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

SUBCOMMITTEE NO. 3 Agenda

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

Thursday, April 26, 2018
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Scott Ogus

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PUBLIC COMMENT

Pursuant to the Americans with Disabilities Act, individuals who, because of a disability, need special assistance to attend or participate in a Senate Committee hearing, or in connection with other Senate services, may request assistance at the Senate Rules Committee, 1020 N Street, Suite 255 or by calling (916) 651-1505. Requests should be made one week in advance whenever possible.

4440 DEPARTMENT OF STATE HOSPITALS

Issue 1: 2018-19 Program Updates

Background. DSH oversees five state hospitals which comprise the largest inpatient forensic mental health hospital system in the nation. In addition to forensic admissions, which comprise 91 percent of its population, the five state hospitals admit individuals civilly committed under the Lanterman-Petris-Short (LPS) Act because they require physically secure 24-hour care and meet legal criteria that they represent a danger to themselves or others.

The five state hospitals operated by DSH are:

- **Atascadero State Hospital –** Located on the Central Coast in San Luis Obispo County, Atascadero is a self-contained psychiatric hospital with an all-male population primarily composed of MDO, *Coleman*, IST, and NGI patients. Atascadero has a licensed bed capacity of 1,275 and an operational bed capacity of 1,185.

- **Coalinga State Hospital** – Located in the Central Valley in Fresno County, Coalinga is a self-contained psychiatric hospital with an all-male population primarily composed of MDO, *Coleman*, and SVP patients. Coalinga has a licensed bed capacity of 1,500 and an operational bed capacity of 1,310.

- **Metropolitan State Hospital** – Located in Norwalk in Los Angeles County, Metropolitan is an "open" style campus within a security perimeter. Due to community concerns, a formal agreement with the City of Norwalk and the county sheriff prohibits Metropolitan from accepting patients charged with murder or a sex crime, or at high risk for escape. Metropolitan primarily serves LPS, IST, MDO, and NGI patients and has a licensed bed capacity of 1,106 and an operational bed capacity of 826.

- **Napa State Hospital** – Located in Napa County, Napa has an "open" style campus within a security perimeter. Napa primarily treats IST, NGI and LPS patients and has a licensed bed capacity of 1,418 and an operational bed capacity of 1,270.

- **Patton State Hospital** – Located in the town of Highland in San Bernardino County, Patton is an "open" style campus within a security perimeter operated by correctional officers from CDCR due to concerns from the surrounding community. Patton primarily serves LPS, IST, MDO, and NGI patients, has a licensed bed capacity of 1,287, and an operational bed capacity of 1,527.

The categories of individuals admitted to state hospitals for treatment are:

- **Incompetent to Stand Trial (IST)** – IST patients are referred to DSH under Section 1370 of the Penal Code if a court has determined they are unable to understand the nature of criminal proceedings or assist counsel in their defense. IST patients receive competency-based treatment and are returned to court once able to participate in court proceedings. Most IST patients are charged with felonies, with some misdemeanors.

- **Not Guilty by Reason of Insanity (NGI)** – NGI patients are individuals found guilty of an offense, but are admitted to DSH if a court determines the individual was "insane" at the time the crime was committed. NGI patients are committed for a term equal to the maximum sentence which could have been imposed, though may be recommitted for an additional two years if the individual represents a substantial danger of physical harm.

- **Mentally Disordered Offenders (MDO)** – MDO patients are parolees who meet the following six criteria for MDO classification: (1) presence of a severe mental disorder, (2) the mental disorder is not in remission or requires treatment to be kept in remission, (3) the mental disorder was a factor in the commitment offense, (4) the prisoner has been in treatment at least 90 days in the year prior to release, (5) the commitment offense involved force or violence or serious bodily injury, (6) the prisoner continues to be dangerous due to the severe mental disorder. MDO commitments under Section 2962 of the Penal Code span the length of the parole term, but may be extended for up to one year if the patient represents a danger of physical harm to others.

- **Sexually Violent Predators (SVP)** – SVP commitments are civil commitments of prisoners released from prison who meet certain criteria under the Sexually Violent Predator Act, including being convicted of certain sex offenses and diagnosed with a mental disorder that increases the likelihood of engaging in sexually violent criminal behavior. SVP patients undergo an annual review process to evaluate the patient's suitability for release into the community, either conditionally or without supervision.

- **Lanterman-Petris-Short (LPS)** – LPS patients are individuals that require physically secure 24-hour care and are committed through civil court proceedings that determine the individual is a danger to themselves or others or suffers from a grave disability. LPS patients are discharged when their county of residence places them in a different facility, in independent living, or with family, or if a court removes the conservatorship.

- ***Coleman*** **Class Patients (Mentally Ill Prisoners)** – *Coleman* patients are referred by the California Department of Corrections and Rehabilitation (CDCR) when they are found to be mentally ill while in prison. *Coleman* patients return to CDCR custody when they have received the maximum benefit from treatment. If these individuals are still mentally ill at the end of their prison term, they may be committed to DSH as MDO.

- **Conditional Release Program (CONREP)** – CONREP provides outpatient treatment to individuals ordered by a court to be released if their symptoms have been stabilized and they no longer represent a danger to society. After one year, a court hearing determines if the patient will continue in the program, be sent back to DSH, or be released.

	2017-18	2018-19
Population by Hospital		
Atascadero	1,247	1,175
Coalinga	1,318	1,393
Metropolitan	807	1,043
Napa	1,269	1,269
Patton	1,509	1,492
Population Total	**6,150**	**6,372**
Population by Commitment Type		
Incomptent to Stand Trial (IST)	1,523	1,774
Not Guilty by Reason of Insanity (NGI)	1,407	1,404
Mentally Disordered Offender (MDO)	1,328	1,296
Sexually Violent Predator (SVP)	920	920
Lanterman-Petris-Short Civil Commitments (LPS)	628	634
Coleman Referrals	336	336
Dept. of Juvenile Justice (DJJ)	8	8
Jail-Based Competency Treatment (JBCT) Programs		
Riverside JBCT	25	25
San Bernardino JBCT	126	146
Sacramento JBCT (Male and Female)	44	44
San Diego JBCT	30	30
Sonoma JBCT	10	10
Kern Admission, Evaluation, and Stabilization (AES) Center	60	60
Mendocino JBCT	TBD	TBD
Stansislaus JBCT	12	12
Proposed Expansion of JBCT	--	54
Total JBCT Programs	**307**	**381**

Figure 1: State Hospital Population by Hospital, Commitment Type and JBCT Programs
Source: *2018-19 Governor's Budget Proposals and Estimates, Department of State Hospitals, January 2018*

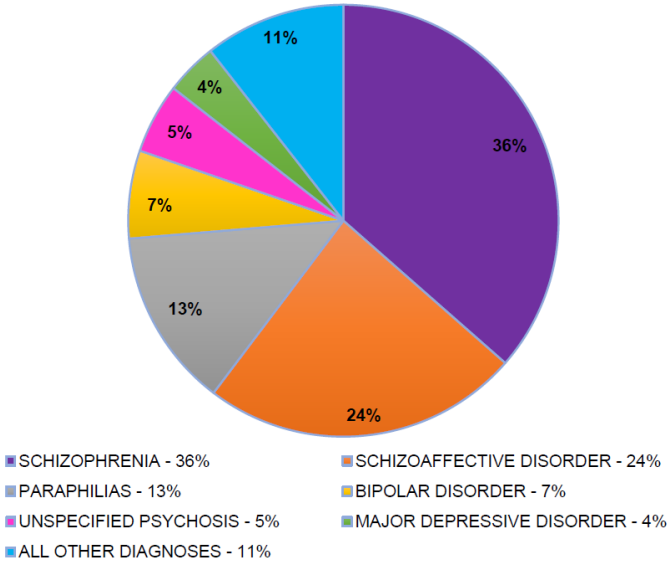

Figure 2: State Hospital Population By Major Diagnosis, as of July 1, 2017
Source: *Report on Measures of Patient Outcomes, Department of State Hospitals, January 2018*

Program Update: Enhanced Treatment Program (ETP) Staffing. AB 1340 (Achadjian), Chapter 718, Statutes of 2014, authorized DSH to establish an ETP pilot project to expand the range of clinical treatment options for patients determined to be at the highest risk of dangerous behavior or violence against other patients or hospital staff and cannot be safely treated in a standard treatment environment. According to DSH, the risk of violence against other patients or hospital staff imposes both a threat to health and safety, as well as a barrier to the effective treatment of other patients who may fear for their physical safety in a standard treatment environment with a potentially violent patient. The pilot project period extends approximately five years from the first patient admitted to the ETP and imposes certain requirements on admission and treatment within an ETP.

Patients are evaluated for admission to an ETP based on requirements contained in AB 1340. A patient referred to an ETP by state hospital clinical staff is assessed by a dedicated forensic psychologist within three business days to make an initial determination regarding the appropriateness of the referral. If the referral is appropriate, the patient is further assessed by a panel comprised of a state hospital medical director, psychiatrist, and psychologist to certify admission to the ETP within seven days of the original referral. Upon admission, a forensic needs assessment team psychologist conducts a violence risk assessment and develops a treatment plan in writing and, if possible, with the collaboration of the patient. The treatment plan, which must be reviewed and updated every ten days, must include information about the patient's mental health status and diagnoses, prescribed medications, goals of treatment, planned interventions and methods, documentation of success in meeting objectives, evaluation of the factors contributing to or detracting from the patient's progress, an activity plan, plans for other services needed by the patient, discharge criteria, goals for an aftercare plan in a standard treatment environment upon discharge, and a plan for post-discharge follow up.

In addition to the admission and treatment criteria, each ETP has specified staff-to-patient ratios, housing and facility requirements, and accessibility requirements. Each ETP is also required to maintain a full-time independent patient's rights advocate to provide advocacy services to patients admitted to an ETP.

The 2017 Budget Act authorized 44.7 positions and $8 million in 2017-18 and 115.1 positions and $15.2 million annually thereafter to activate the first two ETP units at Atascadero State Hospital. According to DSH, construction for the first unit was expected to begin in December 2017 and be completed in April 2018, while construction for the second unit was expected to begin April 2018 and be completed in August 2018. DSH reports these timelines have been delayed by the inability of the State Fire Marshall to complete approval of the final working plans, as fire resources have been deployed elsewhere in the state to assist with the emergency fire situation in several California counties.

DSH requests reversion of $2.3 million of anticipated General Fund savings related to the construction delays of the ETP units and reallocation of $2.4 million to fund unanticipated additional costs related to earthquake repairs at Napa State Hospital (see "Program Update: 2014 South Napa Earthquake Repairs"). DSH reports it will only spend $3 million of its $8 million 2017 Budget Act authority for ETP unit construction.

DSH also requests 23.2 positions and $2.8 million in 2018-19 and 65.7 positions and $8.4 million annually thereafter over the department's 2017 Budget Act authority for ETP unit construction. If approved, these resources would allow DSH to complete staffing and activation for the first two ETP

units at Atascadero, as well as the planned activation of two additional ETP units, one at Atascadero and one at Patton State Hospital. According to DSH, as of October 2017, the expected timeline for construction for each of these units is as follows:

Units/Hospital	Construction Initiated	Construction Completed
DSH-Atascadero Unit 1	March 31, 2018	August 18, 2018
DSH-Atascadero Unit 2	August 19, 2018	December 9, 2018
DSH-Atascadero Unit 3	December 10, 2018	April 1, 2019
DSH-Patton Unit 1	December 1, 2018	April 15, 2019

Program Update: 2014 South Napa Earthquake Repairs. The 2014 South Napa Earthquake caused damage to buildings at Napa State Hospital with historical significance, within the hospital's secure treatment area, and in non-secured areas of the hospital. The 2015 Budget Act approved a total of $22.9 million ($5.7 million General Fund and $17.2 million federal disaster funds) for building repairs related to the earthquake. According to DSH, total project cost estimates have changed significantly over the past three years, rising by an additional $2.4 million from the costs estimated in the 2017 Budget Act.

DSH requests authority to utilize $2.4 million of savings from construction delays for its ETP units at Atascadero State Hospital to fund the increased costs for these repair projects. If approved, these savings would allow DSH to complete all of these repairs by the end of 2019. According to DSH, the timeline of construction and expenditures on these repairs is as follows:

	DGS PROJECT 1 Three Historical Buildings	**DGS PROJECT 2** Buildings Outside the STA	**DSH PROJECT 3** Buildings Inside the STA
Design Completion	July 6, 2017	May 2018	N/A
Begin Construction	March 21, 2018	July 21, 2018	October 1, 2017
Complete Construction	December 22, 2018	July 26, 2019	December 31, 2019

Project	2015-16	2016-17	2017-18	2018-19	2019-20	Grand Total
1. Three Historical Buildings	$989,900	$0	$7,129,000	$0	$0	$8,118,900
2. Buildings Outside the STA	$0	$326,200	$2,562,600	$0	$0	$2,888,800
3. Buildings Inside the STA	$0	$0	$1,624,958	$1,216,958	$608,479	$3,450,395
Totals	**$989,900**	**$326,200**	**$11,316,558**	**$1,216,958**	**$608,479**	**$14,458,095**

Program Update: Lanterman-Petris-Short (LPS) Population and Personal Services Adjustment. LPS patients are individuals that require physically secure 24-hour care and are committed through civil court proceedings that determine the individual is a danger to themselves or others or suffers from a grave disability. LPS patients are discharged when their county of residence places them in a different facility, in independent living, or with family, or if a court removes the conservatorship. Counties reimburse state hospitals for the costs of treatment for LPS patients.

According to DSH, the focus of treatment for the LPS population is on psychiatric stabilization and psychosocial treatments to reduce the risk of danger to themselves or others and develop basic life skills to function optimally in a lower level of care in the community. DSH provided care to a total of 849 LPS patients in 2016-17 with an average daily census of 670, or nine percent of the overall population. Of the 849 LPS patients in the state hospital system, 462 received treatment at Metropolitan, 258 at Napa, 118 at Patton, 10 at Atascadero, and one at Salinas Valley.

DSH requests an increase in reimbursement authority of $20.1 million in 2017-18 and annually thereafter. If approved, these resources would allow DSH to receive reimbursements from counties for the care and treatment of LPS patients. According to DSH, the currently budgeted LPS capacity systemwide is 628. As of June 2017, DSH had a total LPS census of 670.

Program Update: Forensic Conditional Release Program (CONREP) – General/Non-Sexually Violent Predator (Non-SVP) Program. The Forensic Conditional Releae Program (CONREP) was established in 1986 and provides outpatient treatment to individuals ordered by a court to be released if their symptoms have been stabilized and they no longer represent a danger to society. The CONREP population includes patients committed to state hospitals as Not Guilty by Reason of Insanity (NGI), Mentally Disordered Offenders (MDO), felony Incompetent to Stand Trial (IST) and Mentally Disordered Sex Offenders. After one year, a court hearing determines if the patient will continue in the program, be sent back to DSH, or be released.

According to DSH, when a patient is discharged to CONREP, the goal is to provide an independent living environment in the least restrictive setting. However, if the patient has not demonstrated the ability to live in the community without direct staff supervision, the patient is referred to a Statewide Transitional Residential Program (STRP), a resource used by CONREP to provide patients the opportunity to learn and demonstrate appropriate community living skills in a controlled setting with 24 hour supervision. DSH currently contracts for one 17 bed STRP in Los Angeles County. A 16 bed STRP in Fresno County was closed in November 2017, which was funded by General Fund expenditure authority of $976,000 in 2017-18 approved in the 2017 Budget Act.

DSH requests General Fund expenditure authority of $976,000 in 2018-19 and annually thereafter to establish a new 16 bed STRP contract to replace the capacity lost upon closure of the Fresno County STRP. The funding would be ongoing, contingent upon securing a new contract provider.

Program Update: Forensic CONREP – Sexually Violent Predator (SVP) Program. Beginning in 1996, Sexually Violent Predators (SVP) were added to the CONREP population and are conditionally released to their county of domicile by court order with sufficient funding to provide treatment and supervision services. According to DSH, the CONREP-SVP program offers patients direct access to an array of mental health services with a forensic focus, as well as regularly scheduled sex offender risk assessments, polygraph testing, and review of Global Position System (GPS) data and surveillance. DSH reports it is on track to achieve a total 2017-18 caseload of 17 SVPs in CONREP by June 30, 2018.

Although no caseload growth is expected, DSH reports it will achieve $96,000 one-time General Fund savings in 2017-18 in the CONREP-SVP program based on adjustments to caseload due to the timing of conditional release dates from state hospital commitments.

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 each of the program updates referenced in this item.

Issue 2: Coalinga: New Activity Courtyard Reappropriation

Capital Outlay Budget Issue. DSH requests reappropriation of $5.7 million General Fund originally approved in the 2017 Budget Act. If approved, these resources would allow DSH to complete construction of a new activity courtyard at Coalinga State Hospital.

Program Funding Request Summary		
Fund Source	**2018-19***	**2019-20**
0001 – General Fund	$5,738,000	$-
Total Funding Request:	**$5,738,000**	**$-**

***** Reappropriation from Item 4440-301-0001, Budget Act of 2017

Background. The 2017 Budget Act authorized $5.7 million to design and construct a new secure activity treatment courtyard at Coalinga State Hospital. According to DSH, the current main courtyard at Coalinga is too small for its intended usage, with a capacity of 60 patients. As of April 2018, Coalinga State Hospital has a current census of 1,293 patients, nearly all of whom have been admitted under forensic commitments. The small main courtyard and other courtyards are insufficient for exercise and treatment purposes and provide inadequate clearance from hospital buildings for the purpose of evacuation in the event of fires or other emergencies. In addition, Coalinga patients have threatened litigation against the state regarding the limited outdoor space, claiming a violation of patient rights. DSH indicates construction of the new courtyard will allow for appropriate outdoor recreation for hospital patients and allow for the required clearance for emergency evacuations.

Planning and design for this project began with an allocation of $219,000 General Fund approved in the 2015 Budget Act for preliminary planning, and an allocation of $603,000 for designs and working drawings approved in the 2016 Budget Act. According to DSH, the expected approval for a contract bid was April 2018 and the expected date for project completion is May 2019. The total expected cost for the project is $6.6 million and would continue to be fully funded by the requested reappropriation of General Fund resources.

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: Metropolitan: Consolidation of Police Operations

Capital Outlay Budget Issue. DSH requests General Fund expenditure authority of $1.5 million in 2018-19. If approved, these resources would allow DSH to construct a new building to accommodate the Department of Police Services, Office of Special Investigation, and the Emergency Dispatch Center at Metropolitan State Hospital.

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

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, sheriffs 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.

DSH requests General Fund expenditure authority of $1.5 million in 2018-19 for design and working drawings for continuation of the project. According to DSH, preliminary plans are expected to be approved in July 2018, the project is expected to proceed to bid in August 2019, the contract is expected to be awarded in December 2019, and the expected date for project completion is December 2021. The total expected cost for the project is $21 million, of which $18.2 million 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 4: Metropolitan: CTE Fire Alarm System Upgrade Reappropriation

Capital Outlay Budget Issue. DSH requests reappropriation of $3.4 million General Fund originally approved in the 2017 Budget Act. If approved, these resources would allow DSH to upgrade existing fire alarm systems for the Chronic Treatment East building at Metropolitan State Hospital.

Program Funding Request Summary		
Fund Source	**2018-19***	**2019-20**
0001 – General Fund	$3,392,000	$-
Total Funding Request:	**$3,392,000**	**$-**

***** Reappropriation from Item 4440-301-0001, Budget Act of 2017

Background. The 2017 Budget Act approved General Fund expenditure authority of $3.9 million to upgrade the existing fire alarm systems for the Chronic Treatment East (CTE) building at Metropolitan State Hospital. According to DSH, the current fire alarm system at Metropolitan is over 25 years old, resulting in a lack of consistent and trained personnel to maintain the system. Numerous devices connected to the system fail on a frequent basis, requiring hospital staff to respond to false alerts. In addition, the existing fire alarm system does not currently meet National Fire Protection Association (NFPA) safety standards, which is a requirement of the federal Centers for Medicare and Medicaid Services (CMS).

During a previously approved fire alarm upgrade for psychiatric patient housing units and a central monitoring system at Metropolitan, the CTE building was removed from the planned fire alarm upgrades to keep the project on schedule and achieve savings of $747,0000.

DSH requests reappropriation of $3.4 million of the original $3.9 million General Fund provided in the 2017 Budget Act. According to DSH, preliminary plans were approved in January 2018, the project is expected to proceed to bid in July 2018, to have a contract awarded in November 2018, and be completed in March 2020. If approved, this reappropriation request would allow DSH to fund construction costs for the fire alarm upgrade beginning in 2018-19.

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 5: Patton: Fire Alarm System Upgrade

Capital Outlay Budget Issue. DSH requests General Fund expenditure authority of $9.4 million in 2018-19. If approved, these resources would allow DSH 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	$-
Total Funding Request:	**$9,428,000**	**$-**

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.

DSH requests 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. Preliminary plans were approved in May 2017, the project is expected to proceed to bid in October 2018, to have the contract awarded in January 2019, and to be completed in December 2020.

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 6: Patton: Construct New Main Kitchen - Reappropriation

Capital Outlay Spring Finance Letter. DSH requests reappropriation of $33.1 million from the Public Buildings Construction Fund originally approved in the 2008 Budget Act and reappropriated in the 2010 and 2012 Budget Acts. If approved, these resources would allow DSH to continue the construction phase for a new main kitchen at Patton State Hospital.

Program Funding Request Summary		
Fund Source	**2018-19***	**2019-20**
0660 – Public Buildings Construction Fund	$33,086,000	$-
Total Funding Request:	**$33,086,000**	**$-**

***** Reappropriation from Item 4440-301-0660, Budget Act of 2008

Background. The 2006 Budget Act approved expenditure authority from the General Fund and the Public Buildings Construction to construct a new main kitchen of approximately 32,000 square feet at Patton State Hospital. According to DSH, the new kitchen will accommodate a modern cook and chill preparation system and all dietary support facilities. The new kitchen facility will allow meals to be prepared and chilled, and temperature maintained until serving to avoid risk of spoilage or illness.

DSH reports the project has been delayed for various reasons, including inclement weather and design errors and omissions. Construction funding for this project was last appropriated in the 2008 Budget Act with $35.2 million of the total $38.1 million project cost already expended.

DSH requests reappropriation of unspent funds from the $33.1 million originally appropriated for construction in the 2008 Budget Act. Preliminary plans were approved in October 2008, the project proceeded to bid in July 2015, the project contract was awarded in March 2016, and the project is expected to be completed in March 2019.

The amount of the unspent funds needed to complete the project is $2.9 million. However, according to the Legislative Analyst's Office (LAO) the authority for the remaining $2.9 million expired almost 11 months ago and should have been reverted to the original fund. As a result, the LAO notes this funding must be provided as a new appropriation, rather than a reappropriation.

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. Please respond to the LAO assessment that these funds would require a new appropriation, rather than reappropriation of previous authority.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Proposition 55 – Calculation of Available Revenue for Medi-Cal

Background. Proposition 55, approved by voters in 2016, extended by twelve years the temporary personal income tax increases enacted in Proposition 30 (2012). In addition to the tax extensions, the initiative requires the Director of Finance, before June 30, 2018, and before every June 30 thereafter until 2030, to calculate the amount of additional tax revenue needed to fully fund: 1) the minimum guarantee to education pursuant to Proposition 98; and 2) the state's workload budget for the following fiscal year. If the additional revenue received exceeds amounts required for education and the workload budget, 50 percent of the additional revenue is transferred to the Department of Health Care Services, up to $2 billion, for additional expenditures on critical, emergency, acute, and preventive health care services to children and their families in the Medi-Cal program.

Calculation of the Workload Budget. The initiative defines the term "workload budget" by reference to the definition contained in Section 13308.05 of the Government Code:

> **13308.05.** For purposes of Section 13308, "workload budget" means the budget year cost of currently authorized services, adjusted for changes in enrollment, caseload, or population, or all of these changes and any of the following:
> (a) Statutory cost-of-living adjustments.
> (b) Chaptered legislation.
> (c) One-time expenditures.
> (d) The full-year costs of partial-year programs.
> (e) Costs incurred pursuant to constitutional requirements.
> (f) Federal mandates.
> (g) Court-ordered mandates.
> (h) State employee merit salary adjustments.
> (i) State agency operating expense and equipment cost adjustments to reflect price increases.

The initiative also specifies that for purposes of the "workload budget" calculation, the term "currently authorized services" means only those services that were understood as currently authorized as of January 1, 2016.

Department of Finance Calculation of Available Revenue and Workload Budget. With the release of the Governor's January budget, the Department of Finance released its analysis of available revenue and the workload budget, estimating a $1.9 billion deficit resulting in no additional allocation to the Medi-Cal program. According to Finance, it first calculated the total amount of available General Fund revenue, net of transfers. Finance then estimated the minimum funding guarantee to education under Proposition 98 and the workload budget. Based on this analysis, Finance estimates the state has $129.8 billion of available General Fund revenue, a minimum funding guarantee for education of $54.6 billion, and a workload budget of $77.1 billion.

Available Revenue is Net of Optional Transfer to Budget Stabilization Account. According to Finance, the calculation of available revenue is net of transfers, including the Administration's proposed $3.5 billion transfer to the Budget Stabilization Account (BSA). Proposition 2, approved by voters in

2014, requires a minimum deposit to the BSA of 1.5 percent of General Fund revenue, as well as capital gains-derived revenues in excess of eight percent of total General Fund receipts. Proposition 2 requires minimum transfers to the BSA until it achieves an account balance equal to ten percent of total General Fund revenues.

Pursuant to Proposition 2, the required deposit to the BSA for 2018-19 would be approximately $1.5 billion. The Administration is proposing to transfer an additional $3.5 billion to the BSA, which would result in the account balance reaching the ten percent maximum threshold. For the purpose of the calculation of Proposition 55 revenues and expenditures, Finance has calculated the value of available revenues as net of General Fund transfers, including the discretionary transfer of $3.5 billion to the BSA. According to Finance, no other significant discretionary General Fund transfers are removed from its calculation of available General Fund revenue for the purposes of Proposition 55.

The Legislative Analyst's Office (LAO) notes a more reasonable interpretation of available revenues for the purposes of Proposition 55 would not include the discretionary transfer of funds to the BSA. According to the LAO's analysis, if the $3.5 billion discretionary transfer were not removed from the calculation of available revenue, the Proposition 55 calculation would allocate $800 million to the Medi-Cal program.

Figure 2

Department of Finance's Medi-Cal Calculation Under Proposition 55

(In Billions)

Available revenues	$129.8
Minimum funding guarantee	-54.6
Workload budget	-77.1
Resulting Deficit	**-$1.9**

Figure 3

Medi-Cal Calculation Under Proposition 55 With Optional Deposit

(In Billions)

Available revenues	$133.3
Minimum funding guarantee	-54.6
Workload budget	-77.1
Resulting Surplus	**$1.6**
Additional Funding for Medi-Cal	**$0.8**

Figure 1: LAO Analysis of Proposition 55 Allocations With and Without $3.5 billion BSA Deposit
Source: *LAO Report: The 2018-19 Budget: The Administration's Proposition 55 Estimates, March 2018*

Calculation of Minimum Funding Guarantee to Education and Workload Budget. Finance indicates its calculation of the minimum guarantee is consistent with the minimum amount required to be allocated to education pursuant to Proposition 98. The text of Proposition 55 requires Finance to calculate the "minimum funding guarantee of [Proposition 98] for that following fiscal year". A reasonable interpretation of this requirement would exclude any additional discretionary allocations to education proposed or approved in the budget, which is consistent with Finance's calculation. However, the LAO notes that higher appropriated levels of education funding would result in a higher minimum funding guarantee for Proposition 98 in subsequent fiscal years.

Finance's calculation of the workload budget is based on references in Proposition 55 to definitions of "workload budget" and "currently authorized services" found in Government Code Section 13308.05. Finance has interpreted these definitions to determine the workload budget includes any budgetary or legislative augmentations to programs that were authorized as of January 1, 2016. An example of an augmentation to an existing program that Finance includes in its workload budget calculation is the restoration of adult dental benefits in Medi-Cal. Finance excludes from its workload budget calculation

new programs authorized since January 1, 2016, such as the medically tailored meals pilot program approved in the 2017 Budget Act.

The LAO notes the Government Code section reference to "chaptered legislation" could lead to an interpretation that any adjustments authorized in any Budget Act, which is considered chaptered legislation, could be included in the calculation of the workload budget. However, the LAO also notes this interpretation would likely undermine the intent of Proposition 55. The Finance interpretation of the workload budget, while not reflective of a maximalist interpretation of "chaptered legislation", does nonetheless use this definition to define the workload budget expansively, including significant discretionary General Fund augmentations approved since 2016.

No Apparent Legislative Remedy to Change Finance's Calculation. While the Legislature and LAO have raised concerns about Finance's calculations of both available revenue and the value of the workload budget, the Legislature lacks authority to require changes to the estimate. Proposition 55 explicitly authorizes the Director of Finance to make these calculations, which are the source of any determinations of required allocations from Proposition 55 revenues to the Medi-Cal program. However, the Legislature retains its discretionary authority over allocations of General Fund revenue to state programs.

Subcommittee Staff Comments 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 Finance to respond to the following questions:

1. Please provide an overview of the estimate of available revenues and the workload budget under Proposition 55 for the purposes of allocation to Medi-Cal.

2. Please provide a brief description of the methodology used by Finance to determine available revenues. In particular, please describe the rationale for removing the discretionary transfer to the Budget Stabilization Account from the total of available revenues.

3. What criteria did Finance use to distinguish between new expenditures since 2016 that could be considered part of the workload budget, compared to new expenditures since 2016 that would not be considered part of the workload budget?

4. Will Finance update this calculation after May Revision? If the updated calculation results in an allocation to the Medi-Cal program, what is the Administration's view regarding permissible uses of that allocation for Medi-Cal expenditures?

Issue 2: Denti-Cal - Overview

Dental Services for Medi-Cal Beneficiaries. The budget includes $1.2 billion ($434.9 million General Fund and $797.8 million federal funds) in 2017-18 and $1.4 billion ($485.1 million General Fund and $879.4 million federal funds) in 2018-19 for base fee-for-service expenditures for dental services in the Medi-Cal Dental Program, known as Denti-Cal.

The budget also includes $118.2 million ($40.8 million General Fund and $77.4 million federal funds) in 2017-18 and $104.2 million ($37 million General Fund and $67.2 million federal funds) in 2018-19 for base dental services provided through dental managed care (DMC) plans.

Dental Services Funding Summary			
Fiscal Year:	**2017-18**	**2018-19**	**BY to CY**
Denti-Cal Fee-for-Service			
Fund Source	***Revised***	***Proposed***	***Change***
0001 – General Fund	$434,901,050	$485,090,200	$50,189,150
0890 – Federal Trust Fund	$797,756,950	$879,373,800	$81,616,850
Total Expenditures	**$1,232,658,000**	**$1,364,464,200**	**$131,806,200**
Dental Managed Care (DMC)			
Fund Source	***Revised***	***Proposed***	***Change***
0001 – General Fund	$40,822,620	$37,020,060	($3,802,560)
0890 – Federal Trust Fund	$77,374,380	$67,155,940	($10,218,440)
Total Expenditures	**$118,197,000**	**$104,176,000**	**($14,021,000)**

Background. Medi-Cal's Dental Program, known as Denti-Cal, provides an array of services to eligible Medi-Cal beneficiaries including diagnostic, preventive, restorative, and endodontic services; periodontics; removable and fixed prosthodontics; maxillofacial prosthetics; implant services; oral and maxillofacial surgery; and orthodontic and adjunctive services. Children under age 21 receive the full scope of dental benefits. Adults had received a more limited set of services until January 2018, when full scope adult dental benefits were restored pursuant to the 2017 Budget Act.

DHCS provides dental services to Medi-Cal beneficiaries through two primary delivery systems:

1. Fee-for-Service – The department contracts with Delta Dental to provide dental care to most Medi-Cal beneficiaries in exchange for a prepaid capitation rate. The previous contract, which expired at the end of January 2018, required Delta to also provide dental fiscal intermediary (FI) services, as well as administrative services such as claims processing, provider enrollment, and beneficiary outreach. After January 2018, Hewlett Packard Enterprise was awarded a multi-year contract to provide FI services, while Delta Dental received a multi-year contract to serve as the Administrative Services Organization (ASO) contractor.

2. Dental Managed Care (DMC) - The department contracts with six DMC plans that provide dental care to approximately 960,000 Medi-Cal beneficiaries in Sacramento and Los Angeles counties. DMC plans are Knox-Keene licensed and are also regulated by the Department of Managed Health Care.

2014 Audit Found Low Children's Dental Utilization and Provider Reimbursement. In 2014, the California State Auditor performed an audit of the Denti-Cal program which found several weaknesses in the program's operation that limited children's access to dental care. In particular, the audit reported the following:

1. Children's utilization rate of dental services, 43.9 percent, was 12th worst among states submitting data to CMS in 2013. The utilization rate is defined as the percentage of beneficiaries having one dental procedure performed during the year.
2. While the availability of dental providers was adequate on a statewide basis, many counties had insufficient providers, with five counties reporting no providers at all.
3. California's provider reimbursement rates for the 10 most common dental procedures were only 35 percent of the national average in 2011.
4. The department had not performed annual reimbursement rate reviews, as required by law, between 2001 and 2011.
5. The department had not enforced provisions of its contract with Delta Dental designed to improve outreach and increase utilization of services.

The audit also observed that provider surveys suggest that low provider participation is based in part on the program's low reimbursement rates compared to national averages.

The audit made 24 specific recommendations for improvements to the Denti-Cal program, including but not limited to: 1) establishing assessment criteria for beneficiary utilization and provider participation; 2) developing procedures for identifying areas with low utilization or provider participation; 3) simplifying administrative processes for providers; 4) monitoring beneficiary utilization, access and enrollment; 5) resumption of annual review of reimbursement rates; 6) requiring Delta Dental to provide additional dental services in underserved areas, either in fixed facilities or mobile clinics; and 7) requiring Delta Dental to develop a dental outreach and education program each year.

Forgiveness of AB 97 Provider Rate Reductions for Dental Services. As part of a budget-balancing General Fund reduction, AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, reduced most Medi-Cal provider rates by up to 10 percent, including for dental services. The rate reductions were enjoined by the courts until December 2012, when the reductions were allowed to be implemented for dates of service on or after June 2011. This period of injunction led to a retroactive recoupment liability for reductions not imposed between 2011 and the time the injunction was lifted. Most providers were subject to both prospective 10 percent rate reductions and retroactive recoupment for the reduction applied to prior claims.

AB 97 also provided authority to the Director of DHCS to forgive any portion of the AB 97 reductions if there were concerns the reductions would lead to adverse impacts on the ability of Medi-Cal beneficiaries to access necessary medical care. Under this authority, the Director forgave retroactive recoupment amounts in 2014-15 for several classes of providers including dental. The forgiven

recoupment amounts were intended to provide support to the state's health care delivery system during the implementation of the federal Affordable Care Act. In the 2015 Budget Act, the Legislature approved elimination of the prospective AB 97 provider rate reductions for dental services for dates of service on or after July 1, 2015.

Annual Dental Reimbursement Rate Review. After the 2014 audit, DHCS resumed its annual review of dental reimbursement rates in Denti-Cal. The most recent report was released in October 2017 for the 2014-15 and 2015-16 fiscal years. The report found that in 2014-15, for the 25 most frequent utilized procedure codes, Denti-Cal paid an average of 106.4, 100.0, 76.9, and 65.0 percent of Illinois, Florida, New York, and Texas Medicaid Program's dental fee schedules, respectively. For 2015-16 the overall averages were 105.3, 98.8, 76.5, and 63.3 percent of Illinois, Florida, New York, and Texas Medicaid Program's dental fee schedule, respectively. The report also found a decrease in providers rendering Denti-Cal services, from 9,527 in calendar year 2008 to 8,129 in calendar year 2016.

Dental Outreach. The audit also recommended the department enforce and enhance its contract with Delta Dental to conduct outreach to Denti-Cal beneficiaries to improve utilization of dental services. One of the primary findings of the audit was that more than 50 percent of children had not visited a dentist in the preceding 12 months.

In its 2016 ASO contract, DHCS implemented several new outreach requirements for Delta Dental. Delta was required to:

- Adhere to DHCS established baseline target rates for utilization for precedent to payment items.
- Implement provider and beneficiary services to provide education in addition to dental services in clinics.
- Target all areas in the state for outreach, focusing on underserved areas/subpopulations.
- Increase utilization by selected adults, such as for systemic disease conditions.
- Maximize beneficiary awareness of the Medi-Cal Dental Program, information about the covered benefits available to them, and the tools at their disposal to schedule appointments and/or receive other assistance.
- Establish four major goals around the Annual Dental Visit, increase of preventive dental services for children, increase of sealants, and annual increases to precedent to payment items.
- Utilize and promote the use of evidence-based and age-appropriate preventive procedures, including fluoride varnish and dental sealants.
- Help families understand the importance of dental benefits and how to access dental services.
- Develop American Dental Association (ADA) compliant education for parents on the need to bring children in for their first dental visit by age one.
- Develop all beneficiary materials in both English and all threshold languages and assure that all written materials are at no higher than a sixth grade reading level.
- Develop material to inform parents/guardians, medical providers, other governmental and non-governmental organizations, and community advocates on key information to promote oral health and the utilization of dental services under the Medi-Cal Dental Program.
- For children, EPSDT Services must include identifying and contacting families of children who are due for a dental screening, examination, preventive visit, and those who have missed such visits, and assist them in scheduling any necessary appointments.

In addition to these new requirements for Delta Dental, the department has conducted its own outreach activities. In particular, the department identified beneficiaries between 0 and 3 years of age that had not had a dental visit in the preceding 12 months. The department mailed each of these beneficiaries' parents or legal guardians information about the importance of early dental visits and encouraged them to take their children to see a dental provider. According to DHCS, after its mailing campaign that began in January 2015, 29 percent of children whose families received a letter subsequently scheduled a dental visit.

1115 Waiver – Medi-Cal 2020 Dental Transformation Initiative. Effective January 2016, the federal Centers for Medicare and Medicaid Services approved California's new 1115 Demonstration Waiver, known as Medi-Cal 2020. Through the Medi-Cal 2020 Waiver, DHCS is implementing four dental "domains", collectively referred to as the Dental Transformation Initiative (DTI) in order to improve the quality of care and increase utilization of dental services. The four domains of the DTI program are:

1. Increase Preventive Services Utilization for Children - This domain aims to increase the statewide proportion of children ages one through twenty enrolled in Medi-Cal who receive a preventive dental service in a given year. The domain's goal is to increase the utilization amongst children by at least 10 percent over a five year period. DHCS will offer financial incentives for dental service office locations that increase delivery of preventive oral care to Medi-Cal eligible children.

   According to DHCS, Domain 1 costs for incentive payments to providers for increasing preventive services over the baseline will be $54.5 million ($27.2 million General Fund and $27.2 million federal funds) in 2017-18 and $61.3 million ($30.6 million General Fund and $30.6 million federal funds) in 2018-19.

2. Caries Risk Assessment and Disease Management – Under this domain, dental providers receive incentive payments for performing caries risk assessments and for each service performed under a pre-identified treatment plan for children ages six and under. This domain will initially be implemented on a pilot basis in select counties based on ratios of restorative to preventive services, representative sampling across the state, and likelihood of provider participation.

   According to DHCS, Domain 2 costs for caries risk assessment and disease management will be $2.9 million ($1.4 million General Fund and $1.4 million federal funds) in 2017-18 and $28.9 million ($14.4 million General Fund and $14.4 million federal funds) in 2018-19.

3. Increase the Continuity of Care - This domain aims to encourage continuity of care among Medi-Cal beneficiaries age 20 and under. Dental provider service office locations will receive an incentive payment for maintaining continuity of care for enrolled child beneficiaries for two, three, four, five, and six year continuous periods. This domain will initially be implemented on a pilot basis in select counties based on the ratio of service office locations to beneficiaries, current levels of continuity of care at, above and below the statewide continuity of care baseline, and representation throughout the state. Incentive payments will be made annually.

According to DHCS, Domain 3 costs for incentive payments for continuity of care will be $13.2 million ($6.6 million General Fund and $6.6 million federal funds) in 2017-18 and $31 million ($15.5 million General Fund and $15.5 million federal funds) in 2018-19.

4. Local Dental Pilot Programs (LDPPs) – A maximum of 15 LDPPs will be approved to address one or more of the previous three domains through alternative programs, using strategies focused on rural areas, including local case management initiatives and education partnerships. DHCS will require LDPPs to have broad-based provider and community support and collaboration, including Tribes and Indian health programs, with incentives related to goals and metrics that contribute to the overall goals of any one of the three domains. No more than 25 percent of the annual DTI funding will be allocated to this domain.

   According to DHCS, Domain 4 costs for LDPPs will be $36.2 million ($18.1 million General Fund and $18.1 million federal funds) in 2017-18 and $38.5 million ($19.2 million General Fund and $19.2 million federal funds) in 2018-19.

Restoration of Adult Dental Benefits. ABX3 5 (Evans), Chapter 20, Statutes of 2009, discontinued optional dental benefits in the Medi-Cal program for adults including full denture procedures and "restore but not replace" procedures. Adults retained some limited sets of services that were federally required. AB 82 (Committee on Budget), Chapter 23, Statutes of 2013, restored partial adult optional dental benefits beginning in May 2014. The restored benefits included examinations; radiographs/photographic images; prophylaxis; fluoride treatments; amalgam and composite restorations; stainless steel, resin, and resin window crowns; anterior root canal therapy; complete dentures, including immediate dentures; and complete denture adjustments, repairs and relines. The 2017 Budget Act restored the remaining full scope adult dental benefits effective January 1, 2018. According to DHCS, dental providers were notified the department would reimburse claims for the restored benefits beginning January 1 pending federal approval, which was received March 27, 2018.

Proposition 56 Funds Supplemental Reimbursement for Certain Dental Services. Proposition 56, approved by voters in 2016, increased the excise tax rate on cigarettes by $2 per pack, with an equivalent increase on other tobacco products, including electronic cigarettes. After allocations for administration, auditing, and backfills of other revenue streams, Proposition 56 requires 82 percent of remaining funds be transferred to the Healthcare Treatment Fund to increase funding for existing healthcare programs and services by providing improved payments for all healthcare, treatment, and services in the Medi-Cal program. The 2017 Budget Act included up to $140 million of Proposition 56 revenues for increased supplemental reimbursement of dental providers in Medi-Cal.

In an effort to increase provider participation, DHCS began providing supplemental payments to dental providers of 40 percent of the dental Schedule of Maximum Allowances (SMA) for certain dental services. These services included the following categories:

- Visits and Diagnostics – Three codes, including comprehensive or periodic oral evaluation
- Restorative – 35 codes, including amalgams, composites, and crowns
- Endodontic – 18 codes, including pulpotomy, pulpal debridement, endodontic therapy, pulpal regeneration, and apicoectomy

- Prosthetic – 86 codes, including complete dentures, partial dentures, broken tooth repair, tissue conditioning, various prostheses (nasal, nasal septal, auricular, orbital, ocular, facial), bridges, and crowns
- Oral and Maxillofacial Surgery – 111 codes, including extraction, biopsy, lesion or tumor excision, incision and drainage of abscess, and various maxillofacial surgical procedures.
- Adjunctive Services – 19 codes, including palliative treatment, anesthesia, conscious sedation, facility calls, office visits, occlusion analysis and adjustment.

The budget includes $223.8 million ($78.8 million Proposition 56 funds and $145 million federal funds) in 2017-18 and $461.5 million ($164.5 million Proposition 56 funds and $297 million federal funds) in 2018-19. The 2018-19 allocation includes an additional $69.9 million of Proposition 56 funds as part of an Administration proposal to provide additional supplemental reimbursements for dental providers. While the proposed additional allocation is in excess of the revised expenditures under DHCS' current supplemental payment program, the total Proposition 56 allocation for 2018-19 is only $24.5 million over the $140 million allocated to dental services for 2017-18 in the 2017 Budget Act. The Administration indicates it will work with the Legislature to modify the supplemental payments to better promote the goals of the initiative.

Current Status of Provider Participation and Dental Utilization. According to recent data provided by DHCS in its two most recent quarterly reports for the 1115 Waiver, which includes DTI, the children's preventive utilization was 42.8 percent as of July 2017 and had grown to 44.7 percent as of November 2017. During the same period, the number of rendering dental providers in fee-for-service grew from 8,881 to 9,044 and service offices grew from 5,543 to 5,579. The number of rendering providers and service offices were relatively flat in dental managed care, and the number of safety net clinics also remained relatively stable.

According to DHCS' most recent fee-for-service performance measures report, 20.8 percent of adults 21 and over had an annual dental visit between July 2016 and June 2017. 12.1 percent of adults 21 and over used a preventive service during that period. Approximately 50 percent of continuously covered adults 21 and over utilized a dental service in the prior three years. These data precede the restoration of full adult dental benefits and the implementation of Proposition 56 supplemental provider payments approved in the 2017 Budget Act.

Proposals for Investment and Program Changes. Several stakeholders have proposed the following investments or program changes in Denti-Cal:

Collection of Demographically Stratified Utilization Data on Restored Dental Benefits – The California Pan-Ethnic Health Network (CPEHN) requests DHCS be required to collect, analyze and report on trends in utilization and coverage as services become available under the restoration of adult dental, including stratification of outcomes by race, ethnicity, language, region and other critical demographic factors. According to CPEHN, the restoration occurred alongside historic investments in enhanced provider payments funded through revenues from Proposition 56's tobacco tax increases. These critical steps have the potential to address a dire gap in the state's oral health care system for adults.

Dental Services Managed Care Integration Pilot in San Mateo County – Health Plan of San Mateo (HPSM) proposes a pilot project to integrate dental services into managed care in San Mateo County.

HPSM, which is a county organized health system, would establish a network and provide reimbursement to providers of dental services to Medi-Cal beneficiaries in the county. HPSM would receive an enhanced, at-risk capitation payment to account for the additional dental services provided.

Increased Denti-Cal Reimbursement for Services to Children with Special Needs – WestHealth Institute requests additional reimbursement for Denti-Cal services provided to children with special health care and mental health needs. According to WestHealth, Denti-Cal-eligible patients often have difficulty finding access to care because of low reimbursement rates and burdensome administrative requirements. This barrier to care can be even more significant for patients with special needs such as those with chronic conditions and disabilities which require more than routine delivery of care. In addition, patients with special needs often are at high risk for developing oral diseases. These patients often forego care, resulting in later stage complications. Additional reimbursements will give the vital financial support to Denti-Cal providers currently serving these patients and may incentivize others to ensure all patients have access to high-quality and appropriate dental care.

Silver Diamine Fluoride Coverage in Denti-Cal – The California Dental Association (CDA) requests resources to add silver diamine fluoride as a Denti-Cal benefit. According to CDA, dental caries remains the most common, yet preventable, chronic disease of children. Application of silver diamine fluoride is one of the most promising approaches in dental care to arrest dental caries. Silver diamine fluoride is being used in a very limited fashion in California's Dental Transformation Initiative but is not a benefit covered by Denti-Cal. It is a painless topical medication that can provide enormous benefit and eliminate the need for more extensive restorative procedures. Modernizing the benefits offered under Denti-Cal provides vulnerable patients with expanded quality of care as part of an overall comprehensive dental treatment plan and has the potential to reduce state 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 DHCS to respond to the following:

1. Please provide a brief overview of utilization rates for primary preventive services for both children and adults in the Denti-Cal program.

2. Please describe current outreach efforts by DHCS and the ASO to improve children's utilization of preventive dental services. Will the mailing campaign continue, or will the department pursue other strategies?

3. Please describe the Administration's current thinking regarding the additional allocation of Proposition 56 provider rates for dental services. What outreach to stakeholders has occurred to date on this topic?

Issue 3: Medi-Cal Optional Benefits

Background. Federal Medicaid law requires certain benefits to be included in a state's Medicaid plan for providing services to its beneficiaries. In addition to the required benefits, states are authorized to include certain optional benefits for Medicaid beneficiaries. Both mandatory and optional benefits are eligible for federal matching funds. According to the federal Centers for Medicare and Medicaid Services, the mandatory and optional benefits in federal Medicaid laws and regulations are as follows:

Mandatory Benefits	Optional Benefits
Inpatient hospital services	Prescription Drugs
Outpatient hospital services	Clinic services
EPSDT	Physical therapy
Nursing Facility Services	Occupational therapy
Home health services	Speech, hearing and language disorder services
Physician services	Respiratory care services
Rural health clinic services	Other diag./screening/preventive/rehab. services
FQHC services	Podiatry services
Laboratory and X-ray services	Optometry services
Family planning services	Dental Services
Nurse Midwife services	Dentures
Certified Pediatric/Family NP services	Prosthetics
Freestanding Birth Center services	Eyeglasses
Transportation to medical care	Chiropractic services
Tobacco cessation counseling (pregnant women)	Other practitioner services
	Private duty nursing services
	Personal Care
	Hospice
	Case management
	Services for Individuals 65 or Older in an IMD
	Services in an ICF-DD
	State Plan HCBS - 1915(i)
	Self-Directed Pers. Assistance Services- 1915(j)
	Community First Choice Option- 1915(k)
	TB Related Services
	Inpatient psychiatric services-individuals under 21
	Other services approved by the Secretary
	Health Homes (for Chronic Conditions)- 1945

Elimination of Medi-Cal Optional Benefits. In 2009, facing a significant General Fund deficit, the budget included several reductions in reimbursement and benefits in the Medi-Cal program. ABX3 5 (Evans), Chapter 20, Statutes of 2009, eliminated several optional Medi-Cal benefits, including adult dental services, acupuncture, audiology, speech therapy, chiropractic services, optician and optical lab services, podiatric services, psychology services, and incontinence creams and washes. These benefits were not eliminated for beneficiaries under the Early and Periodic Screening Diagnosis and Treatment Program, beneficiaries in a skilled nursing facility or intermediate care facility, or pregnant beneficiaries. Recent budget and legislative actions have restored acupuncture services, full adult dental services as of January 2018, and optical benefits effective January 2020 upon inclusion by the Legislature in the budget process.

Costs to Restore Remaining Optional Benefits. According to DHCS, the costs to restore each of the previously discontinued optional benefits in 2018-19 are as follows:

Optional Benefits	FFS	Managed Care	TF	GF
Audiology	$3,859,000	$6,632,000	$10,491,000	$3,124,000
Chiropractic	$483,000	$4,866,000	$5,349,000	$1,262,000
Incontinence Creams/Washes	$7,102,000	$9,789,000	$16,891,000	$5,208,000
Optician/Optical Lab*	$16,772,000	$58,104,000	$74,876,000	$20,810,000
Podiatry	$2,131,000	$12,768,000	$14,899,000	$3,404,000
Speech Therapy	$246,000	$2,357,000	$2,603,000	$722,000
Grand Total	**$30,593,000**	**$94,516,000**	**$125,109,000**	**$34,530,000**

***** The 2017 Budget Act restored Optician/Optical Lab benefits January 2020 upon inclusion in the budget process.

Various stakeholders have proposed restoration of previously discontinued optional benefits, as well as addition of new benefits to the Medi-Cal program. These proposals are as follows:

Restoration of Remaining Optional Benefits – The Western Center on Law and Poverty (WCLP) and a coalition of other groups request $50.2 million ($13.7 million General Fund and $36.5 million federal funds) to restore the remaining optional benefits not previously restored. This request is in addition to the expected restoration of optical benefits in January 2020, as currently prescribed in statute adopted in the 2017 Budget Act. According to WCLP, access to these services prevents deterioration of health and the need to utilize costlier emergency services. For example, podiatry services are particularly critical for many diabetics who often need more expensive services from complications if they don't get the podiatric services, including amputations. Access to podiatrists can prevent complications for patients and provide savings in addition to improved quality of life. Restoring audiology, podiatry, speech therapy, and incontinence cream & washes benefits would greatly improve the health outcomes for some poor Californians. In a time of recovery and surplus, it is paramount that the state's most vulnerable residents have access to these medically necessary services.

The California Podiatric Medical Association (CPMA) requests specifically to restore podiatric benefits for Medi-Cal beneficiaries. According to CPMA, the elimination of the podiatry benefit removed Medicaid coverage by a type of provider (podiatrist), but not the services themselves, which may be provided by a physician or surgeon. Currently, podiatrists perform physician services and have full medical staff admitting and surgical privileges in hospitals and surgery centers. However, they are

prohibited from providing podiatric services to patients in the Medi-Cal system unless certain conditions are met or the treatment is provided in a specific setting. This limitation on podiatry has led to delayed treatment of diabetic foot care, traumatic foot, and ankle injuries and has resulted in reduced access, higher costs, and a 31 percent rise in lower limb amputations between 2010 and 2016.

Asthma Home Visiting Benefit – The California Pan-Ethnic Health Network (CPEHN) and the California Children's Hospital Association (CCHA) request up to $2 million ($1 million General Fund and $1 million federal funds) to provide access to medically necessary asthma education and home environmental trigger assessments for Medi-Cal beneficiaries with poorly controlled asthma. Specifically, these organizations request DHCS to allow qualified professionals that fall outside of the state's clinical licensure system to provide these services as long as a licensed practitioner has initially recommended the services. According to CCHA, ample research indicates asthma education, including home environmental assessments, frequently provides a return on investment due to decreased utilization of more costly health care services such as emergency department visits and hospitalizations Increasing access to asthma education and home environmental asthma trigger assessments will help fulfill California's Quadruple Aim of strengthening the quality of care, improving health outcomes, reducing health care costs and advancing health equity.

Hypertension Awareness Pilot Project – The American Heart Association (AHA) and American Stroke Association (ASA) request $10 million General Fund to create a 3-5 county pilot program for hypertension awareness, education, prevention, and control. The pilot program would focus on the counties with the highest prevalence of hypertension and establishes best practices in participating health care systems (federally qualified health centers, rural health centers, and/or private providers). According to the AHA and ASA, the program would fund the following activities:

- Identify 5 counties with the highest prevalence of blood pressure.
- Increase utilization rates of blood pressure cuffs among participating Medi-Cal patients. Blood pressure equipment is a covered benefit, but the utilization rates are incredibly low. Participating providers are encouraged to consistently prescribe blood pressure cuffs for self-measured home blood pressure monitoring. Formalizing this best practice will empower patients to fully engage in their own self-care through home monitoring.
- Patients will record their own blood pressure readings daily and subsequently transfer their readings to a patient's electronic health record.
- The care team will require patients to return for a follow-up no later than three months after the initial diagnosis, ideally returning within one month.
- Harness the power of community health workers (CHW) to expand the care team to provide more comprehensive health care. CHWs will make home visits to high-risk patients to provide more education on blood pressure, ensure that patients are using the blood pressure cuffs properly, tracking their readings, and assist in lifestyle modification.
- The program's goal would be to increase the hypertension control rate to at least 70% of participating patients.

Medi-Cal Reimbursement for Mobile Vision Services – Vision to Learn, a non-profit organization that partners with schools to deliver vision services to students, requests $5 million General Fund in 2018-19 to support operation of mobile vision services offering vision screenings, eye examinations, and glasses at no out-of-pocket cost to children in low-income communities throughout the state. According to Vision to Learn, this one-time funding is intended to temporarily address an ongoing need for and access

to vision services for children in low-income communities until a permanent Medi-Cal funding solution can be pursued. The proposal would also direct DHCS to ensure that, no later than July 2019, the department develop a mechanism for direct Medi-Cal reimbursement for qualified mobile vision services providers like Vision To Learn, pursuant to the requirements of subdivision (b) of Section 14087.9730 of the Welfare and Institutions Code. The requested one-time funding would be available for encumbrance or expenditure until June 30, 2020.

Medi-Cal Coverage for Continuous Glucose Monitoring – The California Life Sciences Association, the American Diabetes Association (ADA) and a coalition of diabetes patient advocacy organizations request $13 million General Fund and trailer bill language to require coverage of continuous glucose monitoring for diabetic patients in Medi-Cal. According to the ADA, real-time continuous glucose monitoring systems continuously monitor blood glucose levels and use alarms and alerts to inform patients when levels are exceeding or falling below specified thresholds. The technology can be administered as a stand-alone device, or integrated with insulin pump therapy. The coalition believes use of this technology in Medi-Cal could help lower costs associated with adults treated for diabetes and aid patients and their caregivers in making optimal treatment decisions.

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 DHCS to respond to the following:

1. Please provide an overview of the optional Medi-Cal benefits discontinued under ABX3 5 that have not yet been restored.

Issue 4: Medi-Cal Provider Reimbursement Rates, Access to Care, and Proposition 56

Background. Section 1396a(a)(30)(A) of Title 42 of the United States Code requires state Medicaid programs to pay reimbursement rates "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area". However, this requirement has been the subject of decades of litigation to determine what constitutes compliance and what level of reimbursement rate should be considered sufficient. In California, provider organizations and independent surveys of individual providers suggest low reimbursement rates for services provided in the Medi-Cal program have led to a decrease in providers willing to participate in the program.

Ten Percent Reduction of Provider Reimbursement Rates. AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, implemented a ten percent reimbursement rate reduction for most providers of services to Medi-Cal beneficiaries and an actuarially equivalent reduction in capitation rates paid to Medi-Cal managed care plans. The reduction applies to dates of service on or after June 1, 2011. Due to court injunctions, which were subsequently lifted in December 2012, the department was unable to reduce reimbursements during this period. This delay, coupled with system implementation issues, required the department to retroactively recoup the overpayments to providers that occurred while the reductions were enjoined or delayed. Over time, the department eliminated many of the reductions and forgave much of the retroactive recoupment amounts due to concerns that the reductions might adversely impact beneficiaries' access to necessary medical care. In addition, the federal government's approval of the State Plan Amendment to implement these reductions was contingent on the state agreeing to implement an access monitoring plan. The plan identifies 23 separate metrics in the three key areas of beneficiary measures, provider availability, and service use and outcomes. The budget includes savings of $579.7 million ($192.1 million General Fund and $387.6 million federal funds) in 2017-18 and $575.3 million ($196.2 million General Fund and $379 million federal funds) in 2018-19 for the provider rate reductions imposed pursuant to AB 97.

Audit Findings for Denti-Cal Program Suggest Limitations to Beneficiary Access. In 2014, the California State Auditor performed an audit of the Denti-Cal program which found several weaknesses in the program's operation that limited children's access to dental care. In particular, the audit reported the following:

1. Children's utilization rate of dental services, 43.9 percent, was twelfth worst among states submitting data to CMS in 2013.
2. Many counties had insufficient providers, with five counties reporting no providers at all.
3. Reimbursement rates for the ten most common dental procedures were 35 percent of the national average in 2011.
4. The department had not performed annual reimbursement rate reviews, as required by law, between 2001 and 2011.
5. The department had not enforced provisions of its contract with Delta Dental designed to improve outreach and increase utilization of services.

The audit also observed that provider surveys suggest low provider participation is based in part on the program's low reimbursement rates compared to national averages.

Proposition 56 Provides Supplemental Reimbursements to Medi-Cal Providers. Proposition 56, approved by voters in 2016, increased the excise tax rate on cigarettes by $2 per pack, with an equivalent increase on other tobacco products, including electronic cigarettes, to provide funding for various public health and tobacco-related law enforcement programs.

Proposition 56 Expenditures
(Dollars in Millions)

Investment Category	Department	Program	2018-19 Governor's Budget
Enforcement	Department of Justice	Local Law Enforcement Grants 1/	$30.0
	Department of Justice	Distribution and Retail Sale Enforcement 1/	$6.0
	Board of Equalization	Distribution and Retail Sales Tax Enforcement 1/	$6.0
	Department of Public Health	Law Enforcement 1/	$6.0
Education, Prevention, and Research	University of California	Cigarette and Tobacco Products Surtax Medical Research Program	$57.0
	University of California	Graduate Medical Education 1/	$40.0
	Department of Public Health	State Dental Program 1/	$30.0
	Department of Public Health	Tobacco Prevention and Control	$125.9
	Department of Education	School Programs	$22.2
Health Care	Department of Health Care Services	Health Care Treatment	$850.9
Administration and Oversight	State Auditor	Financial Audits	$0.4
	Board of Equalization	Sales and Use Tax	$1.3
Revenue Backfills	Proposition 99, Breast Cancer Research Fund, Proposition 10, and General Fund		$125.8
Total			**$1,301.5**

1/ Annual amount specified in statute.

Figure 1: Proposition 56 Expenditures, 2018-19 Governor's Budget
Source: *2018-19 Governor's Budget Summary – Health and Human Services, January 2018*

After allocations for administration, auditing, and backfills of other revenue streams, Proposition 56 requires 82 percent of remaining funds be transferred to the Healthcare Treatment Fund to increase funding for existing healthcare programs and services by providing improved payments for all healthcare, treatment, and services in the Medi-Cal program. Proposition 56 also provides that "funds shall not be used to supplant existing state general funds for these same purposes", "the funding shall be used only for care provided by health care professionals, clinics, health facilities" and "health plans contracting with the State Department of Health Care Services to provide health benefits".

Beginning with the Governor's 2017 January budget, the Administration has interpreted the statutory provisions of Proposition 56 to allow allocation of revenue to fund growth in Medi-Cal program expenditures over the level contained in the 2016 Budget Act. Although these expenditures would have otherwise been funded with state General Fund, the Administration asserts this use of funds does not violate the non-supplantation provisions of Proposition 56. The 2017 January budget allocated all $1.2 billion allocated to Medi-Cal in 2017-18 for program growth. However, the 2017 Budget Act ultimately allocated Medi-Cal funding for supplemental payments in the following categories:

- $650 million ($325 million Proposition 56, $325 million federal funds) for physician services.

- $280 million ($140 million Proposition 56, $140 million federal funds) for dental services.
- $167 million ($50 million Proposition 56, $117 million federal funds) for women's health.
- $54 million ($27 million Proposition 56, $27 million federal funds) to unfreeze reimbursement rates to intermediate care facilities for individuals with developmental disabilities (ICF-DDs).
- $8 million ($4 million Proposition 56, $4 million federal funds) to increase reimbursement to providers serving beneficiaries of the AIDS Waiver.
- $711.2 million from Proposition 56 to fund Medi-Cal program growth over the General Fund appropriation levels approved in the 2016 Budget Act.

Additional Supplemental Reimbursements for Medi-Cal Providers. The budget includes $1.1 billion ($360.1 million Proposition 56, $788.2 million federal funds) in 2017-18 and $2 billion ($649.9 million Proposition 56, $1.4 billion federal funds) in 2018-19 for supplemental provider payments in Medi-Cal. The supplemental payments by category are as follows:

Supplemental Payments *(dollars in thousands)*	FY 2017-18 2017 Budget Act	FY 2017-18 2018 Gov Budget	FY 2018-19 2018 Gov Budget
Physician Services			
Total Fund	$ 650,000	$ 746,051	$ 1,338,039
Proposition 56	$ 325,000	$ 229,756	$ 416,593
Federal Funds	$ 325,000	$ 516,295	$ 921,446
Dental Services			
Total Fund	$ 280,000	$ 223,809	$ 461,501
Proposition 56	$ 140,000	$ 78,819	$ 164,519
Federal Funds	$ 140,000	$ 144,990	$ 296,982
Women's Health Services			
Total Fund	$ 167,000	$ 158,347	$ 183,259
Proposition 56	$ 50,000	$ 42,608	$ 49,001
Federal Funds	$ 117,000	$ 115,739	$ 134,258
ICF-DDs			
Total Fund	$ 54,000	$ 13,257	$ 35,616
Proposition 56	$ 27,000	$ 5,472	$ 16,412
Federal Funds	$ 27,000	$ 7,785	$ 19,204
AIDS Waiver			
Total Fund	$ 8,000	$ 6,800	$ 6,800
Proposition 56	$ 4,000	$ 3,400	$ 3,400
Federal Funds	$ 4,000	$ 3,400	$ 3,400
TOTAL, ALL PROVIDERS			
Total Fund	$ 1,159,000	$ 1,148,264	$ 2,025,215
Proposition 56	$ 546,000	$ 360,055	$ 649,925
Federal Funds	$ 613,000	$ 788,209	$ 1,375,290

The overall Proposition 56 allocation for supplemental provider payments is $185.9 million lower in 2017-18, and $103.9 million higher in 2018-19, compared to the 2017 Budget Act. The Governor's Budget Summary indicates the budget "allocates $649.9 million in 2018-19, an increase of $232.8

million, for supplemental payments and rate increases based on those approved in the 2017 budget package." However, the Healthcare Treatment Fund, which distributes the Proposition 56 allocation for Medi-Cal, reflects a final fund balance of $331.1 million in 2017-18 and $414.7 million in 2018-19. The Administration indicates a portion of this fund balance is being retained to account for a lag in the payment of claims caused by system changes and deferrals into 2019-20. Some portion of the fund balance is likely attributable to underutilization of the claiming codes identified for physician and dental supplemental payments, as well as a higher federal match than estimated in the 2017 Budget Act.

The budget continues to include $711.2 million in 2017-18 for Medi-Cal program growth over levels in the 2016 Budget Act. In 2018-19, the allocation for Medi-Cal program growth is $169.4 million.

Home Health Rate Increase Funded by Proposition 56. The budget includes $64.5 million ($31.6 million Proposition 56, $32.8 million federal funds) to fund a 50 percent increase in reimbursement rates paid to providers of medically necessary, in-home services to children and adults in the fee-for-service system or through the state's home- and community-based services waivers. While other Proposition 56-related reimbursement changes are delivered through time-limited supplemental payments, the proposed increase for home health providers would be applied to base reimbursement rates and would be ongoing.

Continuity of Proposition 56 Supplemental Provider Payments. DHCS has submitted State Plan Amendments (SPAs) for the supplemental provider payments authorized in the 2017 Budget Act for physician services, dental services, women's health services, ICF-DDs and the AIDS Waiver. However, each of these SPAs was written to cover dates of service during the 2017-18 fiscal year only. DHCS indicates that it does not intend to submit SPAs for the 2018-19 fiscal year until Proposition 56 funds are appropriated for this purpose in the 2018 Budget Act. DHCS has acknowledged that, because there will be a lag between the start of the 2018-19 fiscal year and federal approval of a new SPA to continue supplemental payments, there may be a disruption in the flow of supplemental payments to providers pending SPA approval. This discontinuity and lack of long-term certainty regarding reimbursement levels may have detrimental effects on the willingness of providers in these categories to provide services to additional Medi-Cal beneficiaries or for new providers to begin providing services in Medi-Cal. Improvements in access to necessary medical care for Medi-Cal beneficiaries, a primary goal of the allocation of Proposition 56 revenues for this program, may be limited as a result of the department's decision to request federal approval for the supplemental payment program on an annual, rather than a multi-year, basis.

Provider Panel. The subcommittee has asked the following speakers to address the topic of provider reimbursement and access to necessary medical care for Medi-Cal beneficiaries:

- **John D. Stobo, M.D.** – Executive Vice President, UC Health
- **Crystal Strait –** CEO/President, Planned Parenthood of California
- **Dr. John Luther –** Chief Dental Officer, Western Dental and Orthodontics
- **Michelle Baca –** Associate Dir. Governmental Relations, California Medical Association
- **Kimberly Chen –** Government Affairs Manager, California Pan-Ethnic Health Network

Proposals for Investment to Improve Provider Reimbursement and Access to Care in Medi-Cal. Various stakeholders have proposed the following investments of tobacco tax revenue provided by Proposition 56, as well as other Medi-Cal-related investments of General Fund resources.

Proposition 56-Related Proposals

Pediatric Preventive Health, Preventive Dental and Specialty Reimbursement. Children Now proposes the following additional targeted Proposition 56 supplemental payments:

(1) pediatric preventive services, such as well-child visits and developmental screenings
(2) children's fluoride varnish application and preventive dental services; and
(3) pediatric specialty care services, provided as part of the California Children's Services (CCS) Program

Pediatric Day Health Centers Rate Increase. A coalition of pediatric day health center (PDHC) providers request $7.8 million ($3.9 million Proposition 56 funds and $3.9 million federal funds) for PDHCs to receive parity with the 50% rate increase proposed for home health agencies by the Administration. According to the providers, approximately 544 children and their families are currently-served by PDHCs. The services provided by PDHCs make it possible for medically fragile and technology-dependent children to remain in the community with their families. Under the Early and Periodic Screening, Diagnostic and Treatment Supplemental Services program, children who are medically-fragile or technology dependent can receive home and community-based skilled nursing care from a PDHC, in-home nursing provided by home health agencies, or both. Each child is assessed for their level of care needs and authorized a maximum number of service hours. The child and family can choose a PDHC or home health agency or a mix of both – to use the authorized hours, and meet each child's individual needs, allow the child to remain at home, and keep families intact. Each approach to care has benefits. In-home nursing provides skilled care at home in familiar surroundings, while PDHCs provide skilled care in a setting that provides socialization and developmentally-appropriate programs. The PDHC provider community fully supports the increase for home health agencies providing in-home services for children and adults. However, it is important that children and adults can use their authorized hours at their preferred site of care: in-home and/or PDHCs.

General Fund Investments

Breast Pump Rate Increase. The California WIC Association requests $6.6 million ($3.3 million General Fund and $3.3 million federal funds) to increase reimbursements for breast pumps for Medi-Cal beneficiaries. According to the California WIC Association, a huge barrier to obtaining quality breast pumps and supplies under Medi-Cal for low-income women is the inadequate reimbursement rates for breast pumps and supplies, which were set 30 years ago. These low rates are untenable for durable medical equipment suppliers and manufacturers to provide breast pumps. As a result it has gotten more difficult to acquire an effective breast pump through a Medi-Cal plan. A recent actuarial analysis reported that for total breastfeeding support, counseling and breast pump supplies, the per member per year costs would be only $1.16, while Medi-Cal could realize a savings of $405,000 to $940,000 per 100,000 births, by providing breastfeeding support and supplies.

Rate Increase for Stand-Alone Pediatric Sub-Acute Facilities. Sun Valley Specialty Healthcare requests General Fund expenditure authority of $4 million to increase reimbursement rates for stand-alone pediatric sub-acute facilities. According to Sun Valley, the daily rate for these facilities has not increased in 10 years. As a result, providers are facing ongoing and growing shortfalls that threaten their ability to continue providing services. Because these free-standing sub-acute services are much more cost-effective than acute facilities, increasing their daily rate will help preserve this important step-down level of care for medically-fragile children.

Air Ambulance Provider Rate Increase to Replace Expiring Supplemental Payments. The California Association of Air Medical Services (Cal-AAMS) requests General Fund resources to increase air ambulance provider reimbursements commensurate with rural Medicare rates. According to Cal-AAMS, the Emergency Medical Air Transportation Act (EMATA) placed a $4 penalty on moving violations which is then matched with federal funds, and distributed to providers by way of supplemental payments. In the face of growing concerns over the magnitude of penalties assessed on moving violations, the Legislature has determined that the EMATA program will expire in 2019. The loss of these funds will be devastating to these emergency providers. The rural Medicare fee schedule reimburses providers approximately 2/3rds of their cost of providing the service, while the 20 plus year old Medi-Cal fee schedule pays less than half of the rural Medicare rate. Unlike hospitals and ground ambulance services who are able to augment their Medi-Cal payments by use of a Quality Assurance Fee, air ambulances are precluded from doing so by federal law, as they are licensed air carriers. Air ambulance providers will be devastated by the impending decrease in the EMATA rate. An increase to the rural Medicare rate will sustain services, preventing potential base closures or reductions in services.

Blood Factor Reimbursement at Wholesale Acquisition Cost. Advocating for Access (AfA) requests trailer bill language to change the current statute to require blood factor reimbursement to be based on Wholesale Acquisition Cost (WAC), not to exceed the current reimbursement rate of 120 percent of the Average Sales Price (ASP). According to AfA, the proposed DHCS blood clotting factor reimbursement methodology would drastically cut reimbursement to specialty pharmacies by approximately 75-90 percent, which would threaten patient access, quality of care and patient safety. AfA is concerned that the proposed reimbursement methodology of billing for the administrative service fee will require another prior authorization, adding to provider's administrative cost as well as the states cost of processing this per diem. AfA is also concerned that patients will not have access to clotting factor medications in their homes to treat bleeds promptly and prevent devastating joint damage and prompt treatment of any life-threatening bleed before getting to the ER. Patient quality of care and access to care could revert to the 1980s, when patients had a median of 23.5 bleeds (range 1-107) annually and a median of 20 joint bleeds (range 0-52) annually.

Limit Erroneous Payment Correction Recoupments for Physicians. The California Medical Association (CMA) requests trailer bill language to limit the length of time that DHCS can recoup overpayments for state errors to one year and the percentage of a current payment that can be withheld to 20 percent until the total amount is recouped. According to CMA, there is no limit on the timeframe that DHCS can retroactively recoup overpayment for services or on the amount of a provider's current payment that can be withheld and used to pay the amount owed. As a result, providers are essentially required to work without pay for providing services to current beneficiaries. In contrast, under the Knox-Keene Act, health plans have a one-year timeframe to recoup overpayments from providers. With over 13.5 million Californians enrolled in Medi-Cal and continued growth expected in the program, it is imperative that the state also explore additional ways to encourage provider participation. CMA believes that placing reasonable limits on the recoupment of provider overpayments resulting from state errors will help to reduce another barrier that physicians face when deciding to become Medi-Cal providers.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends these proposals for investment be held open pending further discussions on their fiscal impact and pending release of updates to the state's General Fund condition at the May Revision.

Issue 5: California 1115 Waiver - Medi-Cal 2020

Budget Issue. DHCS requests extension of limited-term expenditure authority of $4.5 million ($2.2 million General Fund and $2.2 million federal funds) in 2018-19 and $263,000 ($132,000 General Fund and $131,000 federal funds) in 2019-20. If approved, these resources would support continued compliance and administration of California's Section 1115 Waiver: Medi-Cal 2020.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20**
0001 – General Fund	$2,232,000	$132,000
0890 – Federal Trust Fund	$2,231,000	$131,000
Total Funding Request:	**$4,463,000**	**$263,000**

Background. Section 1115 of the Social Security Act authorizes the federal Department of Health and Human Services to allow experimental, pilot, or demonstration projects likely to assist in promoting the objectives of Medicaid. The broad authority under Section 1115 allows states to request a waiver of Medicaid coverage requirements, such as the requirement that Medicaid benefits be offered uniformly statewide, which allows operation of demonstration components in specified counties or provision of benefits to specific populations. States may also request waiver of restrictions on expenditure authority, which allows states to receive federal financial participation for certain benefits not ordinarily eligible for federal Medicaid funds.

California's first 1115 Waiver, the Medi-Cal Hospital/Uninsured Care Demonstration, was approved in 2005 for five years and restructured the state's hospital financing system. California renewed the 1115 Waiver for an additional five years in 2010, renaming it "Bridge to Reform" and focusing on readying state health programs for implementation of the federal Affordable Care Act. Specifically, the Bridge to Reform Waiver: 1) allowed for health care coverage of up to 500,000 uninsured individuals in county Low Income Health Programs who would later become eligible for the state's optional expansion of Medi-Cal, 2) increased funding for uncompensated care, 3) improved care coordination for vulnerable populations such as dual-eligibles, and 4) promoted transformation of public hospital care delivery systems.

The most recent Waiver renewal, titled "Medi-Cal 2020", was approved on December 30, 2015, and contains four primary components: Public Hospital Redesign and Incentives in Medi-Cal, the Global Payment Program, Whole Person Care Regional Pilots, and the Dental Transformation Initiative.

Public Hospital Redesign and Incentives in Medi-Cal (PRIME). PRIME is a five-year initiative under the Medi-Cal 2020 Waiver that builds upon the public hospital delivery system reforms implemented under the previous Bridge to Reform Waiver. PRIME is designed to continue improving the way care is delivered in California's safety net hospitals to maximize health care value and move toward alternative payment models, such as capitation and other risk-sharing arrangements. Participating PRIME entities, Designated Public Hospital (DPH) systems or District/Municipal Public Hospitals (DMPH), must submit plans to achieve goals within one of the following domains:

- **Domain 1: Outpatient Delivery System Transformation and Prevention**. These projects are meant to ensure patients experience timely access to high-quality, efficient, and patient-centered care. In addition, these projects identify and increase rates of cost-effective standard approaches to prevention services for a select group of high-impact clinical conditions and populations such as cardiovascular disease, breast, cervical and colorectal cancer, and obesity. The projects also aim to reduce disparities and variation in performance of targeted prevention services within their systems. Required and optional projects under this domain and the number of approved projects are as follows:

  i. Integration of Physical and Behavioral Health (required) – 23 Projects
  ii. Ambulatory Care Redesign: Primary Care (required) – 24 Projects
  iii. Ambulatory Care Redesign: Specialty Care (required) – 19 Projects
  iv. Patient Safety in the Ambulatory Setting (optional) – 13 Projects
  v. Million Hearts Initiative (optional) – 18 Projects
  vi. Cancer Screening and Follow-up (optional) – 12 Projects
  vii. Obesity Prevention and Healthier Foods Initiative (optional) – 9 Projects

- **Domain 2: Targeted High-Risk or High-Cost Populations.** These projects are focused on specific populations that would benefit most significantly from care integration and alignment. Particular attention will be focused on managing and coordinating care during transitions from inpatient to outpatient and post-acute settings. Required and optional projects under this domain and the number of approved projects are as follows:

  i. Improved Perinatal Care (required) – 20 Projects
  ii. Care Transitions: Integration of Post-Acute Care (required) – 30 Projects
  iii. Complex Care Management for High-Risk Medical Populations (required) – 26 Projects
  iv. Integrated Health Home for Foster Children (optional) – 4 Projects
  v. Transition to Integrated Care: Post-Incarceration (optional) – 3 Projects
  vi. Chronic Non-Malignant Pain Management (optional) – 14 Projects
  vii. Comprehensive Advanced Illness Planning and Care (optional) – 13 projects

- **Domain 3: Resource Utilization Efficiency.** These projects are meant to reduce unwarranted variation in use of evidence-based, diagnostics, and treatments targeting overuse, misuse, as well as inappropriate underuse of effective interventions. Projects will also eliminate the use of ineffective or harmful targeted clinical services. Optional projects under this domain and the number of approved projects are as follows:

  i. Antibiotic Stewardship – 12 Projects
  ii. Resource Stewardship: High-Cost Imaging – 8 Projects
  iii. Resource Stewardship: Therapies Involving High-Cost Pharmaceuticals – 8 Projects
  iv. Resource Stewardship: Blood Products – 5 Projects

DHCS has approved a total of 17 plans submitted by DPHs and 37 submitted by DMPHs to become PRIME entities. These entities may receive up to $3.7 billion combined in federal Medicaid funding over five years for achieving metrics in implementing clinical projects designed to change the way care

is delivered. 1115 Waiver financing regulations require these funds to be matched with a non-federal share of funding, which is provided by other governmental health entity funds that are transferred to DHCS as intergovernmental transfers (IGTs). The budget includes $1.7 billion ($885.5 million intergovernmental transfers and $885.5 million federal funds) in 2017-18 and $1.5 billion ($760 million intergovernmental transfers and $760 million federal funds) in 2018-19 for the PRIME program.

Global Payment Program. The Global Payment Program establishes a statewide pool of funding for the remaining uninsured by combining federal Disproportionate Share Hospital and uncompensated care funding. The program establishes individual public hospital system "global budgets" for each hospital from overall annual threshold amounts determined through analysis of services provided to the uninsured. Public hospital systems can achieve their "global budget" by meeting a service threshold that incentivizes movement from high cost, avoidable services to providing higher-value and preventative services. The program divides services into four categories for evaluating funding:

- Traditional provider-based, face-to-face outpatient encounters
- Other non-traditional provider, groups, prevention/wellness, face-to-face
- Technology-based outpatient
- Inpatient facility

The budget includes $2.3 billion ($1.1 billion intergovernmental transfers and $1.1 billion federal funds) in 2017-18 and $2.5 billion ($1.2 billion intergovernmental transfers and $1.2 billion federal funds) in 2018-19 for the Global Payment Program.

Whole Person Care (WPC) Pilots. The WPC Pilots are intended to coordinate health, behavioral health, and social services in a patient-centered manner with the goals of improved beneficiary health and well-being through more efficient and effective use of resources. WPC Pilots allow individual public entities or a consortium of public entities to integrate care for a particularly vulnerable group of Medi-Cal beneficiaries who have been identified as high users of multiple systems and continue to have poor health outcomes. WPC Pilot entities will identify target populations, share data between systems, coordinate care in real time, and evaluate individual and population progress. Target populations may include but are not limited to individuals:

i. with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement.
ii. with two or more chronic conditions.
iii. with mental health and/or substance use disorders.
iv. who are currently experiencing homelessness.
v. individuals who are at risk of homelessness, including individuals who will experience homelessness upon release from institutional settings.

WPC Pilots targeting individuals at risk of or experiencing homelessness can implement housing interventions, such as tenancy-based care management services or county housing pools.

DHCS approved eighteen applications for WPC Pilots from the following entities:

Lead Entity	Estimated Five-year Beneficiary Count	Total Five-Year Budget
Alameda County Health Care Services Agency	20,000	$283,453,400
City of Sacramento*	4,386	$64,078,680
Contra Costa Health Services	52,500	$203,958,160
County of Marin, Dept. of Health and Human Services*	3,516	$20,000,000
County of Orange Health Care Agency**	9,303	$31,066,860
County of San Diego, Health & Human Services Agency	1,049	$43,619,950
County of Santa Cruz, Health Services Agency*	1,000	$20,892,336
County of Sonoma, Dept. of Health Services*	3,040	$16,704,136
Kern Medical Center	2,000	$157,346,500
Kings County Human Services Agency	790	$12,848,360
L.A. County Department of Health Services**	154,044	$1,260,352,362
Mendocino County Health and Human Services Agency*	600	$10,804,720
Monterey County Health Department**	500	$34,035,672
Napa County	800	$22,921,433
Placer County Health and Human Services Department	450	$20,126,290
Riverside University Health System - Behavioral Health	38,000	$35,386,995
San Bernardino Co. - Arrowhead Regional Med. Center	2,000	$24,537,000
San Francisco Department of Public Health**	16,954	$161,750,000
San Joaquin County Health Care Services Agency**	2,255	$18,365,004
San Mateo County Health System	5,000	$165,367,710
Santa Clara Valley Health and Hospital System**	10,000	$250,191,859
Small County Whole Person Care Collaborative*	427	$10,362,176
Shasta County Health and Human Services Agency	600	$19,403,550
Solano County Health & Social Services	250	$4,667,010
Ventura County Health Care Agency**	2,280	$107,759,837

* New program beginning July 1, 2017

** Expansion of previously approved program approved beginning July 1, 2017

The budget includes $581.8 million ($290.9 million intergovernmental transfers and $290.9 million federal funds) in 2017-18 and $646.7 million ($323.4 million intergovernmental transfers and $323.4 million federal funds) in 2018-19 for funding WPC Pilots.

1115 Waiver – Medi-Cal 2020 Dental Transformation Initiative. Effective January 2016, the federal Centers for Medicare and Medicaid Services approved California's new 1115 Demonstration Waiver, known as Medi-Cal 2020. Through the Medi-Cal 2020 Waiver, DHCS is implementing four dental "domains", collectively referred to as the Dental Transformation Initiative (DTI) in order to improve the quality of care and increase utilization of dental services. The four domains of the DTI program are:

1. Increase Preventive Services Utilization for Children - This domain aims to increase the statewide proportion of children ages one through twenty enrolled in Medi-Cal who receive a preventive dental service in a given year. The domain's goal is to increase the utilization amongst children by at least 10 percent over a five year period. DHCS will offer financial

incentives for dental service office locations that increase delivery of preventive oral care to Medi-Cal eligible children.

According to DHCS, Domain 1 costs for incentive payments to providers for increasing preventive services over the baseline will be $54.5 million ($27.2 million General Fund and $27.2 million federal funds) in 2017-18 and $61.3 million ($30.6 million General Fund and $30.6 million federal funds) in 2018-19.

2. Caries Risk Assessment and Disease Management – Under this domain, dental providers receive incentive payments for performing caries risk assessments and for each service performed under a pre-identified treatment plan for children ages six and under. This domain will initially be implemented on a pilot basis in select counties based on ratios of restorative to preventive services, representative sampling across the state, and likelihood of provider participation.

   According to DHCS, Domain 2 costs for caries risk assessment and disease management will be $2.9 million ($1.4 million General Fund and $1.4 million federal funds) in 2017-18 and $28.9 million ($14.4 million General Fund and $14.4 million federal funds) in 2018-19.

3. Increase the Continuity of Care - This domain aims to encourage continuity of care among Medi-Cal beneficiaries age 20 and under. Dental provider service office locations will receive an incentive payment for maintaining continuity of care for enrolled child beneficiaries for two, three, four, five, and six year continuous periods. This domain will initially be implemented on a pilot basis in select counties based on the ratio of service office locations to beneficiaries, current levels of continuity of care at, above and below the statewide continuity of care baseline, and representation throughout the state. Incentive payments will be made annually.

   According to DHCS, Domain 3 costs for incentive payments for continuity of care will be $13.2 million ($6.6 million General Fund and $6.6 million federal funds) in 2017-18 and $31 million ($15.5 million General Fund and $15.5 million federal funds) in 2018-19.

4. Local Dental Pilot Programs (LDPPs) – A maximum of 15 LDPPs will be approved to address one or more of the previous three domains through alternative programs, using strategies focused on rural areas, including local case management initiatives and education partnerships. DHCS will require LDPPs to have broad-based provider and community support and collaboration, including Tribes and Indian health programs, with incentives related to goals and metrics that contribute to the overall goals of any one of the three domains. No more than 25 percent of the annual DTI funding will be allocated to this domain.

   According to DHCS, Domain 4 costs for LDPPs will be $36.2 million ($18.1 million General Fund and $18.1 million federal funds) in 2017-18 and $38.5 million ($19.2 million General Fund and $19.2 million federal funds) in 2018-19.

The budget includes total funding of $106.8 million ($53.4 million General Fund and $53.4 million federal funds) in 2017-18 and $159.6 million ($79.8 million General Fund and $79.8 million federal funds) in 2018-19 for all four domains of the DTI.

Extension of Resources for Compliance and Administration of the Waiver. DHCS requests extension of limited-term expenditure authority of $4.5 million ($2.2 million General Fund and $2.2 million federal funds) in 2018-19 and $263,000 ($132,000 General Fund and $131,000 federal funds) in 2019-20 to support continued compliance and administration of California's Section 1115 Waiver: Medi-Cal 2020. The resources would fund staff equivalent to **one Research Program Specialist II (RPS II) position** and **one Associate Governmental Program Analyst (AGPA)** in the Managed Care Quality and Monitoring Division (MCQMD) and external contracts for evaluation of three 1115 Waiver programs: Whole Person Care (WPC), the managed care transition for Seniors and Persons with Disabilities (SPDs), and the Whole Child Model.

The staff resources are an extension of previously approved limited-term resources for 1115 Waiver administration. The RPS II position would provide continued support of complex data mining, analysis, and exchange from the DHCS data warehouse to support the Whole Person Care Pilot. The AGPA position would continue monitoring and overseeing Waiver pilots by retaining program subject expertise and analytical skills necessary in the evaluation and reporting requirements specified in the Waiver Special Terms and Conditions (STCs).

MCQMD also requests funding for three external evaluation contracts:

- Whole Person Care – MCQMD requests $1 million in funding to perform an independent evaluation of the Whole Person Care pilot, as mandated by the Waiver STCs. According to DHCS, funding for this contract was approved in the 2016 Budget Act, but the contract was delayed due to pending federal approval of the contract design.
- SPD Managed Care Transition – MCQMD requests $1.6 million in funding for continued evaluation of the impacts of transition to managed care of the SPD population, using pre-mandatory enrollment as a baseline.
- Whole Child Model – MCQMD requests $1.6 million in funding for evaluation of managed care plans participating in the Whole Child Model, a pilot program to integrate California Children's Services (CCS) into managed care. The evaluation is designed to evaluate managed care performance compared to the performance of the CCS program prior to implementation of the program.

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 DHCS to respond to the following:

1. Please provide an update on implementation, participation, and expenditures in each of the four domains of the 1115 Waiver.

2. Please provide a brief overview of the proposed extension of limited-term resources for administration of the 1115 Waiver.

Issue 6: Hospital Quality Assurance Fee Program

Budget Issue and Trailer Bill Language Proposal. DHCS requests 11.5 positions and expenditure authority of $2.3 million ($1.1 million Hospital Quality Assurance Revenue Fund and $1.1 million federal funds) in 2018-19, $2.9 million ($1.4 million Hospital Quality Assurance Revenue Fund and $1.4 million federal funds) in 2019-20 and 2020-21, and $1.6 million ($806,000 Hospital Quality Assurance Revenue Fund and $806,000 federal funds) annually thereafter. The position request includes two permanent positions and conversion of 9.5 expiring limited-term positions to permanent, as well as limited-term resources equivalent to 9.5 positions until 2020-21. If approved, these positions and resources would allow DHCS to provide ongoing administration and implementation of the Hospital Quality Assurance Fee, which was reauthorized on a permanent basis by Proposition 52, approved by voters in 2016. DHCS also requests trailer bill language to authorize retention of up to $500,000 each fiscal quarter to cover the non-federal share of administrative costs. State law currently allows retention of up to $250,000 each fiscal quarter for this purpose.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0890 – Federal Trust Fund	$1,134,000	$1,436,000
3158 – Hospital Quality Assurance Revenue Fund	$1,135,000	$1,435,000
Total Funding Request:	**$2,269,000**	**$2,871,000**
Total Positions Requested:	**11.5**	**11.5**

***** Additional fiscal year resources requested: 2020-21: $2,871,000, 2021-22 and ongoing: $1,612,000

Background. Federal Medicaid regulations allow states to impose certain provider-related fees on health care service providers as long as certain conditions are met. The revenue from these taxes may serve as the non-federal share of spending for health care services in a state's Medicaid program, which allows the state to draw down additional federal funding for those services. California imposes three provider-related taxes: a fee on certain general acute-care hospitals (Hospital Quality Assurance Fee or HQAF), a fee on free-standing skilled nursing facilities (AB 1629 Quality Assurance Fee), and a tax on enrollment in health care service plans in the state of California (Managed Care Organization or MCO Tax).

AB 1383 (Jones), Chapter 627, Statutes of 2009, authorized the first HQAF on applicable general acute care hospitals. The fee was reauthorized twice by the Legislature, in 2011 and 2014. Revenue from the fee is deposited into the Hospital Quality Assurance Revenue Fund and used to provide supplemental payments to private hospitals, grants to designated public hospitals and non-designated public hospitals, and increased capitation payments to managed care plans. In addition, the fund is used to pay for health care coverage for children, as well as administrative expenses required to implement the HQAF program. The budget assumes HQAF revenue of $3.8 billion in 2017-18 and $4 billion in 2018-19.

Proposition 52, approved by voters in 2016, permanently extended the HQAF program. Previously, resources and staff provided to DHCS to administer the HQAF program were approved on a limited-term basis as the program was always reauthorized for a limited number of years. DHCS currently administers the program with 9.5 limited-term positions approved in the 2015 Budget Act for the Safety Net Financing Division (SNFD), the Third Party Liability Recovery Division (TPLRD), the Capitated Rates Development Division), and the Office of Legal Services (OLS).

In May 2016, the federal Centers for Medicare and Medicaid Services (CMS) issued a final rule regarding payments to managed care organizations in Medicaid programs. Under the new rule, the supplemental payments to hospitals under the HQAF constitute an unallowable direction of payment, and must be discontinued over a 10 year period or converted into an allowable directed payment model. DHCS indicates it is converting the majority of HQAF program payments into an allowable directed payment model with a uniform dollar or percentage increase in reimbursements based on actual utilization of services, structured utilizing a pool approach that caps payments to a maximum amount each year.

DHCS requests 11.5 positions and expenditure authority of $2.3 million ($1.1 million Hospital Quality Assurance Revenue Fund and $1.1 million federal funds) in 2018-19, $2.9 million ($1.4 million Hospital Quality Assurance Revenue Fund and $1.4 million federal funds) in 2019-20 and 2020-21, and $1.6 million ($806,000 Hospital Quality Assurance Revenue Fund and $806,000 federal funds) annually thereafter. If approved, these resources would fund the following HQAF administrative functions:

- Safety Net Financing Division
  1.5 Associate Governmental Program Analysts (AGPA)
  One Associate Accounting Analyst (AAA)
  Two Research Analyst II (RA II)
  One Research Program Specialist II (RPS II)

  These positions would develop and secure federal approvals, consult with OLS on legal matters, monitor and perform audits to reconcile HQAF costs, coordinate with administrative staff on cost accounting, maintain the HQAF website, plan and develop archive mapping for electronic and physical documents, research state and federal policy changes, and respond to requests for information from the public and the federal government.

- Third Party Liability Recovery Division
  One AGPA
  One Staff Services Analyst (SSA)

  These positions would manage the fee collection process, including financial and policy analysis, customer service, developing repayment agreements, reconciliation and dispute resolution, preparing withholds-payment adjustment notices, maintaining withhold accounts, and maintaining collection cases.

- Capitated Rates Development Division
  Three AGPAs
  Three-Year Limited-Term Resources Equivalent to:
  One Staff Services Manager II (SSM II)
  Two Staff Services Manager I (SSM I)
  Two Research Program Specialist I (RPS I)
  One RA II
  1.5 AGPAs

These staff and resources would be responsible for capitation rate-setting including discussions with actuaries to ensure compliance with rate development requirements, monitoring plan compliance, initiating a recovery process for non-compliant plans, conducting stakeholder meetings, consulting with other DHCS staff to facilitate use of appropriate data for rate development, developing managed care policy regarding HQAF requirements and securing federal approvals.

The limited-term resources are related to the conversion of the HQAF unallowable directed payments to allowable directed payments under the federal Medicaid rule.

- Office of Legal Services
  One Attorney

  This position would be responsible for legal advice and counsel to program staff regarding the HQAF program and compliance with federal requirements.

- Managed Care Quality and Monitoring Division
  Three-Year Limited-Term Resources Equivalent to:
  Two RPS I

  These limited-term resources would collect and analyze encounter data, provide technical assistance, assess the quality of hospital data using statistical techniques, investigate data quality issues, develop and produce data quality reports, and provide technical assistance to CRDD during their analysis of encounter data.

In addition, DHCS requests $100,000 for a legal contract for advice on federal compliance and $100,000 for its contracted actuary, Mercer, to provide consultation and rate-setting services.

DHCS also requests trailer bill language to authorize retention of up to $500,000 each fiscal quarter to cover the non-federal share of administrative costs. State law currently allows retention of up to $250,000 each fiscal quarter for this purpose. According to DHCS, hospital providers are supportive of this administrative augmentation.

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 DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 7: Graduate Medical Education (GME) Program Oversight and Monitoring

Budget Issue. DHCS requests two positions and expenditure authority of $244,000 ($122,000 Designated Public Hospital GME Special Fund and $122,000 federal funds) annually. If approved, these positions and resources would support fiscal oversight and monitoring of the department's implementation of a Medicaid Graduate Medical Education Program for designated public hospitals.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0890 – Federal Trust Fund	$122,000	$122,000
8113 – DPH GME Fund**	$122,000	$122,000
Total Funding Request:	**$244,000**	**$244,000**
Total Positions Requested:	**2.0**	**2.0**

* Positions and resources ongoing after 2019-20.

** DPH GME Fund receives county intergovernmental transfer funds for the non-federal share of program costs.

Background. According to DHCS, although most states support GME through their Medicaid programs, California does not currently have a Medicaid GME program despite being the state with the second largest number of teaching hospitals and medical residents in the nation. Changes in California hospital financing enacted in 2005 have prevented implementation of such a program. However, recent federal regulations authorize DHCS to make new GME payments to Designated Public Hospitals (DPHs) and their affiliated government entities. DHCS submitted a State Plan Amendment to allow these entities to provide an intergovernmental transfer (IGT) as the non-federal share of GME payments to draw down additional federal matching funds.

The following are the state's participating DPHs, as of 2013:

Alameda Health System	San Joaquin General Hospital
Arrowhead Regional Medical Center	Santa Clara Valley Medical Center
L.A. County - Olive View UCLA Medical Center	L.A. County University of Southern California
Kern Medical Center	San Francisco General Hospital
Riverside County Regional Medical Center	Ventura Medical Center
Contra Costa Regional Medical Center	L.A. County – Harbor-UCLA Medical Center
Rancho Los Amigos Natl Rehabilitation Center	UC Irvine Medical Center
UC San Diego Medical Center	Ronald Reagan UCLA Medical Center
UCLA Medical Center Santa Monica	Natividad Medical Center
San Mateo Medical Center	UC Davis Medical Center
UC San Francisco Medical Center	

DHCS requests **one Associate Governmental Program Analyst (AGPA), one Health Program Specialist I (HPS I) position** and expenditure authority of $244,000 ($122,000 Designated Public Hospital GME Special Fund and $122,000 federal funds) annually to support fiscal oversight and monitoring of the department's implementation the GME program for DPHs. The AGPA would be responsible for developing and executing reimbursement agreements for DPHs, processing and tracking IGT payments, coordinating with stakeholders, and updating policy amendments. The HPS I would

provide analysis and validation of DPH claims for direct and indirect GME costs, fiscal analysis, compilation of monthly and quarterly reports, and prepare necessary information for audits, data collection, data mining, and data analysis from internal and external sources.

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 DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

2. What is the status of federal approval of the GME program for DPHs?

Issue 8: Home- and Community-Based Services Waiver Programs

Background. The Medicaid Home- and Community-Based Services (HCBS) waiver program is authorized in Section 1915(c) of the Social Security Act. The program permits states to furnish an array of home- and community-based services that assist beneficiaries to live in the community and avoid institutionalization. States have broad discretion to design waiver programs to address the needs of the waiver's target population. Waiver services complement or supplement the services that are available to participants through the state plan and other federal, state and local public programs as well as the supports that families and communities provide.

California operates several home- and community-based services waivers for Medi-Cal beneficiaries.

Acquired Immune Deficiency Syndrome (AIDS) Waiver. Local agencies, under contract with the California Department of Public Health, Office of AIDS, provide home and community-based services as an alternative to nursing facility care or hospitalization. Services provided include: administrative expenses, attendant care, case management, financial supplements for foster care, home-delivered meals, homemaker services, in-home skilled nursing care, minor physical adaptations to the home, non-emergency medical transportation, nutritional counseling, nutritional supplements, and psychotherapy.

Clients eligible for the program must be Medi-Cal recipients whose health status qualifies them for nursing facility care or hospitalization, in an aid code with full benefits and not enrolled in the Program of All-Inclusive Care for the Elderly (PACE). Participants must also have a written diagnosis of HIV disease or AIDS, certified by the nurse case manager to be at the nursing facility level of care, and score 60 or less using the Cognitive and Functional Ability Scale assessment tool. Children under 13 years of age are eligible if they have been certified by the nurse case manager as HIV/AIDS symptomatic. All waiver participants must have a home setting that is safe for both the client and service providers. According to DHCS, federal approval for renewal of the AIDS Waiver was received on March 27, 2017.

Assisted Living Waiver. The Assisted Living Waiver pays for assisted services and supports, care coordination, and community transition in 14 counties (Sacramento, San Joaquin, Los Angeles, Riverside, Sonoma, Fresno, San Bernardino, Alameda, Contra Costa, San Diego, Kern, San Mateo, Santa Clara and Orange). Waiver participants can elect to receive services in a Residential Care Facility for the Elderly (RCFE), an Adult Residential Facility (ARF), or through a home health agency while residing in publicly subsidized housing. Eligibility into the ALW is based on a qualifying skilled nursing level of care which is captured through the assessment tool used by care coordination agencies to assess potential participants. Approved capacity of unduplicated recipients for the ALW is currently 3,744. The federal government approved a renewal of the ALW on August 28, 2014 effective from March 1, 2014 through February 28, 2019.

DHCS is seeking federal approval of a waiver amendment to expand the ALW by 2,000 slots from 3,744 to 5,744 between July 2017 and June 2020 to accommodate current and anticipated need. According to DHCS, a reserve capacity would be set for new enrollments which will require that 60 percent of all new enrollments be reserved for individuals transitioning from institutional settings after residing in them for a minimum of 90 consecutive days. The budget includes savings of $155,000 ($77,500 General Fund and $77,500 federal funds) in 2017-18 and $14 million ($7 million General Fund and $7 million federal funds) in 2018-19 for ALW expansion. The costs of ALW services are offset by

a higher level of savings from transitions of individuals from skilled nursing facilities into community settings under the ALW.

In-Home Operations Waiver. The In-Home Operations (IHO) Waiver serves either: 1) participants previously enrolled in the Nursing Facility A/B Level of Care (LOC) Waiver who have continuously been enrolled in a DHCS administered HCBS waiver since prior to January 1, 2002, and require direct care services provided primarily by a licensed nurse, or 2) those who have been receiving continuous care in a hospital for 36 months or greater and have physician-ordered direct care services that are greater than those available in the Home and Community Based Alternatives Waiver, for the participant's assessed LOC. CMS approved the IHO waiver renewal from January 1, 2015 through December 31, 2019. DHCS indicates it will not renew the IHO Waiver at the expiration of the current waiver term. At the point of annual reassessment for each participant, DHCS will offer the option of transitioning to the Home- and Community-Based Alternatives Waiver. All IHO Waiver participants will be given sufficient notice of the waiver expiration and provided options to transition prior to the expiration of the IHO Waiver.

Home- and Community-Based Alternatives Waiver. The Home- and Community-Based Alternatives (HCBA) Waiver provides Medi-Cal members with long-term medical conditions, who meet the acute hospital, adult or pediatric subacute or nursing facility Level of Care (LOC), with the option of returning to or remaining in his or her home or home-like setting in the community in lieu of institutionalization. DHCS will contract with waiver agencies for the purpose of performing waiver administration functions and directing the comprehensive care management waiver service. The waiver agencies are responsible for functions including: participant enrollment, LOC evaluations, plan of treatment and person-centered care and service plan review and approval, waiver service authorization, utilization management, provider enrollment and network development, quality assurance activities and reporting to DHCS, billing the fiscal intermediary, and provider claims adjudication.

DHCS indicates it will continue its role in administering the program by determining all waiver participant eligibility, setting enrollment goals, and providing continuous, ongoing monitoring and oversight. DHCS received approval of the HCBA Waiver in May 2017 with a January 2017 effective date. DHCS reports it will implement the waiver agency model no sooner that January 2018. DHCS expects the waiver renewal will serve up to 8,964 participants by the end of the five year waiver term.

Multipurpose Senior Services Program (MSSP) Waiver. Under the MSSP Waiver, the California Department of Aging contracts with local agencies to provide social and health care management for frail elderly clients who are at risk of placement in a nursing facility, but who wish to remain in the community. The MSSP arranges for and monitors the use of community services to prevent or delay premature institutional placement of these individuals. Clients eligible for the program must be 65 years of age or older, live within an MSSP site service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, be currently eligible for Medi-Cal, and can be certified for placement in a nursing facility. Services provided by MSSP include adult day care and support center, housing assistance, household and personal care assistance, protective supervision, care management, respite, transportation, meal services, social services, and communication services. Under the approved waiver, beginning July 1, 2014 through June 30, 2019, capacity of unduplicated recipients is as follows:

- Waiver Year 1: 12,000
- Waiver Year 2: 11,684
- Waiver Year 3: 11,684
- Waiver Year 4: 11,684
- Waiver Year 5: 11,684

HCBS Waiver for Persons With Developmental Disabilities (DD Waiver). The DD Waiver provides home and community-based services to persons with developmental disabilities who are Regional Center consumers as an alternative to care provided in a facility that meets the federal requirement of an intermediate care facility; in California, intermediate care facility-developmental disabilities-type facilities, or a state developmental center. Approved capacity of unduplicated recipients for this waiver is 110,000 in 2013, 115,000 in 2014 and 120,000 in 2015. The waiver is approved from March 29, 2012 through March 28, 2017. As of March 29, 2017, behavioral health treatment services for waiver participants under the age of 21 will be a state plan benefit and paid through the managed care delivery system or fee-for-service for members not eligible to enroll into managed care.

DHCS is in the process of renewing the DD Waiver, which expired on March 29, 2017. To ensure a sufficient review period, CMS approved the extension of the current waiver through June 27, 2017. DHCS submitted a second extension for the waiver through September 24, 2017 in order to resolve issues with the revenue application. The proposed effective date of the waiver renewal is October 2017.

Pediatric Palliative Care (PPC) Waiver. The PPC Waiver provides children hospice-like services, in addition to state plan services during the course of an illness, even if the child does not have a life expectancy of six months or less. The objective is to minimize the use of institutions, especially hospitals, and improve the quality of life for the participant and family unit, including siblings, parents and legal guardians, and others living in the residence. The pilot waiver was approved for April 1, 2009, through March 31, 2012. CMS has approved renewal of the Pediatric Palliative Care Waiver for a period of five additional years effective April 1, 2012, through December 26, 2017. Approved capacity of unduplicated recipients for this waiver is 1,800. The PPC Waiver is expected to be renewed prior to the December 26, 2017 expiration. Through the renewal, DHCS is proposing to shift the waiver program to an organized health care delivery system model. DHCS intends to implement an administrative fee to compensate waiver agencies who are responsible for performing waiver administration functions.

Stakeholder Proposals for Investment. Stakeholders have proposed the following investments and other changes related to home- and community-based services and long-term care.

Stakeholder Proposal for CCT Services in the HCBA Waiver. Disability Rights California (DRC), Justice in Aging, East Bay Innovations, and Choice in Aging request $19.1 million ($2.5 million General Fund and $16.7 federal funds) and trailer bill language to continue the California Community Transitions (CCT) program. According to DRC, the Governor's proposed budget reduces the CCT program from $19.1 million in 2017-18 to $8 million in 2018-19 due to a phase out of federal financial participation (FFP), which ends September 30, 2020 when the program expires. These organizations propose that on-going program costs be budgeted at the 2017-18 appropriated amount ($19 million), and annually thereafter. After September 30, 2020, no FFP would be available unless the federal Money Follows the Person Demonstration Program is reauthorized. General Fund would replace the loss of the FFP at the expiration of the federal program. Total program savings in 2018-19 are estimated to be

$28.2 million ($14.1 million General Fund). Continuing the program with General Fund beyond September 2020 will allow the program to continue in 2018-19 and the first quarter of 2019-20 without program reductions.

Stakeholder Proposal to Adjust Rates for MSSP Providers. The Multipurpose Senior Services Program Site Association (MSA) requests General Fund expenditure authority of $4.6 million for a rate adjustment for MSSP to prevent further erosion of individual site budgets and the resulting negative impact upon services and supports provided to the frail elderly age 65 and older. The proposed rate adjustment would increase the per client rate by 25 percent to $5,356 beginning July 1, 2018. According to the MSA, this adjustment will create a sustainable operation by making up for deficits currently being covered by host agencies, make it possible to retain and hire staff, and increase the amount of funds available for services to assist beneficiaries remain in the community.

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 DHCS to respond to the following:

1. Please provide a brief overview of the status of renewal and expansion of the Assisted Living Waiver.

Issue 9: Federally Qualified Health Center Audits (AB 1863)

Budget Issue. DHCS requests expenditure authority of $282,000 ($141,000 General Fund and $141,000 federal funds) in 2018-19 and $1.3 million ($670,000 General Fund and $669,000 federal funds) in 2019-20. If approved, these resources would support new audit workload to manage the addition of marriage and family therapists (MFTs) to the list of health care professionals whose services may be reimbursed as a separate visit at a federally qualified health center (FQHC) or rural health clinic, pursuant to the requirements of AB 1863 (Wood), Chapter 610, Statutes of 2016.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$141,000	$670,000
0890 – Federal Trust Fund	$141,000	$669,000
Total Funding Request:	**$282,000**	**$1,339,000**

Background. The Medi-Cal program reimburses FQHCs and rural health clinics using an all-inclusive per-visit rate, known as the Prospective Payment System (PPS), for the provision of health care services, including primary care, dental services, pharmacy, psychology/psychiatry, drug counseling, and occupational/physical therapy. A clinic's per-visit rate is calculated by determining its annual total allowable costs for services provided and dividing those costs by the number of eligible visits. Clinics submit cost reports and an accounting of annual visits to the department, which audits the reports and calculates the per-visit rate. Once this rate is set, it grows annually by the Medicare Economic Index, a measure of medical practice cost inflation used by the federal government, unless the rate is recalculated due to a change in the scope of services offered by the clinic.

A clinic may only receive a single per-visit reimbursement on any one day, as the rate is meant to be inclusive of all of the services provided by the clinic. A beneficiary may receive one or more services offered by a clinic on a single day, such as primary care and mental health services, but will only be reimbursed for one visit. If a clinic schedules additional services on a different day, it may receive reimbursement for a second visit at the per-visit rate. However, clinics report that the beneficiary return rate for subsequent referrals is a challenge, particularly for mental health referrals and in rural areas. Under certain circumstances, such as the provision of dental services, clinics may elect to receive reimbursement in Medi-Cal's fee-for-service delivery system, even if the clinic has already received a per-visit rate reimbursement for other services that day.

AB 1863 Allows Separate Billing for MFTs. AB 1863 includes, beginning July 1, 2017, marriage and family therapists (MFTs) as a health care professional for which an FQHC may be reimbursed for a separate clinic visit. An FQHC that currently includes the cost of MFT services in its PPS rate must apply to the department for an adjustment to the rate if it chooses to bill these services as a separate visit. An FQHC that does not provide MFT services and elects to add these services to bill as a separate visit, must submit a request to the department for a change in its scope of service.

DHCS estimates 384 clinics currently provide MFT services within their PPS rate and 50 percent of those clinics will elect to receive reimbursement for MFT services as a separate visit. As a result, the department expects to process 192 change in scope of service requests (CSOSRs). According to DHCS,

each CSOSR request requires 160 hours to perform, and the department expects 48 CSOSRs, or 25 percent, in 2018-19 and 144 CSOSRs, or 75 percent, in 2019-20. Each CSOSR will require an audit of the clinic's cost reports, including a full year of MFT costs and visits. In addition, AB 1863 requires the audits to be completed 90 days after a request is received.

DHCS requests expenditure authority of $282,000 ($141,000 General Fund and $141,000 federal funds) in 2018-19 and $1.3 million ($670,000 General Fund and $669,000 federal funds) in 2019-20, equivalent to four Auditor I positions in 2018-19 and 13 Auditor I positions in 2019-20. DHCS reports these auditors are necessary on a limited-term basis to process the expected CSOSRs within the required timelines and allow clinics to receive reimbursement for MFT services as a separate visit.

Stakeholder Proposal to Allow Separate Day Visits for Mental Health Services in a Single Day. California Health+ Advocates and the Steinberg Institute request trailer bill language to allow FQHCs and RHCs to better provide integrated behavioral health services to patients by allowing reimbursement for mental health services provided on the same day as medical services. According to California Health+ Advocates, patients qualify for Medi-Cal based on having low-income, and often come from a background of economic hardship that makes getting to a health center difficult in the first place. By requiring a 24 hour gap in services between referral from primary care and being seen by a mental health provider, many of these patients are not able to follow through and receive care, resulting in costly visits down the line. Same day visits for medical and mental health care are currently authorized in 32 state Medicaid programs, including Washington, Oregon, Nevada, and Arizona. Allowing for patients to access care in the primary care setting helps to lower the overall cost of care to the health system by lowering emergency room utilization, preventing illnesses from escalating into more serious conditions, and improving quality of life for patients.

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 DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

2. Please describe the timeline of when FQHCs and RHCs will be reimbursed for MFT services as a separate clinic visit.

Issue 10: Clinics/Community Treatment Facilities Supplemental Payments

Trailer Bill Language Proposal. DHCS proposes trailer bill language to repeal statutory requirements to establish a supplemental payment program for clinics and community treatment facilities, pursuant to AB 959 (Frommer), Chapter 162, Statutes of 2006. In addition, the trailer bill language eliminates an ongoing annual General Fund appropriation of $45,000 related to implementation of regulations for community treatment facilities, which generally remains unexpended as DHCS has implemented the required regulations.

Background. Federal Medicaid law authorizes states to claim certified public expenditures (CPEs), which are the certified actual costs of care provided by a governmental provider such as a public hospital or clinic, as the non-federal share of health care expenditures eligible to receive federal financial participation. To receive federal funding, the Centers for Medicare and Medicaid Services (CMS) requires providers to submit cost reports to accurately document the cost of providing the services.

AB 959 allows state veterans homes and public clinics to receive federal matching funds for services provided to Medi-Cal beneficiaries and claimed as CPEs. AB 959 requires an eligible veterans home or public clinic to reimburse DHCS for the cost of administering the supplemental reimbursement program as a condition of participation. The department developed an initial version of the required cost report template for providers to document CPEs, which was approved by CMS in June 2013. However, the department reports CMS has requested additional revisions to the report. Once the revised cost report is approved by CMS, the clinics will submit their completed cost reports, which will be audited by DHCS and submitted to CMS for federal matching funds. Because CMS has not yet approved the new cost report template, no cost reports have been submitted, no audits have been conducted, and no claims have been submitted to CMS.

Limited-Term Resources Approved in 2015. The 2015 Budget Act approved limited-term resources equivalent to approximately ten positions for implementation of the supplemental reimbursement program pursuant to AB 959. At the time, the department indicated it needed five Health Program Auditor III positions, two Health Program Auditor IV positions, one Health Program Audit Manager II, one Administrative Law Judge II, and equivalent of one Attorney. These positions were approved to manage workload related to the auditing of AB 959 clinic cost reports, conducting review of appealed cost report determinations, and litigating administrative appeals through the state hearing process. According to DHCS, in the absence of submitted cost reports these positions have been assisting with the development of the template, the audit program and procedures, and with provider training. DHCS also reports these positions have been assisting with audit workload for other programs. It is unclear how these positions were funded in the absence of reimbursement from AB 959 clinics, given no cost reports have been submitted.

Two-Year Extension of Resources Approved in 2017. The 2017 Budget Act approved a two-year extension of limited-term expenditure authority of $1.4 million ($697,000 federal funds and $697,000 reimbursements) to continue implementing the AB 959 program. These resources were equivalent to the ten positions in the previously request, except with two Health Program Auditor III positions replaced with one Attorney and one Legal Analyst. The department indicated it expected cost report auditing, appeal, and litigation workload once CMS approved the new cost report template.

Insufficient Provider Eligibility to Maintain Program. According to DHCS, CMS approved the revised cost report necessary to implement the program in June 2017. DHCS organized training webinars and sent out notification letters to 300 potentially eligible clinics. In response to the notification letters, 16 clinic representatives expressed interest and participated in the training webinars and only two clinics have submitted the required program eligibility documents for participation in fiscal year 2017-18, which were due July 31, 2017. In response to the limited interest from potential participants, DHCS reached out to stakeholder groups for assistance in identifying potentially eligible clinics.

DHCS reports that strict participation requirements result in many clinics not being eligible to participate. Specifically, clinics that provide services to Medi-Cal enrollees in local initiatives, managed care health plans, and geographic managed care health plans are not eligible to seek reimbursement under the program. Federally qualified health centers and rural health clinics are also ineligible to participate in the program. Given that managed care is now available in all counties and serves roughly 80 percent of the Medi-Cal population, most clinics that participate in the Medi-Cal program serve Medi-Cal managed care enrollees, making them ineligible for the PFNC Program. The limited number of eligible providers, coupled with the cost to participating clinics to reimburse DHCS for the non-federal share of administrating the program, has resulted in the program not generating interest from clinics. As a result, DHCS is proposing trailer bill language to repeal the statutory authorization for the AB 959 supplemental payment program. In addition, DHCS is proposing trailer bill to eliminate an ongoing annual General Fund appropriation of $45,000 related to implementation of regulations for community treatment facilities, which generally remains unexpended as DHCS has implemented the required regulations.

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 DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 11: Ombudsman Customer Relations Management System

Spring Finance Letter. DHCS requests expenditure authority of $500,000 ($250,000 General Fund and $250,000 federal funds) in 2018-19 and $173,000 ($86,000 General Fund and $87,000 federal funds) annually thereafter. If approved, these resources would allow DHCS to procure a new cloud-based Customer Relations Management (CRM) Software as a Service (SaaS) solution from the Office of Technology Services (OTech) and increased ongoing subscription costs to support the Office of the Ombudsman's Call Center.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$250,000	$86,000
0890 – Federal Trust Fund	$250,000	$87,000
Total Funding Request:	**$500,000**	**$173,000**

***** Resources ongoing after 2019-20.

Background. The 1995 Budget Act authorized DHCS to establish the Office of the Ombudsman within its Medi-Cal Managed Care Operations Division. The primary mission of the Ombudsman is to investigate and find resolution for Medi-Cal managed care beneficiaries' issues regarding access to medically necessary services. The Ombudsman assists beneficiaries in navigating the managed care system by facilitating discussions between beneficiaries and their Medi-Cal managed care plans from a neutral standpoint so appropriate actions are taken for beneficiaries to get the care and services they need, and by coordinating any care and services with facilities and providers.

Limited-Term Resources Approved in 2015. The 2015 Budget Act approved nine limited-term positions to allow time for the Ombudsman to properly assess the number of staff needed to properly manage the number of calls received daily. These positions had previously been redirected from other divisions to manage a significant increase in call volume due to various transitions of fee-for-service populations into managed care. In addition to these nine positions, DHCS reported it had redirected staff from Health Care Options, its managed care enrollment broker, to assist with call volume received by the Ombudsman. According to DHCS, call volume data demonstrated that the office was unable to successfully operate its call center with less than the 15 limited-term and redirected staff.

Permanent Staff and Demographic Reporting Requirements Approved in 2017. The 2017 Budget Act approved permanent extension of the nine limited-term positions and added six new positions to allow the redirected contract staff from Health Care Options to return to their original workload. In addition, the Legislature adopted trailer bill language requiring the Ombudsman to provide quarterly reporting on the calls it receives including demographic information such as race, ethnicity, age, gender, preferred language, county of residence, and health plan.

Customer Relations Management System Supports Ombudsman Workload. According to DHCS, the Ombudsman utilizes an 11 year old Customer Relations Management (CRM) system to input and track information received during beneficiary calls. The system is currently operating within a 2008 Microsoft server environment, which is no longer supported, and is not equipped to receive the demographic information required by the Legislature in the 2017 Budget Act.

DHCS requests expenditure authority of $500,000 ($250,000 General Fund and $250,000 federal funds) in 2018-19 and $173,000 ($86,000 General Fund and $87,000 federal funds) annually thereafter to procure a new cloud-based Customer Relations Management (CRM) Software as a Service (SaaS) solution from the Office of Technology Services (OTech) and increased ongoing subscription costs to support the Office of the Ombudsman's Call Center. According to DHCS, a new and more efficient CRM would allow the Ombudsman to further reduce its call wait time, currently at six minutes, and collect required demographic information from beneficiaries. The adoption of cloud-based software would also be consistent with the state's "Cloud First" policy and technology guidance described in Technology Letter 17-06 from the California Department of Technology.

The CRM contract would include a SaaS solution from OTech for approximately 100 users. Application support services would include purchasing, customizing, and installing new user licenses, providing written instructions and in-person training to DHCS users and IT staff, transitioning existing data from the 2008 Microsoft server to the new cloud-based CRM, and integrating with existing systems such as the Medi-Cal Eligibility Data System (MEDS).

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 DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 12: HIPAA Privacy Rule Compliance

Budget Issue. DHCS requests four positions and expenditure authority of $513,000 ($257,000 General Fund and $256,000 federal funds) in 2018-19 and $477,000 ($239,000 General Fund and $238,000 federal funds) annually thereafter. If approved, these resources would allow the department to manage the response to an increase in privacy and security incidents related to the handling of protected health information and personally identifiable information.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$257,000	$239,000
0890 – Federal Trust Fund	$256,000	$238,000
Total Funding Request:	**$513,000**	**$477,000**
Total Positions Requested:	**4.0**	**4.0**

***** Positions and resources ongoing after 2019-20.

Background. The Health Insurance Portability and Accountability Act (HIPAA) imposes certain administrative simplification and information security requirements on health care providers, health plans and health care clearinghouses, known as covered entities. Covered entities, among other requirements, must notify individuals and the federal government when a breach of protected health information occurs. If the breach involves fewer than 500 individuals, covered entities must notify individuals within 60 days and the federal Health and Human Services (HHS) Secretary within 60 days of the end of the calendar year in which the breach occurred. If the breach involves more than 500 individuals, covered entities must notify individuals, the HHS Secretary and the media within 60 days.

DHCS is a covered entity under HIPAA and is responsible for the security of protected health information for the nearly 14 million beneficiaries covered by Medi-Cal and other health care programs. In addition to its responsibilities under HIPAA, DHCS is required to comply with similar requirements under state law. The department's Information Protection Unit (IPU) within the Office of HIPAA Compliance is responsible for monitoring information privacy and security for Medi-Cal and coordinates the response, including required notifications, when a privacy or security breach occurs.

In addition to its breach reporting responsibilities, IPU is responsible for receiving HIPAA-related complaints from the public. IPU logs, researches, and responds to each complaint, consistent with HIPAA requirements. According to DHCS, the average monthly reports of privacy and security incidents received by IPU have grown from 23 in 2010 to 206 in 2016. The department reports as of November 2017 it has a backlog of 278 unresolved reports of privacy and security incidents.

DHCS requests three Associate Governmental Program Analysts (AGPAs) and one Research Analyst II (RA II) position to support the increased HIPAA and privacy related workload experienced by the department. The three AGPAs will allow IPU to address the backlog of unresolved reports of privacy and security incidents by conducting investigations and developing corrective action plans for reported breaches, supporting development of tools and documents for responding to privacy complaints and conducting breach investigations, and monitoring and tracking reports submitted to IPU.

The RA II would have similar responsibilities to the AGPA positions, but would also serve as a subject matter expert on state and federal regulatory requirements, determining impacts of new state and federal legislative or regulatory changes, and making recommendations to management regarding complex privacy incident reports.

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 DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 13: California Technical Assistance Program (CTAP) Extension

Budget Issue. DHCS requests a two-year, no-cost extension and reappropriation of any remaining funding from the 2014 Budget Act allocation of $3.8 million from the Major Risk Medical Insurance Fund for the California Technical Assistance Program (CTAP). If approved, the reappropriation of funding will allow DHCS to continue to implement and administer CTAP, which provides assistance to providers to adopt the use of electronic health records.

Background. In 2011, the Centers for Medicare and Medicaid Services (CMS) established the Medicare and Medicaid Electronic Health Record (EHR) Incentive Program to encourage eligible professionals, eligible hospitals, and critical access hospitals (CAHs) to adopt, implement, upgrade (AIU), and demonstrate meaningful use (MU) of certified EHR technology. DHCS established the Office of Health Information Technology (OHIT) within its Information Management Division to implement and administer the Medi-Cal EHR Incentive Program. OHIT received federal approval for a 90 percent federal match for implementation of the California Technical Assistance Program (CTAP), which provides technical assistance to providers to support the adoption of EHR.

SB 870 (Committee on Budget and Fiscal Review), Chapter 40, Statutes of 2014, authorized expenditure authority of $3.8 million from the Major Risk Medical Insurance Fund (MRMIF) to provide the ten percent non-federal share of total anticipated CTAP expenditures of $37.5 million. The funds were reappropriated in the 2015 Budget Act to allow program expenditures to continue until June 30, 2018. CTAP provides technical assistance to providers to advance adoption of EHRs, which is intended to reduce medical errors and improve quality and continuity of health care services for Medi-Cal beneficiaries. According to DHCS, federal regulatory changes regarding how providers may attest to achieving AIU and MU for EHRs delayed the ability of CTAP vendors to meet certain milestones required for federal payments. As a result, CTAP retains an unexpended fund balance of $28.4 million ($2.8 million MRMIF and $25.6 million federal funds) as it approaches the June 30, 2018, expiration of the 2015 Budget Act reappropriation.

DHCS is requesting a two-year, no-cost extension of the CTAP program to continue implementing the provider technical assistance activities to encourage the adoption of EHR. According to DHCS, the program has resulted in 6,691 of the 7,500 eligible providers becoming enrolled for assistance through CTAP. Continued use of these previously approved resources will allow these providers to meet the Medi-Cal EHR Incentive Program milestones for adopting EHR. DHCS reports CMS is supportive of the extension and will continue to support its financial commitment to the program.

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 DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 14: Medi-Cal Program Integrity Data Analytics

Spring Finance Letter and Budget Bill Language Proposal. DHCS requests expenditure authority of $9 million ($2.3 million General Fund and $6.8 million federal funds) in 2018-19 and up to $10 million ($2.5 million General Fund and $7.5 million federal funds) in 2019-20. If approved, these resources would allow DHCS to contract with a data analytics vendor, which would provide access to numerous proprietary databases, sort approximately 200 million fee-for-service reimbursement claims, and utilize statistical models and intelligent technologies to identify aberrant utilization and billing practices that are potentially fraudulent or erroneous.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$2,250,000	$2,500,000
0890 – Federal Trust Fund	$6,750,000	$7,500,000
Total Funding Request:	**$9,000,000**	**$10,000,000**

***** Proposed provisional language allows augmentation up to $1 million ($250,000 General Fund and $750,000 federal funds)

Background. The DHCS Audits and Investigations (A&I) division is responsible for financial auditing and detection of fraud and abuse among providers of health care services to Medi-Cal beneficiaries. The mission of A&I's Medi-Cal Fraud Investigations Branch is to protect the fiscal integrity of California's publicly funded health care programs. Investigations Branch fraud investigators are sworn law enforcement officers and conduct criminal, administrative and civil investigations into various types of suspected Medi-Cal program fraud. This fraud may involve beneficiaries and/or providers of programs under the purview of the Department of Health Care Services, as well as the In-Home Supportive Services program.

In 2010, Congress mandated the federal Centers for Medicare and Medicaid Services (CMS) to implement a predictive analytic modeling system to detect fraud in the Medicare program. Based upon the successful implementation of this system for Medicare, CMS is encouraging state Medicaid programs to pursue new data analytics technologies, as well. According to DHCS, the current model of recoveries for overpayment or fraud and abuse is "pay and chase", in which efforts must be made to recoup overpayments identified after the payments have already been made. Data analytics are a strategy intended to provide front-end fraud prevention and program integrity.

In 2013, after news reports identified significant numbers of fraudulent providers in the Drug Medi-Cal system, A&I engaged in a comprehensive review of all Drug Medi-Cal providers. The Investigations Branch visited 497 facilities, suspended 87 providers, and sent 98 fraud referrals to the California Department of Justice resulting in criminal charges against 48 providers and 137 affiliated individuals to date. During its review of the Drug Medi-Cal program, DHCS complemented its field work with a short-term limited scope contract for enhanced data analytics services. According to DHCS, the data analytic tool identified many of the same suspect providers in a fraction of the time spent identifying fraudulent providers via labor intensive field visits.

The 2014 Budget Act authorized limited-term expenditure authority of $5 million ($1.3 million General Fund and $3.8 million federal funds) in 2014-15, $10 million ($2.5 million General Fund and $7.5

million federal funds) in 2015-16 and 2016-17, and $5 million ($1.3 million General Fund and $3.8 million federal funds) in 2017-18 to secure a data analytics contractor to expand on the success of these activities experienced during the review of Drug Medi-Cal providers. However, due to procurement challenges, only a portion of the appropriated funds were used for a narrow pilot focused on Drug Medi-Cal and specialty mental health services claims. The investigative use of these tools occurs in a multi-disciplinary Special Investigations Unit within the Investigations Branch at A&I.

DHCS requests expenditure authority of $9 million ($2.3 million General Fund and $6.8 million federal funds) in 2018-19 and up to $10 million ($2.5 million General Fund and $7.5 million federal funds) in 2019-20. The request includes proposed budget bill language to allow the Department of Finance to augment the 2019-20 allocation by $1 million ($250,000 General Fund and $750,000 federal funds) if certain data analytics milestones are met. If approved, these resources would allow DHCS to contract for data analytics services for the entirety of DHCS programs monitored by A&I.

According to DHCS, the previous procurement challenges have been resolved and the department and the new contractor have completed most planning and implementation requirements, with an expected full implementation date of the expanded services in April 2018. The contract is expected to provide DHCS access to a cloud-based interactive dashboard that includes geo-mapping capabilities, provider and beneficiary information, and the ability to sort, group, and flag for potential fraud indicators. The service uses several public records databases to perform link analysis, which can identify warning signs for fraud based on a provider's known business associates. In addition, the use of data analytics is expected to reduce workload and improve safety for A&I investigators by identifying potential fraudulent activity prior to the need for labor intensive site visits.

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 DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 15: Health Care Reform Financial Reporting

Budget Issue. DHCS requests expenditure authority of $1.9 million ($963,000 General Fund and $963,000 federal funds) in 2018-19, 2019-20, and 2020-21. If approved, these resources would allow DHCS to continue compliance with federal reporting requirements of the Affordable Care Act.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$963,000	$963,000
0890 – Federal Trust Fund	$963,000	$963,000
Total Funding Request:	**$1,926,000**	**$1,926,000**

* Additional fiscal year resources requested: 2020-21: $1,926,000

Background. According to the federal Centers for Medicare and Medicaid Services (CMS), the form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program, has been used since January 1980 by Medicaid state agencies to report actual program benefit costs and administrative expenses. CMS uses this information to compute quarterly grants to states of federal matching funds for the state's Medicaid program costs.

According to DHCS, federal financial reporting requirements to calculate federal matching funds increased in both quantity and complexity under the Affordable Care Act (ACA). Under provisions of the ACA, California expanded its Medi-Cal program to provide health care coverage to an additional 4 million primarily childless adults up to 138 percent of the federal poverty level. The federal match for the expansion population was set at 100 percent for three years, and will phase down over time to 90 percent in calendar year 2020. The expanded population of covered Medi-Cal beneficiaries, as well as the need to reconcile claims for a new beneficiary population with a different federal match contributed to increased workload for DHCS staff to complete required financial reporting.

The 2015 Budget Act authorized 18 three-year, limited-term positions to address the increased federal financial reporting workload. The ACA requirements are expected to continue, despite the risk of significant changes proposed by Congress and the federal Administration. DHCS requests three-year extension of 18 limited-term positions approved in 2015, which expire on June 30, 2018, as follows:

- **Eight Account Trainees**
- **Six Associate Accounting Analysts**
- **One Staff Services Analyst**
- **One Accounting Officer**
- **One Staff Services Manager I**
- **One Accounting Administrator I**

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 DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 16: Orange County Office Consolidation

Budget Issue. DHCS requests expenditure authority of $562,000 ($281,000 General Fund and $281,000 federal funds) in 2018-19 and $423,000 ($212,000 General Fund and $211,000 federal funds) annually thereafter. If approved, these resources would allow DHCS to relocate and consolidate program staff from two buildings in Orange County into a single location.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$281,000	$212,000
0890 – Federal Trust Fund	$281,000	$211,000
Total Funding Request:	**$562,000**	**$423,000**

* Resources ongoing after 2019-20.

Background. DHCS maintains program staff in two locations in Orange County, with 67 staff located in a building in Santa Ana and 89 staff in a building in the city of Orange. According to DHCS, the Santa Ana State Building has been the subject of numerous employee concerns including leaking windows, floors with uneven surfaces that are not compliant with the Americans with Disabilities Act (ADA), and walls that are not structurally sound. The Department of General Services (DGS) has identified more than $16 million of required repairs for the building.

DHCS requests expenditure authority of $562,000 ($281,000 General Fund and $281,000 federal funds) in 2018-19 and $423,000 ($212,000 General Fund and $211,000 federal funds) annually thereafter to relocate staff from the Santa Ana State Building, as well as from the building in the city of Orange, to a new location. Because the Orange location is not able to accommodate the additional 67 staff from Santa Ana, the department is proposing to consolidate staff from both locations in a new building. DGS is currently performing a site search for the new location and DHCS estimates the annual rent will increase by $407,000 per year, growing by four percent annually. The request for 2018-19 also includes $155,000 in one-time relocation costs.

Occupied Location	2016-17	2017-18	2018-19	2019-20	2020-21
Orange, CA (existing)	$191,000	$195,000	$49,000	$-	$-
Santa Ana, CA (existing)	$417,000	$431,000	$108,000	$-	$-
New Location (pending)	$-	$-	$775,000	$1,033,000	$1,074,000
One-time Fees					
Moving Contracts	$-	$-	$45,000	$-	$-
Telecommunications	$-	$-	$65,000	$-	$-
Electrical Contracts	$-	$-	$15,000	$-	$-
Unforeseen Change Orders	$-	$-	$30,000	$-	$-
TOTAL	**$608,000**	**$626,000**	**$1,087,000**	**$1,033,000**	**$1,074,000**

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 DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 17: Family Health Estimate Overview

Budget Issue. The November 2017 Family Health Local Assistance Estimate includes $233 million ($182.2 million General Fund, $4.5 million federal funds, and $46.3 million special funds and reimbursements) for expenditures in 2017-18, and $257.7 million ($210.7 million General Fund, $4.5 million federal funds, and $42.5 million special funds and reimbursements) for expenditures in 2018-19.

Family Health Local Assistance Funding Summary			
Fiscal Year:	**2017-18**	**2018-19**	**BY to CY**
California Children's Services (CCS)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$77,478,000	$83,372,000	$5,894,000
Federal Funds	$-	$-	$-
Special Funds/Reimbursements	$5,453,000	$5,453,000	$-
County Funds [non-add]	[$82,771,000]	[$88,128,000]	[$5,357,000]
Total CCS Expenditures	**$82,931,000**	**$88,825,000**	**$5,894,000**
Child Health and Disability Prevention (CHDP)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$3,000	$3,000	$-
Total CHDP Expenditures	**$3,000**	**$3,000**	**$-**
Genetically Handicapped Persons Program (GHPP)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$98,718,000	$118,327,000	$19,609,000
Special Funds and Reimbursements	$18,435,000	$18,435,000	$-
Total GHPP Expenditures	**$117,153,000**	**$132,850,000**	**$19,609,000**
Every Woman Counts Program (EWC)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$6,000,000	$8,962,000	$2,962,000
Federal Funds	$4,509,000	$4,509,000	$-
Special Funds and Reimbursements	$22,427,000	$22,504,000	$77,000
Total EWC Expenditures	**$32,936,000**	**$35,975,000**	**$3,039,000**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$182,199,000	$210,664,000	$25,580,000
Federal Funds	$4,509,000	$4,509,000	$-
Special Funds and Reimbursements	$46,315,000	$42,480,000	($3,835,000)
County Funds [non-add]	[$82,771,000]	[$88,128,000]	[$5,357,000]
Total Family Health Expenditures	**$233,023,000**	**$257,653,000**	**$24,630,000**

Background. The Family Health Estimate forecasts the current and budget year local assistance expenditures for four state-only funded programs that provide services for low-income children and adults with special health care needs who do not qualify for enrollment in the Medi-Cal program.

The programs included in the Family Health Estimate are:

- **California Children's Services (CCS)**: The CCS program, established in 1927, is one of the oldest public health care programs in the nation and is administered in partnership with county health departments. The CCS state-only program provides health care services to children up to age 21 who have a CCS-eligible condition such as: cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer or traumatic injury; and either do not qualify for full-scope Medi-Cal or whose families cannot afford the catastrophic health care costs for the child's care.

  Caseload Estimate (Medi-Cal): The budget estimates Medi-Cal CCS caseload of 175,322 (152,993 Medi-Cal and 22,329 OTLICP) in 2017-18, a decrease of 765 or 0.4 percent, compared to the 2017 Budget Act. The budget estimates Medi-Cal CCS caseload of 178,062 (155,733 Medi-Cal and 22,329 OTLICP) in 2018-19, an increase of 2,740 or 1.6 percent, compared to the revised 2017-18 estimate.

  Caseload Estimate (State-Only): The budget estimates state-only CCS caseload of 15,621 in 2017-18, a decrease of 448 or 2.8 percent, compared to the 2017 Budget Act. The budget estimates state-only CCS caseload of 15,621 in 2018-19, unchanged compared to the revised 2017-18 estimate.
- **Child Health and Disability Prevention (CHDP):** The CHDP program, established in 1973, provides complete health assessments and immunizations for children at or under 18 years of age whose family income is at or below 200 percent of the federal poverty level and who are not enrolled in Medi-Cal. This program also administers the Early and Periodic Screening, Diagnosis, and Treatment benefit for fee-for-service Medi-Cal beneficiaries.

  Caseload Estimate: The budget estimates state-only CHDP caseload of 36 in 2017-18, an increase of 36 compared to the 2017 Budget Act estimate of zero caseload. The budget estimates state-only CHDP caseload of 36 in 2018-19, unchanged compared to the revised 2017-18 estimate. According to DHCS, recent significant reductions in CHDP caseload are primarily due to eligibility of all children, regardless of immigration status, for full-scope Medi-Cal pursuant to SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015.
- **Genetically Handicapped Persons Program (GHPP):** The GHPP program, established in 1975, provides medically necessary services and administrative case management for individuals age 21 and over with a GHPP-eligible condition such as cystic fibrosis, hemophilia, sickle cell, Huntington's, or metabolic diseases. The GHPP state-only program is for those individuals who do not qualify for full-scope Medi-Cal.

  Caseload Estimate (Medi-Cal): The budget estimates Medi-Cal GHPP caseload of 1,026 in 2017-18, an increase of 10 or 0.1 percent, compared to the 2017 Budget Act. The budget estimates Medi-Cal GHPP caseload of 1,046 in 2018-19, an increase of 20 or 0.2 percent, compared to the revised 2017-18 estimate.

  Caseload Estimate (State-Only): The budget estimates state-only GHPP caseload of 655 in 2017-18, a decrease of 296 or 31.1 percent, compared to the 2017 Budget Act. The budget estimates state-only GHPP caseload of 659 in 2018-19, an increase of 4 or 0.6 percent, compared to the revised 2017-18 estimate.

- **Every Woman Counts (EWC) Program:** The EWC program provides free breast and cervical cancer screening and diagnostic services to uninsured and underinsured women who do not qualify for Medi-Cal. Women diagnosed with breast or cervical cancer may be referred to the Breast and Cervical Cancer Treatment Program (BCCTP).
  Caseload Estimate: The budget estimates EWC caseload of 27,000 in 2017-18, an increase of 2,500 or 10.2 percent, compared to the 2017 Budget Act. The budget estimates EWC caseload of 27,000 in 2018-19, unchanged compared to the revised 2017-18 estimate.

Whole Child Model Implementation. SB 586 (Hernandez), Chapter 625, Statutes of 2016, authorizes DHCS to establish the Whole Child Model program in designated County Organized Health System (COHS) or Regional Health Authority counties. The program would transition services currently provided to CCS beneficiaries on a fee-for-service basis into a Medi-Cal managed care plan contract. After stakeholder discussions, DHCS has proposed implementation of the Whole Child Model program in 21 counties with 5 health plans to improve care coordination for primary, specialty, and behavioral health services for CCS and non-CCS conditions.

The 21 counties and 5 health plans that will participate in the Whole Child Model are as follows:

- Participating Counties: San Luis Obispo, Santa Barbara, Merced, Monterey, Santa Cruz, San Mateo, Orange, Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Siskiyou, Shasta, Solano, Sonoma, Trinity, and Yolo
- Participating Health Plans: CenCal Health, Central California Alliance for Health, Health Plan of San Mateo, CalOptima, Partnership Health Plan of California

The budget assumes the Whole Child Model will begin implementation in five COHS counties beginning July 1, 2018, with the remaining counties implemented beginning July 1, 2019. The budget includes $45.4 million ($21.3 million General Fund and $24.1 million federal funds) for implementation of the Whole Child Model.

Stakeholder Proposal – Elimination of Treatment Limitations for State-Only BCCTP. Susan G. Komen for the Cure requests General Fund expenditure authority of $8.4 million and trailer bill language to eliminate treatment limitations in the Breast and Cervical Cancer Treatment Program (BCCTP). According to Susan G. Komen for the Cure, the state-funded BCCTP's period of coverage is limited to 18 months for breast cancer and 24 months for cervical cancer. There are no similar treatment limitations for BCCTP coverage for Medi-Cal beneficiaries. This discrepancy causes gaps in service and leaves women that are stuck in the middle untreated, since women who qualify for state-only BCCTP may not qualify for BCCTP in Medi-Cal.

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 DHCS to respond to the following:

1. Please describe the status of implementation of the Whole Child Model program.

Issue 18: Additional Proposals for Investment

Stakeholder Proposals for Investment. Stakeholders have proposed the following additional investments in Medi-Cal and other DHCS programs.

Long-Term Services and Supports (LTSS) Data Collection in California Health Interview Survey. The California Collaborative for Long-Term Services and Supports (CCLTSS) requests General Fund expenditure authority of $3.5 million to address the need for data that assesses the use of and demand for long-term services and supports (LTSS) in California. Specifically, CCLTSS proposes to add LTSS screening questions and a 15 minute follow-on survey to the 2019-20 and 2023-24 cycles of the California Health Interview Survey (CHIS), conduct in-person, in-depth qualitative interviews with 100 Californians with LTSS needs in 2021, and support the continuation of a module of caregiver questions in CHIS during the 2023-24 cycle.

Children's Data Collection in California Health Interview Survey. The California Children's Health Coverage Coalition requests General Fund expenditure authority of $750,000 to implement a pilot expansion for the California Health Interview Survey (CHIS) to strengthen data collection efforts of California's children and youth. According to the Coalition, CHIS is experimenting with alternative modes of data collection, including a Spring 2018 test with an online survey. The use of an online response is expected to yield more child and teen interviews due to the fact that younger households tend to be more likely to respond online, whereas older persons tend to respond more by telephone. Due to funding limitations, the test will only be conducted in three California counties (Los Angeles, Tulare, and Santa Clara), and the online questionnaire will only be available in English, leaving speakers of other languages to respond by telephone. This proposal seeks to conduct a second test in the fall of 2018 that would: 1) explore methods to increase the data obtained for children age 0-11 by experimentally reversing the questionnaire sequence to ask questions first about the selected child followed by questions about the selected adult; 2) refine methods for obtaining interviews from adolescents age 12-17 through additional enhancements to the text, email, and paper mail materials that request their participation; 3) conduct the test among a sample of households in all California counties to measure the impact of such a design change across the state and inform future decisions about the need for customized approaches in different parts of the state; and 4) add a Spanish version of the online CHIS questionnaire, which will increase the data we collect about teens and children in Spanish-speaking households.

Collect AANHPI Data in Eligibility Systems. The Southeast Asia Resource Action Center (SEARAC) and the California Pan-Ethnic Health Network (CPEHN) request $1.4 million for DHCS to expand disaggregated demographic data collection of Asian-American, Native Hawaiian, and Pacific Islander (AANHPI) ethnicities for enrollees in Medi-Cal and other health programs through SAWS, CalHEERs and MEDS.

Enhanced Medi-Cal Funding for Health Information Exchanges. The California Medical Association (CMA) requests General Fund expenditure authority of $5 million for DHCS to provide a state match to draw down additional Health Information Technology for Economic and Clinical Health (HITECH) funds. These funds, for which the federal government provides a 90 percent match, would provide the state with a total of $50 million to assist Health Information Exchanges (HIEs) with onboarding new providers and connecting them to the HIE so that they can successfully use its services.

Taking advantage of this enhanced federal matching rate will allow HIEs to significantly expand, bringing thousands of new providers into data exchange networks.

Extension of Minor Consent. The Minor Consent Medi-Cal Advocacy Group, an alliance of service providers, advocates, and public health professionals, requests changes in the Minor Consent Medi-Cal program to increase access to outpatient substance abuse treatment and PrEP and other minor consent services. Specifically, the group requests trailer bill language to extend Minor Consent Services for 12-months, allowing youth to engage in treatment with providers over a more significant period of time, and without the additional obstacle of seeking recertification for services each month.

Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends these proposals for investment be held open pending further discussions on their fiscal impact and pending release of updates to the state's General Fund condition at the May Revision.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Birth Certificate Processing Increase for Real ID Compliance

Budget Issue. DPH requests expenditure authority of $796,000 from the Health Statistics Special Fund in 2018-19, 2019-20, and 2020-21. If approved, these resources would allow DPH to meet the demand for an increased number of birth certificate requests due to requirements of the federal Real ID Act. DPH also requests budget bill language to authorize up to $1.59 million of additional expenditure authority from the Health Statistics Special Fund if necessary to support additional workload.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0099 – Health Statistics Special Fund	$796,000	$796,000
Total Funding Request:	**$796,000**	**$796,000**

* Additional fiscal year resources requested: 2020-21: $796,000

Background. In 2005, Congress passed the Real ID Act, establishing minimum security standards for state-issued driver's licenses and identification cards. Additionally, the Act prohibits federal agencies from accepting non-compliant licenses and identification cards for official purposes, including domestic air travel. In 2013, the Department of Homeland Security announced a phased enforcement plan for the Act. Starting October 1, 2020, every air traveler will need a Real ID compliant license, or another acceptable form of identification to fly domestically.

To meet the requirements of the Act, Californians must have an updated, federally compliant identification card to board an aircraft, access federal facilities, and nuclear power plants. Since July 2016, the California Department of Motor Vehicles (DMV) has required proof of legal presence in the United States for all new, federally compliant driver's license and identification applications in accordance with federal law. To obtain a federally compliant driver's license or identification, applicants will need to provide documents that support they are legally present in the United States, primarily certified copies of birth certificates.

DPH estimates that, assuming 10 percent of DMV driver's license and identification applicants will need a birth certificate and six percent will make birth certificate requests to DPH, the department will process approximately 37,000 additional requests annually in addition to its existing workload. DPH requests expenditure authority of $796,000 from the Health Statistics Special Fund in 2018-19, 2019-20, and 2020-21 to meet the demand for processing birth certificate requests. The request for budget bill language will allow DPH to increase its expenditure authority if demand increases beyond its current estimate. DPH indicates it will redirect four positions for this workload.

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 DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 2: Center for Healthcare Quality

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

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

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

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

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

Los Angeles County Investigation, Audit (2014) – In 2014, an investigative report published in the *Los Angeles Daily News* discovered the Los Angeles County Department of Public Health was administratively closing health care facility complaints of abuse and neglect that were submitted anonymously without completing an investigation. In response, the county's Board of Supervisors ordered an audit of the county department's Health Facilities Inspection Division (HFID). This review

found more than 30 percent of complaint investigations had been open for more than two years, there was no central state or county monitoring of complaint investigation completion or timeliness, and HFID could neither identify the number of staff devoted to investigations nor the number of staff it would need to complete investigations timely.

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

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

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

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

2015 Budget Act – The 2015 Budget Act included*:*

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

determination. Any citation issued as a result of the complaint investigation must be issued and served within thirty days of the completion of the complaint investigation.

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

2016 Budget Act – The 2016 Budget Act included*:*

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

2017 Budget Act – The 2017 Budget Act included*:*

- $2 million from the Internal Departmental Quality Improvement Account for IT assessment, performance dashboards, implementation of tablet use, automation of caregiver applications, outcomes and effectiveness evaluation, quality improvement facilitation, onboarding and

retention contract for Health Facilities Evaluator Nurses (HFEN), and contracts to continue the redesign of the CAU and HFCIS.

- $1.1 million to augment the Los Angeles County contract to account for salary increases approved by the Los Angeles County Board of Supervisors.
- Implementation of requirements that free-standing skilled nursing facilities have a minimum number of direct care services hours of 3.5 per patient day, including a minimum of 2.4 hours per patient day for certified nurse assistants, beginning July 1, 2018.

Vacancy Rates: Center for Health Care Quality and HFEN Classification. According to DPH's Vacancy Reports Metrics Dashboard, the Center for Health Care Quality, which oversees the L&C Division, had a 13.11 percent vacancy rate for all positions reported as of the first quarter of 2017-18, compared to 15.98 percent in the first quarter of 2016-17. The vacancy rate for the Health Facilities Evaluator Nurse (HFEN) classification, the primary classification conducting health facility oversight and investigation, was 11.61 percent in the first quarter of 2017-18, compared to 19.52 percent in the first quarter of 2016-17.

DPH reports it hired two contractors to help remedy the high vacancy rates for HFENs in the L&C program. An onboarding and retention contractor assists hiring candidates to navigate the state civil service process and helps improve retention of hired staff. In addition, a recruitment contractor seeks candidates for these positions at job fairs, conducts outreach to registered nurses in California, develops marketing materials and attempts to meet recruitment targets. Funding for these contracts was approved in the 2015 Budget Act from the Internal Departmental Quality Improvement Account. These activities represent two of the recommendations from the Hubbert assessment. According to DPH, the work of these two contractors was the primary driver of the L&C program's significant reduction in its HFEN vacancy rate since 2016-17.

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

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

- Providing written feedback to HFID management regarding identified concerns and requiring corrective action plans when appropriate.

Persistent Complaint Investigation Backlog. Beginning in 2014, L&C has produced quarterly reports on the number, investigation, completion and other details about health care facility complaints and ERIs. According to the program's Complaints and Entity-Reported Incidents (ERI) Dashboard, since the first quarter of 2014-15, the number of open complaints has grown from 4,303 to 5,541 in the first quarter of 2017-18, while the number of ERIs has grown from 7,427 to 10,962 during the same period. The backlog of open complaints and ERIs continues to grow despite the approval of significant staff resources for the division and contract resources for the Los Angeles County contract. DPH reports that it is attempting to utilize enhanced data tools, such as dashboards and metrics in its district offices, to better manage its complaint and ERI investigation workload.

2017 Budget Act Requires Higher Direct Care Service Hours for Skilled Nursing Facilities. SB 97 (Committee on Budget and Fiscal Review), Chapter 52, Statutes of 2017, requires effective July 1, 2018, all freestanding skilled nursing facilities (SNFs) to increase staffing from the current 3.2 to 3.5 direct care service hours with a minimum of 2.4 of those hours being performed by certified nurse assistants (CNAs). The previous standard of 3.2 nursing hours per patient day was established in January 2000 by AB 1107 (Cedillo), Chapter 146, Statutes of 1999. According to the Service Employees International Union (SEIU), the sponsors of the budget proposal that led to SB 97, increased direct care service hours lead to improved patient quality.

In addition to the new direct care service hour requirements, SB 97 requires DPH to develop a waiver process for SNFs seeking a waiver of the 3.5 overall direct care service hour requirement and/or the 2.4 CNA requirement due to a workforce shortage. SB 97 also requires DPH to develop a waiver process for SNFs seeking a waiver of the 2.4 CNA requirement to address patient acuity.

Workforce Shortage Waiver Requirements

According to DPH's draft workforce shortage waiver requirements, SNFs applying for a workforce shortage waiver would be required to submit evidence to support the workforce shortage, including:

1) Office of Statewide Health Planning and Development data identifying registered nurse (RN) shortages in the county where the facility is located.
2) Department of Labor reports with CNA, RN, and/or licensed vocational nurse (LVN) salary ranges in the county where the facility is located compared to the facility's salary ranges for CNAs, RNs, and LVNs.

SNFs would also be required to submit evidence of efforts to address the workforce shortage, including:

1) A detailed description of the facility's recruitment plan, including how the facility has implemented the plan and for how long
2) When, where, and how long the facility advertised the vacancies
3) The length of the vacancy or vacancies
4) How many applicants applied to the position(s)
5) How many applicants the facility interviewed and hired
6) The salary for the position

7) Other recruitment and retention activities
8) Detail of the use of registry services, if available, to fill vacant positions

SNFs would also be required to provide detailed plans that specify actions the facility will take to resolve its workforce shortage, how the facility will implement those actions, time frames for the action plan, and how the facility will meet residents' needs and ensure quality care despite the workforce shortage.

In its evaluation of workforce shortage waiver applications, DPH would consider whether the facility:

1) Complies with state and federal regulations
2) Had its license suspended or revoked
3) Provided complete and accurate documentation of the workforce shortage
4) Demonstrated recruitment efforts to address the workforce shortage
5) Is located in a rural area
6) Provided an acceptable plan to achieve compliance with the 3.5 and/or 2.4 staffing standard based on the particular situation of the facility
7) Effectively implemented the action plan to comply with the 3.5 and/or 2.4 staffing standards.

Patient Acuity Waiver Requirements

According to DPH, SNFs will submit waiver requests using the program flexibility procedures specified in Title 22 of the California Code of Regulations section 72213. DPH indicates it will consider resident quality of care and the needs and acuity level of residents at the facility during the program flexibility request review.

Stakeholder Concerns Regarding Waivers and Implementation of New Standards. A variety of stakeholders have expressed concerns about implementation of the new standards and the guidance regarding the ability for SNFs to receive a waiver for workforce shortages or patient acuity. The California Association of Health Facilities (CAHF) has expressed concerns about the department's evaluation of past compliance to determine eligibility for a workforce waiver. CAHF believes using past compliance as a denial criteria for waiver eligibility is inconsistent with the mandate of SB 97.

California Advocates for Nursing Home Reform (CANHR) has expressed its opposition to all of the waiver provisions included in SB 97. According to CANHR, while increasing the minimum hours of nursing care per resident day from 3.2 to 3.5 hours for freestanding skilled nursing facilities, SB 97 made other changes that directly undermine this increase. SB 97 retains an existing waiver procedure, added another broad system to waive the new staffing requirements, permitted nursing homes to count the hours of nursing assistant trainees and repealed a provision requiring separate licensed nurse to resident ratios. These harmful changes were made behind the scenes without any awareness or involvement by consumers or their advocates.

Stakeholder Proposal to Require DPH to Post Data on Applications Metrics. The California Hospital Association (CHA) requests trailer bill language requiring DPH to publicly post information on the Centralized Application Unit's (CAU) workload volume and timeliness of processing health facility applications. According to CHA, hospitals continue to experience long wait times for CAU to complete and approve applications for licensure, change of ownership, change of location, change of name,

change of services, and reports of changes. Currently it takes eight to ten months for an application to be assigned to a CAU analyst. The requested language is similar to uncodified trailer bill language approved in SB 857 (Committee on Budget and Fiscal Review), Chapter 31, Statutes of 2014.

Stakeholder Proposal to Improve Integrity of Inspections. The California Nurses Association (CNA) requests trailer bill language to allow employees of entities inspected by DPH to have the right to discuss possible regulatory violations or patient safety concerns with an inspector privately during the course of an investigation or inspection by DPH. These provisions are similar to Labor Code sections regarding inspections by the California Division of Occupational Safety and Health (Cal-OSHA).

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 DPH to respond to the following:

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

2. How many waiver submissions does the department expect for the workload shortage waivers and the patient acuity waivers? How long will the department take to process these waivers?

3. What is the maximum amount of time a SNF may waive the direct care staffing requirements under either the workforce shortage waiver or the patient acuity waiver?

4. Please describe the department's assessment of whether the workforce is currently available to support the new CNA requirements. How is the department helping to facilitate training and recruitment to assist facilities to comply with the new requirements?

5. How will the department measure improvements in SNF quality of care related to the increased direct care service hours?

Issue 3: Licensing & Certification - Los Angeles County Contract Extension

Budget Issue and Trailer Bill Language Proposal. DPH requests expenditure authority of $1.9 million from the Licensing and Certification Program Fund in 2018-19. If approved, these resources will allow DPH to augment the Los Angeles County contract to fund a one-year extension to account for adjustments to the indirect cost rate, employee benefits rate, personnel costs, and lease costs. DPH also requests trailer bill language to authorize a supplemental license fee on facilities located in Los Angeles County to offset additional costs necessary to regulate entities in the county.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20**
3098 – Licensing and Certification Program Fund	$1,900,000	$-
Total Funding Request:	**$1,900,000**	**$-**

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

In July 2015, DPH and LA County renewed the contract for a three-year term, ending June 30, 2018, for an annual budget of $41.8 million to fund 224 positions. The 2016 Budget Act authorized an additional $2.1 million in expenditure authority to fully fund LA County to conduct tier 1 and tier 2 federal workload, long-term care complaints and entity-reported incidents, and pending complaints and entity-reported incidents. The 2017 Budget Act approved an additional $1.1 million for general salary increases approved by the LA County Board of Supervisors for employees covered by the LA County contract after the negotiation of the contract renewal.

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

DPH proposes to extend the current contract for an additional year until June 30, 2019. For the contract beginning July 1, 2019, the department and LA County are negotiating the terms of a revised contract that emphasizes pay for performance with defined quality, quantity, and service metrics. According to DPH, the proposal includes $1.9 million to fund changes to the LA County employee benefit rates, indirect cost rate, personnel costs, and lease costs, which will increase the total annual budget of the contract to $47.7 million.

DPH is also requesting trailer bill language to assess a supplemental license fee on facilities located in LA County to offset additional costs necessary to regulate these entities in LA County. The proposed supplemental fee will prevent the need to increase license fees on health care facilities statewide to absorb these increasing contract costs. The supplemental fee would allow health care facilities in LA

County to receive services comparable to other health care facilities statewide and ensure that facilities pay license fees that are more commensurate with their regulatory costs. According to DPH, the imposition of the supplemental fee is meant to allow regulatory activities in LA County to be fully funded by fee revenue paid by LA County facilities, rather than subsidized by fees paid in other parts of the state.

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 DPH to respond to the following:

1. Please provide a brief overview of this proposal.

2. Please describe how the department will determine the correct amount of the supplemental fee to match expenditures in LA County?

3. What performance metrics does the department intend to include in the new LA County contract?

4. Does the department have any concerns regarding negative financial impacts on facilities in LA County due to the resulting significant increase in total fees paid by these facilities over recent years?

Issue 4: Licensing & Certification - Health Care Licensing and Oversight

Spring Finance Letter. DPH requests 22 positions and expenditure authority of $2.7 million ($2.4 million Licensing and Certification Program Fund and $294,000 Internal Departmental Quality Improvement Account) annually. If approved, these resources would allow DPH to improve core operations and effectiveness, foster quality improvement projects, and address workforce needs, particularly in the licensing of certified nurse assistants.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0942 – Internal Dept. Quality Improvement Account	$294,000	$294,000
3098 – Licensing and Certification Program Fund	$2,373,000	$2,373,000
Total Funding Request:	**$2,669,000**	**$2,669,000**
Total Positions Requested:	**22.0**	**22.0**

* Positions and resources ongoing after 2019-20.

Background. DPH's Center for Healthcare Quality, Licensing and Certification (L&C) Program is responsible for three significant functions that ensure health care facilities and professionals can provide safe, effective, and quality health care for all Californians. The three functions include the following.

1) Regulatory oversight of licensed health care facilities including periodic inspections and complaint investigations of health care facilities, ensuring compliance with federal and state laws and regulations and issuing state citations and administrative penalties for facilities out of compliance.
2) Certification of certified nurse assistants (CNAs), home health aides (HHAs), certified hemodialysis technicians (CHTs), and the licensing of nursing home administrators (NHAs). L&C also oversees the approval of the CNA, HHA, and CHT training programs and continuing education, and the criminal record clearance of these four health care professional types.
3) Quality of care and patient safety through the prevention of infections in California health care facilities.

According to DPH, in addition to ongoing quality improvement needs, recent legislation has created new and increased workload for L&C. Effective July 1, 2018, all freestanding skilled nursing facilities (SNFs), excluding distinct parts of general acute care hospitals, state-owned hospitals, or developmental centers, are required to increase staffing from the current 3.2 nursing hours per patient day requirement to 3.5 direct care service hours per patient day, with CNAs performing a minimum of 2.4 hours per patient day. This requirement will create a demand for more CNAs to enable facilities to meet the staffing requirements and a commensurate demand for more CNA training programs. DPH anticipates an increase in the number of applications for approval of new training programs as well as applications for individuals seeking CNA certification.

Additionally, the new staffing standard requires DPH to develop two waiver processes. One waiver is for SNFs seeking to waive the 3.5 direct care service hours requirement and/or the 2.4 CNA hours requirement due to a workforce shortage. A facility with an approved workforce shortage waiver may not staff below 3.2 direct care hours. The other waiver is for SNFs to staff at lower levels of CNAs while

maintaining the overall 3.5 direct care service hours requirement based on the resident acuity. A SNF seeking either waiver must submit a waiver application to CDPH for review, and approval or denial.

DPH requests 22 positions and expenditure authority of $2.7 million ($2.4 million Licensing and Certification Program Fund and $294,000 Internal Departmental Quality Improvement Account) annually to improve core operations and effectiveness, foster quality improvement projects, and address workforce needs, particularly in the licensing of certified nurse assistants. These positions and resources would be allocated as follows:

Research and Evaluation Section
One Health Program Manager II (HPM II)
Two Research Analyst II (RA II)
One Research Program Specialist II (RPS II)
One Information Technology Specialist II

According to DPH, these positions would oversee data quality and management and provide the necessary infrastructure to bring the various amounts and sources of L&C data into a single system and meaningful structure to better inform, streamline, and coordinate the work of the various L&C activities.

Quality Improvement Project Management and Oversight
One HPM II
One RPS II

According to DPH these positions would fully implement in all the field offices the continuous quality improvement projects L&C has conducted in the past several years and will conduct in future years. Previously contracted services and expertise will be brought in-house for more cost-effective, continuous, coordinated, and outcomes-focused quality improvement efforts. The RPS II will evaluate and develop policies and procedures for center-wide (and district offices) consistent documentation and standardized processes for all CHCQ work products.

Professional Certification Branch

- Aide and Technician Certification Section (ATCS) - **Four Program Technician II (PT II) positions** will address unmet call volume demand and provide improved customer service to the public. ATCS certifies CNAs, HHAs and CHTs, and maintains a registry for these categories of health care workers.
- Training Program Review Unit - **Two Associate Governmental Program Analyst (AGPA)** and **two PT II positions** to manage the expected increase in the number of training programs for CNAs it will have to review and approve each year to meet the demand of CNAs needed to meet the new requirements.
- Criminal Background Section - **Four AGPAs** will improve the processing times of criminal record reviews in order to complete the certification process for CNA and other licensing applicants.

3.5 and 2.4 Staffing Waiver Review
One HFEN
One AGPA
One PT II

According to DPH, these positions would support the timely review of workforce shortage and resident acuity waivers facilities may submit to the department pursuant to Health and Safety Code section 1276.65.

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 DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 5: Use of Federal Standards for State Regulation

Trailer Bill Language Proposal. DPH requests trailer bill language to allow use of federal certification standards for state licensure for certain facilities. The language would also allow use of federal standards during the rulemaking process for regulations related to intermediate care facilities for individuals with developmental disabilities (ICF-DDs), expected to be released in 2018.

Background. According to DPH, until January 2018, California statute authorized the department to use federal regulatory standards as the state licensing standards for chronic dialysis clinics (ESRD), rehabilitation clinics (CORF), and ambulatory surgical clinics (ASC). Prior to 2018, DPH was directed to conduct a study to determine whether the federal regulations adequately protect the health and safety of patients. DPH contracted with the Institute for Population Health Improvement (IPHI) at UC Davis to conduct the study. In December 2015, UC Davis published the report, titled: "A Review of Regulatory Standards, Quality of Care Concerns, and Oversight of Ambulatory Surgery Clinics, Comprehensive Outpatient Rehabilitation Facilities, and End-Stage Renal Disease Facilities". The study concludes that federal regulations are sufficient for regulating these specialty clinics and that expanded state-specific regulations would be of uncertain, marginal value. In addition, ESRD, CORF, and ASC clinics must currently meet federal certification standards in order to participate in Medicare and Medicaid.

The law also authorized DPH to use federal certification standards for the regulation of intermediate care facilities for individuals with developmental disabilities (ICF-DD) nursing and ICF-DD continuous nursing until January 1, 2018. ICF-DD nursing and ICF-DD continuous nursing facilities were not included as part of the study because DPH is currently developing regulations for these categories of ICF-DDs.

DPH requests trailer bill to reinstate the statutory authority to use federal certification standards for ESRD, CORF, and ASCs, as well as to use federal standards during the rulemaking process for ICF-DDs. The statutory authority expired on January 1, 2018.

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 DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 6: AIDS Drug Assistance Program (ADAP)

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

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

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

1. Medication Program – This program pays prescription costs for medications on the ADAP formulary for the following coverage groups (either the full cost of medications or deductibles and co-pays):
   a. *ADAP-only clients* – These clients are people living with HIV who are uninsured. ADAP pays 100 percent of the cost of prescription medications on the ADAP formulary
   b. *Medi-Cal Share of Cost clients* – These clients are people living with HIV enrolled in Medi-Cal, but who have a share of cost. ADAP pays 100 percent of the cost of prescription medications on the ADAP formulary up to the client's Medi-Cal share of cost amount
   c. *Private insurance clients* – These clients are people living with HIV enrolled in private health insurance. ADAP pays prescription drug deductibles and co-pays for these clients
   d. *Medicare Part D clients* – These clients are people living with HIV enrolled in Medicare and who have purchased Medicare Part D. ADAP pays the Medicare Part D drug deductibles and copays for these clients
2. Office of AIDS-Health Insurance Premium Payment (OA-HIPP) Program – This program pays for private health insurance premiums or Medicare Part D premiums for clients co-enrolled in the ADAP medication program. ADAP pays health insurance premiums for eligible clients with one of three different types of health insurance:
   a. *Non-Covered California private insurance* (OA-HIPP/non-Covered California)
   b. *Private insurance through Covered California* (OA-HIPP/Covered California)
   c. *Medicare Part D* (OA/Medicare Part D)
3. Pre-Exposure Prophylaxis (PrEP) Assistance Program – This program, which is scheduled to begin in early 2018, covers medication costs and out-of-pocket costs for PrEP for individuals at risk for, but not infected with HIV. PrEP is a daily medication taken by HIV-negative individuals that significantly reduces the risk of HIV infection.

ADAP is funded by federal funds and the ADAP Rebate Fund (Fund 3080). The federal government began funding state programs to assist people living with HIV to purchase antiretroviral medications in 1987. Since 1990 with the passage of the Ryan White Comprehensive AIDS Resources Emergency Act,

now known as the Ryan White Program, the federal Health Resources and Services Administration (HRSA) provides funding to states for ADAP programs. In addition to federal funds, ADAP receives significant funding from mandatory and voluntary manufacturer rebates for ADAP drug expenditures.

ADAP Local Assistance Estimate. The November 2017 ADAP Local Assistance Estimate reflects revised 2017-18 expenditures of $398.1 million, which is an increase of $2.4 million or 0.6 percent compared to the 2017 Budget Act. According to DPH, this increase is primarily due to a one-time need for system enhancements to the program's Insurance Benefits Manager and Medical Benefits Manager (IBM/MBM) platform to implement the PrEP Assistance Program and accommodate expansion of OA-HIPP benefits to individuals with employer based insurance and Medicare Part D. For 2018-19, DPH estimates ADAP expenditures of $434.4 million, an increase of $38.7 million or 9.8 percent compared to the 2017 Budget Act. According to DPH, this increase is primarily due to an increase in medication expenditures per client and overall caseload.

ADAP Local Assistance Funding Summary		
Fund Source	**2017-18**	**2018-19**
0890 – Federal Trust Fund	$111,400,000	$132,400,000
3080 – AIDS Drug Assistance Program Rebate Fund	$286,700,000	$302,000,000
Total ADAP Local Assistance Funding	**$398,100,000**	**$434,400,000**

ADAP tracks caseload and expenditures by client group. DPH estimates ADAP caseload and expenditures for 2017-18 and 2018-19 will be as follows:

Caseload by Client Group	**2017-18**	**2018-19**
Medication-Only	12,472	12,273
Medi-Cal Share of Cost	175	175
Private Insurance	8,963	10,436
Medicare Part D	7,952	8,021
PrEP Assistance Program	333	1,533

Expenditures by Client Group	**2017-18**	**2018-19**
Medication-Only	$310,988,705	$321,906,295
Medi-Cal Share of Cost	$1,075,087	$1,075,087
Private Insurance	$52,111,849	$70,985,170
Medicare Part D	$21,002,426	$23,522,070
PrEP Assistance Program	$516,547	$2,142,715

In addition, enrollment costs were $8 million in both 2017-18 and 2018-19.

Enrollment and Case Management. In addition to expenditures for services to clients, the ADAP Local Assistance Estimate also includes funds for a variety of enrollment, case management, and quality improvement efforts to support the program. Previously, enrollment sites received a fixed reimbursement for these activities. Beginning in 2017-18, a new reimbursement methodology will include a payment floor and total payment dependent on volume of the following services:

1. New Medication Enrollment
2. Bi-Annual Self-Verification
3. ADAP Annual Re-Enrollment
4. New Insurance Assistance Enrollment
5. Insurance Assistance Annual Re-Enrollment
6. New PrEP Enrollment
7. PrEP Re-Enrollment
8. Paid PrEP Related Out-of-Pocket Claims
9. Paid Insurance Assistance Medical Out-of-Pocket Claims.

HIV Alliance Proposals for Investment. The HIV Alliance has proposed the following investments:

- Comprehensive HIV Prevention Services Including PrEP and PEP – The HIV Alliance requests $10 million General Fund annually to provide grants to support comprehensive HIV prevention services including PrEP and PEP, including outreach and navigation, HIV testing for high risk populations, and related prevention services. Because the specific needs of local health jurisdictions vary widely, the Request for Proposals should allow applicants to identify the range of HIV prevention services needed in their individual communities with special attention given to applicants serving key populations in resource limited areas.
- Economic Empowerment and Linkage to HIV Care and Prevention for Transgender Women – The HIV Alliance requests $2 million General Fund over three years to support demonstration projects that provide economic empowerment services for transgender women in coordination with linkage to HIV care and prevention services. These demonstration projects would include assessing client needs and potential barriers to employment, client-centered career development trainings, referrals to inclusive and affirming employers and culturally competent referrals to HIV care and prevention services.
- Health and Psychosocial Needs of Older Adults Living with HIV – The HIV Alliance requests $3 million General Fund over three years to establish demonstration projects that address the health and psychosocial needs of people living with HIV over the age of 50. The demonstration projects would serve both rural and urban jurisdictions as well as diverse groups of clients. The demonstration projects would include an evaluation component, a plan for disseminating lessons learned in order to strengthen ongoing programs, and would be evaluated based on multiple factors including need in the area, population served, competency of the entity applying, project design and evaluation design. CDPH OA would oversee the demonstration projects in consultation with the Department of Aging.
- Public Health Detailing to Educate Medical Providers about HIV and STD Prevention – The HIV Alliance requests $1 million General Fund annually to provide grants to local health departments and/or community-based organizations to develop public health detailing initiatives for HIV and STD prevention at the city, county or regional level. Available data should be used to identify PCPs who serve populations most at risk of HIV and STD infection and would be most likely to benefit from these initiatives. This funding may also be used to provide capacity building assistance to

grantees and develop user-friendly educational resources and decision-support tools for medical providers and their staff.

- Modify PrEP Assistance Program to Provide More Comprehensive Coverage for PrEP and PEP – The HIV Alliance proposes trailer bill language to modify the PrEP Assistance Program to expand coverage. Currently the program is limited to individuals 18 years old and above, does not provide financial assistance for post-exposure prophylaxis (PEP) and is not authorized to provide health insurance premium support. The program is also not authorized to cover the full cost of PrEP and PEP medications under any circumstances. These limitations prevent the program from providing adequate safety-net coverage for PrEP and PEP to those who qualify. The trailer bill language would make the following changes:
  1. Change program eligibility to include all residents of California at least 12 years of age.
  2. Authorize program to provide financial assistance for PEP.
  3. Cover the full cost of PrEP and PEP medications for uninsured individuals under 18 years old.
  4. Provide health insurance premium support.
  5. Cover the full cost of PrEP and PEP, including medication and medical costs, for individuals unable to use their insurance for confidentiality or safety reasons.
  6. Cover all PrEP- and PEP-related drug costs not covered by the individual's health insurance plan when manufacturer's copay assistance program imposes an undue burden.
  7. Cover starter packs for PrEP and PEP.

Hepatitis C (HCV) Prevention, Testing, and Linkage to and Retention in Care Services. The California Hepatitis Alliance (CalHEP) requests $6.6 million General Fund annually for HCV prevention, testing, and linkage to, and retention in, care projects and capacity building support services to assist new programs. These resources are an expansion of a 2015-16 investment of $2.2 million a year for three years for HCV testing and linkage to care demonstration projects. The outcomes of these pilots in San Luis Obispo, Monterey, Butte, San Diego, and San Francisco counties, as well as Central and Southern Los Angeles, were excellent, and worth expanding. According to CalHEP, this funding allowed the California Department of Public Health's STD Control Branch Office of Viral Hepatitis to support efforts related to three goals: 1) using surveillance to improve HCV outcomes, 2) hepatitis C testing and linkages to care, 3) HCV care coordination.

Sexually Transmitted Disease (STD) Prevention Activities. Essential Access Health (EAH) requests $10 million General Fund annually to the DPH's STD Control Branch for STD prevention activities and outreach and education efforts. Activities may include:

- Collection of more robust, geo-coded data and epidemiological research to inform and evaluate STD prevention and intervention programs.
- Conducting and coordinating targeted, culturally appropriate and responsive outreach and health promotion efforts.
- Providing STD screening, testing, and treatment for the remaining uninsured and populations at high risk for STD transmission who might otherwise not receive care.
- Implementation of innovative community-based projects to effectively reduce local STD rates.

Substance Use Disorders Treatment Navigators at Harm Reduction Programs. The Drug Policy Alliance requests $11 million for the California Department of Public Health Office of AIDS (OA) for grants to harm reduction programs, including syringe access programs, to provide outreach to people

who use drugs who are not in treatment and assist them with linkage to health care services. This outreach would increase the number of people who are able to benefit from medication assisted treatment such as methadone and buprenorphine and reduce the burden of opioid misuse, drug overdose deaths, hepatitis C and HIV in our communities by connecting individuals with substance use disorders to effective treatment and other services.

Sunset Extension for Needle Exchange Programs. The Drug Policy alliance requests trailer bill language to eliminate the sunset date for needle exchange programs. Needle exchange programs lower the risks of infection by blood-borne diseases such as HIV and HCV by limiting syringe sharing and providing safe disposal options. These programs also provide people who inject drugs with referrals to drug treatment, detoxification, social services, and primary health care. The statutory authority for these programs is scheduled to expire on January 1, 2019.

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 DPH to respond to the following:

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

Issue 7: AIDS Drug Assistance Program: Eligiblity and Enrollment

Budget Issue. DPH requests expenditure authority of $250,000 from the ADAP Rebate Fund in 2017-18 and 15 positions and expenditure authority of $2.7 million from the ADAP Rebate Fund annually thereafter. If approved, these resources would allow DPH to manage the workload of transitioning ADAP eligibility and enrollment services to the Office of AIDS.

Program Funding Request Summary		
Fund Source	**2017-18***	**2018-19****
3080 – ADAP Rebate Fund	$250,000	$2,700,000
Total Funding Request:	**$250,000**	**$2,700,000**
Total Positions Requested:	**0.0**	**15.0**

* Resources in 2017-18 fund two administratively established positions.

** Positions and resources ongoing after 2018-19.

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

In November 2016, the enrollment portal was unexpectedly unavailable for enrollment worker and client use. DPH identified security vulnerabilities in the new system and identified two breaches of confidential client information. After the portal became unavailable, DPH took several actions to address the problems with enrollments and eligibility determinations:

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

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

DPH terminated its EBM vendor relationship with A.J. Boggs in March 2017, citing material breach of contract. A.J. Boggs ceased processing applications and DPH began processing applications received by fax. At the same time, DPH began implementation of a new enrollment system developed in consultation with Deloitte since the failure of the A.J. Boggs enrollment portal. DPH staff provided training and access to the new system for enrollment workers and redirected 21 staff positions from other divisions to support these efforts.

DPH reports the redirection of staff could only be sustained for a short period and these staff returned to their prior workload in June 2017. DPH established 11 temporary positions for eligibility and enrollment work in its ADAP Call and Data Processing Center. The permanent establishment of these positions is included in the department's request.

DPH requests expenditure authority of $250,000 from the ADAP Rebate Fund in 2017-18 and 15 positions and expenditure authority of $2.7 million from the ADAP Rebate Fund annually thereafter to manage the workload of transitioning ADAP eligibility and enrollment services to the Office of AIDS. The requested positions are as follows:

Office of AIDS (13 positions)
One Staff Services Manager II
One Staff Services Manager I
One Associate Governmental Program Analyst (AGPA)
Two Supervising Program Technician II
Six Program Technician II

According to DPH, these 11 positions would respond to over 36,000 annual calls with questions about eligibility, access to enrollment sites, pharmacy claims, and insurance premium and out-of-pocket assistance. These positions would also be responsible for processing 10,800 applications for the ADAP insurance assistance program, 14,400 supplemental documents and other applications, and 63,000 self-verification forms and re-enrollment postcard reminders.

One Public Health Medical Administrator I
One Research Scientist Supervisor I

According to DPH, these positions would provide oversight of ADAP data-related activities, including eligibility management systems oversight, system requirements development, data management, analysis, and fiscal forecasting.

Research Scientist Supervisor I

According to DPH, this position would direct and oversee the ADAP Research and Evaluation Section to provide data collection, reporting and analysis, fiscal forecasting, quality improvement, program monitoring and evaluation, and research needs.

Information Technology Services Division (One position)
One System Software Specialist III

According to DPH, this position would oversee and maintain the information technology (IT) structure for the interim EBM system, and support the IT infrastructure for data exchanges with the PBM and IBM vendors.

Administration (One Position)
One AGPA

According to DPH, this position would perform administrative duties associated with the increased staffing requested in the balance of the proposal including human resources, contracting, purchasing, and other administrative support.

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 DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 8: Richmond Lab: Viral Rickettsial Disease Lab Upgrade

Capital Outlay Budget Issue. DPH requests reversion of $3.8 million General Fund and a new appropriation of $4.9 million General Fund to upgrade the Richmond Campus Viral Rickettsial Disease Laboratory to meet Bio-Safety Level-3 requirements established by the Centers for Disease Control and the National Institute of Health.

Program Funding Request Summary		
Fund Source	**2018-19***	**2019-20**
0001 – General Fund	$4,866,000	$-
Total Funding Request:	**$4,866,000**	**$-**

* Includes reversion and a new appropriation of $3,799,000 approved in the 2015 Budget Act.

Background. According to DPH, at the time of construction the Richmond Campus Viral Rickettsial Disease Laboratory (VRDL) was designed to meet the existing Centers for Disease Control (CDC) and National Institute of Health (NIH) requirements as a Bio-Safety Level 3 (BSL-3) facility. BSL-3 facilities are required to handle, identify, and respond to outbreaks of certain deadly viruses including hantavirus, poxviruses, novel influenza, Middle East Respiratory System (MERS)-CoV, Severe Acute Respiratory System (SARS), Chikungunya virus, Japanese encephalitis virus, and West Nile virus. In 2006, in response to world health concerns, the CDC and NIH implemented enhanced requirements for BSL-3 certified laboratories.

To upgrade the Richmond VRDL to meet the new BSL-3 requirements, approximately 2,000 square feet of existing space will need to be demolished and replaced with a new laboratory. The new space will include three laboratories, one work room, two entry and changing rooms with a shower, a staging area with freezer space and an autoclave, a decontamination room large enough to move large pieces of equipment, a clean autoclave room, a viewing area, and a valve room to house mechanical equipment. All rooms, with the exception of the clean autoclave room and the valve room, will be within a containment area.

Planning and design for this project began with an allocation of $241,000 General Fund approved for preliminary planning, and an allocation of $232,000 for designs and working drawings approved in the 2007 Budget Act. An additional $534,000 General Fund was allocated for working drawings and $3.8 million General Fund allocated for construction in the 2015 Budget Act. However, according to DPH, construction was delayed due to delayed approval of the final working drawings by the State Fire Marshall, due to the 2015 California fires.

DPH requests reversion of the $3.8 million General Fund allocation for construction and a new appropriation of General Fund expenditure authority of $4.9 million. The new appropriation consists of a $64,000 allocation for working drawings and $4.8 million for construction. The increase in construction costs is due to a contract bid received by the Department of General Services (DGS) that exceeded the award amount by 23 percent. DGS concluded the bid should be accepted as there was limited interest by other bidders, the specialized nature of the project limited potential bidders, the original construction estimate did not reflect Bay Area market conditions, and the bid that was received was competitive and reflected the current construction market.

According to DPH, the expected approval to proceed to bid is August 2018, the expected contract award is January 2019, and the expected date for project completion is January 2020. The total expected cost for the project is $5.8 million and would be fully funded by the requested reversion and new appropriation of General Fund resources.

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 DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 9: Baby BIG Infant Botulism Treatment and Prevention

Spring Finance Letter. DPH requests provisional language to allow flexibility to meet manufacturing costs if the timeline for the next production cycle of Human Botulism Immune Globulin (BabyBIG) shifts into the 2018-19 fiscal year.

Background. The Infant Botulism Treatment and Prevention Program was created to provide and improve the treatment of infant botulism and to prevent infant botulism and related diseases. BabyBIG is an orphan drug that consists of human-derived anti-botulism-toxin antibodies and is approved by the U.S. Food and Drug Administration (FDA) for the treatment of infant botulism types A and B. DPH is the only producer of BabyBIG in the world, with only one facility, Shire Biotechnology located in Los Angeles, approved by the FDA for production of the drug.

According to DPH, production of BabyBIG is difficult to schedule. The budget currently assumes a production timeline for BabyBIG in the 2019-20 fiscal year. However, due to the uncertain timing for manufacturing, DPH is seeking flexibility regarding its budget authority for production of BabyBIG.

Provisional Language. DPH requests the following provisional language:

Item 4265-001-0272

1. In the event the production schedule for BabyBIG® Lot 7 is accelerated and begins in the 2018-19 fiscal year, the Department of Finance may augment this item in the amount necessary to support these production costs. Any augmentation shall be authorized no sooner than 30 days after notification in writing to the Chairperson of the Joint Legislative Budget Committee, or no sooner than whatever lesser time the Chairperson of the Joint Legislative Budget Committee, or his or her designee, may determine.

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 DPH to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 10: Emergency Response: Public Health Crisis Response Grant

Spring Finance Letter. DPH requests provisional language to allow augmentation of appropriation authority for federal funds to quickly accept public health emergency funding pursuant to a new Centers for Disease Control and Prevention (CDC) Public Health Crisis Response Grant.

Background. According to DPH, the department received approval in February 2018 to be placed on an "Approved-But-Unfunded" list of grantees, which stipulates its recipients have certified they can submit an amended budget to CDC within 14 days of notice of intent to make an award, and complete hiring and execute contracts within 30 days of the notice. The proposed provisional language will allow the department to meet these requirements in response to public health emergencies.

Provisional Language. DPH requests the following provisional language:

Item 4265-001-0890

3. Notwithstanding any other provision of law, the Department of Finance may augment this item in excess of the amount appropriated upon notice by Public Health of available funds by the Centers for Disease Control and Prevention's Cooperative Agreement for Emergency Response: Public Health Crisis Response Grant. Within 10 working days of authorizing such an augmentation, the Department of Finance shall provide written notification of the augmentation to the chairpersons of the fiscal committees in each house of the Legislature and the Chairperson of the Joint Legislative Budget Committee.

Item 4265-111-0890

3. Notwithstanding any other provision of law, the Department of Finance may augment this item in excess of the amount appropriated upon notice by Public Health of available funds by the Centers for Disease Control and Prevention's Cooperative Agreement for Emergency Response: Public Health Crisis Response Grant. Within 10 working days of authorizing such an augmentation, the Department of Finance shall provide written notification of the augmentation to the chairpersons of the fiscal committees in each house of the Legislature and the Chairperson of the Joint Legislative Budget Committee.

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 DPH to respond to the following:

1. Please provide a brief overview of this proposal.