration of global budgets
  - Cost containment
  - Participant cost sharing
  - Quality monitoring and disparities reduction
  - Information technology systems and financial management systems
  - Data sharing and transparency
  - Governance and administration, including integration of federal funding sources

The commission would not be permitted to implement any provision of the reports without further action by the Legislature and Governor.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

Issue 6: Proposal for Investment – CalQualityCare.org

Stakeholder Request. A coalition of 17 advocacy organizations including California AARP, California Advocates for Nursing Home Reform, Disability Rights California, and Health Plan of San Mateo request expenditure authority from the Office of Patient Advocate Trust Fund of $500,000 annually. If approved, these resources would fund maintenance and operation of CalQualityCare.org, which provides a single portal for long-term services and supports (LTSS) information that displays free unbiased information on access, quality, and costs, along with quality ratings for 20,000 licensed California LTSS providers. The website would be hosted as a joint project with the Office of Patient Advocate and the University of California, San Francisco (UCSF).

According to the proponents, over 2 million individuals use LTSS each year in California but currently there is a lack information about the availability, quality and costs of LTSS providers. To address the need for comprehensive information, the CalQualityCare.org website was launched through a partnership between the California Healthcare Foundation (CHCF) and UCSF in 2004. The website is unique in its comprehensiveness and ease of use, by bringing together public information from three federal and two state websites and other government agencies and accreditation sources. Current state websites only have state data while federal websites only provide federal data.

Funding expired from the CHCF a couple of years ago, and while UCSF has continued to allow public access to the website, it does not have funds to update the information, therefore limiting its usefulness.

The proponents are seeking instead to have the website operated by the Office of the Patient Advocate (OPA) in conjunction with UCSF. The website is consistent with the OPA charge to offer reports cards on health plans, commercial medical groups, and medical groups for Medicare Advantage members and would have ongoing financial support to maintain the database.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

Questions. The subcommittee has requested stakeholders to present this proposal for investment.

4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 1: Pharmacy Benefit Management (AB 315)

Spring Finance Letter. DMHC requests two positions and expenditure authority from the Managed Care Fund of $2.2 million in 2019-20, $904,000 in 2020-21 and 2021-22, and $775,000 annually thereafter. If approved, these positions and resources would allow DMHC to conduct registration and other oversight of pharmacy benefit managers, pursuant to the provisions of AB 315 (Wood), Chapter 905, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0933 – Managed Care Fund	$2,180,000	$904,000
Total Funding Request:	**$2,180,000**	**$904,000**
Total Requested Positions:	**2.0**	**2.0**

* Additional fiscal year resources requested – 2021-22: $904,000; 2022-23 and ongoing: $775,000

Background. Pharmacy benefit managers (PBMs) are independent entities that contract with health plans to manage prescription drug coverage offered by the plan. Health plan contracts with PBMs may include negotiations with drug manufacturers for pricing and rebate terms, processing and payment of prescription drug claims, utilization management, adjudication of appeals or grievances, contracting with network pharmacies, and controlling costs of covered prescription drugs. Under the Knox-Keene Act, health plans that contract with a PBM to provide a prescription drug benefit maintain their responsibility and liability for providing required benefits to enrollees. DMHC reviews PBM contracts to ensure compliance with the consumer protections in the Knox Keene Act.

AB 315 imposes several new requirements on health plans and PBMs under the Knox-Keene Act. These include the following:

- Health plans must disclose to pharmacy providers information included on enrollees' prescription drug benefit cards including how providers may contact the plan for assistance and information necessary to process claims.
- Health plans may not include a "gag clause" in a contract with a pharmacy provider that prohibits the provider from informing patients of a less costly alternative to a prescribed medication.
- Health plan contracts with a PBM must require the PBM to do the following:
  - Comply with the information requirements and gag clause prohibitions
  - Register with DMHC as a PBM
  - Exercise good faith and fair dealing in the performance of its contractual duties
  - Comply with provisions of state law applicable to PBMs
  - Inform pharmacists subject to contracts with the PBM of their rights under the Knox-Keene Act to submit complaints to DMHC and have contractual protections specified in state law.

AB 315 also imposes several new requirements regarding how PBMs register with DMHC and authority for DMHC to impose disciplinary action on PBMs for non-compliance. The bill also requires DMHC to create a Task Force on Pharmacy Benefit Management Reporting to provide recommendations to the

Legislature on information related to pharmaceutical costs that should be gathered through reporting by health care service plans or their contracted PBMs. AB 315 also establishes a pilot project in Riverside and Sonoma Counties to assess the impact of health plan and PBM prohibitions on dispensing of certain amounts of prescription drugs by network retail pharmacies. Health plans are required to report data on the pilot to DMHC annually and DMHC will summarize the data in a report to the Governor and Legislature by December 31, 2022.

DMHC requests two positions and expenditure authority from the Managed Care Fund of $2.2 million in 2019-20, $904,000 in 2020-21 and 2021-22, and $775,000 annually thereafter to upgrade the eFiling System to conduct registration and other oversight of pharmacy benefit managers, respond to increases in provider complaints, staff the Task Force on Pharmacy Benefit Management Reporting, and manage legal workload. Specifically, these resources would support the following positions and infrastructure:

Help Center – One position

- **One Associate Governmental Program Analyst** would address the anticipated increase in workload in the Help Center processing pharmacy provider complaints related to PBMs. DMHC estimates an additional increase of approximately 400 provider complaints per year based on the volume of claims processed by PBMs.

Office of Administrative Services – Limited-term resources equivalent to one position and contracting

- Limited-term resources equivalent to **one Associate Governmental Program Analyst** would address workload related to the Task Force on Pharmacy Benefit Management Reporting including soliciting and summarizing data received from health plans related to the pilot project and changes to costs and utilization of prescription drugs.
- Contract resources of $500,000 for a consultant to assist DMHC in planning, organizing, and facilitating the task force.

Office of Legal Services **–** One position

- **One Attorney** would prepare legal memoranda, conduct legal research, and assist in rulemaking activities.

Office of Technology and Innovation – Contract costs for consulting and platform licensing

- $738,000 in 2019-20 for consulting to upgrade DMHC's existing eFiling system, which is currently inadequate to manage the implementation of PBM registration requirements pursuant to AB 315. According to DMHC, the California Department of Technology has approved its Stage 1 Business Analysis for upgrading the system and is commencing its Stage 2 Alternatives Analysis and market research to identify potential solutions for upgrading the eFiling system.
- $483,000 annually for platform licensing costs related to upgrading the eFiling system.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

Issue 2: Health Care Service Plan Disciplinary Actions (AB 2674)

Spring Finance Letter. DMHC requests nine positions and expenditure authority from the Managed Care Fund of $2.1 million in 2019-20 and $1.7 million annually thereafter. If approved, these resources would allow DMHC to process provider complaints alleging unfair payment patterns by health plans, as required by the provisions of AB 2674 (Aguiar-Curry), Chapter 303, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0933 – Managed Care Fund	$2,072,000	$1,704,000
Total Funding Request:	**$2,072,000**	**$1,704,000**
Total Requested Positions:	**9.0**	**9.0**

* Positions and resources ongoing after 2020-21.

Background. Current provisions of the Knox-Keene Act authorize health care providers to report to DMHC instances in which the provider believes a plan is engaging in an unfair payment pattern. According to DMHC, unfair billing patterns are defined as engaging in a demonstrable and unjust pattern of unbundling, upcoding, delaying, reducing or denying payments for claims. DMHC generally receives and responds to provider unfair billing pattern complaints through the Provider Complaint Unit in the DMHC Help Center. DMHC may conduct financial audits to determine whether plans are engaging in unfair billing patterns.

AB 2674 requires DMHC to annually review provider complaint data to determine if a possible unfair payment pattern exists. In response, DMHC may conduct an audit or enforcement action under its existing authority. According to DMHC, the Provider Complaint Unit is not fully resourced to manage the current provider complaint workload, which has increased by approximately 2,000 annual complaints since 2017. Because of the mandated workload of AB 2674, DMHC is requesting resources to fully staff the Provider Complaint Unit.

DMHC requests nine positions and expenditure authority from the Managed Care Fund of $2.1 million in 2019-20 and $1.7 million annually thereafter to process provider complaints alleging unfair payment patterns by health plans. Specifically, these positions and resources would fully support workload in the Provider Complaint Unit with the following staff and contracts:

Help Center – Seven positions and contract resources for IT upgrades

- **One Staff Services Manager II, one Staff Services Manager I,** and **five Associate Governmental Program Analysts** would fully staff the Provider Complaint Unit to process complaints a the current level of workload.
- $296,000 one-time contract costs to upgrade the current Provider Complaint System database to handle the increased number of cases and attachments. According to DMHC, the California Department of Technology has approved the department's Stage 1 Business Analysis for this project and the department has commenced its Stage 2 Alternatives Analysis.
- $472,000 ongoing for platform licensing costs related to the system upgrade.

Office of Financial Review – One position

- **One Corporation Examiner** would conduct financial examinations of plans based on data provided by the Provider Complaint Unit to determine whether plans have engaged in an unfair payment patterns.

Office of Technology and Innovation – One position

- **One Information Technology Specialist I** would support and maintain the replacement Provider Complaint System.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

4440 DEPARTMENT OF STATE HOSPITALS

Issue 1: Metropolitan: Consolidation of Police Operations – Reappropriation

Capital Outlay Spring Finance Letter. DSH requests reappropriation of General Fund expenditure authority of $1.5 million approved in the 2018 Budget Act. If approved, these resources would allow DSH to complete the design phase for construction of a new building for the Department of Police Services, Office of Special Investigation, and Emergency Dispatch Center at Metropolitan State Hospital.

Program Funding Request Summary		
Fund Source	**2018-19***	**2019-20**
0001 – General Fund	($1,509,000)	$1,509,000
Total Funding Request:	**($1,509,000)**	**$1,509,000**

***** Reappropriation of General Fund authority from 2018-19 to 2019-20.

Background. Metropolitan State Hospital's Department of Police Services (DPS), Office of Special Investigations (OSI), and the Emergency Dispatch Center (EDC) provide essential police, security, and safety functions for the hospital campus. These entities are currently located in buildings with significant health and safety issues, including asbestos in floor tiles and non-compliance with code requirements for seismic safety in hospital and police facilities. In addition, the current buildings do not qualify as Essential Services Buildings, defined by California regulations as buildings used or designed to be used as fire stations, police stations, emergency operations centers, California Highway Patrol offices, sheriff's offices, or emergency communication dispatch centers. Essential Services Buildings must be capable of providing essential services to the public after a disaster and be designed and constructed to minimize fire hazards and to resist the forces generated by earthquakes, gravity, and winds.

The 2017 Budget Act approved General Fund expenditure authority of $1.3 million for preliminary planning for construction of a new building to consolidate DPS, OSI, and EDC and meet regulatory requirements as an Essential Services Building. The 2018 Budget Act included General Fund expenditure authority of $1.5 million in 2018-19 for design and working drawings for continuation of the project. At the time, DSH reported preliminary plans would be approved in July 2018, the project would proceed to bid in August 2019, the contract awarded in December 2019, and the project completed in December 2021. According to DSH, the project experienced delays due to a lengthy Environmental Impact Review process needed because of the demolition component of the project. DSH currently expects preliminary plans to be completed in October 2019, working drawings completed in December 2020, construction would begin in April 2021 and would be completed in October 2022.

DSH requests reappropriation of General Fund authority of the $1.5 million approved in the 2018 Budget Act for encumbrance or expenditure until June 30, 2020. The total expected cost for the project is $21 million, of which $18.2 million for construction will be requested in future budget requests.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

Issue 2: Patton: Fire Alarm System Upgrade – Reappropriation

Capital Outlay Spring Finance Letter. DSH requests reappropriation of General Fund expenditure authority of $9.4 million approved in the 2018 Budget Act. If approved, these resources would allow DSH to continue the project to remove and replace deficient SimplexGrinnell Fire Alarm Control Panels and associated components in four patient-occupied buildings at Patton State Hospital.

Program Funding Request Summary		
Fund Source	**2018-19***	**2019-20**
0001 – General Fund	($9,428,000)	$9,428,000
Total Funding Request:	**($9,428,000)**	**$9,428,000**

***** Reappropriation of General Fund authority from 2018-19 to 2019-20.

Background. According to DSH, the existing alarm systems at Patton are not serviceable and have reached the end of their usable life. In addition, the Department of General Services reports the systems are not in compliance with regulatory requirements and industry standards including occupancy requirements (I-2 and I-3) set by the State Fire Marshal, National Fire Protection Association (NFPA) codes, and Underwriters Laboratory (UL) standards. The project will remove and replace alarm systems in four buildings at Patton that house the majority of patients and contain satellite kitchens, dining rooms, medical clinics, and dental clinics.

The 2015 Budget Act authorized General Fund expenditure authority of $731,000 for preliminary plans and the 2016 Budget Act authorized General Fund expenditure authority of $554,000 for working drawings. The 2018 Budget Act included General Fund expenditure authority of $9.4 million in 2018-19 to continue to the construction phase of the fire alarm replacement project at Patton. At the time of approval, DSH expected the project to proceed to bid in October 2018, the contract to be awarded in January 2019, and the project to be completed in December 2020.

According to DSH, a reappropriation of these funds are needed due to delays in the regulatory review process. DSH currently expects working drawings to be completed in July 2019, construction will begin in September 2019 and would be completed in September 2022.

DSH requests reappropriation of General Fund expenditure authority $9.4 million approved in the 2018 Budget Act, available for encumbrance or expenditure until June 30, 2020. The total expected cost for the project is $10.7 million, of which $731,000 funded the preliminary plans, $554,000 funded working drawings, and the $9.4 million in the current request is intended to fund construction.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

Issue 3: Extension of Liquidation Period – Metropolitan and Napa Kitchen Projects

Capital Outlay Spring Finance Letter. DSH extension of the liquidation period for expenditure authority from the Public Buildings Construction Fund for construction closeout activities for two previously approved projects: 1) Metropolitan: Construct New Main Kitchen and Remodel Satellite Serving Kitchens; and 2) Napa: Construct New Main Kitchen

Background – Metropolitan Kitchen Project. The 2007 Budget Act approved expenditure authority from the Public Buildings Construction Fund to construct a new main kitchen and remodel satellite kitchens at Metropolitan State Hospital. According to DSH, the previous kitchen had been constructed in the 1950s, had not had any major renovations since its construction, had an inefficient layout, and had outdated electrical, mechanical, and plumbing systems. The funds for the project were reappropriated in the 2012 Budget Act. According to DSH, preliminary plans were completed in July 2005, working drawings were completed in August 2007, and construction began in October 2007 and was completed in October 2018. The total cost of the project was $34.1 million, of which $912,000 was for preliminary plans, $1.3 million was for working drawings, and $31.9 million was for construction.

Background – Napa Kitchen Project. The 2008 Budget Act approved expenditure authority from the Public Buildings Construction Fund to construct a new main kitchen at Napa State Hospital. According to DSH, the previous kitchen had been constructed in the 1950s, had not had any major renovations since its construction, had an inefficient layout, and had outdated electrical, mechanical, and plumbing systems. The funds for the project were reappropriated in the 2010 Budget Act and again in the 2018 Budget Act. According to DSH, preliminary plans were completed in October 2008, working drawings were completed in July 2014, and construction began in January 2015 and was completed in July 2018. The total cost of the project was $33.4 million, of which $1.9 million was for preliminary plans, $2.8 million was for working drawings, and $28.5 million was for construction.

DSH requests extension of the liquidation period for the expenditure authority approved for these projects. According to DSH, the extension is required to pay outstanding invoices following resolution of a dispute between contractors. The requested budget bill language extending the liquidation period is as follows:

4440-493—Reappropriation, Department of State Hospitals.
Notwithstanding any other provision of law, the period to liquidate encumbrances for the following citation is extended to June 30, 2020.

0660—Public Buildings Construction Fund
(1) Item 4440-301-0660, Budget Act of 2007 (Chs. 171 and 172, Stats. 2007), as reappropriated by Item 4440-491, Budget Act of 2012 (Chs. 21 and 29, Stats. 2012)
  (1) 55.35.295-Metropolitan: Construct New Main Kitchen and Remodel Satellite Serving Kitchens—Construction
(2) Item 4440-301-0660, Budget Act of 2008 (Chs. 268 and 269, Stats. 2008), as reappropriated by Item 4440-490, Budget Act of 2010 (Ch. 712, Stats. 2010) and Budget Act of 2018 (Chs. 29 and 30, Stats. 2018), and Item 4440-491, Budget Act of 2012 (Chs. 21 and 29, Stats. 2012)
  (1) 55.40.280-Napa: Construct New Main Kitchen—Construction

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of these proposals.

Issue 4: Vocational Services and Patient Minimum Wage

Budget Issue, Spring Finance Letter, and Trailer Bill Language Proposal. DSH requests one position and General Fund expenditure authority of $3.2 million annually. If approved, these positions and resources would allow DSH to standardize the patient wage structure across patient-worker commitment types and across residency hospitals and continue patient vocational treatment programs. This request reflects net funding of the original January budget request and a spring finance letter request for a $151,000 reduction in General Fund expenditure authority due to a calculation error. DSH also requests trailer bill language to exempt DSH patient workers from state minimum wage requirements.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$3,193,000	$3,190,000
Total Funding Request:	**$3,193,000**	**$3,190,000**
Total Requested Positions:	**1.0**	**1.0**

* Position and resources ongoing after 2020-21.

Background. DSH administers the Vocational Rehabilitation Program, which assists over 1,500 state hospital patients in developing therapeutic skills to reduce recidivism, developing social and occupational skills, preparing for discharge or transition to the next level of care, integrating successfully into the community, and finding employment. In addition to the Vocational Rehabilitation Program, Napa State Hospital operates a sheltered workshop, which provides remunerative work to mimic real-life work settings and standards. Sheltered workshops are authorized, in part, to simulate trade and industry. The sheltered workshop operates as Magnolia Enterprises and is a fully integrated vocational rehabilitation program. Federal law requires sheltered workshops to obtain a certification so that it is unnecessary to pay its patient-workers the higher of the federal or state minimum wage.

DSH evaluated the patient wages paid to patient-workers across the DSH system that are either associated with its Vocational Rehabilitation Programs or the sheltered workshop in response to a letter from Disability Rights California (DRC). DRC requested that DSH pay the state minimum wage and asked that DSH standardize wages across all hospitals. Specifically, DRC raised equal protection arguments noting the types of work performed and the wages received differ by commitment type and hospital. DSH does not have a system-wide pay structure and most hospitals do not pay state minimum wage. Patients earn different wages depending on commitment type or in which hospital they reside. Currently, DSH hospitals pay the patient-workers on a monthly pay cycle and the gross wages are deposited to the patient's trust fund account. Historically, DSH has not withheld taxes or deductions from its patient wages.

DSH requests one position and General Fund expenditure authority of $3.2 million annually to standardize the patient wage structure across patient-worker commitment types and across residency hospitals and continue patient vocational treatment programs. Specifically, DSH proposes to pay its patient workers' the federal minimum wage, currently $7.25 per hour. DSH also requests trailer bill language to exempt DSH patient workers from state minimum wage requirements.

These positions and resources would support centralization and standardization of payroll processing and tax withholding and deductions from patient-workers' wages.

One Associate Accounting Analyst position would facilitate payroll process and implement the required withholdings and payment of employer share of payroll taxes. Additionally, these resources would support a payroll accounting software system so that patients are paid timely, appropriate taxes are deducted from the patients' account and appropriate tax documents are generated. In addition, DSH would be required to pay the employer share of payroll taxes for Social Security, Medicare, and unemployment insurance taxes for approximately 1,408 patient workers amounting to an annual cost of $470,284.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

2. Why is DSH proposing to pay the federal minimum wage, rather than the state minimum wage to its patient-workers?

Issue 5: Workforce Development

Budget Issue and Spring Finance Letter. DSH requests eight positions and General Fund expenditure authority of $1.8 million in 2019-20, $2.2 million in 2020-21, $2.4 million in 2021-22 and 2022-23, and $2.6 million annually thereafter. If approved, these positions and resources would allow DSH to support development and implementation of a Psychiatric Residency Program and expand resources for nursing recruitment to meet the mission of providing mental health services to patients and reduce vacancy rates for mental health providers. This request reflects net funding of the original January budget request and a spring finance letter request for a $370,000 reduction in General Fund expenditure authority and an increase in $370,000 of reimbursement authority due to an opportunity to receive reimbursements from Cuesta Community College.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$1,385,000	$1,784,000
0995 – Reimbursements	$370,000	$370,000
Total Funding Request:	**$1,755,000**	**$2,154,000**
Total Requested Positions:	**8.0**	**8.0**

* Additional fiscal year resources requested – 2021-22 and 2022-23: $2,404,000; 2023-24 and ongoing: $2,604,000

Background. According to DSH, the state hospital system requires minimum staffing levels to meet legally prescribed licensing and certification requirements and safety standards. To comply with these requirements, shifts must be covered even if positions are vacant. DSH reports that, although it has 259.3 authorized psychiatrist positions, it has a current statewide psychiatrist vacancy rate of 40.6 percent. DSH has engaged in the following options to recruit and retain psychiatrists:
DSH has explored and implemented other options available to recruit and retain psychiatrists including:

- Developed a recruitment unit that partners with residency and fellowship programs, attending job fairs, medical conferences, residency retreats/career fairs, and follows up with potential applicants
- Partnered with UC Davis and UC Irvine to develop strong academic ties and ongoing research and forensic training that develop national models of care
- Partnered with the military (Hire a Hero, Work for Warriors and Military Medical News)
- Continuous posting of job opportunities on social media (e.g. Twitter, Indeed, Linkedin)
- Mass mailings distributed twice a year via email, including to all the Training Directors of psychiatry residency programs nationwide
- Development of an internal DSH Customer Resource Management (CRM) tracking tool (SharePoint Portal) to track candidate application process, which allows DSH recruitment unit to export active candidate lists for emailing recruitment materials
- Created online and print advertisements in four professional journals for Psychiatry (advertising career opportunities at DSH)
- Annual attendance at the largest recruitment conference for Psychiatrists - the U.S. Psych Congress conferences in-state and out of state
- Created detailed marketing materials (i.e. flyers, brochures, and advertisements, banners) for professional publications and outreach events (DSH has created branded marketing materials system-wide for these classifications)

- Provision of DSH mentorship to interested psychiatrist residents
- Establishment of a psychiatry ambassador/subject matter expert program across all the DSH facilities for the recruitment of psychiatrists and provision of answers to clinically oriented questions
- Contracted with professional head hunters (minimal success)
- Provision of interview travel expense assistance for potential new hire candidates
- Relocation assistance for new to state hires
- Provide group tours of DSH facilities for psychiatry residents seeking employment opportunities
- Update and continual improvement of the DSH careers Internet page (ongoing)
- Provide assistance to each new candidate throughout the entire recruitment process
- Partnered with various psychiatric associations (California Psychiatric Association, Northern and Central California Psychiatric Association, Southern California Association, San Diego and Orange County)

DSH also reports it has experienced a significant vacancy rate for nursing care positions. Similar to psychiatrist vacancies, the high-risk environment and remote geographic location of its hospitals lead to difficulties in recruitment and retention of nursing care staff. According to DSH, the statewide vacancy rate for registered nurses (RNs) has ranged from 13 to 18 percent, and for psychiatric technicians (PTs) of 10 to 21 percent. The rates at Atascadero and Coalinga State Hospitals are generally higher due to their geographic location. DSH's short term solution to the nursing care vacancies is to use a combination of overtime, internal registries, temporary help and external registries to fill these posts when vacant. However, the persistent staffing shortages and mandatory overtime negatively affect staff, causing staff to burn out and seek less stressful opportunities elsewhere.

DSH requests eight positions and General Fund expenditure authority of $1.8 million in 2019-20, $2.2 million in 2020-21, $2.4 million in 2021-22 and 2022-23, and $2.6 million annually thereafter to partner with Touro University to develop an employer consortium comprised of DSH, Touro University, as well as two additional county mental health departments to create a new Psychiatric Residency Program. In the first year of the residency program, **one Senior Psychiatrist** would serve as program director and **one Program Assistant** would be hired to: 1) establish the residency program, 2) authorize Touro University to move forward with the development of the residency program and acquire approval through the Accreditation Council for Graduate Medical Education (ACGME), 3) develop curriculum, 4) develop the clinical rotations, 5) proceed with the match process to place residents, 6) review and approve overall treatment plans and evaluate forensic patient progress, 7) plan, coordinate, implement, and evaluate program objectives and results, 8) establish operational policies and procedures to meet program objectives, 9) establish standards of performance necessary to achieve program objectives, 10) assist with the training and development plans for hospital staff involved with the residency program, 11) participate in program planning, development, and implementation, 12) plan, coordinate, audit, and evaluate forensic patient caseloads for residents, and appropriate staffing patterns.

DSH expects the residency program would open to its first cohort of four residents in 2020-21 and continue to add an additional four residents on-going for each year of the program, for an eventual total of 16 residents participating in the program, with four completing the program each year beginning in 2024-25.

In addition, the requested positions and resources would fund expansion of existing partnerships with local community colleges to expand their RN and PT classes, as follows:

- Atascadero has a PT training partnership with Cuesta College in San Luis Obispo County. The program currently offers three cohorts each year, with about thirty students per cohort. It is estimated that in recent years approximately 75 percent of students graduating from this program have accepted positions at Atascadero. There is a lottery system to get into the program with a waiting list of approximately 100 students for each cohort. This proposal would add **three Nurse Instructor** positions at DSH Atascadero to expand upon the existing partnership at Cuesta College and provide an additional three training cohorts a year of 30 students each.
- Coalinga has partnerships with West Hills College and Porterville College in the Central Valley to train PTs and RNs. The West Hills College PT program offers two cohorts of 15 students each year and the RN program has one cohort of 24 students each year. The Porterville College PT program offers one cohort of students each year and the RN program offers one cohort of students each year. It is estimated that approximately 50 percent of the students graduating from these programs accept positions at DSH Coalinga. This proposal would add **one Nurse Instructor** position at Coalinga to provide an additional cohort of students.
- Napa has a PT training partnership with Napa Valley College that offers two cohorts each year with 30 students per cohort. This proposal would add **one Nurse Instructor** position at Napa to expand upon the existing partnership at Napa Valley College students seeking this program and increase the number of new graduates Napa will be able to hire.
- To effectively coordinate these recruitment efforts, DSH proposes to expand the current Sacramento Recruitment Unit by providing **one Associate Governmental Program Analyst** in Sacramento to focus only on RN and PT recruitments statewide.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

2. With such a significant vacancy rate for psychiatrists, why is this proposal limited to four psychiatric residency slots per year?

Issue 6: Court Evaluations and Reports

Budget Issue. DSH requests 43 positions and General Fund expenditure authority of $8.1 million in 2019-20, an additional 34.5 positions and General Fund expenditure authority of $5.9 million in 2020-21, an additional 17.1 positions and General Fund expenditure authority of $4.2 million in 2021-22 and General Fund expenditure authority of $18.1 million annually thereafter. If approved, these positions and resources would allow DSH to implement a staffing standard to support the forensic services workload associated with court directed patient treatment.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$8,074,000	$13,991,000
Total Funding Request:	**$8,074,000**	**$13,991,000**
Total Requested Positions:	**43.0**	**77.5**

* Additional fiscal year resources requested – 2021-22: 94.6 positions and $18,162,000; 2022-23 and ongoing: $18,144,000

Background. DSH reports in 2013 it initiated a comprehensive effort to evaluate staffing practices at the five state hospitals. The DSH Clinical Staffing Study was comprised of four components: 1) Hospital Forensic Departments, 2) 24 Hour Care Nursing Services, 3) Protective Services, and 4) Treatment Planning and Delivery. Each of these components received a comprehensive examination of current staffing practices and development of staffing methodologies. This request is related to the scope of hospital forensic services.

Hospital Forensic Services. The Forensic Services Departments at each hospital manage the forensic evaluations and court reports, forensic case management and data tracking and neuropsychological assessments and treatment for state hospital patients. DSH staff are responsible for keeping the courts apprised of the status of patients through mandatory reporting or upon request by the court for appearances or written communications. Evaluations are completed by forensically trained psychologists or psychiatrists, who are able to respond to the courts from an unbiased clinical perspective as it relates to the statutory criteria directing forensic commitments.

According to DSH, the following state hospital commitment types have the following reporting requirements:

Incompetent to Stand Trial (IST)	Mentally Disordered Offender (MDO)
Initial 90-day report	Certification Appeal
9 Month Progress Report	Placement Hearing Report
15 Month Progress Report	First Annual Report
21 Month Progress Report	Second Annual Report
27 Month Progress Report	Third Annual Report
Certificate of Restoration (1372 Report)	One Year MDO Extension Report
Unlikely to Regain Competency (B1 Report)	MDO Annual Extension Report
Maximum Term of Commitment (C1 Report)	MDO Extension Report
	Mentally Disordered Sex Offender Report
	Report to court requesting CONREP placement

Not Guilty by Reason of Insanity (NGI)	Sexually Violent Predator (SVP)
Progress Report	Annual Report to the Court
Extension of Commitment	Report to the Court - Unconditional Release
Application for Release	Report to the Court – Conditional Release
Report to court requesting CONREP placement	Report to the Court – Unconditional release from Liberty/CONREP

Each of the above reports includes: reviewing patient files, meeting with treating clinicians, patient evaluation, and drafting clinical recommendations. Additionally, DSH indicates that forensic evaluation is generally conducted by the treating clinician, as no forensic evaluation staff has ever been specifically allocated for this purpose. DSH notes that ethics guidelines for forensic psychiatry recommend that treating psychiatrists should not also perform forensic evaluations of their patients due to the potential for conflict of interest. For this reason, DSH is seeking resources to separate forensic evaluation responsibilities from clinical treatment responsibilities.

DSH staff also support forensic case management and data tracking workload. This workload includes review, processing, tracking, and filing of required court documentation, coordination with entities involved in the forensic commitment process, collaboration with various law enforcement personnel, patients' rights advocates, county outpatient medical facilities, county conservators, and internal DSH legal staff. DSH is seeking resources in this request to more effectively manage its forensic case management and data tracking workload.

Academic literature and DSH internal research have identified that nearly all patients with severe mental illness have significant cognitive deficits that contribute to increased lengths of stay, aggressive acts, and reduced effectiveness of clinical treatment. Research at Patton State Hospital suggests all DSH patients should receive a brief initial cognitive screen and that 50 percent of those patients should be receiving additional comprehensive neuropsychological assessments. The results of those assessments should be provided to the treatment team and incorporated into the patient's treatment plan. DSH indicates it has minimal resources for neuropsychological assessments and providing neurological consultation for these cognitive deficits and is requesting additional psychologist positions to perform this workload.

DSH requests 43 positions and General Fund expenditure authority of $8.1 million in 2019-20, an additional 34.5 positions and General Fund expenditure authority of $5.9 million in 2020-21, an additional 17.1 positions and General Fund expenditure authority of $4.2 million in 2021-22 and General Fund expenditure authority of $18.1 million annually thereafter to implement a staffing standard to support the forensic services workload associated with court directed patient treatment. Specifically, these positions and resources would support the following:

Forensic Evaluations and Court Reports – 53.1 additional positions (three year phase-in)
According to DSH, the staffing methodology identified by the Clinical Staffing Study for forensic evaluations and court reports analyzed, for each commitment type, an accounting of all court reports, a description of each report, identification of the datasets used to approximate the number of court reports required annually and the total amount of time needed to complete the full report including evaluation, team meetings, review of patient files, and report preparation. These analyses were conducted for IST patients, MDO patients, NGI patients, and SVP patients, and account for the need for independent forensic evaluation by a psychologist, rather than the treating clinician. In addition, based on a three-

month sampling of data, the study was able to make a preliminary estimate of the need for testimony and travel for court hearings. Based on these analyses, DSH identified a total workload need of 88.5 positions for this purpose. With its current resources of 35.4 positions, DSH is requesting 53.1 additional positions. These positions are as follows:

Position Classification	Staffing Need	Current Resources	Remaining Need
Senior Psychiatrist Supervisor	6.0	4.0	2.0
Senior Psychiatrist Specialist	6.1	1.0	5.1
Staff Psychiatrist	0.0	0.5	(0.5)
Senior Psychologist Supervisor	6.9	1.0	5.9
Senior Psychologist Specialist	52.6	7.4	45.2
Consulting Psychologist	15.9	11.0	4.9
Psychologist	0.0	10.5	(10.5)
Research Program Specialist	1.0	0.0	1.0
TOTAL	88.5	35.4	53.1

Forensic Case Management and Data Tracking – 16.3 additional positions (three year phase-in)
The staffing methodology based estimates of workload for forensic case management and data tracking on the number of patients admitted and the average census maintained with each hospital annually. Each hospital's case management team was interviewed and current caseload levels assessed. Based on this analysis, DSH identified a total workload need of 52.3 positions for this purpose. With its current resources of 36 positions, DSH is requesting 16.3 additional positions. These positions are as follows:

Position Classification	Staffing Need	Current Resources	Remaining Need
Staff Services Manager II/I	5.0	4.0	1.0
Correctional Case Records Supervisor	0.0	1.0	(1.0)
Psychiatric Technician	0.0	6.0	(6.0)
Associate Governmental Program Analyst	21.1	2.0	19.1
Correctional Case Records Analyst	0.0	14.5	(14.5)
Staff Services Analyst	21.2	3.5	17.7
Office Technician	5.0	5.0	0.0
TOTAL	52.3	36.0	16.3

Neuropsychological Assessments – 11.2 additional positions (three year phase-in)
DSH research indicates nearly all its patients have significant cognitive deficits and recommend all patients receive a brief initial cognitive screen and that 50 percent of those patients receive an additional comprehensive neuropsychological assessments to be shared with the patient's treatment team. However, DSH is requesting resources for conducting the additional screen on only 25 percent of admissions, which would allow time to document and assess the impact on referrals. DSH estimates the average time for each patient for neuropsychologist tasks would be 18.6 hours. This translates into a total DSH estimated need for 18 positions. With its current resources of 6.8 positions, DSH is requesting 11.2 additional positions. These positions are as follows:

Position Classification	Staffing Need	Current Resources	Remaining Need
Senior Psychologist Supervisor	5.0	1.5	3.5
Senior Psychologist Specialist	13.0	5.3	7.7
TOTAL	18.0	6.8	11.2

Cognitive Remediation Pilot Program – 14 additional positions (three year phase-in)
The requested resources would also support a pilot program to focus cognitive remediation treatment for patients identified as having severe neurocognitive deficits. The program would prioritize patients who are aggressive, are likely to achieve rapid benefit from the intervention, and are likely to improve their functionality in life. The treatment would be delivered through tablets or computers and through traditional DSH groups. According to DSH, three of the state hospitals have no cognitive rehabilitation services for patients identified as having severe cognitive deficits. DSH has identified a total need for 14 positions to support the workload for the pilot. There are no current staff, so DSH is requesting all 14 positions to begin the pilot. The positions are as follows:

Position Classification	Staffing Need	Current Resources	Remaining Need
Senior Psychologist Specialist	4.0	0.0	4.0
Psychiatric Technician	10.0	0.0	10.0
TOTAL	14.0	0.0	14.0

According to DSH, the positions requested within this proposal would be phased in across a three-year period with the initial positions established beginning January 1, 2020, and full implementation on July 1, 2021.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

2. While this request appears intended to place appropriate workload with appropriate position classifications, addition of these positions represents a significant net increase in position count for the department. Please describe the workload that is currently not being performed that approval of these positions would support.

Issue 7: Direct Care Nursing

Budget Issue. DSH requests a total of 379.5 positions and General Fund expenditure authority of $46 million phased in across a three year period. If approved, these positions and resources would support the workload of providing 24-hour care nursing services in state hospitals.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$14,970,000	$34,320,000
Total Funding Request:	**$14,970,000**	**$34,320,000**
Total Requested Positions:	**117.3**	**274.5**

* Additional fiscal year resources requested – 2021-22: 379.5 positions and $45,963,000; 2022-23 and ongoing: 379.5 positions and $45,858,000

Background. DSH reports in 2013 it initiated a comprehensive effort to evaluate staffing practices at the five state hospitals. The DSH Clinical Staffing Study was comprised of four components: 1) Hospital Forensic Departments, 2) 24 Hour Care Nursing Services, 3) Protective Services, and 4) Treatment Planning and Delivery. Each of these components received a comprehensive examination of current staffing practices and development of staffing methodologies. This request is related to the scope of hospital forensic services.

Nursing Services. According to DSH, nursing services provides the essential 24 hour care necessary to treat and house patients with psychiatric needs. Nursing services involves observation and recording duties, medication and treatment delivery, identification of and response to emergency situations, safety and security roles and assisting in the implementation of individualized patient treatment and recovery plans. DSH utilizes staffing ratios that were the result of task force recommendations, court orders, and state regulations that date back to the 1980s. Minimum nursing staff allocations are one to six on day and evening shifts and one to twelve on night shifts for units licensed as acute and skilled nursing facilities, and one to eight on day and evening shifts and one to sixteen on night shifts for units licensed as intermediate care facilities.

According to DSH, the current staffing standards and resources continue to be limited by the minimum staffing levels although actual nursing services required to be provided, and the tasks involved in providing them, have become increasingly more complex and time-intensive. This increased complexity and timing are the result of a more forensic oriented, older, and more aggressive population in the state hospitals. In addition, procedures for provision of care have increased required tasks and documentation due to the need to standardize care on evidence-based practices to improve patient outcomes.

As part of the Clinical Staffing Study, the 24 Hour Care Nursing Services component sought information from the five state hospitals on current staffing practices, commonalities and differences among treatment and housing units, development of a classification system for units with similar staffing needs, identification of staff to patient ratios for each category, documentation of nursing duties within each hospital, assessment of the relief factor needed to ensure adequate coverage, and identification of the necessary staff resources based on the proposed methodology and ratios.

Based on the staffing study data and analysis, DSH proposes the following groupings and staff to patient ratios:

Group	AM	PM	NOC	N†
Admissions				
PC Standard Admissions	1: 4.5	1: 5.0	1: 8.0	13
Hybrid Admissions	1: 5.5	1: 5.5	1: 9.5	10
Medical Treatment				
Medical Unit	1: 2.0	1: 2.0	1: 2.5	4
Skilled Nursing Facility	1: 2.5	1: 2.5	1: 4.0	3
Medically Fragile/Geropsych	1: 4.5	1: 5.0	1: 7.5	8
Specialized Services Treatment				
High Aggression/Enhance Treatment Unit/Program (ETU/ETP)	1: 1.5	1: 1.5	1: 3.0	2
PC Specialized Services: Polydipsia, DBT, Substance Abuse	1: 5.5	1: 5.5	1: 9.0	4
LPS Specialized Services: Polydipsia, DBT, Pre-DBT	1: 3.0	1: 3.0	1: 4.5	4
PC Specialized Services: Intermediate Care High Behavior Acuity	1: 4.5	1: 4.5	1: 7.5	2
Specialized Services: Sex Offender Treatment	1: 7.5	1: 7.5	1: 14	2
Specialized Services: Deaf, Hard of Hearing	1: 3.0	1: 3.0	1: 6.0	1
Specialized Services: Monolingual	1: 5.0	1: 5.5	1: 8.0	1
Incompetent to Stand Trial (IST) Treatment				
IST Admission to Discharge	1: 5.5	1: 5.5	1: 9.5	11
IST Permanent Housing-Single	1: 5.5	1: 6.5	1: 9.5	4
IST Permanent Housing-Dorm, Mixed	1: 6.5	1: 6.5	1: 12.0	8
Mentally Disordered Offender (MDO) Treatment				
MDO Permanent Housing-Single, Mixed	1: 5.0	1: 5.0	1: 10.0	9
Multi-Commitment Treatment				
MDO, NGI, LPS Permanent Housing-Dorm, Mixed	1: 6.5	1: 6.5	1: 11.5	27
MDO, NGI Permanent Housing-Single	1: 5.5	1: 6.5	1: 10.5	2
CDCR/MDO Permanent Housing	1: 7.5	1: 8.0	1: 12.5	4
CDCR (Coleman) Treatment				
CDCR Permanent Housing	1: 5.5	1: 6.0	1: 11.5	2
Sexually Violent Predator (SVP) Treatment				
SVP Permanent Housing	1: 6.0	1: 6.5	1: 13.5	7
SVP Residential Recovery Unit	1: 13.0	1: 17.0	1: 32.5	7
Lanterman-Petris Short (LPS) Treatment				
LPS Permanent Housing	1: 5.0	1: 5.0	1: 9.0	4
Discharge Preparation Units				
Discharge Ready	1: 7.0	1: 7.5	1: 12.5	3

† Total number of units used in calculating the system-wide group's ratio

According to DSH, these proposed staffing ratios reflect the actual average staffing currently being delivered on the various units at state hospitals. This request is meant to align workload across hospitals including addition of temporary help and overtime, resulting in a net-zero change in position count to achieve the proposed ratios. However, additional workload needs relieve the burden on the nursing care positions to allow for this net-zero alignment.

In addition to establishing new proposed staffing ratios, the staffing study identified needs for administrative staff to support workload currently performed by a nursing classification that was found to be more appropriate for an administrative classification. The positions requested are primarily Staff Services Analysts, which would allow nursing classifications to focus on clinical workload and reduce the need for overtime needed to align with the proposed staffing ratios.

The staffing study also identified a need for additional psychiatric technicians to perform medication pass workload. Medication pass prepares, administers, documents, and manages the medication administration process within each unit, which occurs four times a day. DSH indicates the psychiatric technicians assigned to medication pass are included in the staffing ratios previously discussed. The staffing study recommends adding stand-alone psychiatric technician positions to focus on the

medication pass and maintain the staffing ratios as proposed. In addition, the staffing study identified a need for additional after hours supervision per hospital.

DSH requests a total of 379.5 positions and General Fund expenditure authority of $46 million phased in across a three year period to support the workload of providing 24-hour care nursing services in state hospitals according to the DSH Clinical Staffing Study. Specifically, DSH requests the following positions by category and hospital:

	Ratio-Driven Unit Staffing	**Medication Pass**	**Afterhours Supervision**	
Hospital	**Total Positions**	**Total Positions**	**Total Positions**	**Grand Total**
Atascadero	1,003.6	81.1	7.9	1,092.6
Coalinga	989.5	44.5	7.9	1,041.9
Metropolitan	803.4	41.9	7.9	853.2
Napa	1,204.6	81.1	10.5	1,296.1
Patton	1,164.7	86.4	10.5	1,261.6
DSH - Total	**5,165.8**	**335.0**	**44.5**	**5,545.4**

The requested positions and resources would be phased in as follows:

	Total Funding	**Positions**	**Total Funding**	**Positions**
	Medication Pass – Psych. Technicians		**Afterhours Supervision – Sup. RNs**	
2019-20	$10,669,000	95.0	$4,301,000	22.3
2020-21	$25,754,000	230.0	$8,566,000	44.5
2021-22	$37,418,000	335.0	$8,545,000	44.5
2022-23+	$37,313,000	335.0	$8,545,000	44.5
	Temporary Help Positions		**Administrative Positions**	
2019-20	-	254.0	-	50.0
2020-21	-	254.0	-	50.0
2021-22	-	254.0	-	50.0
2022-23+	-	254.0	-	50.0
Grand Total (2022-23+)			**$45,858,000**	**683.5**

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

Issue 8: Pharmacy Modernization

Spring Finance Letter. DSH requests General Fund expenditure authority of $2.2 million in 2019-20. If approved, these resources would fund implementation of the department's Pharmacy Modernization planning including inventory control, unit repackaging, automated dispensing, standardized patient specific medication data improvements, and pharmacy data integration. This request includes staffing and other resources required to support project planning under the California Department of Technology's Project Approval Lifecycle process.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$2,196,000	$-
Total Funding Request:	**$2,196,000**	**$-**

Background. DSH patients typically have complex medication needs and nursing staff is required to remain vigilant so that orders written by clinical staff are processed in a timely manner. However, many of the medication processes currently employed rely on hard copies of documentation for prescriptions. According to DSH, current processes for pharmacy services vary among the state hospitals. In four state hospitals, medication orders are written in paper format and hand delivered to the pharmacy or received through fax. Upon receipt, a pharmacy technician enters the order and a pharmacist confirms the order is correct, the dosage appropriate, and evaluates drug interactions.

In 2018-19 DSH began implementation of a Pharmacy Modernization project to address the need for standardization of pharmacy practices across the state hospitals. The project would address inventory control, unit dose repackaging, automated dispensing, patient specific medication billing, and data integration. According to DSH, the project has received agency approval of its Stage 1 Business Analysis and has completed initial drafts of its Stage 2 Alternatives Analysis as part of the California Department of Technology's Project Approval Lifecycle (PAL) process.

DSH requests General Fund expenditure authority of $2.2 million in 2019-20 to support continuation of the Pharmacy Modernization project. Specifically, these resources would fund two teams, as follows:

Core Planning Team - $1.1 million
The core planning team would consist of contracted staff, as follows:

- **One Planning Project Manager** would oversee the Planning Team, be responsible for the master project schedule and provide project status, issues, risk and accomplishments to the project sponsor and director.
- **One Planning Business Analyst** would be responsible for data gathering, research, and analysis of the requirements for the Pharmacy Modernization project.
- **One Pharmacist** would ensure business requirements of the pharmacy operations are met, participate in development and validation and validate business processes and other deliverables.
- **One PAL Manager** would monitor project status and provide feedback to the Planning Team, ensure oversight requirements are met and monitor and report risk and variations during the project.

- **One CDT State Technology Procurements** position would work with the Planning and Technical Teams to develop a request for proposal during the PAL planning phases.
- **Procurement Analysts** would be responsible for working with the project manager to develop procurement deliverables.

Technical Team - $1 million
The technical team would consist of contracted staff, as follows:

- **One Technical Project Manager** would oversee the activities of the Technical Team using DSH best practices to prepare for the development required to integrate data, ensure consistency with DSH information technology and industry best practices, and serve as primary point of contact for all project activities.
- **One Technical Analyst** would solicit, analyze, and interpret the technical requirements to prepare for the development required to integrate data, coordinate with the planning business analyst to ensure technical requirements support the business requirements, and develop solution requirements and use case specification documentation for integration of the current five systems to a single back-end system.
- **Technical Architects** would work with the technical analyst to analyze and interpret all requirements and policies and make recommendations for system development to integrate data, Enterprise Data Analytics and mainframe enhancements required for the integration of the five systems to a single back-end system.

Included in these resources are $45,000 for travel costs and other administrative costs.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

Issue 9: Technical Adjustments - Various

Spring Finance Letter. DSH requests a net-zero realignment of existing expenditure authority in 2019-20 to properly align budget and position authority with existing expenditures.

Background. DSH is requesting net-zero adjustments of expenditure authority between programs to align authority with actual expenditures. Specifically, DSH requests a realignment of positions and funding associated with workers' compensation, information technology, clinical operations positions reclassifications, state hospitals, the Hospital Police Academy, protected health information implementation, incompetent to stand trial diversion, position authority for accounting, and the enhanced treatment program. The shifts would be as follows:

Alignment for Workers' Compensation					
Program	**4400-Administration**	**4420-Conditional Release Program**	**4430-Contracted Patient Services**	**4440-Evaluation and Forensic Services**	**Net Change**
Funding	$447,000	($65,000)	($12,000)	($370,000)	$0

Alignment for Information Technology			
Program	**4400-Administration**	**4410-State Hospitals**	**Net Change**
Funding	$1,540	($1,540)	$0

Alignment for Clinical Operations Position Reclassifications			
Program	**4400-Administration**	**4410-State Hospitals**	**Net Change**
Funding	($171,000)	$171,000	$0

Alignment for State Hospitals			
Program	**4400-Administration**	**4410-State Hospitals**	**Net Change**
Funding	($9,200,000)	$9,200,000	$0

Alignment for Hospital Police Academy			
Program	**4400-Administration**	**4410-State Hospitals**	**Net Change**
Positions	(3.0)	3.0	0.0
Funding	($5,806,000)	$5,806,000	$0

Alignment for Protected Health Information			
Program	**4400-Administration**	**4410-State Hospitals**	**Net Change**
Positions	(5.0)	5.0	0.0
Funding	($545,000)	$545,000	$0

Alignment for Incompetent to Stand Trial Diversion			
Program	**4400-Administration**	**4430-Contracted Patient Services**	**Net Change**
Funding	$356,000	($356,000)	$0

Alignment for Associate Accounting Analyst			
Program	**4400-Administration**	**4410-State Hospitals**	**Net Change**
Positions	1.5	(1.5)	0.0
Funding	$198,000	($198,000)	$0

Alignment for Enhanced Treatment Program – 2019-20			
Program	**4400-Administration**	**4410-State Hospitals**	**Net Change**
Funding	$957,000	($957,000)	$0

Alignment for Enhanced Treatment Program – 2020-21			
Program	**4400-Administration**	**4410-State Hospitals**	**Net Change**
Funding	$978,000	($978,000)	$0

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Innovation Incubator Implementation

Spring Finance Letter. MHSOAC requests expenditure authority from the Mental Health Services Fund of $285,000 in 2019-20 and 2020-21. If approved, these resources would support administrative workload associated with implementation of innovation strategies targeted toward criminal justice-involved persons deemed incompetent to stand trial.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
3085 – Mental Health Services Fund	$285,000	$285,000
Total Funding Request:	**$285,000**	**$285,000**

Background. In 2004, voters approved Proposition 63, the Mental Health Services Act (MHSA), to change the way California treats mental illness by expanding the availability of innovative and preventative programs, reduce stigma and long-term adverse impacts for those suffering from untreated mental illness, and hold funded programs accountable for achieving those outcomes. The act directed the majority of revenues to county mental health programs and services in the following five categories:

1. *Community Services and Supports (CSS):* 80 percent of county MHSA funding treats severely mentally ill Californians through a variety of programs and services, including full service partnerships and outreach and engagement activities aimed at reaching unserved populations.

2. *Prevention and Early Intervention (PEI):* Up to 20 percent of county MHSA funds may be used for PEI programs, which are designed to identify early mental illness, improve timely access to services for underserved populations, and reduce negative outcomes from untreated mental illness, such as suicide, incarceration, school failure or dropping out, unemployment, homelessness and removal of children from homes.

3. *Innovation:* Up to five percent of MHSA funds received for CSS and PEI may be used for innovative programs that develop, test and implement promising practices that have not yet demonstrated their effectiveness.

The Innovation component of MHSA expenditures provide county mental health programs the opportunity to develop and test new, unproven approaches to service delivery, or to adapt existing strategies to improve mental health services. This component includes specific goals for improving delivery of services under the CSS and PEI components of the MHSA by: increasing access to underserved groups, increasing the quality of services, promoting interagency collaboration, and increasing access to services including permanent supportive housing. One of the primary goals of the MHSA PEI component is reducing negative outcomes from mental illness including incarceration.

MHSOAC is responsible for approving county expenditure plans for Innovation funding. Prior to submitting an Innovation plan for consideration, counties must provide a 30 day public review, conduct a local mental health board hearing, and either have approval or a calendared appearance date for

approval by the county board of supervisors. After these steps have been completed, counties submit a final Innovation plan, including a budget, to the MHSOAC, which reviews the proposal and provides technical assistance to make any necessary modifications to address questions or concerns. Finally, counties present the Innovation plan to the MHSOAC, which approves or rejects the proposal.

Challenges for Innovation Expenditures While MHSA provided significant new funding to counties for mental health programs, the funds are required to be expended within three years. Funds not expended within three years are subject to reversion to the state for redistribution to other counties. According a DHCS review of unexpended funds, $391 million of MHSA funds were subject to reversion as for periods prior to July 1, 2017. Of that figure, $187.5 million (48 percent) were funds allocated for Innovation.

Incompetent to Stand Trial Community Mental Health Diversion. Mental Health Diversion – The 2018 Budget Act included a mental health diversion package of $117.3 million ($114.8 million General Fund and $2.5 million Mental Health Services Fund) to increase the state-county partnership to address the growing number of people in the criminal justice system found incompetent to stand trial due to mental health impairments. According to MHSOAC, its $2.5 million allocation funded an Innovation Incubator, which coupled MHSOAC staff with an external contractor to assist counties in proposing and implementing Innovation project with high statewide priority and significant potential to transform the public mental health system. However, this funding does not support sufficient capacity to provide services for all Innovation proposals and MHSOAC lacks sufficient staff to manage the increased workload from its responsibilities to evaluate and approve Innovation projects.

MHSOAC requests expenditure authority from the Mental Health Services Fund of $285,000 in 2019-20 and 2020-21 to support the increased administrative workload associated with implementation of innovation strategies targeted toward criminal justice-involved persons deemed incompetent to stand trial. This funding would be equivalent to two positions, as follows:

- **One Research Data Specialist II** position would focus primarily on analyzing outcomes from completed Innovation projects, developing technical assistance materials to support identification of statewide priority areas for Innovation investment, and developing technical assistance materials to support dissemination of lessons learned from completed Innovation Projects.
- **One Associate Governmental Program Analyst** would serve as the primary contract manager for external contracts for the Innovation Incubator and associated activities, and would provide analysis and technical leadership to cross-county Learning Community activities to disseminate lessons learned from completed projects

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

Issue 2: Commission Budget Requests and Proposals for Investment

Commission Request. MHSOAC requests the following augmentations and changes to its budget:

Data and Outcome Reporting – MHSOAC requests five positions and expenditure authority from the Mental Health Services Fund of $2 million annually. If approved, these positions and resources would allow MHSOAC to extend its work on improving transparency for all mental health funding including research and information technology (IT) staff, website development and maintenance, and IT consulting costs. According to MHSOAC, in response to critical comments from the Little Hoover Commission, in 2017 the Commission began an effort to make publicly available information on MHSA funding, the programs supported with those funds and the outcomes achieved. MHSOAC launched a fiscal transparency tool that reports on MHSA revenues, spending and unspent funds. The work to launch that tool, and the process of making the information available, resulted in dramatic improvements in reporting and fundamental changes in how the Department of Health Care Services oversees county spending.

MHSOAC will soon launch a similar tool that allows the public and stakeholders to review information on more than 2,100 MHSA funded county mental health programs. That effort will allow the public to see how those funds are spent in their counties and allow searchable reviews of county spending priorities. Over time the tool will add information on who is served by those programs – to the extent the data are available – including information on race, ethnicity, age, sexual orientation, gender identity, language spoken, disability status, and veteran status. The goal is to support community awareness of how counties are responding to community needs.

The third component of our transparency work is to report on outcomes. MHSA identifies a range of outcomes, including: improving educational outcomes, reducing criminal justice involvement, supporting employment, preventing child welfare involvement and homelessness, among others. We have done preliminary work to link mental health data and criminal justice data to better understand criminal justice involvement rates and to identify strategies to improve those outcomes. We also have analyzed data on people served by Full Service Partnerships, which are typically the most expensive and highest level of care for people outside of a locked program.

Innovation Incubator Funding – In addition to the resources requested for the Innovation Incubator included in the Administration's spring finance letter, MHSOAC requests the $2.5 million annual funding from the Mental Health Services Fund for the Innovation Incubator be extended permanently. MHSOAC also requests more flexibility in the use of these funds, eliminating the restriction that the funds support work exclusively limited to reducing criminal justice involvement.

Technical Assistance Strategy – MHSOAC requests expenditure authority from the Mental Health Services Fund of $5 million annually. If approved, these resources would fund technical assistance centers to provide support to counties in response to high-priority needs identified by the state and the counties. According to MHSOAC, as part of its discussions with county behavioral health directors over how best to support their innovation work, county leaders indicated that the most significant need they face is technical assistance. Whether focused on how to maximize draw down of federal Medi-Cal funding, or best practices in meeting the needs of young children, the counties indicate they struggle to find reliable guidance on how best to design and deliver mental health care. While many counties have

developed successful strategies in response to a range of mental health needs, individual counties may not be aware of what others are doing, what approaches are in place in other states or countries, or how they might improve their local programs. California has subject matter experts working for counties, in our universities, among research partners and private providers. MHSOAC is seeking support to establish these technical assistance centers that can respond to county needs.

Stakeholder Contracts for Immigrant and Refugee Mental Health – The 2018 Budget Act included expenditure authority from the Mental Health Services Fund of $670,000 to support stakeholder advocacy funding for meeting the mental health needs of immigrants and refugees. In response to receiving these funds, MHSOAC engaged organizations that work with immigrants and refugees to better understand their needs, and whether the commission's traditional approach to releasing advocacy funds would be appropriate to meet the needs of these populations. MHSOAC heard compelling testimony from organizations that serve immigrants and refugees from across that state that the expansive diversity of refugee and immigrant communities, along with the significant trauma experienced by these communities, calls for a more focused approach by community organizations that are primarily focused on improving access to care through community mental health programs. These organizations called for multiple, small contracts that focus on the needs of a particular group of community members. In response, MHSOAC is requests additional expenditure authority from the Mental Health Services Fund of $670,000 annually to double its support for the mental health needs of immigrants and refugees.

Prevention and Early Intervention – SB 1004 – MHSOAC requests four positions and expenditure authority from the Mental Health Services Fund of $598,000 annually. If approved, these resources would allow MHSOAC to support oversight and monitoring workload of prevention and early intervention (PEI) programs required pursuant to SB 1004 (Wiener), Chapter 843, Statutes of 2018. According to MHSOAC, SB 1004 requires it to: 1) establish statewide priorities for the use of PEI funds, 2) develop a statewide strategy for monitoring implementation of PEI services, 3) create metrics for assessing the effectiveness of how PEI funds are used and the outcomes that are achieved, and 4) establish a strategy for technical assistance, support, and evaluation to support the successful implementation of the objectives, metrics, data collection, and reporting strategy. To meet these requirements, the requested resources would fund the following positions:

- **One Staff Services Manager II** or **Health Program Manager II**
- **Two Research Data Specialist II**
- **One Associate Governmental Program Analyst**

These positons would support the work of the existing PEI unit and address the new, ongoing workload created by the mandates of SB 1004, expand MHSOAC's analytical and technical assistance capacity, and enhance MHSOAC's capacity to pursue the goals SB 1004 and the PEI provisions of the MHSA.

Stakeholder Proposal – Reducing Disparities and Improving Cultural Competence in County Mental Health. The California Pan-Ethnic Health Network, the Steinberg Institute, Out4MentalHealth, the Southeast Asia Resource and Action Center, and the Latino Coalition for a Healthy California request expenditure authority from the Mental Health Services Fund of $15 million annually for MHSOAC to support county behavioral health departments and stakeholders in meeting mental health

disparities goals. MHSOAC would be responsible for administering the funds for the following purposes:

- Data: $4 million would support production of statewide and county level data on mental health disparities, including but not limited to disparities related to access and outcomes by race, language, age, gender identity, sexual orientation, and disability status. This includes providing technical assistance to counties, directly or through a technical assistance provider, regarding use of disparities data, including community-driven data, to drive performance improvement.
- Technical Assistance: $4 million would support a contract with one or more consultants with expertise in cultural competency, stakeholder engagement, language access, and trauma informed care, to assist counties in the development of population-specific and community-driven approaches to reducing disparities. Technical assistance would also be provided to support counties with the facilitation of stakeholder engagement in the development of disparities reduction strategies. Finally, the MHSOAC would convene cross-county learning collaboratives related to disparities reduction.
- Innovation: $4 million would allow MHSOAC to provide funds to counties, community-based organizations, schools, or other entities to develop and implement community-defined or population-specific approaches to mental health for underserved communities. These programs would contain an evaluation component and have a sustainability plan contingent on the program having positive results.
- Incentives: $3 million would allow MHSOAC to provide funds to counties, school districts, courts, or other state programs as incentive payments for work related to disparities reduction, including for providing additional cultural competency training to staff, engaging new or diverse stakeholders in the process, or producing outcomes related to disparities reduction.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of these proposals.