Senate Budget and Fiscal Review

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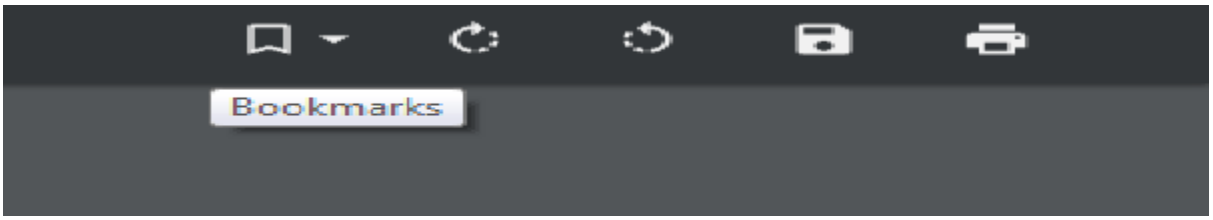

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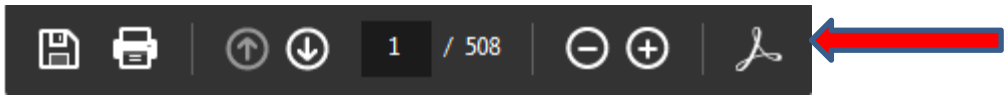

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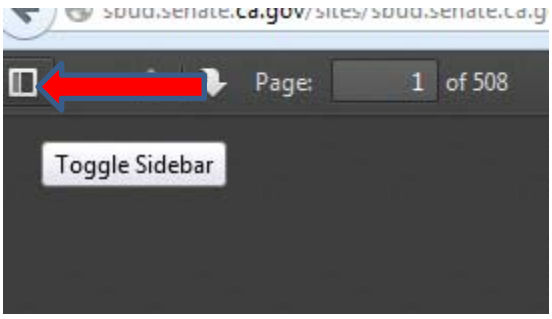

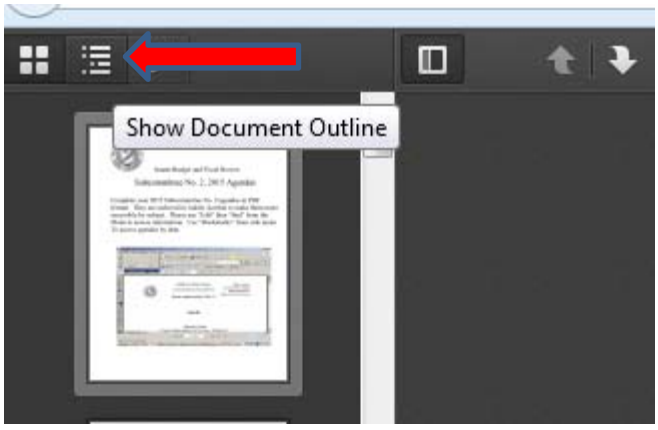

Senate Budget and Fiscal Review—Holly J. Mitchell, Chair

SUBCOMMITTEE NO. 3 Agenda

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

March 2, 2017
9:30 a.m. or Upon Adjournment the Joint Legislative Budget Committee
State Capitol, Room 4203

Consultant: Theresa Pena

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4170 DEPARTMENT OF AGING (CDA)

Issue 1: Overview

With a proposed 2017-18 budget of $200.6 million ($33.8 million General Fund), the California Department of Aging (CDA) administers community-based programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities throughout the state. The department is the federally-designated State Unit on Aging, and administers funds allocated under the federal Older Americans Act, the Older Californians Act, and through the Medi-Cal program.

Area Agencies on Aging. CDA contracts with a statewide network of 33 Area Agencies on Aging (AAAs), which directly manage federal and state-funded services to help older adults find employment, support older adults and individuals with disabilities to live as independently as possible in the community, promote healthy aging and community involvement, and assist family members in their caregiving. Each AAA provides services in one of the 33 designated Planning and Service Areas (PSAs), which are service regions consisting of one or more counties and the City of Los Angeles. Examples of AAA services include: supportive and care management services; in-home services; congregate and home delivered meals; legal services; Long-Term Care Ombudsman services; and elder abuse prevention.

CDA also contracts directly with agencies that operate the Multipurpose Senior Services Program (MSSP) through the Medi-Cal home and community-based waiver for the elderly, and certifies Community Based Adult Services (CBAS) centers for the Medi-Cal program.

Overview of Programs.

Senior Nutrition. Provides nutritionally-balanced meals, nutrition education and nutrition counseling to individuals 60 years of age or older at congregate meal sites or for those who are homebound due to illness, disability or isolation, at home. A one-time $2 million General Fund augmentation for additional home-delivered meals for seniors was provided in the 2016-17 budget.

Supportive Services. Provides assistance to older individuals to help them live as independently as possible and access services available to them. Services include: information and assistance, transportation services, senior centers, in-home and case management and legal services for frail older persons.

Senior Legal Services. Assess legal service needs and assists older adults with disabilities in their community with a variety of legal problems. This is a priority service under Title IIIB and each AAA must include it as one of their funded programs. There are 39 legal services projects in California.

Family Caregiver Support. Provides support to unpaid family caregivers of older adults and grandparents (or other older relatives) with primary caregiving responsibilities.

Ombudsman and Elder Abuse Prevention. Investigates and resolves community complaints made by, or on behalf of, individual residents in long-term care facilities.

Health Insurance Counseling and Advocacy (HICAP). Provides personalized counseling, outreach and community education to Medicare beneficiaries about their health and long-term care (LTC) coverage options.

Senior Community Employment. Provides part-time, subsidized work-based training and employment in community service agencies for low-income persons, 55 years of age and older, who have limited employment prospects.

Funding. Between July 2007 and June 2012, the CDA budget was reduced by approximately $30.1 million in General Fund. This includes the elimination of state funding for Community-Based Services, Supportive Services, Ombudsman and Elder Abuse Prevention, Senior Community Employment, and a reduction in MSSP funding. Below is a historical recap of budget changes:

- Senior Community Employment. All General Fund for the Senior Community Employment Program (SCSEP) was eliminated in FY 2008-09. Since that time the program has been funded solely by the federal government. In FY 2011-12, SCSEP suffered a 25 percent cut in its Department of Labor baseline funding, a loss of approximately $2.6 million.

- Sequestration - Federal Fiscal Year (FFY) 2013 and ongoing. CDA lost approximately $9.8 million in federal funding in FFY 2013 for its senior programs due to the federal sequestration. The nutrition sequestration reduction was partially offset in FY 2013-14 and FY 2014-15 with $2.7 million received from the Assembly Speaker's Office. In 2014, nutrition federal funding was restored to the 2012 funding levels. Sequestration cuts have continued for Supportive Services, Preventive Health, Family Caregiver, Ombudsman, and Elder Abuse Prevention in the FFYs 2014 and 2015.

- Ombudsman Funding Changes. All General Fund local assistance funding for the Ombudsman program was eliminated during FY 2008-09. Between FY 2009-10 and FY 2011-12, several one-time appropriations and funding solutions were utilized to partially backfill lost General Fund and federal Citation Penalties Account monies. In 2012-13 and 2013-14, the implementation of federal sequestration reduced federal Ombudsman funding by about $0.2 million. Local Assistance funding for the Ombudsman currently amounts $6.3 million and includes federal and state funds from the Skilled Nursing Facility Quality Assurance Fund and the state Citation Penalties Account funds. According to the department, this is $2.3 million lower than the 2008-09 funding level. The 2016-17 budget included a one-time $1 million augmentation to the Long-Term Care Ombudsman Program using funds from the State Health Facilities Citation Account. These funds were used to increase staffing hours and/or limited-term appointments for local Ombudsman programs, support volunteers through additional training classes and mileage reimbursement, purchase office equipment, and outreach to consumers.

Current Competitive Federal Demonstration Grants. CDA has been awarded several competitive federal demonstration grants, including:

- Chronic Disease Self-Management Demonstration Grant. Funding for this grant ended in June 2016. At the grant's conclusion, 17,732 Californians had participated in the six-week chronic disease self-management program workshops in various counties. Although federal funding has ended, these workshops continue to be offered in 22 counties by AAAs, County Public Health Departments, and other healthcare and community based organizations.

- Expanding Capacity to Serve Persons with Dementia in the Coordinated Care Initiative. This grant ended in September 2016. However, in September 2016, CDA received additional federal funding to expand the collaboration already underway in providing training and technical assistance to Cal MediConnect care managers to increase their ability to better identify and serve plan members with dementia and refer these individuals and family caregivers to community-based services. Under the original federal grant, these activities were provided in Los Angeles, San Mateo, and Santa Clara counties. With the new funding, these activities will be expanded to Riverside, San Bernardino, and San Diego counties. The Alzheimer's organizations serving those counties are the lead agencies in providing these activities and the federally required matching funds. The total funding for the 18-month expansion grant is $323,493. Although the CCI has been discontinued, CDA does not anticipate any changes to this grant.

Staff Comment and Recommendation. This is an informational item, and no action is required.

Questions.

1. Please provide an overview of the department's programs and services, and discuss caseload and demographics of caseload.

Issue 2: Multi-Purpose Senior Services Program (MSSP) - Update

Background. MSSP provides social and health case management services for frail, elderly clients who wish to remain in their own homes and communities. Clients must be aged 65 or older, eligible for Medi-Cal, and certified (or certifiable) as eligible to enter into a nursing home. Teams of health and social service professionals assess each client to determine needed services, and work with the clients, their physicians, families, and others to develop an individualized care plan. Services provided with MSSP funds include: care management; adult social day care; housing assistance; in-home chore and personal care services; respite services; transportation services; protective services; meal services; and, special communication assistance.

CDA currently oversees operation of the MSSP program statewide and contracts with local entities that directly provide MSSP services to around 12,000 individuals. The program operates under a federal Medicaid Home and Community-Based, Long-Term Care Services waiver.

MSSP as Part of the Coordinated Care Initiative. Under California's Coordinated Care Initiative (CCI), most Medi-Cal beneficiaries in CCI counties must be enrolled in a participating Medi-Cal managed care health plan to receive their Medi-Cal benefits, including MSSP. MSSP sites in a CCI county have entered into contracts with the participating managed care health plans to deliver MSSP waiver services to eligible plan members and are reimbursed by the health plans.

In six of the seven CCI counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Santa Clara), MSSP continues to be a 1915(c) Home- and Community-Based Services waiver benefit until it transitions to being a fully integrated managed care health plan benefit that is administered and authorized by the plan. In San Mateo County, the transition into managed care occurred on October 31, 2015. While the Department of Finance has informed the Legislature that the CCI is no longer cost-effective pursuant to Chapter 37, Statutes of 2013 (SB 94), in the remaining six counties, the MSSP sites will continue to contract with the managed care health plans participating in the Cal MediConnect program, which continues mandatory enrollment of dual eligibles, and integrate long-term services and supports (except IHSS) into managed care. The proposed Governor's budget delays the MSSP transition into managed care in the six remaining counties until no sooner than January 1, 2020.

Beginning in 2018, the California Department of Aging will continue to work closely with the Department of Health Care Services DHCS, MSSP sites, and managed care health plans to address any operational issues and prepare for MSSP's transition to a fully integrated managed care plan benefit in all the designated counties by January 1, 2020. Continuation of Cal MediConnect and integration of long-term services and supports in the six formerly-CCI counties will affect 12 MSSP sites and approximately 4,856 participants. These MSSP sites will continue to contract with managed health care plans and receive payment from them.

Staff Comment and Recommendation. This is an informational item, and no action is required.

Questions.

1. Please provide a brief overview of the MSSP program, and discuss any impacts of the discontinuance of CCI on the MSSP program.

Issue 3: Proposals for Investment

The subcommittee has received the following aging-related proposals for investment.

- Senior Nutrition Program

Budget Issue. The California Association of Area Agencies on Aging and other advocates requests $12.5 million General Fund to augment existing senior nutrition programs. Area Agencies on Aging operate these programs, including Congregate Mealsites and Home-delivered Meals (known as Meals on Wheels). The increase in funds would provide an additional one half-million meals to California seniors.

Staff Comment and Recommendation. Hold open. The 2016-17 Budget included a one-time augmentation of $2 million General Fund specifically for the Home-delivered Meals.

4185 CALIFORNIA SENIOR LEGISLATURE (CSL)

Issue 1: Budget Change Proposal: 2016 Budget Act General Fund Reappropriation

Governor's Proposal. The California Senior Legislature (CSL) requests a reappropriation of any unexpended General Fund appropriated in the 2016 Budget Act to be available for expenditure until the end of fiscal year 2017-18 in order to support state operations while the Senior Legislature pursues an ongoing revenue source. The amount projected to roll over is $175,000.

Background. SCR 44 (Mello), Chapter 87, Statutes of 1982, established the CSL. The CSL is a nonpartisan, volunteer organization comprised of 40 senior senators and 80 senior assemblymembers, who are elected by their peers in elections supervised by the Advisory Councils in 33 Planning and Services Areas. The CSL's mission is to gather ideas for state and federal legislation and to present these proposals to members of the Legislature and/or Congress. Each October, the CSL convenes a model legislative session in Sacramento, participating in hearing up to 120 legislative proposals.

Since 1983, the CSL has been funded through voluntary contributions received with state income tax returns, appearing as the California Fund for Senior Citizens. State law allows taxpayers to contribute money to voluntary contribution funds (VCFs) by checking a box on their state income tax returns. With a few exceptions, VCFs remain on the tax form until they are repealed by a sunset date or fail to generate a minimum contribution amount. For most VCFs, the minimum contribution amount is $250,000, beginning in the fund's second year. In 2013 the CSL did not meet the minimum contribution amount, and it fell off the tax check-off for the 2014 tax return. The CSL managed to maintain their funding status through VCF by establishing the new California Senior Legislature Fund through SB 997 (Morrell), Chapter 248, Statutes of 2014, and repealing the California Fund for Senior Citizens. But in 2015, the new VCF revenue was only $60,000. In 2016, the California Senior Legislature Fund was removed from the tax check-off list once again for not meeting the minimum requirement. The Legislature included a one-time $500,000 General Fund appropriation in the Budget Act of 2016 to keep the CSL operative.

Staff Comment. Given the instability of the tax check-off VCF as a funding source over the last several years and the many competing demands for General Fund resources, staff recommends that the CSL remain proactive in finding other funding sources.

Questions.

1. Please provide an overview of the proposal.

2. What are specific alternative funding sources the CSL is pursuing? When does the CSL anticipate having enough funding from these other sources of funding or the tax check-off?

Staff Recommendation. Hold open.

5180 – DEPARTMENT OF SOCIAL SERVICES – ADULT PROTECTIVE SERVICES (APS)

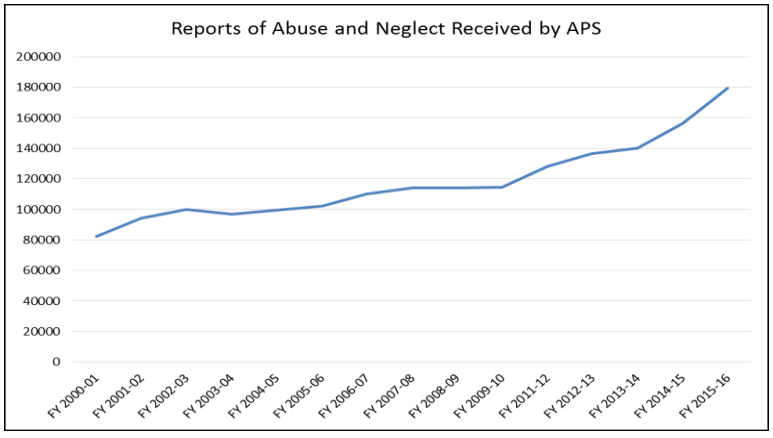
Issue 1: Overview – Adult Protective Services

Background. Each of California's 58 counties has an APS agency to help adults aged 65 years and older and dependent adults who are unable to meet their needs, or are victims of abuse, neglect, or exploitation. The APS program provides 24/7 emergency response to reports of abuse and neglect of elders and dependent adults who live in private homes, apartments, hotels or hospitals, and health clinics when the alleged abuser is not at staff member. APS social workers evaluate abuse cases and arrange for services such as advocacy, counseling, money management, out-of-home placement, or conservatorship. APS social workers conduct in-person investigations on complex cases, often coordinating with local law enforcement, and assist elder adults and their families navigate systems such as conservatorships and local aging programs for in-home services. These efforts often enable elder adults and dependent adults to remain safely in their homes and communities, avoiding costly institutional placements, like nursing homes.

Realignment. In 2011, Governor Brown and the Legislature realigned several programs, including child welfare and adult protective services, and shifted program and fiscal responsibility for non-federal costs to California's 58 counties.[1] The Department of Social Services, (DSS) retains program oversight and regulatory and policy making responsibilities for the program, including statewide training of APS workers to ensure consistency. DSS also serves as the agency for the purpose of federal funding and administration.

Training. In 2015-16, $176,000 ($88,000 General Fund) was allocated to DSS for APS training. Funding for statewide APS training had not increased in 11 years, even as APS reports have risen by 90 percent between 2000-01 and 2014-15.

The chart below shows the upward trend of reports of abuse and neglect received by APS:



[1] AB 118, (Committee on Budget), Chapter 40, Statutes of 2011, and AB 16 x 1 (Committee on Budget), Chapter 13, Statutes of 2011, First Extraordinary Session, realigns funding for Adoption Services, Foster Care, Child Welfare Services, and Adult Protective Services, and programs from the state to local governments and redirects specified tax revenues to fund this effort.

The 2014 Budget Act included $150,000 in funding for one staffing position within the Department of Social Services to assist with APS coordination and training. In 2015, trailer bill language was adopted that codified the responsibilities of this staff person. The 2016 Budget Act included one-time funding of $3 million General Fund for APS training for social workers. So far, the funding has been used to:

- Amend the current (2015-2017) contracts with the three Regional Training Academies (RTAs) (San Diego State University, UC Davis, and Cal State Fresno) to increase their delivery of core competency classes.

- Add three new (2017-2019) contracts with the same three RTAs to provide "APS Core Competency Academies" in each region, provide tracking and documentation for national APS certification, and five advanced trainings and three supervisor trainings.

- Provided funding to the Public Administrators (PA), Public Guardians (PG) and Public Conservators (PC) Association to support their need to train their employees.

Federal Grants. APS has received a federal Administration for Community Living grant of $250,000 to study and develop an improved comprehensive data collection system in line with the National Adult Maltreatment Reporting System (NAMRS).

Staff Comment and Recommendation. This is an informational item and no action is required.

Questions.

1. Please briefly summarize the program and services.

2. Please provide an update on how the one-time funds provided in 2016-17 are being used.

Issue 2: Proposals for Investment

The subcommittee has received the following proposal for investment.

- Adult Protective Services Home Safe

Budget Issue. The California Welfare Directors Association requests one-time funding of $10 million General Fund in 2017-18 to establish APS-Home Safe, a homelessness prevention and rapid re-housing demonstration grant program for victims of elder abuse and neglect. This competitive grant program would allow 10 participating counties or groups of counties to help clients maintain their housing through services such as short-term rental or utility assistance, legal assistance, and expanded case management services.

Background. Many elder abuse victims are at risk of losing their homes as a direct result of abuse, neglect, or exploitation. Adults who become homeless later in life have a higher risk of chronic health problems, and have a higher chance of visiting hospital emergency rooms or dying. APS programs have limited or no resources to prevent homelessness or rehouse victims.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – COMMUNITY CARE LICENSING (CCL)

Issue 3: Overview – Community Care Licensing

Background. The Community Care Licensing (CCL) Division in the Department of Social Services (DSS) oversees the licensure or certification of approximately 73,000 licensed community care facilities that include child care, children's residential, adult and senior care facilities, and home care services. CCL is responsible for protecting the health and safety of individuals served by those facilities. Approximately 589 licensing program analysts investigate any complaints lodged, and conduct inspections of the facilities. The table below indicates facilities licensed by CCL.

Facility Type	Description
Child Care Licensing	
Family Child Care Home	Less than 24 hour non-medical care in licensee's home.
Child Care Center	Less than 24 hour non-medical care in a group setting.
Children's Residential Facilities	
Adoption Agency	Assists families in the adoption process.
Community Treatment Facility	24-hour mental health treatment services for children certified as seriously emotionally disturbed with the ability to provide secure containment.
Crisis Nursery	Short-term, 24 hour non-medical care for eligible children under 6 years of age.
Enhanced Behavioral Supports Home	24-hour nonmedical care, in a residential facility or group home, for individuals with developmental disabilities requiring enhanced behavioral supports, staffing, and supervision in a homelike setting.
Foster Family Agency	Organizations that recruit, certify, train and provide professional support to foster parents; and identify and secure out of home placement for children.
Group Homes	24-hour non-medical care provided to children in a structured environment.
Out of State Group Home	24 hour non medical care provided to children in out-of-state group homes identified by counties to best meet a child's specific and unique needs.
Runaway and Homeless Youth Shelter	A group home to provide voluntary, short-term, shelter and personal services to runaway or homeless youth.
Short Term Residential Treatment Program	Provide short-term, specialized, and intensive treatment and will be used only for children whose needs cannot be safely met initially in a family setting.
Foster Family Home	24-hour care for six or fewer foster children.
Small Family Homes	24-hr. care in the licensee's home for 6 or fewer children, who have disabilities.
Temporary Shelter	County owned and operated facilities providing 24-hour, short-term residential care and supervision to dependent children for up to 10 days after removal from their homes due to abuse or neglect.
Transitional Care Facilities for Children	County owned and operated (or non-profit organization under contract with the County) facilities providing

Facility Type	Description
	short term non-medical care for children to a maximum of 72 hours pending placement.
Transitional Housing Placement	Provides care for 16+ yrs. old in independent living.
Adult & Elderly Facilities	
Adult Day Programs	Community based facility/program for person 18+ years old.
Adult Residential Facilities (ARF)	24-hour non-medical care for adults, 18-59 years old.
Adult Residential Facility for Persons with Special Healthcare Needs	24-hour services in homelike setting, for up to 5 adults, who have developmental disabilities, being transitioned from a developmental center.
Community Crisis Home	24-hour nonmedical care to individuals with developmental disabilities in need of crisis intervention services.
Continuing Care Retirement Communities (CCRC)	Long-term continuing care contract; provides housing, residential services, and nursing care.
Enhanced Behavioral Supports Home	24-hour nonmedical care to individuals with developmental disabilities who require enhanced behavioral supports, staffing, and supervision in a homelike setting.
Residential Care Facilities for the Chronically Ill	Facilities with maximum capacity of 25.
Residential Care Facilities for the Elderly (RCFE)	Care, supervision, and assistance with activities of daily living to eligible persons, usually 60+ yrs. old. Facilities range from 6 beds or less, to over 100 beds.
Social Rehabilitation Facilities	24-hour non-medical care in group setting to adults recovering from mental illness.
Special Agencies	
Certified Family Homes (CFH)	Homes certified by foster family agencies.

As of February 2017, CCL has 1,268 authorized positions and 147 vacancies. There are 140 positions currently in the interview process.

Background Checks. Applicants, licensees, adult residents, and employees of community care facilities who have client contact must receive a criminal background check. An individual submits fingerprint imaging to the California Department of Justice (DOJ). The Caregiver Background Check Bureau, within CCL, processes and monitors background checks. If an individual has no criminal history, DOJ will forward a clearance notice to the applicant or licensee and to the Caregiver Background Check Bureau. If an individual has criminal history, DOJ sends the record to the Bureau, where staff reviews the transcript and determines if the convictions for crimes may be exempt. For individuals associated with a facility that cares for children, an additional background check is required through the Child Abuse Central Index.

Continuum of Care Reform. AB 403 (Stone), Chapter 773, Statutes of 2015, is a multi-year effort to reduce the reliance on group home placements and develop a more robust supply of home-based family settings for foster youth, while providing families with the resources necessary to support foster youth as much as possible. In support of the CCR, the Children's Residential Program drafted or assisted with the drafting of two regulatory packages providing the framework for Foster Family Agencies and Short

Term Residential Therapeutic Programs, four versions of written directives guiding the implementation of the Resource Family Approval (RFA) Program, conducted 10 orientations with provider groups on these new requirements and continued to support the 13 early implementing RFA counties through technical assistance and monitoring visits.

Home Care Services Consumer Protection Act. AB 1217 (Lowenthal), Chapter 70, Statutes of 2013, requires DSS to regulate Home Care Organizations and provide for background checks and a registry for affiliated Home Care Aides, as well as independent Home Care Aides who wish to be listed on the registry. This bill implemented on January 1, 2016. As of December 2016, DSS had licensed over 1,200 Home Care Organizations and registered over 77,000 Home Care Aides and maintains the Home Care Aids Registry.

Facility licensing practices and requirements. All facilities must meet minimum licensing standards, as specified in California's Health and Safety Code and Title 22 regulations. Approximately 1.4 million Californians rely on CCL enforcement activities to ensure that the care they receive is consistent with standards set in law.

DSS conducts pre- and post-licensing inspections for new facilities and unannounced visits to licensed facilities under a statutorily-required timeframe. The adopted 2015 proposal increased the frequency of inspections from at least once every five years to at least once every three years or more frequently depending on facility type. These reforms go into effect incrementally through 2018-19, and as of January 2017, DSS has implemented the required increased visit protocol. Below is a table showing the ramp up of inspections by facility type:

Inspection Frequency: Prior Law and As Enacted in the 2015 Budget

Facility Type	Prior Law	As Enacted in the 2015 Budget		
		Stage 1: January 2017	Stage 2: January 2018	Stage 3: January 2019
	Inspections must occur at least once every. . .			
Child care facilities	5 years	3 years	3 years (unchanged from stage 1)	3 years (unchanged from stage 1)
Children's residential care facilities	5 years	3 years	2 years	2 years (unchanged from stage 2)
Adult and senior care facilities	5 years	3 years	2 years	1 year

The chart below summarizes the total and type of inspections conducted in licensed facilities and how many inspections utilized the Key Indicator Tool (KIT) verses comprehensive inspections triggered after initiation of a KIT visit.

CCL Inspections in All Facilities By Type of Inspection and Protocol Fiscal Year 2015-16			
Type of Inspection	**Total of Inspections**	**Percentage of inspections utilized the Key Indicator Tool (KIT)**	**Percentage of inspections that utilized the KIT triggered a comprehensive inspection**
Annual Required Inspection	5,827	5,182 (88.9%)	944 (18.2%)
Random Inspection	21,706	21,010 (96.8%)	1,610 (7.7%)
Required Five-Yr. Visit	1,281	1,135 (88.6%)	297 (26.2%)

Key Indicator Tool. After various changes in 2003, and because of other personnel reductions,[2] CCL fell behind in meeting the visitation frequency requirements. In response, DSS designed and implemented the key indicator tool (KIT), which is a shortened version of CCL's comprehensive licensing inspection instruction, for all of its licensed programs. The KIT complements, but does not replace, existing licensing requirements. A KIT measures compliance with a small number of rules, such as inspection review categories and facility administration and records review, which is then used to predict the likelihood of compliance with other rules. Some facilities, such as facilities on probation, those pending administration action, or those under a noncompliance plan, are ineligible for a key indicator inspection and will receive an unannounced comprehensive health and safety compliance inspection.

CCL contracted with the California State University, Sacramento, Institute of Social Research (CSUS, ISR) to provide an analysis and recommendations regarding the development and refinement of the KIT, as well as a workload study. The department notes that the work is complete and DSS is in the process of distributing the results of this project and will consider recommendations moving forward. DSS has preliminarily shared a summary of findings for both studies. The workload study concluded that CCL will need 630 LPAs to cover the increased workload through 2018, and 678 LPAs to fully staff the changes that take place beginning 2019. The KIT analysis validated that the third iteration of the KIT was the most effective in identifying the need for further inspections for half of the facility types. However, staff is still waiting to receive the full reports to further understand these findings.

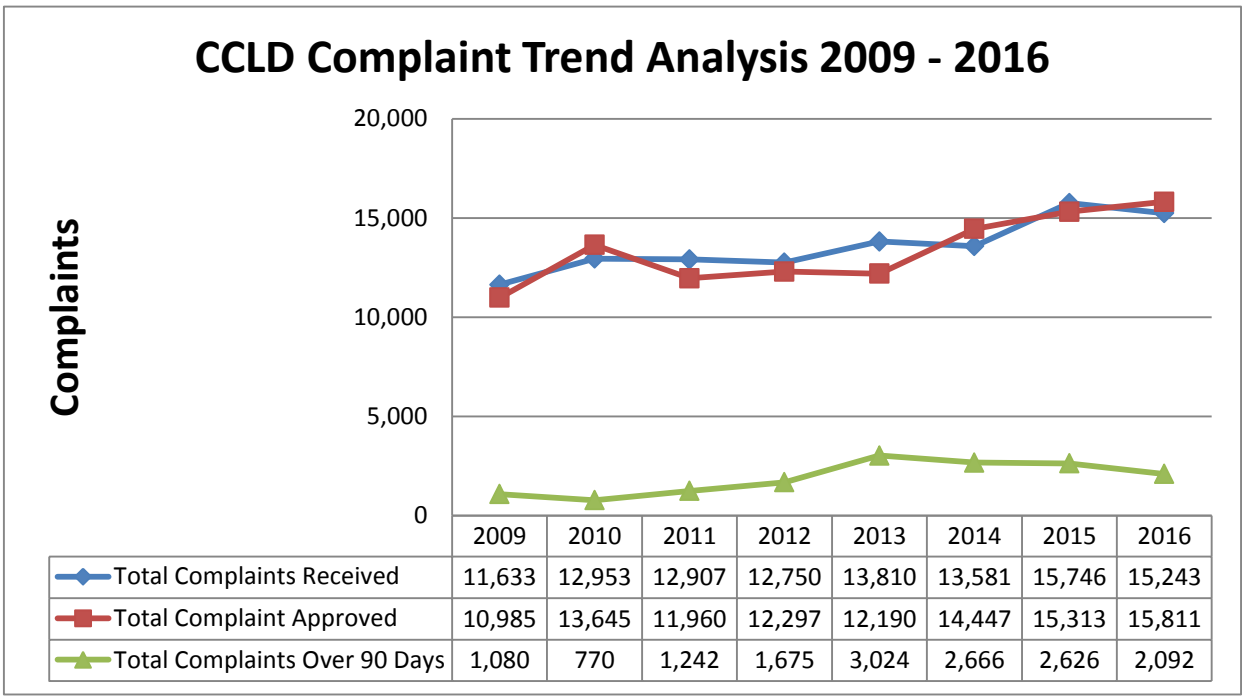
Complaints. Complaints are handled at regional offices. Licensing analysts, who would otherwise be conducting inspections, stay in the regional office two times a month, to receive complaint calls and address general inquiries and requests to verify licensing status from the public. CCL is required to respond to complaints within 10 days. During calendar year 2016, CCL received over 15,000 complaints. The information below provides an analysis of DSS' complaint activity for the years of 2009 through 2016.

[2] CCL estimates that over 15 percent of its staff was lost due to retirements, transfers, and resignations, as well as a prolonged period of severe fiscal constraints.

COMMUNITY CARE LICENSING DIVISION COMPLAINT ANALYSIS 2009 - 2016									
Year	Total Complaints Rolled Over From Prior Year(s)	Total Complaints Received	Total Complaints Received + Prior Year(s) Rollover	Total Complaint Approved	Current Year Net Loss/Gain	Total Complaints Over 90 Days	Total Furlough Days [1]		Avg. Authorized Positions [2]
2009	2,456	11,633	14,089	10,985	3,104	1,080	2 - 5 mo.	3 - 6 mo.	515.4
2010	3,104	12,953	16,057	13,645	2,412	770	3 - 7 mo.	1 - 4 mo.	513.4
2011	2,412	12,907	15,319	11,960	3,359	1,242	1 - 8 mo.	0 - 4 mo.	514.9
2012	3,359	12,750	16,109	12,297	3,812	1,675	0 - 6 mo.	1 - 6 mo.	491.9
2013	3,812	13,810	17,622	12,190	**5,432**	**3,024**	1 - 6 mo.		491.3
2014	5,432	13,581	19,013	14,447	4,566	2,666			501.8 [3]
2015	4,566	15,746	20,312	15,313	4,999	2,626			516.8 [3]
2016	4,999	15,243	20,242	15,811	4,431	2,092			568.8 [4]

Bolded numbers represent highest complaint rollover to next year and total complaints over 90 days

1. Displays the total number of furlough days within the specified period of months for each calendar year. Current Year Net Loss/Gain and Total Complaints Over 90 Days increased annually during the years that furloughs were in effect.
2. Positions include Complaint Specialists.
3. The average authorized positions do not include the LPA positions allocated to the Central Complaint and Information Bureau (CCIB).
4. Total authorized LPA positions as of July 1, 2016. Positions do not include the LPA positions allocated to the CCIB.



Licensing fees and penalties. Licensed facilities must pay an application fee and an annual fee, which is set in statute. The revenue from these fees is deposited into the Technical Assistance Fund (TAF) and is expended by the department to fund administrative and other activities in support of the licensing program. In addition to these annual fees, facilities are assessed civil penalties if they are found to have committed a licensing violation. Civil penalties assessed on licensed facilities are also deposited into the TAF, and are required to be used by the department for technical assistance, training, and education of licensees.

Budget actions. In 2014-15, the budget included $7.5 million ($5.8 million General Fund) and 71.5 positions for quality enhancement and program improvement measures. The additional positions and resources seek to improve the timeliness of investigations; help to ensure the CCL division inspects all licensed residential facilities as statutorily required; increase staff training; establish clear fiscal, program, and corporate accountability; develop resources for populations with medical and mental health needs; and update facility fees. In 2015-16, the budget included an increase of 28.5 positions (13 two-year limited-term positions) and $3 million General Fund in 2015-16 to hire and begin training staff in preparation for an increase in the frequency of inspections for all facility types beginning in 2016-17. In 2016-17, in order to further comply with the increased frequency of inspections including annual random inspections, and various other legislative requirements related to caregiver background checks, licensing and registration activities, and appeals and Residential Care Facility for the Elderly (RCFE) ownership disclosure, the budget includes new funding of $3.7 million General Fund for 36.5 positions. The department filled all of the 70.5 positions within the first seven months of 2014-15 and has also filled all positions authorized in 2015-16. Currently, 70 percent of positions authorized in 2016-17 are filled.

The CCL division has utilized these additional resources to strengthen the infrastructure by implementing many programs which have enhanced best practices, improved resources for licensees and implemented several programs identified below:

Quality Assurance Unit. This unit has developed and implemented performance dashboards for the Adult and Senior Care and Child Care programs. Additionally, the unit has produced documentation of the Most Commonly Cited Deficiencies Analyses for a number of CCL facility types, provided field staff with information that is utilized in preparing for facility inspections, and identified field staff training needs by conducting quality reviews of fieldwork.

Technical Assistance Unit. This unit has re-instituted provider consultation visits and given provider technical assistance inclusive of training, sharing of best practices, and the identification of grant opportunities to assist licensees with physical facility issues such as necessary renovations and repairs. This unit has also published several resource guides that will be posted on CCL's website, available to licensees and utilized for plans of corrections.

Centralized Applications Unit. This unit was established in July of 2014 to centralize the processing of all new Adult and Senior Care applications removing the function from Regional Offices. The unit is focused solely on processing RCFEs and Adult Residential Facilities (ARFs) applications.

Centralized Complaint and Information Bureau. This unit handles all complaint intake as well as facility information calls. DSS developed and widely disseminated a toll free phone number as well as an email address and fax number that is available on CCL's website, and is posted in RCFEs. In 2015,

the contact center received 58, 267 incoming calls and in 2016 this number rose to 97, 052 calls. In 2016, the bureau created 13,770 complaint reports for investigation by the Regional Offices. Additionally, the call center received, reviewed and processed 9,814 faxed or emailed referrals from Child Protective Services, Adult Protective Services, the Long Term Care Ombudsman, Regional Centers, Law Enforcement, Consumers/Residents and the general public. The majority of these referrals resulted in complaint investigations.

Clinical Expertise. The 2014-15 and 2015-16 budgets included resources for a Nurse Practioner and three Nurse Consultants to afford CCL the critical medical expertise necessary to meet the increasing level of medical care of residents in RCFEs and ARFs. With immediate clinical knowledge, skills, and experience, these nurses have enhanced CCL's ability to quickly address the quality of care of residents, address poor performing facilities, and educate struggling operators. The clinicians have conducted two mental health symposiums with expert panels identifying best practices to educate and assist providers in dealing with resident needs. Additionally, they are currently in the process of developing educational guides for providers on addressing pressure ulcers which is a significant care issue in adult and senior care facilities.

Staff Comment and Recommendation. This is an informational item, and no action is required.

Questions.

1. Please provide a brief overview of CCL's program and budget.

2. When can the Legislature expect to see a full KIT analysis or workload study? Can the department share any high-level findings from these publications at this time?

Issue 4: Budget Change Proposal: Continuance of Community Care Licensing Staffing Resources

Governor's Proposal. The Administration requests increased expenditure authority of $3.3 million in the Technical Assistance Fund (TAF) to address various program and service delivery issues within the Community Care Licensing Division. The breakdown of requested funds is as follows:

- $1.4 million to complete timely complaint allegations.
- $1 million to address the growing backlog of RCFE and ARF applications.
- $125,000 to continue implementation of licensing reform efforts related to the RCFE Reform Act of 2014.
- $690,000 in FY 2017-18 and FY 2018-19 and ongoing to fund 5.5 permanent positions (five Licensing Program Analysts (LPAs) and one-half Attorney III) to continue providing functions mandated by AB 388 (Chesbro), Chapter 760, Statutes of 2014.

Background. All licensing fees are deposited into the TAF and are utilized to offset general fund expenditures of licensing functions. The Adult and Senior Care and Children's Residential Programs' civil penalties collected are deposited into the TAF and used only for technical assistance, training, and education of licensees and for emergency resident relocation and care when a license is revoked or temporarily suspended. TAF guidelines specify that the fund should only be used for administrative and other activities to support the licensing program. There is no negative impact to any other programs or departments, as only CCL may utilize these funds.

Complaint Investigations: The 2015 Budget Act approved 13 limited-term (LT) LPA positions to focus on the backlog of complaint investigations that had built up during recession years. At the time, the backlog consisted of 3,300 cases. Since then, DSS has investigated more than 15,500 complaints, resulting in 8,900 citations. The LT positions are set to expire in June 2017, while the amount of complaints continues to rise. Attached is a chart provided by DSS showing the growth of complaints over the last five years.

CCL Children's Residential Program Adult and Senior Care Program Complaints Data

Calendar Year	Total Complaints Rolled Over From Prior Year(s)	Total Complaints Received	Total Complaints Received + Prior Year(s) Rollover	Total Complaints Approved	Ratio of Complaints Approved to Complaints Pending	Current Year Net Loss/gain	Total Complaints Over 90 Days
2012	2,773	8,129	10,902	7,685	0.70	3,217	1,591
2013	3,217	9,228	12,445	7,619	0.61	4,826	2,971
2014	4,826	9,001	13,827	9,780	0.71	4,047	2,600
2015	4,047	10,673	14,720	10,333	0.70	4,387	2,565
2016	4,387	10,319	14,706	10,989	0.75	3,717	2,012

Centralized Application Unit (CAU): DSS states that since the establishment of the Adult and Senior Care Program CAU in 2014, increased statutory and regulatory changes have resulted in staff not being able to process applications in an efficient and timely manner, resulting in the delayed opening of facilities. Examples of increased statutory and regulatory changes include requirements to collect and verify additional information associated with past compliance and financial history. The CAU backlog as of June 2016 was over 691 applications.

RCFE Reform: The establishment of the RCFE reform act, which included nineteen chaptered bills, created a significant policy and regulatory development workload for DSS. The 2015 Budget Act gave DSS a two-year LT Associate Governmental Program Analyst (AGPA) to work with various stakeholders to shoulder this increased workload. While the development of regulations is mostly finished, policy guidance and training is still needed and the LT position is set to expire before this can be completed.

Group Home Oversight: The 2015 Budget Act established 4.5 LT LPAs to implement AB 388. These positions will expire in June 2017, as the workload was expected to decline with the implementation of CCR and phase-out of group homes. However, some group homes will now continue to operate until 2019, and Short-Term Residential Treatment Programs (STRTPs) have been added to the list of facilities required to report to the CCLD. As a result, the AB 388 workload will continue to be ongoing. The requested resources will staff the Regional Offices that conduct this work.

Staff Comment and Recommendation. Hold open. No concerns have been raised to subcommittee staff at this time.

Questions.

1. Please summarize the proposal and provide information on the current state of the TAF.

2. Does the department anticipate that with the resources requested in this BCP, combined with the resources provided over the last several years, it will be able to keep up with the growth in complaints?

5180 – DEPARTMENT OF SOCIAL SERVICES, SUPPLEMENTAL SECURITY INCOME/STATE SUPPLEMENTAL PAYMENT (SSI/SSP)

Issue 5: Overview – SSI/SSP

The Supplemental Security Income/State Supplemental Payment (SSI/SSP) programs provide cash assistance to around 1.3 million Californians, who are aged 65 or older (28 percent), are blind (one percent), or have disabilities (71 percent), and in each case meet federal income and resource limits. A qualified SSI recipient is automatically qualified for SSP. SSI grants are 100 percent federally funded. The state pays SSP, which augments the federal benefit.

Funding. The budget proposes $10.2 billion total funds ($2.9 billion General Fund) for SSI/SSP. The state pays administration costs for SSP, around $189 million for the budget year. From 2016-17 to budget year, the budget is projected to increase by $55.2 million General Fund due to a projected average monthly caseload growth and the full-year costs of the one-time 2017 SSP COLA.

Total spending for SSI/SSP grants—including General Fund and federal expenditures (which are not passed through the state budget)—has increased by about $1.1 billion— or 12 percent—between 2007–08 and 2015–16. Costs for SSI/SSP include the Cash Assistance Program for Immigrants and the California Veterans Case Benefit Program and (to be discussed below).

Cash Assistance Program for Immigrants (CAPI). In 1998, the Cash Assistance Program for Immigrants (CAPI) was established as a state-only program to serve some legal non-citizens who were aged, blind, or had disabilities. After 1996 federal law changes, most entering immigrants were ineligible for SSI, although those with refugee status are allowed seven years of SSI. CAPI benefits are equivalent to SSI/SSP program benefits, less $10 per individual and $20 per couple. The CAPI recipients in the base program include 1) immigrants who entered the United States prior to August 22, 1996, and are not eligible for SSI/SSP benefits solely due to their immigration status; and 2) those who entered the U.S. on or after August 22, 1996, but meet special sponsor restrictions (have a sponsor who is disabled, deceased, or abusive). The extended CAPI caseload, which is separate from the base CAPI caseload, includes immigrants who entered the U.S. on or after August 22, 1996, who do not have a sponsor or have a sponsor who does not meet the sponsor restrictions of the base program. In 2017-18, the estimated monthly average caseload is 15,646 cases for both CAPI and extended CAPI.

California Veterans Cash Benefit Program (CVCB) Program. The California Veterans Cash Benefit Program (CVCB) program is linked to the federal Special Veterans Benefit (SVB) Program, which was signed into law in 1999 and provides benefits for certain World War II veterans. The SVB application also serves as the CVCB application, and payments for both programs are combined and issued by the SSA. CVCB program benefits are specifically for certain Filipino veterans of World War II who were eligible for CA SSP in 1999, who are eligible for the SVB program, and who have returned to live in the Republic of the Philippines. For 2017-18, the department estimates that the caseload is around 313 cases. Grant levels are identical to the SSP portion for individuals.

Caseload. The SSI/SSP caseload has generally experienced slow and steady growth over the last decade at an average of approximately 0.9 percent annually. However, for 2016-17, there is actually a 0.6 percent decline from the prior year. Caseload will increase slightly into 2017-18 by 0.1%. The department attributes this slowing growth to program attrition.

Maintenance-of-Effort. The federal government has established a maintenance-of- effort (MOE) for the amount of SSP paid by California. The current SSP grant for individuals and couples is the state's March 1983 payment level. Violating this MOE would risk all of the state's Medicaid funding. In addition, California's SSI/SSP beneficiaries are ineligible for CalFresh benefits, due to the state's "cash-out" policy.

Cost-of-Living Adjustment (COLA). Under current law, the federal SSI and grant payments for SSI/SSP recipients are adjusted for inflation each January through cost-of-living adjustments (COLAs). The state COLA for the SSP grant was suspended periodically throughout the 1990s and into the 2000s. The SSP COLA was permanently repealed in 2011 through statute. However, in 2016-17, the Administration proposed and the Legislature approved a one-time SSP COLA of 2.76 percent.

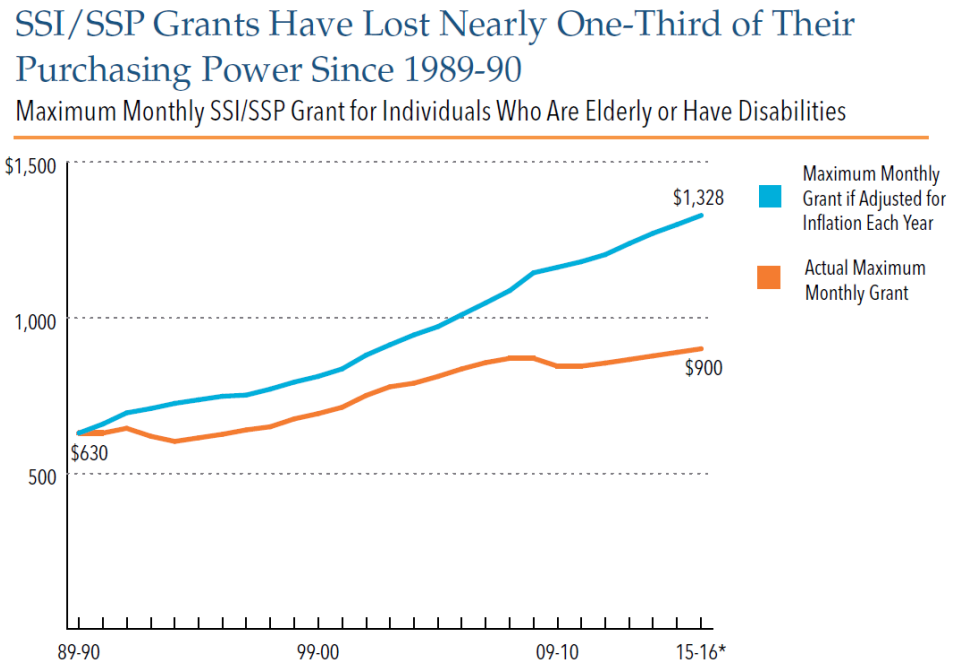
Grant Levels. The chart below displays the maximum monthly SSI/SSP grant for individuals and couples in 2007–08, as compared to grant levels for 2017–18. Reflecting SSP grant reductions and the suspension of the state COLA, the combined SSI/SSP maximum monthly grant for individuals and couples has declined as a percentage of federal poverty level (FPL) over this period.

	2007-08	**2017-18**
Maximum Grant—Individuals		
SSI	$637	$735
SSP	233	160
Totals	**$870**	**$895**
Percent of FPL	102.3%	89.1%
Maximum Grant—Couples		
SSI	$956	$1,103
SSP	568	407
Totals	**$1,524**	**$1,510**
Percent of FPL	133.6%	112.0%

According to the Legislative Analyst's Office (LAO), after using the California Consumer Price Index to adjust for inflation, the proposed maximum combined SSI/SSP grant for 2017-18 has declined in purchasing power since 2007-08:

- Represents roughly $132 less purchasing power for individuals.
- Represents roughly $296 less purchasing power for couples.

The chart below compares an individual's SSI maximum grant amount as a percentage of the federal poverty level and demonstrates its loss of purchasing power since 1989.



Source: California Budget and Policy Center. "California Budget Perspective 2015-16." March 2015. http://calbudgetcenter.org/wp-content/uploads/Budget-Perspective-2015_16-03.04.2015.pdf

Other grant increase options. Other methodologies can be used to provide an adjustment to the SSI/SSP COLA. Last year's COLA applies the CNI to only the SSP portion. However, in prior SSI/SSP grant increases, the CNI was applied to the entirety of the grant. Additionally, last year's COLA is a one-time increase. Prior to 2011, the Legislature had the ability to provide annual COLA adjustments to SSP portion of the grant.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide a brief overview of the SSI/SSP program and budget.
2. Please summarize the changes to SSI/SSP grant levels in recent years.

Staff Comment. Hold open.

Issue 6: Housing Disability and Advocacy Program (HDAP)

Governor's Proposal. Last year, the Senate "No Place Like Home" package of homelessness initiatives included a one-time investment to incentivize local governments to boost outreach efforts and advocacy to get more eligible poor people enrolled in the SSI/SSP program. $45 million General Fund was approved for this purpose, and named the Housing and Disability Advocacy Program (HDAP). $513,000 of the $45 million was carved out to staff the program and get it up and running as soon as possible. However, the Governor's budget proposes to halt implementation of the HDAP and scores the $45 million as savings in the budget year.

Background. Applying to SSI is a complicated and challenging process, particularly for applicants that are homeless or have severe mental disabilities. Some studies have indicated that there may be a significant population of individuals who qualify for SSI who are not currently receiving benefits from the program[3]. In fact, many applicants are denied when they first apply, and it is only upon appeal that they receive assistance. In the meantime, which can range from months to year, they must subsist on General Assistance/General Relief (GA/GR) payments from the county, which are substantially less than an average SSI/SSP grant, and utilize emergency services at a high cost to state and local governments.

Some counties are currently investing in SSI advocacy programs to proactively assist applicants with the application process and helping them stabilize in the interim. Best practices include providing modest housing subsidies, transportation and other supportive services, case management, outreach to participants, and collaboration with medical providers.[4] In particular, for individuals approved for SSI, housing subsidies can be recouped through the Interim Assistance Reimbursement (IAR), and these funds can then be applied toward another applicant in need of a housing subsidy. The federal government covers 72% of the total costs of the SSI/SSP program.

Panel. The subcommittee has requested the following panelists, in addition to the Department of Social Services, to provide comment on SSI Advocacy:

- Mike Herald, Western Center on Law and Poverty
- Trent Rohrer, Executive Director at City and County of San Francisco - Human Services Agency
- Leepi Shimkhada, Director of Housing and Services, Housing for Health, LA County Department of Health Services

Staff Comment and Recommendation. Staff recommends that the Subcommittee not approve the Governor's proposal to halt implementation of the HDAP, and instead use the $45 million General Fund as intended in the 2016-17 budget to fund the HDAP in the current year. The HDAP was part of the Senate's "No Place Like Home" package, many components of which were also included in the 2016 Budget Act. While the rest of the "No Place Like Home" pieces were left in-tact in the Governor's Budget, the Administration chose to cut HDAP despite its potential to provide overall savings by maximizing federal dollars and to combat homelessness.

[3] http://economicrt.org/publication/all-alone/

[4] http://healthconsumer.org/SSIAdvocacyBestPracticesRpt.pdf

Questions.

1. Please discuss what efforts went into getting HDAP ready to implement in the fall of 2016.

2. Please provide insight into why implementation of HDAP halted.

3. Please discuss the department's current efforts to ensure that all eligible individuals are applying to SSI and what help is available to applicants who are denied.

Issue 7: Proposals for Investment

The subcommittee has received the following SSI/SSP-related proposals for investment.

- Restore the SSI/SSP Grant Cuts and the COLA

Budget Issue. The CA4SSI coalition requests restoration on the SSP grant cuts and the COLA to bring individuals to at or above the federal poverty level (FPL). This would be a three-step process: 1) In January 2018, the SSP grant would be increased and equal to 96 percent of the FPL when combined with the SSI grant; 2) In January 2019, the SSP grant would be increased to equal 100 percent of the FPL when combined with the SSI grant; and 3) After 2019, the statutory COLA would be restored.

Background. Currently, the individual SSI/SSP grant is worth 89% percent of the FPL.

Staff Comment and Recommendation. Hold open.

- Restore HDAP SSI Advocacy for GA/GR Recipients

Budget Issue. The Western Center on Law and Poverty opposes the Administration's proposal to defund the HDAP program and urges a strategy that will aid a portion of Californians reliant on GA/GR by assisting them in the SSI application process and providing other services and supports while they are waiting to be approved for SSI.

Background. The Western Center on Law and Poverty notes that approximately 130,000 Californians receiving GA/GR may be eligible for SSI, and that it is in California's interest to maximize the number of people receiving these federal dollars.

Staff Comment and Recommendation. Hold open.

5180 – DEPARTMENT OF SOCIAL SERVICES, IN-HOME SUPPORTIVE SERVICES

Issue 8: Overview - IHSS

The In-Home Supportive Services (IHSS) program provides personal care services to approximately 500,000 qualified low-income individuals who are blind, aged (over 65), or who have disabilities. Services include feeding, bathing, bowel and bladder care, meal preparation and clean-up, laundry, and paramedical care. These services help program recipients avoid or delay more expensive and less desirable institutional care settings.

Budget Issue. The budget proposes $10.6 billion ($3.2 billion General Fund) for services and administration. Of that amount, $3.5 billion ($1.8 billion General Fund) is for IHSS Basic Services, an overall increase due to growth in caseload of 5.3 percent, and higher cost per hour, due to the increase in the hourly minimum wage from $10 to $10.50, effective January 1, 2017, and county wage increases. Caseload growth and wage increases for IHSS providers continue to be two primary drivers of increasing IHSS service costs.

Service delivery. County social workers determine IHSS eligibility and perform case management after conducting a standardized in-home assessment of an individual's ability to perform activities of daily living. In general, most social workers reassess annually recipients' need for services. Based on authorized hours and services, IHSS recipients are responsible for hiring, firing, and directing their IHSS provider(s). If an IHSS recipient disagrees with the hours authorized by a social worker, the recipient can request a reassessment, or appeal their hour allotment by submitting a request for a state hearing to DSS. According to DSS, around 73 percent of providers are relatives, or "kith and kin."

In the current year, IHSS providers' combined hourly wages and health benefits vary by county, and range from approximately $10.00 to $18.00 per hour. Prior to July 1, 2012, county public authorities or nonprofit consortia were designated as "employers of record" for collective bargaining purposes on a statewide basis, while the state administered payroll and benefits. Pursuant to 2012-13 trailer bill language, however, collective bargaining responsibilities in seven counties – Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara – participating in Coordinated Care Initiative (CCI) shifted to an IHSS Authority administered by the state.

Coordinated Care Initiative. CCI requires Cal Medi-Connect to coordinate medical, behavioral health, long-term institutional, and home and community-based services, and to administer IHSS according to current program standards and requirements. The intent of CCI is to improve integration of medical and long-term care services through the use of managed health care plans and to realize accompanying fiscal savings. As IHSS becomes a Medi-Cal managed care benefit in the seven counties, each county is responsible for paying a MOE amount, not a percentage of program costs. However, language embedded in the CCI requires the Department of Finance to annually determine if there are net General Fund savings for CCI. If CCI is not cost-effective, all components of CCI and the county MOE agreement would cease operation. Based on CCI costs, the Governor's budget discontinues the CCI, and along with it the IHSS MOE and statewide bargaining. This will be discussed in more detail later in the agenda.

Universal Assessment Tool. In 2012, the Legislature authorized the development and pilot implementation of a universal assessment tool (UAT). The Department of Health Care Services, DSS, and the Department of Aging were tasked with developing a UAT to assess a Medi-Cal beneficiary's need for Home and Community-Based Services. The goal is to enhance personalized care planning under CCI, and create a common tool that can be used by all involved in the care of beneficiaries who need home and community based long-term care services. The development of the UAT was halted along with the CCI.

Program Funding. The average annual cost of services per IHSS client is estimated to be around $16,891.08 for 2016-17. The program is funded with federal, state, and county resources. Federal funding is provided by Title XIX of the Social Security Act. Before the CCI, the county IHSS share-of-cost (SOC) was determined by 1991 Realignment. When the state transferred various programs from the state to county control, it altered program cost-sharing ratios and provided counties with dedicated tax revenues from the sales tax and vehicle license fee to pay for these changes. Prior to realignment, the state and counties split the non-federal share of IHSS program costs at 65 and 35 percent, respectively. With the enactment of the CCI, the funding structure changed as of July 1, 2012, with county IHSS costs based on a maintenance-of-effort (MOE) requirement.

Other Policy Changes. Several recently enacted policies have also impacted the IHSS program, including:

- **Restoration of the seven percent reduction in service hours.** A legal settlement in *Oster v. Lightbourne* and *Dominguez v. Schwarzenegger*, resulted in an eight percent reduction to authorized IHSS hours, effective July 1, 2013. Beginning in July 1, 2014, the reduction in authorized service hours was changed to seven percent. The 2015 Budget Act approved $225.9 million in one-time General Fund resources, and related budget bill language, to offset the seven-percent across-the-board reduction in service hours. The 2016 Budget Act uses $272.9 million General Fund and a portion of the revenues from a restructuring of the existing Managed Care Organization (MCO) tax to restore the seven percent across-the-board reduction beginning July 1, 2016. 2017-18 costs are estimated to be $188.6 million General Fund. Restoration of the seven percent reduction is tied to the MCO tax, which is up for renewal in 2019.

- **Minimum wage increases.** Assembly Bill 10 (Alejo), Chapter 351, Statutes of 2013, increased the minimum wage from $8 per hour to $9 per hour in July 2014, with gradual increases until the minimum wage reached $10 per hour by January 2016. SB 3 (Leno), Chapter 4, Statutes of 2016, will move the state's current $10 per month for minimum wage to $10.50 at the beginning of 2017, and schedules annual increases to $15 for most employers by 2022. SB 3 also provides three paid sick leave days to IHSS workers beginning July 2018, and requires DSS, in conjunction with stakeholders, to convene a workgroup to implement paid sick leave for IHSS providers and issue guidance by December 1, 2017. DSS began consulting with stakeholders in the fall of 2016, and will continue to meet with them on an ongoing basis as policies and procedures for implementation are developed. $17.2 million General Fund is included in the current year, and $41.4 million General Fund is included in the budget year, for these purposes.

- **Fair Labor Standards Act (FLSA)—Final Rule.** FLSA is the primary federal statute dealing with minimum wage, overtime pay, child labor, and related issues. In September 2013, the U.S. Department of Labor issued a final rule, effective January 1, 2015, which redefined "companionship services" and limits exemptions for "companionship services" and "live-in domestic service employees" to the individual, family, or household using the services (not a third party employer). The rule also requires compensation for activities, such as travel time between multiple recipients, wait time associated with medical accompaniment, and time spent in mandatory provider training. Under the final rule, employers must pay at least the federal minimum wage and overtime pay at one and a half times the regular pay if a provider works more than 40 hours per work week. The final rule began implementation in California on February 1, 2016.

  SB 855 (Committee on Budget and Fiscal Review) Chapters 29, Statutes of 2014, established a limit of 66 hours per week for IHSS providers based on the statutory maximum of 283 hours a month for IHSS recipients and limited travel time for providers to seven hours a week. DSS or counties may terminate a provider in the event of persistent violations of overtime or travel limitations. $437.1 million General Fund is included in the current year, and $303.4 million General Fund is included in the budget year, for these purposes.

Electronic Visit Verification. H.R. 2646 was signed in December of 2016, and contains provisions related to Electronic Visit Verification, or "EVV". These provisions would require states to implement EVV systems for Medicaid-funded personal care and home health care services, such as IHSS. The bill stipulates that the electronic system must verify (1) the service performed, (2) the date and time of service, and (3) the location of the service, and (4) the identities of the provider and consumer. Currently, IHSS has no such system. California has until January 2019 to comply for personal care services, and until January 2023 for home care services. As federal rulemaking and guidance is not yet available, and the department does not yet have a timeline for when they would have a proposal for an EVV system. The department will work with stakeholders to gather input.

Electronic Timesheets. In the last several years, there have been various instances with the processing of paper timesheets that have resulted in delays in payment to providers. The State Auditor is scheduled to release an audit on the broader issues facing the IHSS payroll system in March of 2017. These payroll issues were also discussed in more detail in a Senate Human Services Committee hearing on November 1, 2016.

In an effort to streamline timesheet processing, and in response to requests from IHSS stakeholders, DSS has announced plans to implement online IHSS timesheets in three pilot counties in May 2017. According to DSS, the online timesheet system will use technology that is intuitive and easy to use on PCs, smartphones and tablets. It will provide real-time data validation, which means timesheet errors can be corrected before the timesheet is submitted. Providers and recipients will be able to submit electronic signatures, eliminating the need to place timesheets in the mail. If providers and recipients adopt this optional technology, it is expected to reduce timesheet errors and significantly reduce the time it takes to pay providers by eliminating mail time. The department is also working on plans to increase the use of direct deposit as well as other electronic funds transfer options.

DSS has issued a request for proposals (RFP) for the contract to operate the payroll system (CMIPS II). The RFP requires the vendor to "assess the current payrolling approach and recommend available business, technology and process improvements."

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview for the IHSS program, including caseload and funding levels.

2. Please provide an update on the status of EVV.

3. Please provide more details on the electronic timesheet pilot. When will you have feedback to share from the pilot, and when do you expect the pilot to finish and electronic timesheets to roll out to all counties? How are you working with stakeholders to ensure that consumers and providers are aware of changes in the timesheet process?

4. Please provide more information on both the department's efforts to improve the direct deposit process and other electronic funds transfer options.

Issue 9: Update: Coordinated Care Initiative

Budget Issue. The Governor's budget estimates that CCI will no longer be cost-effective and does not meet the statutory savings requirements. Current law allows the Administration to discontinue the CCI if this is found to be the case. The Governor's proposal for the unwinding of the CCI includes ending the IHSS MOE and returning to the prior state-county sharing ratio, and shifting collective bargaining responsibility back to demonstration counties. The Administration estimates that eliminating the IHSS County MOE provides $622.6 million General Fund savings in 2017-18. Below is a timeline of the unwinding of the CCI provided by the Legislative Analyst's Office (LAO)[5].

Figure 3

Timeline of When Major CCI Policies Become Inoperative Under Current Law[a]

January 2017	Return of responsibility for bargaining for IHSS wages and benefits to the CCI counties.
	End of development of home and community–based services universal assessment tool.
July 2017	Elimination of IHSS Maintenance–of–Effort and return to historical IHSS state–county cost–sharing ratio.
January 2018	Disenrollment of members from Cal MediConnect.[b]
	End of mandatory managed care enrollment for dual eligibles.[b]
	Removal of IHSS financing from managed care.

[a]Given the January 2017 determination by the Department of Finance that the CCI does not generate net General Fund savings.

[b]These are elements we expect to be proposed for continuation under the Governor's proposal.

CCI = Coordinated Care Initiative and IHSS = In–Home Supportive Services.

Coordinated Care Initiative. CCI requires health plans to coordinate medical, behavioral health, long-term institutional, and home and community-based services. Counties continue to administer the program under existing standards and requirements. The intent of CCI is to improve integration of medical and long-term care services through the use of managed health care plans and to realize accompanying fiscal savings by reducing institutional care.

A 2012-13 budget trailer bill related to the enactment of the CCI, changed the funding in IHSS from a state and county split of the non-federal share of IHSS program costs at 65 and 35 percent to a maintenance- of-effort (MOE) requirement as of July 1, 2012. The MOE works differently depending on the county. For a select 15 smaller counties, the MOE levels are based either on the 2011-12 county allocations or county expenditures, whatever is lower. For the other 43 counties, the MOE levels are based on county expenditures in 2011-12. Starting July 1, 2014, a 3.5 percent annual inflation factor was applied to this base along with any adjustments for approved county negotiated wage and health benefit increases. The state assumed responsibility for any additional costs that would have historically been paid under the previous county SOC, although with a $12.10 cap on state wage and benefit participation. Language embedded in the CCI requires the Department of Finance to annually determine if there are net General Fund savings for CCI. If CCI is not cost-effective, all components of CCI and

[5] Legislative Analyst's Office: 2017-18: The Coordinated Care Initiative: A Critical Juncture (February 2017): http://lao.ca.gov/reports/2017/3585/coordinated-care-022717.pdf

the county MOE agreement would cease operation.

Universal Assessment Tool. In 2012, the Legislature authorized the development and pilot implementation of a universal assessment tool (UAT). The Department of Health Care Services (DHCS), the Department of Aging (CDA), and DSS were tasked with developing a UAT to assess a Medi-Cal beneficiary's need for home and community-based services. The goal was to enhance personalized care planning under CCI, and create a common tool that can be used by all involved in the care of beneficiaries who need home and community-based, long-term care services.

As of last year, DSS, DHCS and CDA continued to work with a design team from the UCLA Boren School of Gerontology to prepare a draft UAT for focus group, pre-pilot and pilot testing. UAT focus group testing was expected to begin in May 2016, and pre-pilot testing was slated for early 2017.

Evaluation of IHSS in the CCI. While there is not robust data available on how the IHSS integration into managed care under the CCI is working, given the short duration of the pilot, a couple of preliminary studies provide some insight into the strengths and weaknesses of the program model. A recent report entitled "Evaluation of CalMediConnect: Results of Focus Groups with Beneficiaries"[6] reported that several key stakeholders interviewed found that the program inspired better collaboration and communication between IHSS and plans. Those involved saw the potential for IHSS workers to become more involved and ensure that the number of IHSS hours authorized would be better aligned with the needs of IHSS beneficiaries. However, many IHSS recipients opted out of involvement in the program. Another recent report, "CalMediConnect: How Have Health Systems Responded?"[7] echoed these findings, and both reports emphasize that more outreach to communities with high opt-out rates, IHSS social workers, and IHSS providers, is needed.

Bargaining implications. Pursuant to current law, the Statewide Authority immediately ceased to be the employer of record when the CCI was discontinued, as the Statewide Authority did not execute any contracts while the CCI was in effect.

There is concern among counties and labor organizations about the implications of ending statewide bargaining. Also, while counties have already received notification of the immediate return of collective bargaining, counties and IHSS workers are not clear about when bargaining should resume.

Realignment funding implications. With the elimination of the IHSS MOE and return to the prior state-county sharing ratio, the Administration expects that counties will now also contribute to costs increases that were incurred while the CCI was operative, including FLSA overtime, state minimum wage increases, paid sick leave, and the restoration of the seven percent in service hours. In particular, counties estimate that with current law capping state wage and benefit participation at $12.10 per hour, if state minimum wage increases shift to the counties, costs could grow into the hundreds of millions.

It is likely that counties will have to use 1991 Realignment dollars to pay for IHSS costs; however, many of these funds are used to pay for health and mental health programs, as well as public safety and transportation. Complicating the 1991 Realignment issues further is AB 85 (Assembly Committee on

[6] University of California for the SCAN Foundation, *Evaluation of CalMediConnect: Results of Focus Groups with Beneficiaries* (March 2016): http://www.thescanfoundation.org/sites/default/files/cal_mediconnect_focus_group_report_march_2016.pdf
[7] University of California for the SCAN Foundation, *CalMediConnect: How Have Health Systems Responded* (July 2016): http://www.thescanfoundation.org/sites/default/files/cal_mediconnect_health_system_full_report.pdf

Budget) Chapter 24, Statutes of 2013, which established the Child Poverty and Family Supplemental Support Subaccount, and takes a portion of 1991 Realignment growth revenues. This subaccount currently funds CalWORKs grant increases and eventually the repeal of the Maximum Family Grant Rule, which is currently being paid for with the General Fund. While 1991 Realignment funding, including the subaccount, is currently expected to grow, it is unclear if it will grow enough to cover all of its current costs, in addition to rapidly increasing IHSS costs, particularly in the out years.

The subcommittee has requested the LAO present on 1991 Realignment funding in relation to the CCI.

LAO Comments. In their publication "2017-18: The Coordinated Care Initiative: A Critical Juncture," the LAO notes that while the Department of Finance's methodology for determining whether the CCI generates net General Fund savings is in line with statute, the Governor's proposal does not address the impact of ending the IHSS MOE on counties and programs that draw on 1991 Realignment revenues. The LAO recommends exploring several options, including:

- Continuing to try to integrate IHSS into whatever new managed care system replaces the CCI.

- Providing counties a one-time General Fund grant or loan to cover the IHSS costs incurred in 2017-18.

- Reexamining the cost-sharing ratio for IHSS, including potentially removing the requirement for counties to cover wages above $12.10.

Panel. The subcommittee has requested the following panelists, in addition to DSS and the LAO, to provide comment on the discontinuation of the CCI in relation to IHSS, and respond to the Administration:

- Frank Mecca, County Welfare Director's Association
- Kirsten Barlow, County Behavioral Health Director's Association
- SEIU Representative
- UDW Representative
- County Supervisor

Staff Comment and Recommendation. Hold open. In contemplating how the Administration has chosen to unwind the CCI, the Legislature must take into account the concerns that counties have shared regarding bearing the full brunt of IHSS costs in 2017-18, as well as growing out-year costs that could negatively impact many programs beyond just IHSS. The Legislature should continue to work with the Administration and stakeholders to identify a path forward that meets shared priorities and allows for the stability of critical programs for vulnerable Californians.

Questions.

1. Please describe the status of IHSS in the CCI before it was discontinued.

2. Please describe the status of the UAT before it was halted. Did you consider the UAT to be a valuable tool, outside of the CCI?

3. Do you expect counties to pick up all additional IHSS costs that have been added to the program since 2012, such as overtime, sick leave, and minimum wage increases?

4. How do you expect counties to pay for costs, both upfront and in the out years? How do you respond to counties saying that they cannot bear these costs?

5. Please respond to county concerns about the $12.10 state wage and benefit cap in current statute.

6. In the Governor's budget, the Administration expressed its willingness to work with counties to mitigate impacts of ending the IHSS MOE. What is the status of current conversations?

7. Please respond to the suggestions from the LAO, included in the agenda, to mitigate the situation with counties.

Issue 10: Oversight – Fair Labor Standards Act (FLSA) Overtime Implementation

Governor's Proposal. FLSA implementation, as set forth under SB 855 (Committee on Budget and Fiscal Review) Chapters 29, Statutes of 2014, began on February 1, 2016. The 2017-18 Governor's budget provides $989 million ($465 million General Fund) in 2017-18 for the implementation of the federal requirements. The $989 million is allocated as follows:

- $580.7 million for FLSA Overtime.
- $385.3 million for FLSA compliance (medical accompaniment wait time, travel time, and mandatory provider training).
- $13.1 million for FLSA Provider Exemptions.
- $5 million for FLSA Administration.
- $4 million for the Case Management, Information and Payrolling System (CMIPS II) FLSA changes.

Background. The new FLSA overtime regulations require states to pay overtime compensation, and to compensate for activities such as travel time between multiple recipients, wait time associated with medical accompaniment, and time spent in mandatory provider training. Under the final rule, employers must pay overtime at one and a half times the regular pay if a provider works more than 40 hours per work week.

SB 855 (Committee on Budget and Fiscal Review) Chapters 29, Statutes of 2014, established a limit of 66 hours per week for IHSS providers based on the statutory maximum of 283 hours a month for IHSS recipients and limited travel time for providers to seven hours a week. DSS or counties may terminate a provider in the event of persistent violations of overtime or travel limitations. The final rule was implemented in California effective February 1, 2016. Beginning May 1, 2016, two exemptions were established for limited circumstances that allow the maximum weekly hours to be exceeded:

- Exemption 1 – Live-In Family Care Provider: Is granted for live-in care providers residing in the home for two or more minor or adult children or grandchildren or step-children with disabililities for whom they provide IHSS services and who meet specified requirements on or before January 31, 2016. The projected average monthly caseload is 1,300 providers in 2016-17 and 2017-18. Providers who meet the specific criteria for this exemption will be allowed to work up to 12 hours per day, or 90 hours per week, not to exceed 360 hours per month.
- Exemption 2 – Extraordinary Incurable Circumstances: Is granted on a case-by-case basis for providers who work for two or more IHSS recipients that have extraordinary circumstances including complex medical and behavioral needs, living in a rural or remote area, or language barriers that place the recipient(s) at imminent risk of out-of-home institutionalized care. The projected average monthly caseload is 135 in 2016-17 and 385 in 2017-18. It is estimated that the number of providers who qualify for this exemption will reach 250 by the end of 2016-17 and 500 by the end of 2017-18. Providers who meet the specific criteria for this exemption will

be allowed to work up to 12 hours per day, or 90 hours per week, not to exceed 360 hours per month.

The Governor's budget estimates that 14.1 percent of providers with a single recipient and 9.4 percent of providers with multiple recipients typically work more than 40 hours per week.

Current Status of Implementation. The department has provided the following table documenting milestone implementation activities:

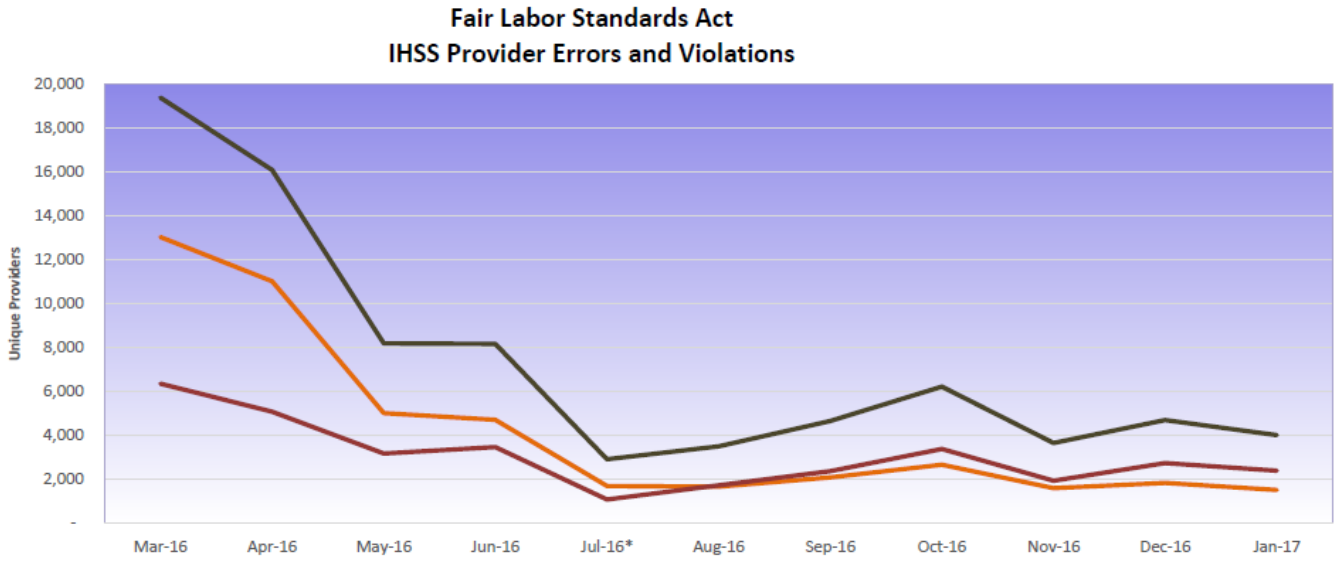
CDSS ADULT PROGRAMS DIVISION
OVERTIME (FLSA IMPLEMENTATION) TIMELINE

Completion Date	Milestone	State/County Activities
January 7, 2016	Implementation of overtime – Effective February 1, 2016	**All County Letter (ACL) Released for Implementation of FLSA requirements – SB 855 and SB 873 workweek and overtime provisions.** • CDSS released ACL 16-01 to provide counties with instructions, including the policies and procedures for implementation of the overtime, workweek requirements, (pursuant to SB 855 and SB 873). These included the revised forms and notices (including the workweek agreements for providers and recipients).
		Timesheets and Travel Claim Form - Timesheet (SOC 2261) and CMIPS modifications were made to accommodate the payment of overtime implemented on February 1, 2016 as well as claiming of travel time.
January 21, 2016	Overtime Exemption 1	**Overtime Exemption 1: Live-In Family Care Provider Overtime Exemption.** • CDSS released ACL 16-07 to provide counties with information for implementing Overtime Exemption 1.
Feb 9, - Feb 26, 2016	Training Sessions	**Training-for-Trainer (T4T) sessions commenced February 9, 2016, and concluded February 26, 2016.** • CDSS conducted the training sessions statewide to approximately 320 trainers at the counties, Public Authorities (PAs), and labor organizations.
April 1, 2016	Overtime Exemption 2	**Overtime Exemption 2: Extraordinary Circumstances.** • CDSS released ACL 16-22 to provide counties with information for implementing Overtime Exemption 2. • The Extraordinary Circumstances Exemption allows IHSS providers to work up to 360 hours per month.
April 15, 2016	Forms and Workweek Agreements	**Deadline for completed workweek agreements (SOC 2255 and SOC 2256) to be returned (completed) to counties for processing.** No consequences to recipients or providers who do not complete and return these forms by the deadline.
April 22, 2016	Violations	**Violations For Exceeding Workweek and/or Travel Time Limits -** CDSS released ACL 16-36 to provides counties with specific information and instructions related to the implementation of violations of the workweek and travel time limitations.
May 1, 2016	Effective date of Violations	**Violations (Non-Compliance with Workweek and Overtime Requirements) -** Grace period ends. While the grace period ended May 1st, no violations were issued until July 1st to allow time for counties to reach out and educate providers in order to avoid future violations.
May 10 and 16, 2016	Systems Modifications	**Modifications to CMIPS for Violations Processing, County Dispute and State Administrative Review Processes**

Exemptions and Violations Data. The department states that it has engaged in an extensive communication campaign in conjunction with stakeholders. This campaign included statewide informational mailings, a training video that was made available on the internet and for counties and public authorities to show locally, and trainings for trainers so that information could be disseminated to providers in the most personalized methods possible.

For Exemption 1, as of February 3, 2017, there were 1,424 providers approved, 571 denied, and eight pending. For Exemption 2, as of January 1, 2017, there were 56 providers approved, 70 denied, and seven pending.

Below are two charts from DSS documenting violations data:



	Providers with Errors				Providers with Violations						
Violation Type	Mar-16	Apr-16	May-16	Jun-16	Jul-16*	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Exceeded Weekly Max of 66 Hours (Multiple Recipients)	13,043	11,025	5,019	4,706	1,694	1,657	2,081	2,660	1,599	1,834	1,510
Exceeded the Monthly Overtime Maximum (Single Recipients)	6,358	5,078	3,172	3,466	1,076	1,728	2,372	3,383	1,935	2,737	2,386
Exceeded the Travel Maximum**					142	113	204	175	117	128	115
Statewide Total	19,401	16,103	8,191	8,172	2,912	3,498	4,657	6,218	3,651	4,699	4,011
^Providers with 2 violations					0	1	526	912	796	1,114	812
^Providers with 3 violations					0	0	0	4	119	196	176
^Providers with 4 violations					0	0	0	0	0	1	13

Ongoing Implementation Monitoring. The department will provide data in quarterly reports starting six months after implementing the FLSA that will include data on the number of timesheets with overtime, the number of exemptions, payroll stats, etc. This is in addition to the requirement for a study that was included in SB 855. The first report to the Legislature is due in April 2017, and is currently undergoing administrative review. The report will include updated facts and figures used to build the May Revision.

Staff Comment and Recommendation. Hold open. As it has been just over one year of FLSA implementation, the department should share its data and findings with the Legislature and stakeholders, and all parties should continue to monitor how providers and recipients are faring under the new regulations and ensure that any unanticipated problems with implementation are addressed.

Questions.

1. Please provide an update on FLSA implementation.

2. Please describe what you are seeing with the two exemptions policies. Why do you think utilization of Exemption 2 is so low compared to what you were estimating last year?

3. Please describe what you are seeing with the violations policy. What preliminary data is the department seeing in terms of errors for those with violations? How many providers have been terminated or are near termination? Please discuss continued efforts to train providers.

4. Can you provide any insight into what the April 2017 FLSA report is showing about implementation?

Issue 11: Proposals for Investment

The subcommittee has received the following IHSS-related proposals for investment.

- FLSA Exemptions

Budget Issue. The IHSS Coalition requests that DSS expand IHSS exemption criteria, that consumers and providers receive notification about the criteria and process to request and exemption, and that DSS establish an appeals process.

Background. Beginning in May of 2016, DSS established two exemptions to weekly caps on hours for IHSS providers. Since the establishment of these exemptions, advocates have shared that they felt the exemptions were too narrow, and were concerned about the lack of notification and appeals process. Advocates are still developing a fiscal estimate.

Staff Comment and Recommendation. Hold Open.

- Oppose dismantling the CCI, the county IHSS MOE, and shifting IHSS collective bargaining to counties

Budget Issue. CSAC, CWDA, and various other advocates are opposed to the cessation of the CCI, the dismantling of the IHSS MOE, and shifting collective bargaining for IHSS workers from the Statewide Authority to the CCI counties.

Background. This year, CCI costs exceeded state savings, triggering the unwinding of the CCI. This also included ending the IHSS MOE and statewide bargaining for the CCI counties. In particular, CWDA estimates that shifting IHSS MOE costs back to the counties could cost upwards of $1 billion dollars by 2022-23, and will put a number of other programs at risk.

Staff Comment and Recommendation. Hold Open.

- Transfer collective bargaining for all IHSS providers from the county level to the state

Budget Issue. SEUI Local 2015 and UDW/AFSCME Local 3930 request to transfer the employer responsibility for collective bargaining for all IHSS providers from the county level to the state effective July 1, 2017. Costs, based on prior legislation, are estimated at approximately $3.5 million General Fund annually.

Staff Comment and Recommendation. Hold Open.

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

SUBCOMMITTEE NO. 3 Agenda

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

March 2, 2017
9:30 a.m. or Upon Adjournment the Joint Legislative Budget Committee
State Capitol, Room 4203

Consultant: Theresa Pena

OUTCOMES

Item	Department	Action
4170	**Department of Aging**	
Issue 1	Overview	Informational
Issue 2	Update: Multi-Purpose Senior Services Program	Informational
Issue 3	Proposals for Investment	Hold Open
4185	**California Senior Legislature**	
Issue 1	BCP: 2016 Budget Act General Fund Reappropriation	Hold Open
5180	**Department of Social Services – Adult Protective Services**	
Issue 1	Overview	Informational
Issue 2	Proposals for Investment	Hold Open
5180	**Department of Social Services – Community Care Licensing**	
Issue 3	Overview	Informational
Issue 4	BCP: Continuance of Community Care Licensing Staffing Resources	Hold Open
5180	**Department of Social Services – SSI/SSP**	
Issue 5	Overview	Hold Open
Issue 6	Housing and Disability Assistance Program	Reject (2-0)
Issue 7	Proposals for Investment	Hold Open
5180	**Department of Social Services – In-Home Supportive Services**	
Issue 8	Overview	Hold Open
Issue 9	Update: Coordinated Care Initiative	Hold Open
Issue 10	Oversight – Fair Labor Standards Act Implementation	Hold Open
Issue 11	Proposals for Investment	Hold Open

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

SUBCOMMITTEE NO. 3 Agenda

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

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

Consultant: Scott Ogus

PUBLIC COMMENT

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.

0530 OFFICE OF SYSTEMS INTEGRATION
4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Overview

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

OSI currently oversees the following projects:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2014-15

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

2015-16

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

2016-17

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

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

Stage 3 Solution Development

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

Stage 4 Project Readiness and Approval

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

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

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

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

[2] BCP amount requested for DHCS.

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

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

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

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

1. Please provide a brief overview of this proposal.

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

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

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

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

0530 OFFICE OF PATIENT ADVOCATE

Issue 1: Overview

Office of Patient Advocate Funding Overview.

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

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

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

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

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

Subcommittee Staff Comment. This is an informational item.

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

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

Issue 2: Complaint Data Reporting Update

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

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

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

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

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

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

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

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Overview

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

According to DPH, their goals include the following:

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

The department is composed of seven major program areas:

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

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

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

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

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

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

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

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

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

Department of Public Health Funding Overview.

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

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

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

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

Issue 2: Childhood Lead Poisoning Prevention Program IT Project Planning

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

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

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

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

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

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

Some of the proposed design components of SHIELD include:

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

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

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

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

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

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

Proposition 56 Allocations
(Dollars in Millions)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Issue 5: AIDS Drug Assistance Program (ADAP)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

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

Issue 7: Preventing Healthcare-Associated Infections in Facilities

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

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 10: L&C: Los Angeles County Contract

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

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 11: Improved Access to Vital Statistics Data

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

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

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

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

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

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

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

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

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

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

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

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

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

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

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

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

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

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

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

Issue 14: Youth Tobacco Enforcement Staffing

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

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

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

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

SUBCOMMITTEE NO. 3 Agenda

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

March 16, 2017
9:30 a.m., or Upon Adjournment of Floor Session
Room 4203, State Capitol

PART A

Consultant: Theresa Pena

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.

5160 DEPARTMENT OF REHABILITATION

Issue 1: Overview

The Department of Rehabilitation (DOR) works in partnership with consumers and other stakeholders to provide direct services and advocacy resulting in employment, independent living, and equality for individuals with disabilities. DOR seeks to assist over 130,000 Californians with disabilities to obtain and retain competitive employment in integrated settings, and to maximize equality and ability to live independently in their communities of choice. With a proposed FY 2017-18 budget of $446.7 million ($61.5 million General Fund) and 1,879 authorized positions, the department offers programs related to vocational rehabilitation, assistive technology, independent living, supported employment, services for individuals with traumatic brain injuries, and workforce development. Overall, federal funding constitutes around 84 percent of the department's total funding. Below is a chart that provides an overview of the department's funding since FY 2015-16.

Fund Source	2015-16 Actuals	2016-17*	2017-18*
General Fund	**$ 59,782**	**$61,456**	**$61,531**
Traumatic Brain Injury Fund	$841	$1,062	$1,114
Vending Stand Fund	$1,273	$2,361	$2,361
Federal Trust Fund	$368,290	$374,089	$373,965
Reimbursements	$6,377	$7,680	$7,680
Total Expenditures	**$436,563**	**$446,648**	**$446,651**
Positions	1,838	1,876	1,879

* Budgeted amount

Eligibility. When the department does not have enough funds to serve all applicants who are deemed eligible for services, the federal government requires DOR to use an Order of Selection (OOS) process, under which the department must serve people with the most significant disabilities first (all those in the "most significantly disabled" category will be served first, followed by those in the "significantly disabled" category and then the "disabled category"). DOR has been operating under an OOS since 1995. Within each category, DOR serves individuals according to date of application. If placed on a waiting list, DOR consumers receive information and referral services and may ask for their priority category to be re-evaluated if they have experienced a change in severity of disability. Currently, there are no consumers on the DOR waiting list.

Services and Programs. In addition to providing services, such as career assessment and counseling, job search and interview skills, and career education and training, DOR offers several programs.

- Vocational Rehabilitation (VR). The Vocational Rehabilitation Services Program delivers vocational rehabilitation services to persons with disabilities through vocational rehabilitation professionals in district and branch offices located throughout the state. DOR has cooperative

agreements with state and local agencies (education, mental health, and welfare) to provide unique and collaborative services to consumers.

- Assistive Technology (AT). The Assistive Technology Act of 1998 (amended in 2004) funds each state and U.S. territory to provide AT services. California's program, known as the California Assistive Technology System (CATS), is funded by a federal grant through the Rehabilitation Services Administration (RSA). For DOR to provide the required services, DOR contracts with the California Foundation for Independent Living Centers (CFILC) to provide statewide AT services.

- Independent Living Services. DOR funds, administers, and supports 28 independent living centers in communities located throughout California. Each independent living center provides services necessary to assist consumers to live independently and be productive in their communities. Core services consist of information and referral, peer counseling, benefits advocacy, independent living skills development, housing assistance, personal assistance services, and personal and systems change advocacy.

- Traumatic Brain Injury (TBI). In coordination with consumers and their families, seven service providers throughout California provide a coordinated post-acute care service model for persons with TBI, including supported living, community reintegration, and vocational supportive services. This will be discussed in more detail later in the agenda.

Workforce Innovation and Opportunity Act. On July 22, 2014, President Obama signed the Workforce Innovation and Opportunity Act (WIOA), which seeks to assist job seekers access employment, education, training, and support services to succeed in the labor market, and to match employers with skilled workers. WIOA seeks to improve services to individuals with disabilities, including extensive pre-employment transition services for youth, better employer engagement, and increasing access to high-quality workforce services. Consistent with WIOA requirements and input received from internal and external stakeholders, DOR has implemented or completed the following:

- Provided training, technical tools and resources to all departmental staff.

- Facilitated multiple public WIOA forums with internal and external stakeholders.

- Collaborated with state and local partners, community rehabilitation programs, stakeholders and national experts to develop and implement new services and identify evidence based practices to meet WIOA requirements.

- Established 39 new contracts providing over 600 students and youth with disabilities the opportunity for work experiences.

- Collaborated with the California Department of Education to develop and streamline the processes, procedures and documentation required before youth and students with disabilities may be employed at sub minimum wages.

- Designated a DOR representative on every Local Workforce Development Board (LWDB) to represent the needs of individuals with disabilities.

- Negotiated and finalized MOUs with each LWDB.

- Supported marketing activities to establish DOR as a talent resource for employers seeking to hire qualified individuals with disabilities.

- Established a team of Vocational Rehabilitation professionals to provide career counseling and information and referral.

The RSA issued final WIOA regulations in September 2016. While many of the key requirements of WIOA have been implemented, DOR expects that the remaining requirements will be fully realized before 2020. Examples of remaining requirements are final modifications to the information technology data collection system, transformation of services to youth with disabilities, and implementation of RSA's new performance metrics.

Social Security Beneficiary Work Incentive Planners. In 1981, Congress established the Cost Reimbursement Program to encourage state Vocational Rehabilitation Agencies to provide services that would result in gainful employment by SSI/SSDI beneficiaries. Under the Cost Reimbursement Program, the Social Security Administration pays DOR for the reasonable costs of services provided to SSI/SSDI consumers if those services result in the consumer achieving work at specified earnings level, known as the Substantial Gainful Activity. The department began a Work Incentives Planning Pilot from September 2013 through August 2015 to increase employment outcomes and self-sufficiency. According to the department, this pilot was successful in leading more individuals to working and earning higher wages, as well as increasing Social Security Cost Reimbursements.

In 2013-14, the DOR was provided nine temporary help positions to develop the WIP Pilot Program to assist additional individuals receiving vocational rehabilitation services improve employment outcomes and decrease their dependency on SSI/SSDI benefits. The WIP Pilot Program generated an additional $684,076 in SSA reimbursements. The 2015 Budget Act included $3.1 million in federal expenditure authority and 31 positions to permanently establish WIP services. These WIP positions generated roughly $1.7 million in SSA reimbursements for 2015-16 and roughly $1.9 million in 2016-17.

Independent Living Center Funding.

Independent Living Centers (ILCs) are private nonprofit organizations that provide a variety of services to individuals with disabilities of all ages. DOR funds, administers, and supports 28 ILCs in communities located throughout California. Each independent living center provides services necessary to assist consumers to live independently and be productive in their communities. Core services consist of information and referral, peer counseling, benefits advocacy, independent living skills development, housing assistance, personal assistance services, and personal and systems change advocacy.

ILCs receive government funding from both Title VII (c) funds from the U.S. Department of Health and Human Services, under the Administration for Community Living (ACL) and Title VII (b) funds through the DOR. State funds come from Social Security Reimbursement Program Income through the DOR.

Last year, the 2016 Budget Act included a $705,000 General Fund augmentation for three ILCs. These ILCs serve Amador, Calaveras, Tuolumne, Mariposa, Stanislaus, San Joaquin, Kern, Placer, El Dorado, and Alpine counties. This year's Governor's Budget proposes to remove this augmentation.

CaPROMISE Grant Update. In fiscal year 2014-15, the DOR was awarded a competitive federal grant, entitled Promoting the Readiness of Minors in Supplemental Security Income (or PROMISE), which began October 1, 2013 and goes through September 30, 2019. The $55 million, five-year CaPROMISE grant seeks to develop and implement model demonstration projects that promote positive outcomes for 14 to 16-year old Supplemental Security Income (SSI) recipients and their families. The grant is 100 percent federal funds without a state match requirement.

As the lead coordinating agency for CaPROMISE, DOR is responsible for statewide leadership, oversight, administration, and coordination of the grant. DOR partners with five other state departments[1] and 21 Local Educational Agencies (LEAs) to coordinate services, direct outreach, recruitment, and involvement of participants.

The grant is currently in its fourth year. All six approved permanent full-time positions have been hired and performing their duties and responsibilities since FY 2014-15. Total enrollment of 3,273 participants was completed on April 30, 2016. Of those enrolled, 1,646 participants were randomly assigned to the CaPROMISE services group (treatment group) and are receiving the services by the CaPROMISE. Services are received from 21 LEAs where Career Service Coordinators provide case management, service coordination, and benefits planning along with three California State Universities (CSUs) who provide interns for pre-vocational services. The main focus is on service provision: benefits and financial planning (by Career Service Coordinators at the LEAs who are also certified benefits planners), work experience (at least one paid and one unpaid work experience for each participant by the end of the project), independent living skills trainings through partnership with four ILCs.

[1] California Department of Education; Employment Development Department; Department of Developmental Services; Department of Health Care Services; and Department of Social Services.

Below is a service delivery and implementation timeline of the grant.

CaPROMISE Activities, Targets, Timelines with Benchmarks

Activities	Targets	Estimated Completion	Update
Career Services Coordinators Receive Basic Training	100% complete training	June 2014	Completed
Career Service Coordinators Receive Cornell Training	100% complete training	September 2014	Completed
Interagency Council Meeting	2 meetings per year	March 2014(Initial Meeting) September 2014 May 2015 December 2015 **September 2016** **January 2017**	All Meetings conducted to date
Recruitment of Students	At least 3,078 child SSI recipients ages 14-16 and their families	April 2016	Completed **3,273 enrolled**
Data Collection System Developed	Developed and initiated	June 2014 **Regularly updated based on the needs of the project**	Completed
Case Management Intervention	100% of students	September 2018	On Track
Benefits Counseling/Financial Planning Intervention	100% of students	September 2018	On Track
Work Experience Intervention	100% of students have at least one volunteer and one paid experience	September 2018	On Track
Parent Training and Information Intervention	100% of families	September 2018	On Track
Employment Preparation Workshops/Soft Skills Training Intervention	100% of students	September 2018	On Track

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide a brief overview of the department and its programs and services.

Issue 2: Proposals for Investment

The subcommittee has received the following proposal for investment.

- Restore 2016-17 Budget Augmentation for Independent Living Centers

Budget Issue. The Subcommittee has received a letter from Assemblymember Rudy Salas, signed by multiple other members of both the Assembly and Senate, requesting that the $705,000 General Fund that was appropriated to ILCs last year be restored.

Background. Last year, the 2016 Budget Act included a $705,000 General Fund augmentation in base funding for three ILCs. The three facilities are the Independent Living Center of Kern County, Disability Resource Agency for Independent Living (in Stockton), and Placer Independent Living Resources, and serve a total of 11 counties. These centers, which were established with federal VII-C funds, were originally excluded from receiving state funded 'base funding' to provide equity across funding for all ILCs. These three centers do receive state funding allocated by formula for Assistive Technology and Population in addition to federal funds.

Staff Comment and Recommendation. Hold open.

Issue 3: Oversight: Traumatic Brain Injury Funding

Traumatic Brain Injury (TBI) Program. The Department of Rehabilitation administers the Traumatic Brain Injury (TBI) Program, where seven providers deliver statewide services, such as coordinated post-acute care, supported living, community reintegration, and vocational supports, to help over 900 impacted individuals lead productive and independent lives. DOR also funds education, information, and referral services for over 10,000 individuals impacted by TBI; as well as serving an additional 1,300 individuals with TBI through its Vocational Rehabilitation Program.

Funding. TBI Fund revenues stem from penalties paid for various violations of California's Vehicle Code. Section 1464 of the Penal Code establishes that 0.66 percent of the state penalty funds imposed upon every fine, penalty, or forfeiture collected by the courts throughout the state for criminal and vehicular offenses, be contributed to the TBI Fund. In addition, fines that are collected for violation of California's seat belt law support the TBI Program.

Sites historically received $150,000 per year from the TBI Fund. However, the California State Controller's Office reports that the Seatbelt Penalty Fund (SPF) has decreased by over $50 million since 2006-07. The TBI Fund has not generated enough revenue to support the $150,000 per site funding level since 2006. In 2015-16, each of the seven sites received $120,000.

The 2014 Budget Act included a one-time revenue transfer of $500,000 from the Driver Training Penalty Assessment Fund (DTPAF) to the TBI Fund. The 2016 Budget Act included a one-time revenue transfer of $360,000 from the DTPAF. The department has been seeking additional funding opportunities, such as federal grants; however, the department has been unsuccessful at identifying a stable funding source for the TBI programs

TBI funds are summarized in the chart below.

TBI FUND REVENUE	
State Fiscal Year	**TBI Fund**
FY 10-11	$1,091,926
FY 11-12	$809,181
FY 12-13	$849,834
FY 13-14	$807,753
FY 14-15	$769,164
*FY 15-16	$664,222
*FY 16-17	$228,758

* Year to date Revenues as of January 2017

Governor's Proposal. Currently, funds from the SPF and the DTPAF are distributed among various special funds. SPF revenues have decreased significantly over the past several years, largely due to a decrease in traffic citations. With the projected decrease, the SPF will no longer be able to support all of the programs that receive this funding. In addition, the cost of these programs has increased, and the statutory formula has not been adjusted accordingly.

The Administration has proposed to amend the process by which the state portion of the assessment is distributed. The Governor's budget proposes to remove the current distribution process and instead provide direct appropriations and transfers from the State Penalty Fund to support these various programs. For the TBI fund, this annual appropriation would be $800,000, and each site would receive $150,000.

Staff Comment and Recommendation. This is an oversight item, and no action is required. The Governor's proposal will be discussed in a future hearing in Subcommittee No.5 on Public Safety.

Questions.

1. Please discuss TBI funding and summarize the Governor's proposal for the State Penalty Fund.

Issue 3: BCP: California Innovations Program: Federal Work-Based Learning Grant for Students with Disabilities

Governor's Proposal. The Administration is requesting one permanent full-time position to provide program oversight and perform contracting and data management activities required to administer the California Innovations Program - Federal Work-Based Learning Grant. The $8.5 million federal grant has a five-year grant period and there is no state match requirement. DOR will use existing federal fund authority for the expenditures.

Background. The California Innovations Program is meant to increase self-sufficiency for students with disabilities through planned education and work-based learning. This program supports the goals of the WIOA, which emphasizes serving students and youth to ensure they have meaningful opportunities to receive training and other services needed to achieve competitive employment outcomes.

The department will collaborate with Local Education Agencies (LEAs) to provide program services such as paid and non-paid career-focused internships, participation in career pathway programs, and entrance in to post-secondary education or competitive integrated employment. DOR is responsible for statewide leadership, oversight, administration, and coordination at the state and federal level for the grant. This includes contract development and administration, invoicing and budgeting, oversight of program evaluations and site visits, coordinating meetings, and providing training and technical assistance, among other duties.

Currently the grant is funding one limited-term (LT) position at the Staff Services Manager level to administer the grant and .25 FTE for a Project Director, at an estimated cost of $153,000 yearly. Since a LT allocation only allowed a maximum of two years, one permanent full-time position is being requested to administer the grant for the full five-year period.

Staff Comment and Recommendation. Hold open. No concerns have been raised to subcommittee staff at this time.

Questions.

1. Please summarize the proposal.

Issue 4: BCP: Supported Employment Program: Increase Job Coaching Rates

Governor's Proposal. The Administration requests $500,000 General Fund in 2017-18 and ongoing to match the increased supported employment provider hourly rate identified in the Department of Developmental Services' (DDS) June 2016 New Provider Rate memo as required by Chapter 3, Statutes of 2016, Second Extraordinary Session AB1 X2 (Thurmond). The additional funding will help DOR sustain the job coaching rate at $36.57 per hour, consistent with the DDS rate, with out reducing other services to individuals with disabilities.

Background. Supported Employment (SE) job coaching is a Vocational Rehabilitation service that provides individuals with the most significant disabilities with on-the-job support, enabling them to become employed in competitive and integrated work environments. SE job coaching services are provided by both the DOR and DDS. DOR provides SE job coaching services to an estimated 3,000 consumers annually.

DDS SE job coaching hourly rates, intake, placement, and retention services are statutorily defined. DOR has historically set a rate structure consistent with DDS to avoid disparity among the job coaching service providers. In 2015-16, AB1 X2 required DDS to restore the SE job coaching rate back to 2008-09 levels, from $30.82 to $36.57 effective July 1, 2016. This resulted in a $500,000 increase to DOR's SE program costs. The 2016 Budget Act provided the department $500,000 in General Fund to enable DOR to increase the SE job coaching hourly rate consistent with DDS.

The requested $500,000 General Fund, combined with the $500,000 General Fund provided in the 2016 budget, will allow DOR to raise its SE job coaching hours rate. Currently, the department is backfilling the increased $500,000 General Fund need with redirection of Vocational Rehabilitation funds, which, if continued, could result in less individuals with disabilities being served.

Staff Comment and Recommendation. Hold open. No concerns have been raised to subcommittee staff at this time.

Questions.

1. Please summarize the proposal.

2. Please explain what other programs may be impacted by the current backfilling with Vocational Rehabilitation funds.

Issue 5: BCP: Information Security Compliance

Governor's Proposal. The Administration is requesting two permanent full-time positions and $281,000 in General Fund to ensure adequate staffing in DOR's Information Security Office (ISO), compliance with the information security regulations prescribed in the State Administrative Manual (SAM) 5300, and to maintain the overall safety and security of DOR data. The requested positions are as follows:

- One Systems Software Specialist (SSS) II
- One Staff Information Systems Analyst Specialist (Staff ISA)

Background. When DOR created its information security program more than a decade ago, it dedicated one position, the Information Security Officer (ISO). Since that time, there has been an increase in the number and type of security threats.

In the past year, DOR has undergone several security assessments and has determined that its information security program is lacking and puts department data at risk. Both the California State Auditor and the Multi-State Information Sharing and Analysis Center's Nationwide Cyber Security Review identified a lack of sufficient staffing resources to meet workload demands, and the California Military Department's Cyber Network Defense team identified several vulnerabilities.

DOR's case management system contains confidential and sensitive information, including social security numbers, on over 100,000 active consumers, as well as information in over 500,000 records that include both open and closed cases. The two requested positions would maintain the safety and security of this personal and private information and save the state from costly data breaches.

Staff Comment and Recommendation. Hold open. No concerns have been raised to subcommittee staff at this time. Staff notes that this proposal is one of twelve such requests put forth by the Administration in the Governor's budget this year.

Questions.

1. Please summarize the proposal.

2. Please discuss current staffing and duties of DOR's Information Security Office.

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

SUBCOMMITTEE NO. 3 Agenda

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

March 16, 2017
9:30 a.m., or Upon Adjournment of Floor Session
Room 4203, State Capitol

PART A

Consultant: Theresa Pena

OUTCOMES

Item	Department	Action
5160	**Department of Rehabilitation**	
Issue 1	Overview	Hold Open
Issue 2	Proposals for Investment	Hold Open
Issue 3	Oversight: Traumatic Brain Injury Funding	Informational
Issue 4	BCP: California Innovations Program: Federal Work-Based Learning Grant for Students with Disabilities	Hold Open
Issue 5	BCP: Supported Employment Program: Increase Job Coaching Rates	Hold Open
Issue 6	BCP: Information Security Compliance	Hold Open

Senate Budget and Fiscal Review—Holly J. Mitchell, Chair
SUBCOMMITTEE NO. 3 **Agenda**

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

Thursday, March 16, 2017
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Part B

Consultant: Peggy Collins

Item **Department** **Page**

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4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

PANEL 1: OVERVIEW AND HEADQUARTERS - ISSUES 1-5

Nancy Bargmann, Department of Developmental Services
Kris Cook, Department of Finance
Sonja Petek, Legislative Analyst's Office

ISSUE 1: Budget Overview

Background: The Department of Developmental Services (DDS) oversees the provision of services and supports to over 300,000 persons with developmental disabilities and their families, pursuant to the provisions of the Lanterman Developmental Disabilities Services Act, also known as the Lanterman Act, (Division 4.5 of the California Welfare and Institutions Code). The Lanterman Act establishes an entitlement to services and supports for Californians with developmental disabilities.

For the majority of eligible recipients, services and supports are coordinated through 21 private, non-profit corporations, known as regional centers. The remaining recipients are served in three state-operated institutions, known as developmental centers and one state-leased and state-operated community-based facility.

Eligibility. To be eligible for services and supports through a regional center or in a state-operated facility, regardless of income, a person must have a disability that originates before their 18th birthday, be expected to continue indefinitely, and present a substantial disability. As defined in Section 4512 of the Welfare and Institutions Code, this includes an intellectual disability, cerebral palsy, epilepsy, and autism, as well as conditions found to be closely related to intellectual disability or that require treatment similar to that required for individuals with an intellectual disability. A person with a disability that is solely physical in nature is not eligible. Infants and toddlers (age 0 to 36 months), who are at risk of having a developmental disability or who have a developmental delay, may also qualify for services and supports. Eligibility is established through diagnosis and assessment performed by regional centers.

Budget Summary. The department's budget proposes expenditures of $6.9 billion ($4.2 billion General Fund) in 2017-18, a net increase of 4.2 percent (6.1 percent General Fund increase) over the updated current year budget. See table below for more information.

Regional centers are anticipated to serve 304,294 individuals in the current year, and 318,043 individuals in the budget year, an increase of 4.81 percent over the enacted budget. It is estimated that developmental centers will house 760 residents by the end of 2016-17 and 490 residents by the end of 2017-18, a reduction of 10.27 percent.

Department of Developmental Services Funding Summary

	2016-171	2017-17	Difference	Percent Change
Community Services	$6,064,913	$6,423,741	$358,828	5.9%
Developmental Centers	529,869	449,796	-80,073	-15.1%
Headquarter Support	51,188	52,302	1,114	2.2%
Total	**$6,645,970**	**$6,925,839**	**$279,869**	**4.2%**
General Fund				
Community Services	$3,558,448	$3,838,894	$280,446	7.9%
Developmental Centers	368,523	329,985	-38,538	-10.5%
Headquarter Support	33,834	34,720	886	2.6%
Total	**$3,960,805**	**$4,203,599**	**$242,794**	**6.1%**

Budget proposals, not discussed further in the agenda, include:

1. **Headquarters.** The budget includes an increase of $0.5 million ($0.4 million General Fund) in the current year and an increase of $1.6 million ($1.3 million General Fund) in the budget year for retirement rate contribution and employee compensation updates.

2. **Developmental Centers.** The budget includes an increase of $3.6 million ($2.2 million General Fund) in the current year and an increase of $3.6 million ($2.2 million General Fund) in the budget year for retirement adjustments pursuant to Control Section 3.60; an increase of $1.1 million ($0.6 million General Fund) in the current year and $1.3 million ($0.8 million General Fund) in the budget year for employee compensation adjustments approved through collective bargaining; a decrease of $0.1 million in the current year and $0.1 million in the budget year in lottery funds; and a decrease of $0.7 million General Fund in the current year and $1.0 million General Fund in the budget year due to an adjustment in lease-revenue debt service pursuant to Control Section 4.30.

Questions:

For Nancy Bargmann, DDS

- *Please provide a brief overview of the proposed budget.*

Staff Comments and Recommendations: Informational Item. No action necessary.

1 Updated current year

ISSUE 2: Headquarters – Update on Previous Actions

In recent years, the department has seen their headquarters staff increased for specific purposes. These include:

State Developmental Centers' Closure. $2.1 million ($1.8 million General Fund) for eight new permanent positions, and the redirection of five vacant positions, for a total of 13 positions. As of March 1, 2017, eight positions have been filled.

Home and Community-Based Services (HCBS) waiver transition plan and regional center and service provider compliance. $483,000 ($330,000 General Fund) and four permanent positions. As of March 1, 2017, three positions have been filled.

Vendor Audits. $952,000 ($650,000 General Fund) to permanently establish seven positions (previously limited-term). As of March 1, 2017, all positions are filled.

Competitive Integrated Employment Program, Provider Rate Increase Oversight, and Provider Rate Study. $752,000 ($513,000 General Fund) and five positions. As of March 1, 2017, three positions have been filled.

New Fiscal and Program Research Section. $923,000 ($630,000 General Fund) for seven new permanent positions and the redirection of one position, for a total of eight positions. As of March 1, 2017, six have been filled, including a PhD-level unit manager.

Background. Last year, the department requested, and the Legislature approved, this new unit to provide fiscal and programmatic analyses to assist the department's response to external requests for data and information related to the regional center and developmental center programs, as well as to inform accurate, reliable, data-driven decisions.

Some of the department's most critical issues require reliable and timely data including regional center purchase- of-service expenditure growth, geographically and by regional center; provider services availability and trends in the community service delivery system; disparities data; maximizing the use of third party funds and federal funds; and rates. Other research issues identified include meeting the needs of individuals with challenging service needs/resource development, compliance with Title 17 regarding special incident reporting requirements, and fair hearing data.

According to the department, since the section began operations in July 2016, executive staff have strategized about how this small can best support the department's short and long-term priorities. Guiding the department are the following:

- A commitment to learning more about the causes of and solutions to differences in service access across certain groups of consumers, including communities of color;

- Legislative requirements to assess certain aspects of regional centers, as outlined in AB 1606, as well as other legislative directives;

- The director's urgent, daily needs for data analysis to make program and policy decisions and provide information to stakeholders; and

- Supporting the analytical and reporting responsibilities of other units in the department, for instance by consulting about data analysis, data quality or data presentation.

In addition, the department recognizes that the section must devote attention to building a thorough, detailed knowledge base about the department's administrative data – including understanding its limitations – and the department's programs and regional center operations. In this context, and through regular discussion of the department's evolving needs, the research section's priorities for FY 2016-17, have been identified, as listed below. Ideas for new projects that may be implemented in FY 2017-18, or later, are also reported below.

Priorities for FY 2016-17

Enhance data analysis and research capacity throughout the department.

- Promulgate professional standards for analyzing and presenting information in the section and in other units.

- Examine and improve data integrity.

- Link data systems across divisions for consistency and improved accuracy and timeliness

Plan and launch a major research project on disparities to service access, with short- and long-term goals and deliverables.

- Assist in crafting the director's Roadmap to Identify and Close Gaps in Service Access.

- Provide data analysis for legislative hearings and briefings and information requests.

- Prepare the first annual assessment of regional center disparities data and plan reports for future years.

- Design a new legislatively-mandated monthly report on progress toward closure of developmental centers; establish a regular process for posting the reports to DDS' website.

- Provide research and data for the director's program and policy decision-making on topics that are not the purview of other units in the department.

- Regional Center Oversight and Accountability: Research, plan and undertake additional data analysis to support the department's oversight of regional centers.

Other Priority Projects Under Consideration

- Analyze the impacts of increased appropriations and rate increases.

- Provide research and data analysis for the director's new Advisory Group on Reducing Disparities.

- Provide analytical support for the department's participation in the Community of Practice on Cultural and Linguistic Competency led by the Georgetown University National Center for Cultural Competence, in partnership with Disability Rights California (DRC), the State Council on Developmental Disabilities (SCDD), University Centers for Excellence in Developmental Disabilities (UCEDDs) at the University of California Davis, the University of California Los Angeles and the University of Southern California/Children's Hospital Los Angeles, and two other stakeholders, if California's proposal is accepted.

- Examine cost drivers, trends and under-utilization of services to better understand some crucial consumer experiences and changing service needs – for example, for individuals at transition points (moving from school-age to adulthood and our aging population) or increases in autism diagnoses.

- Utilize National Core Indicators (NCI) survey data to measure consumer and family outcomes and satisfaction with regional center services.

- Utilize NCI survey data to track progress in increasing cultural competency and reducing barriers to services.

Legislative Analyst's Office (LAO). At the time of consideration, the LAO recommended that the Legislature identify goals and possible deliverables for this new unit. AB 1606 (Committee on the Budget), Chapter 26, Statutes of 2016, require that these resources be used, in part, to "annually assess disparities data reported by regional centers, caseload ratio requirements by regional centers, and performance dashboard data, collected pursuant to Section 4572 of the Welfare and Institutions Code, as it becomes available."

The LAO again recommends the Legislature should set more specific research goals to encourage data-driven decision-making. Specifically, the LAO suggests these goals could include:

- Assessment of service gaps and provider capacity.

- Causes of disparities and purchase-of-services (POS) funding.

- Alternatives to regional center core staffing formula.

Questions.

<u>For Nancy Bargmann, DDS</u>

- *Please provide an overview of the new Fiscal and Program Research Section.*

<u>For Sonja Petek, LAO</u>

- *Please present your recommendation related to the Fiscal and Program Research Section.*

Staff Comments and Recommendations. Informational Item. No action necessary.

ISSUE 3: Headquarters - Information Security and Privacy Support - Budget Change Proposal (BCP)

Proposal: The budget proposes $398,000 ($317,000 General Fund) and three positions to monitor, train, advise, and support required security activities at headquarters, the developmental centers, and the regional centers for compliance with state and federal information security and privacy laws. Specifically, the department requests to hire three systems software specialists. Two specialists will assist and support developmental centers and regional center security efforts, and conduct activities in compliance with the State Administrative Manual, the State Information Management Manual, and federal requirements. The third specialist will be dedicated full-time to threat monitoring and risk reduction, and provide expertise to staff in utilizing complex security monitoring tools, including vulnerability scanning, centralized logging, anti-virus monitoring, patch management and firewall configuration management, and security audit log monitoring.

Background: The department compiles and retains personal, confidential, and protected health information for more than one million consumers who have or who currently receive services. Regional centers also collect and retain personal, confidential, and protected health information on current and former consumers for whom they coordinate and provide services. The department's Information Security & Privacy Section is responsible for departmental compliance, and by extension regional center and regional center vendor compliance, with all federal and state information security and privacy laws and regulations. The section is also responsible for providing guidance and support to staff located at headquarters, the developmental centers, and the 21 regional centers. Critical activities of the section include policy management, asset management, disaster recovery, data breach management/reporting, risk management, information technology systems access oversight, and security awareness and training.

The department argues that this staff will result in improved security over the personal, confidential information for hundreds of thousands of California's most vulnerable citizens. Additionally, increased resources will improve compliance in all areas of security and privacy regulations, improved risk assessments, and improved threat prevention strategies. The federal Office of Civil Rights (OCR) has significantly ramped up its audit efforts this past year and has been levying substantial fines on state departments, universities, and their business associates where deficiencies in HIPAA compliance were identified. Recent OCR fines for audit findings have been averaging in the millions for case settlements.

The department is one of 15 state departments required to comply with federal HIPAA and Health Information Technology for Economic and Clinical Health laws. Failure to comply can result in significant monetary fines. Recent fines levied against health providers and other state departments are as high as $5.5 million. Given that services to consumers are provided statewide at the developmental centers, and through 21 regional centers and 40,000 vendors, the department has the unique responsibility to provide policy guidance and oversight. With additional resources, the department will share the policies and standards it has developed, which reflect federal compliance requirements, as the basis and foundation for reviewing and developing any policies and standards that are lacking. Although the department has temporarily redirected three positions to address some information security issues, it does not have sufficient staff resources that it can permanently assign to travel and support the developmental centers, regional centers, and regional center vendors.

Questions: Staff comments and recommendation: Leave Open.

ISSUE 4: Headquarters - Community Housing Development Oversight - BCP

Proposal. The budget proposes **$597,000 ($554,000 General Fund)** for four permanent positions to oversee the development of permanent community housing by the regional centers. Specifically, the department requests:

- One career executive assignment (CEA) position who will review and make recommendations regarding housing development and funding policies and guidelines, as well as provide overall planning, leadership, and guidance from concept through post development.

- One staff services manager I who will assist the CEA and existing Community Development and Housing Section management with the coordination and implementation of housing review activities.

- Two associate governmental program analysts who will conduct housing review and compliance activities, including reviewing and updating tracking tools.

Background. Community Placement Plan (CPP) funds have been used by regional centers to develop permanent community housing for persons moving from developmental centers, Institutions for Mental Disease (IMDs), other institutional settings, and those at risk of moving to more restrictive settings. The department intends to use these positions to provide necessary infrastructure and oversight to increase these efforts, support the department's expansion of the "buy it once" housing model, and advance the recommendations of the Disabilities Services Task Force to develop specialized community residential resources. The department will use these resources to:

- Provide enhanced due diligence to analyze the qualifications of approved housing developers, review regional centers' and housing developers' contracts, and review new CPP funding requests.

- Process new funding requests, thoroughly review all the CPP housing proposals and requests to acquire properties, and review and monitor required CPP property documents.

- Consistently monitor progress and expenditures during the development and rehabilitation/construction phases after the acquisition of new CPP properties.

- Monitor changes in ownership, financing, and sustainability of the CPP properties.

- Provide ongoing training opportunities for regional centers and housing developers that own the housing.

- Review project proposals for compliance with federal financial participation eligibility requirements.

- Collaborate with state agencies in the development of affordable housing for individuals with developmental disabilities eligible for regional center services.

- Build relationships with state and privately-funded entities to develop additional funding

options for the acquisition of CPP properties.

Questions:

For Nancy Bargmann, DDS

- *Please present this proposal.*
- *Given that most of the housing acquisitions necessary to accommodate movers from developmental centers have been made, why are these positions being requested now?*

Staff recommendation: Leave open pending further review.

ISSUE 5: Headquarters - Self-Determination Implementation Update

Background. SB 468 (Emmerson), Chapter 468, Statues of 2013, establishes a statewide self-determination program (SDP), under which consumers are provided with individual budgets and the ability to purchase services and supports that are consistent with their individual program plan (IPP) and with the assistance of a financial manager. SDP must be consistent with the new federal Home and Community-Based Services (HCBS) regulations discussed in this agenda. Under the provisions of SB 468, participation will be limited to 2,500 individuals for the first three years of implementation, although there is an ability to request an increase. After three years, the program will be open to everyone who receives regional center services.

The department has worked with a stakeholder workgroup to design and submit a federal waiver application to the Centers for Medicare and Medicaid Services (CMS). However, on December 11, 2015, the state received a letter from CMS requesting additional information before the waiver could be approved. Most central to the CMS requests is assurances that the SDP program is compliant with the HCBS final rule. It is unknown at this time when federal approval will occur. On February 24, 2017, the departments of Developmental Services and Health Care Services participated in a technical assistance discussion with CMS, during which CMS indicated general agreement with the department's responses to most of the outstanding questions. In follow-up to this discussion, the department will provide additional information requested by CMS for their informal review this month.

The budget includes budget bill language to allow the transfer of up to $2.8 million from local assistance to state operations once federal approval occurs. This represents the estimated General Fund savings in purchase-of-services associated with the SDP program that would be used to offset the administrative costs incurred by the department.

Questions:

Nancy Bargmann, DDS

- *What is the current state of federal approval of this program?*
- *Once federal approval is achieved, how confident are you that regional centers are prepared and fully committed to implementation and that communities have been sufficiently educated about the program to ensure those who could benefit from this model participate?*
- *How will you measure success?*

Staff Comments and Recommendations: Information Item. No Action Necessary.

PANEL 2: DEVELOPMENTAL CENTERS - ISSUES 6-13
Nancy Bargmann, Department of Developmental Services
Kris Cook, Department of Finance
Sonja Petek, Legislative Analyst's Office
Aaron Carruthers, State Council on Developmental Disabilities
Kathleen Miller, Sonoma Developmental Center Parent Association
Carl London, Lanterman Coalition

ISSUE 6: Developmental Centers - Overview

Background. The department is required under the Lanterman Developmental Disabilities Services Act to provide services and supports for individuals with developmental disabilities, and through those services, help each individual live the most independent and productive life possible. At one time, the department operated seven developmental centers in the state, providing habilitation and treatment services on a 24-hour basis to ensure the health and safety of residents. In the mid-1990s the department closed the Camarillo and Stockton developmental centers. More recently, in 2009, the Department closed the Agnews Developmental Center, followed by the Lanterman Developmental Center closure in 2014. Currently, the department operates three developmental centers in Sonoma, Porterville, and Costa Mesa (Fairview), as well as one community based facility - Canyon Springs, in Cathedral City. The developmental centers are licensed under three categories: general acute care (GAC), nursing facility (NF) residential units, and intermediate care facility/developmental disability (ICF/DD) residential areas. The state-operated community-based facility is smaller and is licensed as an ICF/DD.

AB 1472 (Committee on Budget), Chapter 25, Statutes of 2012, imposed a moratorium on admissions to developmental centers except for individuals admitted to restore competency, determined to be incompetent to stand trial, or who are in acute psychological or behavioral crisis and in need of short-term stabilization. The developmental center resident population has dropped from a high of 13,400 in 1968, with thousands on waiting lists for admission, to 867 on March 1, 20172. The budget estimates a July 1, 2017 developmental center population of 760 and a July 1, 2018 population of 490. Consistent with the recommendations of the Health and Human Services Agency report entitled "Plan for the Future of Developmental Centers in California," and the call for the transformation of developmental center services, the 2015 May Revision proposed to initiate the closure planning process for the remaining developmental centers.

In response to SB 82 (Committee on Budget and Fiscal Review), Chapter 23, Statutes of 2015, which required the department to submit a plan or plans to close one or more developmental center(s) to the Legislature by October 1, 2015, the department submitted a plan to close Sonoma by December 31, 2018. On April 1, 2016, The department submitted to the Legislature a plan for the closure of the Fairview Developmental Center and the Porterville Developmental Center – General Treatment Area by the end of December 2021.

Historically, the department has received federal Medicaid funds for operation of the developmental centers. However, on July 1, 2014, the California Department of Public Health (CDPH), acting on behalf of CMS, terminated the ICF/DD Provider Agreement for Sonoma due to ongoing non-compliance with the federal conditions of participation. In response, the department negotiated with

2 Based on weekly census data provided by DDS, which includes those residents on leave.

CMS, and entered into a settlement agreement on June 30, 2015, to extend the provider agreement for Sonoma until July 2016, with the option for reconsideration to extend the termination date to July 1, 2017. However, CMS subsequently notified the department on May 13, 2016, that federal financial participation for Sonoma would end on June 3, 2016. Although CDPH notified both Fairview and Porterville-General Treatment Area (GTA) that both centers would be decertified effective December 1, 2015, this date was extended a number of times through July 1, 2016. The department entered into a settlement agreement with CMS on July 1, 2016, to extend the provider agreement for the ICF/DD units at Fairview and Porterville-GTA through December 2016, with possible extension dates annually through 2019. In October and November 2016, CMS and CDPH re-surveyed Fairview and Porterville-GTA, and extended federal funding through 2017. Despite these extensions, CMS reserves the right to revoke certification at any time. Should that occur, the department estimates the monthly loss of federal funds at $6.7 million in 2016-17 and $4 million in 2017-18 ($48 million in annual terms).

For the developmental centers, two state-run crisis units on developmental center grounds, and the state-leased and operated community facility (Canyon Springs), the following charts show the populations remaining, movement in and out, and transition activities occurring for residents, as of February 28, 2017.

1. Population

Total population for closing facilities declined by 76 from October 1, 2016 through February 28, 2017. Population for non-closure facilities increased by one (1) for a net decrease in total population of 75. As of February 28, 2017, both the Northern and Southern STAR homes were at full capacity.

POPULATION			**FY 16/17**	
			10/1/16	**2/28/17**
CLOSURE	Fairview (FDC)	NF	82	77
		ICF	125	108
	Porterville (PDC)	NF	45	41
		ICF (GTA)	95	85
	Sonoma (SDC)	NF	151	132
		ICF	183	162
	All Facilities	NF	278	250
		ICF	403	355
		Subtotal	**681**	**605**
NON-CLOSURE	Canyon Springs (CS)	ICF	45	47
	FDC	Southern STAR	4	5
	PDC	ICF (STP)	209	206
	SDC	Northern STAR	4	5
	All Facilities	**Subtotal**	**262**	**263**
TOTAL			**943**	**868**

Acronyms: *GTA = General Treatment Area; STP = Secure Treatment Program*
NF/ICF = Skilled Nursing Facility/Intermediate Care Facility
STAR = Stabilization, Training, Assistance and Reintegration

2. Movement

One hundred two (102) individuals were placed into the community from October 1, 2016, through February 28, 2017 -- 65 from facilities slated for closure.

FDC had 19 placements, one (1) who was returned from provisional placement; PDC had 10 placements from the GTA and 31 from the STP; SDC placements totaled 38 (2 from Northern Star). Canyon Springs had 4 placements and six (6) transfers in: One (1) from PDC GTA, four (4) from PDC STP, and one (1) from FDC.

MOVEMENT FY 16/17: 10/1/16 thru 2/28/17		OUT			IN		
		Placements	Deaths	Transfers to DC/CF	New Admissions	Transfers In	Returns from Placement
CLOSURE	FDC	19	3	1		0	1
	PDC GTA	10	3	1		0	0
	SDC	36	4	0		0	0
	Subtotal	**65**	**10**	**2**	**0**	**0**	**1**
NON-CLOSURE	CS	4	0	0		6	0
	FDC Southern STAR	0	0		1		
	PDC STP	31	1	4	33	0	0
	SDC Northern STAR	2	0		3		
	Subtotal	**37**	**1**	**4**	**37**	**6**	**0**
TOTAL		**102**	**11**	**6**	**37**	**6**	**1**

3. Transition Activity Snapshot

TRANSITION ACTIVITY AS OF 2/28/17		Level of Care	Population 2/28/17	Exploring Community Options	Meet & Greets	Transition Planning Meetings	Transition Review Meetings/ Move Date
CLOSURE	FDC	NF	77	56	7	12	2
		ICF	108	55	33	14	6
	PDC GTA	NF	41	35	0	5	1
		ICF	85	75	2	8	0
	SDC	NF	132	74	27	12	19
		ICF	162	98	10	27	27
	All Facilities Closing	NF	250	165	34	29	22
		ICF	355	228	45	49	33
		Subtotal	**605**	**393**	**79**	**78**	**55**
NON-CLOSURE	CS	ICF	47	39	4	2	2
	FDC Southern STAR	ICF	5	1	1	2	1
	PDC STP	ICF	206	201	2	3	0
	SDC Northern STAR	ICF	5	2	0	2	1
	Non-Closing Facilities	**Subtotal**	**263**	**243**	**7**	**9**	**4**
TOTAL			**868**	**636**	**86**	**87**	**59**

Is the Department on Schedule for Planned Closure Dates? In the current year, the department projected that 228 consumers would transition from a state-run facility to the community. Of the 228, 199 individuals reside in a developmental center slated for closure. As of March 1, 2017, 86 of the 199 consumers had transitioned from developmental centers to the community. The budget projects that

268 consumers (258 closure and 10 non-closure) will transition to community based services in 2017-18.

For Sonoma Developmental Center, which is scheduled to close in December 2018, and where loss of federal funding is highest due to the decertification of its ICF units, the following chart shows the populations remaining in each program type, as of February 28, 2017.

Sonoma

Level of Care	Number of Units Open	Number of Clients
GAC	2	--
NF	8	132
ICF	8	162
Northern STAR	1	5
TOTAL	**19**	**299**

While it is of utmost importance that persons are not moved to the community before the services and supports are available, and that all steps that are necessary to a smooth and successful transition occur with each person who moves, it is also important to note that significant delays will create more significant cost pressures on the General Fund. Not only does the per capita cost for residents remaining in the developmental center increase substantially over time (the LAO notes the annual average cost to serve a person in a developmental center was about $500,000 at the time the closure decision was made, the cost will be nearing $700,000 annually per resident in the budget year), but the risk of further loss of federal funding increases.

Questions:

For Nancy Bargmann, DDS

- *Provide an update on progress toward closure and whether you are on track for the announced closure dates.*

For Aaron Carruthers, State Council on Developmental Services

- *The State Council has consumer advocates at each of the developmental centers. From their perspective, how is the closure process going?*

For Kathleen Miller, Sonoma Developmental Center Parent Association

- *What is your perspective on how the closure process is going?*

Staff comments and recommendations: This is an information item. No action is necessary.

ISSUE 7: Developmental Centers - Revised Estimate Process

Trailer bill language adopted with the 2016 budget act requires that the department provide budget estimates for each developmental center, including a break-out of staffing costs for Porterville Developmental Center's general treatment area and secured treatment area.

To estimate expenditures and funding on a developmental center-specific basis in 2017-18, the department established a new methodology to determine the staffing required to appropriately care for residents and operate each facility and to meet state licensing and the CMS settlement agreement requirements for continued federal funding.

Questions:

For Nancy Bargmann, DDS

- *Briefly describe how this process differs from how estimates for developmental centers were made in the past.*
- *How does this process better inform the Administration and Legislature regarding budgetary needs, trends and management?*
- *Does this process provide a useful tool to developmental centers in the management of their resources at a local level?*

Staff comments and recommendation: Information Item. No action is necessary.

ISSUE 8: Developmental Centers – Update on Previous Actions

The 2016 budget act included the following actions related to the developmental centers.

Developmental Center Employee Retention Stipends. The current year budget includes $20.1 million ($15.9 million General Fund) to provide retention stipends for specified developmental center staff and extends the encumbrance period for payment of these stipends. Historically, the announced closure of a state institution has resulted in an accelerated loss of staff due to retirement, transfer or departure. This can often complicate the difficult and delicate task of balancing the need to reduce staffing levels as resident populations decline, with the need to maintain required staffing ratios and other key staff positions throughout the closure process. Eligible staff accrue payments of $250 each quarter beginning July 1, 2016 through June 30, 2017, and $500 each quarter thereafter. The retention stipends will be paid at a midway point and upon layoff.

Other proposed employee supports that promote workforce stability and provide opportunities for employees post-closure, such as state service credit opportunities, and the ability to guarantee positions or specialized training for employees that stay through the end of a closure, have not been proposed.

Special Managed Care Provisions. AB 1606 extends managed care provisions for Medi-Cal-eligible individuals at the developmental centers that transition to the community and need coordinated medical and specialty care as documented in their individual program plan. These specified managed care provisions include access to specialized medical care, enhanced case management, and expedited enrollment services. The Legislature modified the Administration's proposed trailer bill language by requiring that the plan outlining these special provisions be shared with stakeholders prior to being finalized and be submitted to the Legislature by December 31, 2016. . The Administration is currently reviewing the plan, and once approved will release the plan to stakeholders for review.

Access to Specialized Health Care Services. According to the closure plans, the department will provide key specialized health care/clinic services at the developmental centers, currently being received by DC residents, on an ongoing basis throughout the transition process, and until necessary services are established and operational in the community. These services include, but are not limited to, medical, dental, adaptive engineering, physical therapy, orthotics, mental health, and behavioral services. For people with disabilities, for example, routine dental care is more difficult to provide and access to these specialized services may not be available in the community. Rate differentials, dental coordinators, and the development of specialized clinics have been cited as potential mechanisms to ensure access to these specialized services in the community.

To improve access to healthcare services for individuals transitioning to the community from Sonoma Developmental Center and for other regional center consumers living in the community, North Bay Regional Center secured $2.5 million in Community Placement Plan funding through DDS as start-up funding for a federally qualified health center (FQHC) to provide specialized healthcare services in Sonoma County. A request for proposal was announced in December 2016, for establishment of a healthcare hub in the county designed to provide specialty healthcare, dental care, mental health services, and adaptive equipment and services for individuals with developmental disabilities. In March, the regional center announced that Santa Rosa Community Health Centers was the selected provider.

Community State Staff Program (CSSP). CSSP is designed to assist with the successful transition of developmental center/community facility consumers to community living, or for deflecting the admission of individuals with developmental disabilities to a developmental center, an institution for mental diseases (IMD), an out-of-state placement, or an acute psychiatric hospital. CSSP was originally established under provisions developed through collective bargaining agreements for the closures of Agnews and Lanterman developmental centers. In June 2014, the department received authorization to expand the use of the CSSP for the broader goals of transition or deflection, and in 2015 collective bargaining agreements were subsequently developed to enable the new program.

CSSP provides the opportunity to retain experienced staff within the department system, providing continuity of care to the some consumers, a level of trust and support for some family members of individuals moving from developmental centers, and new employment options for employees who wish to continue serving this population. CSSP also gives service providers and regional centers greater access to qualified staff.

While working in a community setting, these employees retain their civil service status, including salary and benefits; and the state receives full reimbursement via the contract for these services. Ideally, after working in the program, the employees transition to other roles in the service system supporting consumers.

Currently, the CSSP consists of six contracts with 72 positions available to be filled, as follows.

- Twenty-one of the 72 positions are filled with staff from previous DC closures.
- Of the remaining 49 positions, two staff are working in the community, and 18 have received tentative offers with future start dates when consumers transition to the community from DCs. Thirty-one positions are in the interview process and/or are available to be filled.

The following contracts are under negotiation:

- Two contracts are being amended to add positions to the existing agreements.
- Four new contracts are being drafted.
- These contract activities are estimated to create an additional 47 positions.

In a report submitted in February 2017, the department reports that since March 2009, 122 state

Interim Report on Developmental Center Movers. Pursuant to Welfare and Institutions Code Section 4474.12, the department contracts for a mover's longitudinal study that will continue until the developmental centers close. Researchers conducting the study meet with each individual participating in the study at intervals of three months, six months, one year, and two years following the person's move into the community from the developmental center to discuss the individual's quality of life and services and supports.

The department is required to annually submit interim reports to the Legislature regarding the study, and include information about consumer and family satisfaction and adequacy of community services. Upon the completion of the study, the department must submit the study to the Legislature. The department indicates a report covering surveys conducted in 2016 will be issued in May 2017. To date, 106 individuals have been enrolled in the study.

Assessment of Sonoma Developmental Center. In preparation of closure, the department utilized existing funds of $190,000 General Fund in 2015-16 to conduct an environmental impact report and architectural historical evaluation and $2.2 million General Fund was provided in the current year for an assessment of property, buildings, and clinical records. These funds will be used to complete the second and third phase of an environmental site assessment and architectural historical evaluation of center property. According to the Administration, these assessments will help determine: (1) the property value, (2) restrictions on land use, and (3) the potential cost of future investments on the property. The department contracts with the Department of General Services for these activities. DGS anticipates having a contract in place by the end of March or early April, and will remain within budgeted amount of $2.2 million. The assessment is estimated to be completed in 6-8 months.

Questions:

For Nancy Bargmann, DDS:

- *How many employees are participating in the retention stipend program at each facility, and how does participation meet your expectations? Is the department exploring other strategies for retaining experienced staff through the closure process?*

- *When will the department release its special managed care provisions plan for stakeholder input? Can you provide some broad insight into what the plan will say, and how it will be informed by lessons learned from previous developmental center closures?*

- *Access to the kind of specialized health care services available at the developmental centers has been of significant interest to system stakeholders. Where is the department in exploring this issue? How does the proposed "healthcare hub" associated with a federally-qualified health care clinic in Santa Rosa address this? Is the department exploring how staff resources currently at the developmental center, who have unique qualifications and familiarity with this population, can be utilized once the centers have closed?*

- *While it seems to be going a little better, the community state staff program still seems underutilized. What strategies is the department exploring to increase interest and to what degree has the department explored other uses of state staff, including use of state staff as mobile crisis specialists?*

- *What have the assessment activities at Sonoma told us thus far, as to options for future use of this land? What is the next assessment phase intended to tell us? When will the Administration have a proposal for the future use of this land? Is it the intent of the Administration that the land will stay under DDS control until such time that decision is made?*

Staff comments: Information Item. No action is necessary.

ISSUE 9: Developmental Centers – Current Year Budget Shortfall

The budget projects a $27.2 million reduction in estimated Medi-Cal reimbursements to the developmental centers. The budget proposes to backfill for this loss by a transfer from the local assistance budget (regional center purchase-of-services) which is projecting savings in the current year (discussed later in the agenda).

According to the department, the following factors necessitated the need for this request:

- In prior years, DDS used systemwide percentages for funding allocations in the developmental centers budget estimate process that were not always updated in a timely manner based on actual cost reporting. The department submits final Medi-Cal cost reports to Department of Health Care Services (DHCS) for developmental center reimbursements several months after the end of a fiscal year, subject to later audit by DHCS. Audit findings considered from DHCS audits conducted since 2012-13 (2008-09 through 2011-2012 fiscal years) that impacted federal fund reimbursements are as follows:

  - Disallowed workers compensation costs for closed developmental centers going back to Stockton and Camarillo that are only allowable under certain criteria.
  - Disallowed bed days based on system issues and source documentation.
  - Unliquidated encumbrances.
  - Provisional placement days.
  - Disallowed certain ancillary costs and depreciation.

  Corrective actions taken as result of the audits include:

  - DHCS and DDS worked together to update their interagency agreement to include improved documentation and billing procedures/processes.
  - DHCS and DDS have agreed upon acceptable source documentation for billable days and costs.
  - DDS redirected additional staff resources to the Medi-Cal billing unit.
  - DDS improved billing processes to identify potential billing issues and anomalies.
  - DDS revised cost calculations for depreciation, ancillary services, and workers' compensation for closed facilities to reflect audit findings.

- The proposed Governor's Budget for 2017-18 for the developmental centers used a new formula to estimate staffing levels based on number of units and acuity level in each center, with operating expenses, drugs and other client costs based on prior years of expense. The estimated amount of federal fund reimbursement of these costs was also based on acuity level and considers the impact of recent DHCS audits that disallowed certain costs for federal reimbursement.

- The ICF units at Sonoma are decertified.

Questions:

For Nancy Bargmann, DDS:

- *Please describe the reason for this shortfall and your level of confidence that such shortfalls are not likely to occur in the future.*

- *In order to maximize federal funding, to what degree do prioritize persons in ICF units when developing the resources necessary to facilitate a success move to the community?*

Staff comments: Leave Open Pending May Revision.

ISSUE 10: Developmental Centers - Budget Year Adjustments

The budget proposes a number of adjustments in the budget year related to facility downsizing and pre-closure-related activities.

- $78.6 million decrease ($9.7 million General Fund) and 489.2 positions resulting from an estimated developmental center population reduction of 257 residents and associated consolidation of units and reduced operating expenses and equipment (OE&E).

- $0.3 million increase ($0.2 million General Fund) for the disposal and/or relocation of physical property and equipment assets in preparation for closure of Sonoma and Fairview developmental centers, and the general treatment area at Porterville Developmental Center.

- $0.5 million increase ($0.4 million General Fund) to inventory, scan, and archive clinical records at Fairview Developmental Center and the general treatment area of Porterville Developmental Center.

Questions:

For Nancy Bargmann, DDS

- *Briefly described this proposal.*

- *How does the department balance the cost-effectiveness value of unit consolidation at the developmental centers with minimizing the impact of "transfer trauma" on those being moved?*

Staff comments and recommendations: Leave Open Pending May Revision.

ISSUE 11: Developmental Centers: Proposed Trailer Bill Language (TBL): Developmental Center Staff Transitioning to Vendor Status - PROPOSED CONSENT

With the previous closures of Agnews Developmental Center in Santa Clara County and Lanterman Developmental Center in Los Angeles County, the department has utilized strategies to create a pathway from developmental center employment to community employment within the developmental disabilities service systems. AB 1606 (Committee on Budget), Chapter 26, Statutes of 2016, created an exemption to Public Contract Code Section 10410, to allow department employees to continue to work for the state, while under contract with a regional center to develop community-based services for persons with developmental disabilities. This was done to encourage developmental center employees to become community service providers while maintaining state employment and income during the provider start-up period but before the actual provision of services begins. However, as written, the current statute has been subject to different interpretations and the proposed trailer bill, attached, provides necessary clarification.

Staff comments and recommendations: Consent

ISSUE 12: Developmental Centers - Capital Outlay Project - Porterville Developmental Center Water System - PROPOSED CONSENT

Proposal: $3.7 million General Fund for preliminary plans, working drawings, and construction phases to install groundwater nitrate remove system (NRS) at Porterville Developmental Center. The NRS is required to reduce to a safe level, excess nitrates from the domestic water supply, as supported by a Department of General Services contracted study.

Background: Porterville Developmental Center is located on the eastern side of the Tule Subbasin, which is known to have localized nitrate pollution due to agricultural, commercial, and industrial activities including fertilization and discharges from animal operations. Nitrate levels have been up to 33 percent higher than the minimum contamination levels of 45 percent parts per million (ppm). Nitrate is a carcinogen and, if not properly diluted or treated, can pose significant health risks. Through the natural process of groundwater recharge, which is deep drainage or deep percolation of rain, natural streams, water ways, and irrigation into groundwater and aquifers, nitrate levels can be reduced. However, according to the Administration, recent drought conditions have significantly diminished these subsurface inflows and has contributed to excessive nitrate levels.

Staff comments and recommendations: Consent.

ISSUE 13: Developmental Centers -Report on General Funds Savings Associated with Closures

Background: SB 82 (Committee on Budget and Fiscal Review), Chapter 23, Statutes of 2015, requires the department to identify General Fund savings associated with the downsizing or closure of developmental centers. The chart below shows the funding impact of downsizing and closure-related activities on the developmental centers, regional centers, and headquarters budgets.

Developmental Center Closures – Funding Impacts3 Dollars in Thousands						
	FY 2015-16		FY 2016-17		FY 2017-18	
Program/Activity	**TF**	**GF**	**TF**	**GF**	**TF**	**GF**
DCs-Operations Adjustments	$1,500	$800	-$8,800	$22,300	-$80,800	-11,900
DCs-Closure Activities	$1,700	$1,100	$7,100	$5,300	$5,700	$3,600
Community Services-Closure Placements	$46,700	$43,700	$78,800	$69,100	$25,700	$19,200
Community Services-Continuation Costs	$48,100	$30,500	$45,000	$26,000	$68,700	$40,700
HQ-Closure Coordination and Oversight	$0	$0	$2,100	$1,800	$2,100	$1,800
TOTAL	**$98,000**	**$76,100**	**$124,200**	**$124,500**	**$23,200**	**$53,400**

The department does not identify any net savings related to downsizing or closure-related activities in the budget year. As in the previous two fiscal years, increased expenditures related to a higher per capita cost of remaining residents, closure activities, placement costs, and ongoing community costs for persons who have moved continue to outpace cost reductions at the developmental centers. Based on previous experience, it is not anticipated that net savings will be realized until the developmental center is fully closed.

Report on General Fund Backfill Due to Sonoma Developmental Center Federal Decertification. AB 1606 (Committee on Budget), Chapter 26, Statutes of 2016, requires the department to report quarterly to the Joint Legislative Budget Committee on the estimated amount of General Fund expenditures used to backfill federal funding as a result of the decertification of intermediate care facility units at the Sonoma Developmental Center. The report submitted on March 7, 2017, estimates, the need for General Fund backfill, as January 10, 2017, to be $32.4 million. This amount will be updated with the May Revision.

Stakeholder Proposals.

The Lanterman Coalition recommends the restructuring of state and community-based responsibilities by: (a) expeditiously completing the closure of developmental centers, thus recapturing federal funding

3 Chart does not include other costs to the state that are not reflected in the department's budget, such as Medi-Cal and in-home supportive services for persons living in the community. The chart does not include accelerated expenditures to resolve outstanding workers' compensation claims for developmental center employees.

currently suspended due to the decertification of SDC's ICF units; (b) providing timely and sufficient funds to assure community services are available to consumers moving out of developmental centers; and (c) retaining state funds and assets currently devoted to the developmental centers and utilizing them for the community-based system.

The Association of Regional Center Agencies (ARCA) requests that as financial resources become available due to developmental center closures, they should be redirected to stabilizing and supporting community services.

Questions:

For Nancy Bargmann, DDS

- *Has the Administration projected when and how much net savings will be realized relative to the down-sizing and closure of the developmental centers?*

For Carl London, Lanterman Coalition

- *Briefly describe your proposed restricting of state and community-based responsibilities.*

Staff comment and recommendation: Informational Item. No action is necessary.

PANEL 3: REGIONAL CENTERS OPERATIONS - ISSUES 14-18
Nancy Bargmann, Department of Developmental Services
Kris Cook, Department of Finance
Sonja Petek, Legislative Analyst's Office
Amy Westling, Association of Regional Center Agencies
Catherine Blakemore, Disability Rights California
Tiffany Whiten, SEIU

ISSUE 14: Regional Center Operations Overview

Background: The Lanterman Act establishes 21 regional centers as private, non-profit agencies, each directed by the policies and decisions of a locally-established board of directions. However, the department provides necessary oversight through its contractual relationship with each regional center and it is the responsibility of the department to ensure that services and supports provided in the most effective and efficient means possible and that the tenets of the Lanterman Act and other relevant state and federal requirements are met. The 21 regional centers:

Regional Center	Counties Served	Total Served4
Alta California	Alpine, Colusa, El Dorado, Nevada, Placer, Sacramento, Sierra, Sutter, Yolo, Yuba	21,831
Central Valley	Fresno, Kings, Madera, Mariposa, Merced, Tulare	18,216
East Bay	Alameda, Contra Costa	
Eastern L.A.	Eastern L.A., including Alhambra, Whittier	11,200
Far Northern	Butte, Glenn, Lassen, Modoc, Plumas, Shasta, Siskiyou, Tehama, Trinity	7,400
Frank D. Lanterman	Central L.A., including Burbank, Glendale, Pasadena	9,813
Golden Gate	Marin, San Francisco, San Mateo	9,084
Harbor	Southern L.A., including Bellflower, Harbor, Long Beach, Torrance	12,391
Inland	Riverside, San Bernardino	31,958
Kern	Inyo, Kern, Mono	8,245
North Bay	Napa, Solano, Sonoma	8,796
North L.A.	Northern L.A., including San Fernando and Antelope valleys	23,345
Orange County	Orange	20,119
Redwood Coast	Del Norte, Humboldt, Mendocino, Lake	3,756
San Andreas	Monterey, San Benito, Santa Clara, Santa Cruz	16,473
San Diego	Imperial, San Diego	25,108
San Gabriel/Pomona	Eastern L.A., including El Monte, Monrovia, Pomona, Glendale	12,924
South Central L.A.	Southern L.A., including Compton, Gardena	13,967
Tri-Counties	San Luis Obispo, Santa Barbara, Ventura	13,635
Valley Mountain	Amador, Calaveras, San Joaquin, Stanislaus, Tuolumne	12,824
Westside	Western L.A., including Culver City, Inglewood, Santa Monica	8,588

Staff Comment and recommendation: Informational Item. No action is necessary.

4 Caseload data is taken from the Client Master File as of June 25, 2016

ISSUE 15: Regional Center Operations - Update on Previous Actions

The 2016 budget act and ABX2 1 (Thurmond), Chapter 3, Statutes of 2016, provided funding enhancements to the regional centers' operational budgets. These include:

Regional Center Staff Salaries and Benefits. $43.6 million ($29.7 million General Fund) increase for regional center staff salaries and/or benefits (excludes executive staff and unfunded retirement liabilities). Regional centers must report specific information to the department regarding how these funds were used and failure to do so will cause the regional center to forfeit the funds. The department notified regional centers of their allocation amount, which is based on their proportional share of the total core staffing funding, in May 2016. The department will include a description of these increases and impact on caseload ratios at the May Revision.

Regional Center Administration Costs. $1.9 million ($1.4 million General Fund) increase for regional center administration, including the clients' rights advocacy contract. Regional centers must report specific information to the department regarding how these funds were used and failure to do so will cause the regional center to forfeit the funds. In May 2016, the department notified regional centers of their allocation amount based on their proportional share of the total core staffing funding. The clients' right advocacy contract was increased by $21,155 annually (a 2.5 percent increase of contract's administrative costs). The department is required to describe the implementation of these augmentations in the May Revision.

HCBS Waiver Compliance. $1.6 million ($900,000 General Fund) for 21 program evaluators (one at each regional center) to ensure program settings are integrated into the community, as required by the federal HCBS waiver.

Disparities Specialist Staff and Employment Specialist Staff. $4.5 million ($3.1 million General Fund) for one of each position at each regional center.

Case Manager Caseload Ratios. $17 million ($13 million General Fund) for an estimated 200 program coordinator positions to improve compliance with federal caseload ratio requirements. Budget bill language requires each regional center to report on the number of program coordinators hired, the impact on caseloads and, if applicable, justification if funding is not used for this purpose. The department will provide an implementation update based on regional center report at the May Revision.

Background**.** The Association of Regional Center Agencies, in a 2013 report, found that a number of regional centers are not meeting caseload ratio requirements under the HCBS waiver, putting California at risk for a loss in federal funding. In recommending approval of this proposal last year, The LAO noted that because the proposal would not support staffing changes sufficient to bring regional centers into full compliance with all required caseload ratios, federal funds could still be at risk related to HCBS waiver consumers. While special session actions and the $17 million augmentation provided in the current year should help mitigate some of this risk, that risk remains to the extent that regional centers are not meeting caseload requirements for HCBS consumers.

According to the Administration's testimony last year, it had not requested the total number of projected coordinators to meet federal caseload ratio requirements because it wants to consider the impact of this proposal and actions taken during the special session (e.g., wage increases for direct care staff) to get a better understanding for the need for these positions. The LAO recommended the

Administration report at budget hearings this year on the benefits, trade–offs, and implementation issues of targeting caseload ratio requirements where federal funds are at risk.

Stakeholder Proposals.

Service Employees International Union (SEIU), who represents service coordinators at some regional centers, request an augmentation of $34 million General Fund to further reduce regional center case manager caseloads. According to SEIU, this amount would bring California into compliance with federal caseload requirements.

Disability Rights CA proposes reducing service coordinator caseloads for individuals who are receiving residential crisis services.

Questions:

For Nancy Bargmann, DDS

- *How does DDS ensure that these funds provided for specific staffing and outside of the core staffing formula, are used as intended?*
- *Do you have any early indications of the impact of the wage and benefit augmentations on case manager recruitment and retention?*
- *Do you have any early indications of the impact of the $17 million for additional service coordinators in federally-required caseload ratios?*

For Tiffany Whiten, SEIU

- *Briefly present your proposal for additional service coordinator funding.*

For Catherine Blakemore, DRC

- *Briefly present your proposal for decreased service coordinator caseloads for individuals receiving residential crisis services.*

Staff comments and recommendations: Informational Item. No action is necessary.

ISSUE 16: Regional Center Operations - Current Year Adjustments

The Governor's budget requests a $2.0 million increase ($9.6 million General Fund decrease) reflecting caseload and service utilization adjustments. Specifically, the budget proposes:

- $2.1 million increase ($9.6 million General Fund decrease) due to increased caseload, offset by:
    - $13,000 decrease in ICF-DD administrative fees.
    - $34,000 increase for minor adjustments in projects for the affordable housing contract.
    - $112,000 decrease for a minor adjustment in Denti-Cal.

Questions:

For Nancy Bargmann, DDS

- *Briefly present the current year adjustments.*

Staff comment and recommendation: Hold open for May Revision.

ISSUE 17: Regional Center Operations - Budget Year Proposals

The Governor's budget proposes the following in the budget year:

- $26.7 million ($25.2 million General Fund) increase reflecting caseload and service utilization.
- $2.9 million ($1.9 million General Fund) increase related to the minimum wage increase.
- $0.2 million decrease ($0.1 million General Fund decrease) in rent funds based on new rent budget methodology.
- $0.5 million General Fund decrease to correct ABX2 1 regional center operations funding.
- $3.3 million decrease ($3.2 million General Fund decrease) reflecting one-time nature of rate study funding and small adjustment reflecting new rent methodology.

Questions:

For Nancy Bargmann, DDS

- *Briefly present the budget year proposal.*

Staff comment and recommendations: Hold open for May Revision.

ISSUE 18: Regional Center Operations - Reporting of Employment Outcomes by Regional Center – Proposed Trailer Bill Language

Proposal. The proposed language would require regional centers, through the performance contract process, to measure progress and report outcomes in implementing the "employment first" policy. According to the department, the outcomes and measures contained in performance contracts have remained relatively unchanged since 2001. They further report that three years ago, the department began "encouraging" regional centers to include employment outcomes as part of their local measures, however, five regional centers have not done so.

Background: Welfare and Institutions Code (WIC) requires the department to contract with private, non-profit corporations for the establishment of regional centers. Statute sets forth criteria for regional center governing boards, including membership criteria, terms of service, training requirements, conflict of interest prohibitions, the establishment of advisory boards, and other requirements intended to ensure regional centers meet their statutory obligations in a transparent and fiscally responsible manner.

WIC 4629 requires the department to enter into five-year contracts with regional centers, requiring each regional center to render services in accordance with applicable provision of state laws and regulations. The contact must include annual performance objectives that are specific, measurable, and designed to do all of the following:

- Assist consumers to achieve life quality outcomes.
- Achieve meaningful progress above the current baselines.
- Develop services and supports identified as necessary to meet identified needs, including culturally and linguistically appropriate services and supports.
- Measure progress in reducing disparities and improving equity in purchase of service expenditures.
- Be developed through a public process as described in the department's guidelines.

In addition to the performance objectives developed through this public process, the department may specify in the performance contract additional areas of service and support that require development or enhancement by the regional center. In determining those areas, the department must consider public comments from individuals and organizations within the regional center catchment area, the distribution of services and supports within the regional center catchment area, and review how the availability of services and supports in the regional area catchment area compares with other regional center catchment areas.

Each contract is required to include steps to be taken to ensure contract compliance, including, but not limited to, incentives that encourage regional centers to meet or exceed performance standards; and levels of probationary status for regional centers that do not meet, or are at risk of not meeting, performance standards. Statute goes on to describe other steps the department may take to resolve contract disputes with regional center including, when all other efforts fail, termination or non-renewal of the contract.

Stakeholder Proposals: Disability Rights California requests this language be changed to focus on

the state blueprint for competitive integrated employment and federal Work Incentives Opportunity Act language, rather than Employment First language (discussed in Issue 22) and suggest additional measurement criteria, including:

- The number of consumers who have an IPP goal of integrated competitive employment.
- The number of consumers who are receiving integrated competitive employment.
- The number of consumers age 24 or younger in a job earning subminimum wage or lower.
- The number of consumers in an employment setting that does not meet the HCBS regulation.

Questions:

For Nancy Bargmann, DDS

- *Briefly present your proposed trailer bill language.*
- *What rationale have the five regional centers who have not included employment information in their performance contracts given for refusal?*
- *Is it the department's contention that they lack statutory authority to require this?*

For Amy Westling, ARCA

- *Does ARCA believe that the department lacks the authority to require this language in the performance contracts?*

For Catherine Blakemore, DRC

- *Briefly present your proposal.*

Staff Comment and Recommendation: It is unclear why existing authority is insufficient to accomplish the goal of this proposed language. However, the committee may wish to direct staff to work with the department and ARCA to ensure performance contracts are a meaningful tool, including the ability of the department to require within a performance contract those activities, measurements and reporting necessary to ensure regional centers comply with all applicable laws and regulations. Hold open.

PANEL 4: REGIONAL CENTERS PURCHASE-OF-SERVICES - ISSUES 19-29

Nancy Bargmann, Department of Developmental Services
Kris Cook, Department of Finance
Sonja Petek, Legislative Analyst's Office
Rick Rollins, Association of Regional Center Agencies
Marty Omoto, California Person Centered Advocacy Partnership
Catherine Blakemore, Disability Rights California
Aaron Carruthers, State Council on Developmental Disabilities
Barry Jardini, California Disability Services Association
Greg deGiere, The Arc California
Steve Miller, Lanterman Coalition

ISSUE 19: Regional Center Purchase-of-Services Overview

Through their purchase-of-services budget allocation, regional centers provide community-based services to individuals who live with parents or other relatives, in their own houses or apartments, or in more structured community living arrangements (i.e., group homes, residential care facilities, intermediate care facilities) designed to meet their medical or behavioral needs. Once individuals qualify for services under the Lanterman Act, the state provides these supports throughout their lifetime. These services and supports range from day programs to transportation or residential services. Determination of which services an individual needs is made by an interdisciplinary team that develops an Individualized Program Plan or Individual Family Service Plan, if the consumer is an infant/toddler three years of age or younger. Services that are included in these plans are entitlements and regional centers purchase them if necessary (i.e., an individual does not have private insurance that covers the service and there is no "generic" or publicly provided service available). The department uses caseload and utilization data to determine the amount each center receives in purchase-of-service funding annually.

The following chart shows the proposed statewide purchase-of-services budget as it compares to the adjusted purchase-of-services expenditures in the current year.

California Department of Developmental Services *Regional Centers*
November 2016 Estimate

POS Expenditures

The 2017-18 POS caseload expenditures reflect a net increase $290.7 million ($258 million GF), or 6.11 percent, over the updated 2016-17 projections. Of this increase, $209 million is due to expenditure increases in the Base. Community Care Facilities, Support Services, and Day Programs comprise 71 percent of the total increase over the updated 2016-17 projections.

Purchase of Services
Caseload (Utilization and Growth)
(Values in thousands)

	Updated 2016-17	2017-18	Change over Updated 2016-17	Percent Change
Community Care Facilities	$1,193,781	$1,259,012	$65,231	5.46%
Medical Facilities	20,937	22,164	1,227	5.86%
Day Programs	997,648	1,047,134	49,486	4.96%
Habilitation	151,744	155,009	3,265	2.15%
Work Activity Program	51,829	51,818	-11	*-0.02%*
Supported Employment Program - Group	81,236	84,183	2,947	*3.63%*
Supported Employment Program - Individual	18,679	19,008	329	*1.76%*
Transportation	303,293	323,108	19,815	6.53%
Support Services	1,116,468	1,209,519	93,051	8.33%
In-Home Respite	315,036	347,602	32,566	10.34%
Out of Home Respite	40,615	40,941	326	0.80%
Health Care	110,596	120,414	9,818	8.88%
Miscellaneous	498,320	514,194	15,874	3.19%
Quality Assurance Fees	9,324	9,324	0	0.00%
TOTAL	**$4,757,762**	**$5,048,421**	**$290,659**	**6.11%**

Staff Comments and Recommendations. Informational Item. No action is necessary.

ISSUE 20: Regional Center Purchase-of-Services - Update on Previous Actions - Home and Community-Based Services (HCBS) Compliance – Proposed Trailer Bill Language: HCBS Policy Directives

Background. California receives approximately $1.8 billion in federal funding annually for approximately 130,000 persons with developmental disabilities through the federal HCBS programs and 1915(i) State Plan option. These programs provide Medicaid funding for eligible individuals to receive services and supports in home and community-based settings, rather than in an institution. In order to continue to receive these funds, states must comply with new waiver conditions, called the "final rule", by March 2019. The final rule requires a person-centered planning process, greater choice in life decisions and daily living, and requires services and supports be provided in settings that maximize independence and community integration.

Last year, the Legislature approved $15 million ($11 million General Fund) annually to fund modifications to service providers' programs to comply with the HCBS waiver. Regional centers are to report annually to the department on the number of providers receiving this funding. The department will report at May Revision on the implementation of this item.

Additionally, the Legislature approved $46 million ($26 million General Fund) in 2016 to help transition and establish smaller alternative residential model (ARM) four-bed homes for regional center consumers living outside their family. Originally, this model was based on six-bed homes; provisional budget bill language requiring regional centers to report annually to the department the number of facilities receiving these rates; and trailer bill language to establish a rate schedule for residential community care facilities vendored to provide services to a maximum of four persons with developmental disabilities. This trailer bill language also prohibits regional centers from authorizing any residential service-level changes, if the change would increase state costs. This funding is continued at the same level in the budget year.

DDS indicates that there are 4,233 ARM community care facilities (CCFs), serving 21,118 consumers. Regional centers reported that approximately 900 CCFs received this new rate.

Legislative Analyst's Office. The LAO has expressed concern that the department is falling behind in helping providers comply with these new federal rules. According to the LAO, the Department of Health Care Services (DHCS), the lead state agency responsible for ensuring compliance with federal Medicaid rules, is waiting for final approval of the state transition plan (STP) from CMS before beginning official provider compliance assessments, LAO expresses concerns that this may leave little time to make necessary programmatic and facility changes. The revised STP was submitted on November 23, 2016, leaving at best two years to achieve state compliance. LAO notes that the department received requests for more than $130 million when soliciting applications for the $15 million in modification funding. The LAO recommends that the department be required to report on the extent and severity of provider noncompliance and the potential need for additional resources to ensure compliance. Specifically, the LAO suggests the department report on the following:

- The nature of funding requests received and whether they identified any serious compliance issues.

- What providers propose to do and whether the proposals collectively suggest a need for educational efforts about the final rule.

- How much additional funding will be needed.

- Departmental priorities for allocating funding and generally how it decides which requests to approve.

Proposed Trailer Bill Language – HCBS Policy Directives. The federal final rule was published in early 2014 and states are required to submit their transition plan describing how they will bring programs into compliance with the regulations by March 2019. The state submitted its revised transition plan to CMS in November of 2016. The Administration has proposed trailer bill language that will allow them to issue policy directives in advance of emergency regulations in order to align state and federal regulations prior to the implementation deadline. Last year, the Administration proposed trailer bill language expressing the Legislature's intent to enact Legislation to implement changes necessary to comply with the HCBS regulations.

Stakeholder Proposals.

- The Lanterman Coalition. Urges[5] the Legislature to prevent the loss of federal funds that would result from non-compliance with waiver requirements.

- The Disability Services Association requests trailer bill language that facilitate a decision-making process when requirements of one agency, i.e., community-care licensing, conflicts with the waiver requirements.

- Disability Rights CA are concerned that federal regulations could be repealed and suggest adding key elements of the regulations into the Lanterman Act, especially as they relate to person-centered planning and setting requirements related to consumer choice.

Questions:

For Nancy Bargmann, DDS

- *Briefly present your proposed trailer bill.*

For Sonja Petek, LAO

- *Briefly present your concerns about the status of HCBS compliance.*

For Catherine Blakemore, DRC

- *Briefly present your concerns and proposal.*

5 The Lanterman Coalition consists of the following organizations: Association of Regional Center Agencies; Autism Business Association; California Disability Services Association; California Foundation for Independent Living Centers; California Respite Association; California State Council on Developmental Disabilities; California Supported Living Network; Cal-TASH; Disability Rights California; Easter Seals; Family Resource Centers Network of California; Infant Development Association of California; ResCoalition; Service Employees International Union; SoCal Association of People Supporting Employment First; Society of California Care Operators, Inc., The Alliance; and The ARC and UCP California.

For Marty Omoto, California Person Centered Advocacy Partnership

- *What is your perspective on the progress toward HCBS compliance?*

For Barry Jardini, DSA

- *Briefly present your proposal.*

Staff Comments and Recommendations: While it is important that the department has all the tools necessary to ensure the continued receipt of federal funds, it is also important that the requested authority to issue "policy directives" does not serve as a substitute for the statutory or regulatory process. Hold open for further discussion.

ISSUE 21: Regional Center Purchase-of-Services - Update on Previous Actions - Competitive Paid Employment Incentives and Paid Internships – Proposed Trailer Bill Language: **Paid Internships for 18 to 22 Year Olds**

Background. Both state and federal law has moved toward greater emphasis on work opportunities in integrated and competitive settings for persons with developmental disabilities. AB 1041 (Chesbro), Chapter 667, Statutes of 2013, established an "employment first" strategy, making integrated competitive employment the prioritized goal in the IPP process and emphasizing training and internship programs that lead to this goal. At the federal level, the 2014 Workforce Innovation and Opportunities Act (WIOA) stresses competitive paid employment and associated training and supports.

In February 2015, the departments of Education, Rehabilitation and Developmental Services entered into a settlement agreement with Disability Rights California to develop a state blueprint for competitive integrated employment. The draft blueprint was published in November 2016 and the final blueprint is expected to be published in the summer of 2017. The blueprint focuses on moving toward models of competitive integrated employment that pay a livable wage, expanding capacity and the number of supported employment providers, and phasing out programs that pay sub-minimum wages that are currently allowed under federal and state laws, under specified conditions, for people with disabilities.

Finally, the Developmental Services Task Force, led by the California Health and Human Services secretary, has formed a workgroup to examine the status of consumer employment and make recommendations for improvement. The workgroup has met three times and is in the process of developing a list of recommendations for the full task force to consider for future action.

ABX2 1 provided $29 million ($20 million General Fund) for the department to establish a competitive integrated employment (CIE) program that would accomplish the following:

Competitive Paid Employment Incentives – According to the department, guidelines were developed collaboratively with input from various stakeholders during two statewide meetings and other means. The guidelines were sent to regional centers on August 5, 2016. The department is statutorily-required to provide, at the May Revision, the results of a provider survey regarding resulting employment placements.

Paid Internships – According to the department, guidelines were developed collaboratively with input from various stakeholders during two statewide meetings and other means. The department developed and sent guidelines to regional centers on July 24, 2016. The department is statutorily-required to provide, at the May Revision, a description of the implementation of the paid internship program.

Trailer Bill Proposal - Paid Internships for 18 to 22 Year Olds. The Administration has proposed trailer bill language (attached) to exempt 10 to 22 year olds from the provisions of WIC 4648.55 (a) if the consumer is still receiving educational services and participating in a paid internship.

Background. WIC 4648.55 (a) prohibits regional centers from purchasing specified services, including employment-related services, for a consumer aged 18 to 22, if the consumer is eligible for special education and has not received a diploma or certification of completion, unless the individual program plan (IPP) planning team determines the consumer's needs cannot be met by the educational system or an an exemption is granted.

The Administration argues the proposed trailer bill language is necessary to allow individuals who, pursuant to their IPP, express a desire to and could benefit from an internship program.

Stakeholder Proposals.

Disability Services Association requests that the proposed trailer bill language be expanded to also allow regional centers to purchase other employment services, if a consumer aged 18 to 22 has completed a paid internship and is ready to transfer into paid employment if necessary supports are provided.

Questions.

For Nancy Bargmann, DDS

- *Briefly present your proposal.*

For Barry Jardini, DSA

- *Briefly present your proposal.*

For Aaron Carruthers, SCDD

- *As the sponsor of the Employment First legislation, how does the State Council see its role in measuring progress, especially in light of how these new resources improve access to, and readiness for, competitive integrated employment?*

Marty Omoto, California Person Centered Advocacy Partnership

- *What is your perspective on how well these proposals will improve access to, and readiness for competitive integrated employment?*

Staff Comments and Recommendations. Hold open for further discussion.

ISSUE 22: Regional Center Purchase-of-Services - Update on Previous Actions - Special Session Rate Enhancement Updates – Proposed Trailer Bill Language: Service Rate Update - PROPOSED CONSENT

$287 million General Fund was provided in the 2015-16 special session related to healthcare. AB 1606 appropriated an additional $186 million in reimbursements. Specifically, the following was provided:

Community Services Direct Care Staff Wage Increase. $294.8 million ($169.5 million General Fund) for a rate increase, as determined by the department, for enhancing wages and benefits for community services staff who spend a minimum of 75 percent of their time providing direct care. Rate increase applies only to services where rates are set by the department or through negotiations between regional centers and service providers, supported living services, and vouchered services. The department surveyed providers as the basis for rate increases, and provided notice to the regional centers of those rate increases on June 24, 2016**.** The rate increase was the same for all providers within each service category and comparable across service categories based on the surveyed providers' reported costs for direct care staff employees. Funds were allocated to the regional centers for this purpose in August of 2016.

Provider Administrative Costs. $17.3 million ($9.9 million General Fund) for administrative costs for the providers described above. The department surveyed providers as the basis for rate increases, and provided notice to the regional centers of those increases in June 2016 for the new rates that were effective July 1, 2016**.** The rate increases were the same for all providers within each service category and comparable across service categories, based on the surveyed providers' reported administrative costs. Funds were allocated to regional centers in August 2016.

Supported Living and Independent Living Services. $34.3 million ($18 million General Fund) for a five percent rate increase. The department notified regional centers of this increase in June 2016, for rates effective July 1, 2016.

In and Out-Of-Home Respite Services. $16.4 million ($10 million General Fund) for a five percent rate increase. The department notified regional centers of this increase in June 2016, for rates effective July 1, 2016**.**

Transportation Services. $13.9 million ($9 million General Fund) for a five percent rate increase. The department notified regional centers of this increase in June 2016, for rates effective July 1, 2016**.**

Supported Employment. $10.9 million ($8.5 million General Fund) to restore rates to the 2006 level**.** The department notified the regional centers of this increase in June 2016, for rates effective July 1, 2016.

Intermediate Care Facilities for the Developmentally Disabled (ICF-Dds). $24 million ($12 million General Fund) for a five percent rate increase for Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs). This rate increase was effective August 1, 2016. Funding for these programs is in the Department of Health Care Services budget.

Background. On June 16, 2015, the Governor convened a special session of the Legislature to consider and act upon legislation related to the managed care organization tax and to "increase oversight and the effective management of services provided to consumers with developmental

disabilities through the regional center system," among other provisions. AB 2X 1 (Committee on the Budget), Chapter 3, Statutes of 2016, Second Extraordinary Session, which included the rate increase described above, was signed into law on March 1, 2016. This followed multiple years of extensive testimony about the impact of rate freezes on the quality and availability of community resources and regional center case management services, particularly on the ability of regional centers and providers to recruit and retain quality staff.

Reporting on Implementation. The department is required to survey of providers and regional centers to determine how these rate increases were used. Failure of regional centers and providers to report will result in the forfeiture of the funds. The department must report back to the Legislature regarding the implementation of rate increases in the May Revision.

Legislative Analyst's Office. The LAO argues that the targeted nature of the rate increases has required a significant amount of administrative work of the part of the department, regional centers and service providers. According to the LAO, based on its discussions with the department and provider organizations, completion of the vendor survey will be administratively burdensome; many providers are unaware of the reporting requirement; and smaller vendors may have difficulty in collecting the required information. Additionally, the LAO argues that the currently required limitation on using state funds for administrative costs for providers and regional centers should be sufficient to ensure adequate funding goes to direct care staff wages and benefits. The LAO recommends the Legislature consider statutory "clean-up" to ease reporting and enforcement. Specifically, the LAO recommends the Legislature consider the following:

- Relaxing the rule that providers forfeit the increase if they fail to report how it was implemented.
- Remove the survey reporting requirement altogether or extend the October 1, 2017 deadline.
- Consider a more streamlined rate increase process in the future, at least until rate reform is addressed.

Proposed Trailer Bill Language - Service Rate Update. The rate for supported employment services is statutorily set at $34.24 per hour. The maximum rate for vouchered community-based training services is statutorily set at $13.47 per hour. In order to determine the new rate amount for these services and not exceed the allocated funding level, the department first needed to survey providers, which could not be done prior to the passage of AB2X 1. The proposed trailer bill language updates the statute to reflect the higher amounts of $36.57 per hour for supportive employment services and $14.99 per hour for vouchered community-based training services. CONSENT

Questions:

For Nancy Bargmann, DDS

- *Briefly describe how these funds were allocate and the proposed trailer bill language.*

For Sonja Petek, LAO

- *Briefly describe your concerns, and proposed improvements, to the methodology for allocating and reporting on utilization of these funds.*

Staff Comments and Recommendation. Adopt proposed trailer bill language as placeholder on consent.

ISSUE 23: Regional Center Purchase of Services - Unanticipated Rate Adjustments and Health and Safety Waiver Requests

Background. There are two ways the department may increase an existing service provider's rate –a health and safety waiver or an unanticipated rate adjustment. These are described below.

Health and Safety Waiver Requests. State law authorizes the department to approve exemptions to rate freezes when necessary to protect the health and safety of a specific consumer.6 A provider seeking this waiver must first apply to the regional center, who then may submit the request to the department, along with pertinent information including capacity, proposed rate and supporting justification, an explanation of the health and safety basis of the request and ramifications of a denial, and a signed statement from the regional center executive director that he/she concurs with the information and request being submitted. A request must be submitted for each individual consumer, although Association of Regional Center Agencies (ARCA) argues that different statutes may conflict on this point and that guidance from the department has differed over time. The department has received a total of 143 such requests, impacting 2,865 consumers, in fiscal years 2013-14, 2014-15 and 2015-16, as shown in the chart below. Of these, 50 were related to local minimum wage ordinances in the Regional Center of the East Bay and San Andreas Regional Center catchment areas. According to the department, the average time it took to process these requests, once forwarded to the department from the regional center, was 76 days in 2013-14, 143 days in 2014-15, and 90 days in 2015-16. The department notes that some requests are expedited based on the nature of the health and safety risk to the consumer.

Health and Safety Waiver Requests[7]

FY	Approved		Denied		Rescinded		Pending		Total	
	Requests	Consumers	Requests	Consumers	Requests	Consumers	Requests	Consumers	**Requests**	**Consumers**
2013-14	20	841	1	1	3	26			**24**	**868**
2014-15	24	54	19	1488	10	72			**53**	**1614**
2015-16	46	222	4	6	11	18	6	137	**67**	**383**
2016-17	13	16	5	457	2	3	48	2557	**68**	**3033**
Total	**103**	**1133**	**29**	**1952**	**26**	**119**	**54**	**2694**	**212**	**5898**

According to the department, the most common reasons for approvals of health and safety waiver requests include:

- To maintain consistency in staff/providers whose familiarity and expertise help maintain a consumer's health and safety.

- To increase services and supports to allow the consumer to maintain safe, independent living, or to remain living in the family home.

6 Welfare and Institutions Code sections 4648.4(b), 4681.6, 4684.55, 4689.8, 4691.9 and 4691.9.
7 2015-16 and 2016-17 data as of March 9,2017.

- To increase services and supports due to changes in the consumer's medical condition and/or behavioral challenges and mitigate identified health and safety risks.

- Lack of available alternative resources to serve the consumer due to his or her significant behavioral and/or mental health challenges.

It has been reported by ARCA that one regional center is expecting upwards of 4,000 individual health and safety waiver requests for transportation services. Some providers report that some regional centers have advised them not to submit a health and safety waiver request related to local minimum wage issues as the department will not approve them. However, the department has approved them in the past and the January 6, 2017 instructions from the department to regional centers lay out specific directions for such submissions.

Unanticipated Rate Adjustment Requests. Unanticipated Rate Adjustments are guided by Title 17 regulations and apply only to community-based day programs and in-home respite providers. These adjustments can be applied for by eligible providers directly to the department and are not required to first submit through the regional center. Adjustments can be requested for mandated service adjustments due to changes in, or additions to, existing statutes, laws, regulations or court decisions. The chart below summarizes the number of rate adjustment requests made and approved, and the total associated expenditures for fiscal years 2013-14, 2014-15 and 2015-16. Of the 803 requests received in 2014-15, 439 were submitted as a result of the increase in the state minimum wage, effective July 1, 2014, resulting in 257 approved requests. The following chart provides a summary of unanticipated rate adjustments in recent years.

Summary of Unanticipated Rate Adjustment Requests

	Submitted	Approved	Expenditures for Approved Requests	Denied
FY 2012-13 Totals	6	0	$0	6
FY 2013-14 Totals	16	7	$28,213	9
FY 2014-15 Totals	803	265	$75,406,156	538
Grand Total	**825**	**272**	**$75,434,369**	**553**

Stakeholder Proposals.

The Lanterman Coalition urges actions to save community-based services that otherwise would close and would cost the state more to replace. The coalition points to rate freezes, with only sporadic and targeted increases, while mandate-driven and location-specific costs continue to rise without a mechanism for addressing. They argue that, while all program are hard-pressed, some are far closer to the brink of failure than others. They further argue that when a program closes and consumers are transferred to other existing programs or when new programs are created for them, the cost of the service is often significantly higher than if the original program had been stabilized. They recommend

providing the department with the authority to permit programs on the brink of collapse to apply for relief and to negotiate rate increases sufficient to stabilize the program, at rates no higher than the cost of replacement programs, including any transportation costs.

ARC and UCP California Collaboration have submitted specific language they would like adopted which would lay out a process for determining when a rate increase is warranted due to a program's likelihood of closure within six months due to inadequate rates and would require that all information related to this process will remain confidential until the program informs consumers, families, employees or the public of a program termination; or the department determines a rate increase is necessary or unnecessary.

ARCA seeks greater rate flexibility to meet community and individual needs. They note that in 2015-16, of the 169 residential homes that closed, 38 percent cited rate inadequacy or other fiscal reasons as the cause; and of the 39 day and work programs that closed, 45 percent cited rate inadequacy or other fiscal reasons as the cause. They further argue the costs of providing replacement services often exceed the likely cost to keep struggling programs viable. Like the ARC Ca and UCP Collaboration, ARCA supports providing the department with authority to grant rate increases to programs who would otherwise close due to fiscal reasons.

Disability Rights CA recommends that the median rate exception process should be modified to reflect the immediate needs of persons in crisis.

Questions.

For Nancy Bargmann, DDS

- *Describe the difference between a health and safety waiver and an unanticipated rate adjustment request.*

- *Looking at the Health and Safety Waiver Requests chart, the number of requests and impacted consumers ranges significantly from year to year. For example, total requests in 2013-14 are 24, impacting 868 consumers; it rises to a high of 143 programs, impacting 2865 consumers in 2015-16; and drops by more than half to 68 programs, impacting a higher 3033 consumers, last year. What do you think drive these numbers? What do the numbers look like, to date, in the current year?*

- *Similarly, for the Summary of Unanticipated Rate Adjustment Requests, the number submitted in 2012-13 was six, none of which were approved; and the number grew to 803 in 2014-15 (the last year for which data was provided), of which 538 were denied. What drive these numbers? The number of denials is notable. What do you think accounts for the number of programs who lack clarity as to what the criteria might be for approval of this kind of request? What do budget year and current year numbers look like?*

For Barry Jardini, Lanterman Coalition and DSA

- *Briefly describe the Lanterman Coalition proposal regarding programs at risk.*

For Greg deGiere, The ARC California

- *Briefly describe your proposed language associated with the Lanterman Coalition proposal.*

For Catherine Blakemore, DRC

- *Briefly describe your proposal regarding median rate exceptions.*

Staff Comments and Recommendation. Informational Item. No action is necessary.

ISSUE 24: Regional Center Purchase-of-Services - Update on Previous Actions - Rate Study

The department received $3 million General Fund in SB 826 (Leno), Chapter 23, Statutes of 2016 to contract for a service provider rate study and to provide recommendations for a new rate setting methodology. The study and accompanying recommendations are due to the Legislature by March 1, 2019. The study is required to provide an assessment of current methods for setting rates, including whether they provide an adequate supply of vendors; a comparison of the fiscal effects of alternative rate-setting methodologies; how vendor rates relate to consumer outcomes; and an evaluation of the current number and types of service codes and recommendations for restructuring service codes. Additionally, the rate study request for proposal (RFP) requires the chosen contractor to provide a rate maintenance process and with a multi-year impact. The department released its request for proposals for the rate study on February 9, 2017, with a deadline to submit proposals by April 3, 2017. The chosen contractor will be required to provide a documented rate maintenance process and the multiyear impact.

Background. Rates paid to community-based providers for services and supports provided to persons with a developmental disability are established through multiple methodologies, as shown below.

Rates Paid to Regional Center Vendors
Department of Developmental Services set statewide rates established pursuant to cost statement, statute, or regulation.
Department of Health Care Services Schedule of Maximum Allowance.
Negotiated Rates: a rate negotiated up to the applicable median rate for the regional center catchment area, or the current statewide median rate, whichever is lower.
Department of Social Services rates.
Standard Rate Schedule, established by the regional center based upon the cost-effectiveness of providing specific transportation services.
Regional Center set mileage reimbursement set at a per mile rate not to exceed the travel rate paid by the regional center to its own employees.
Usual and Customary Rates is a rate regularly charged by a vendor for a service that is used by both regional center consumers and where at least 30 percent of the recipients of the given service are not regional center consumers.

Prior to ABX2 1, most community-based service providers had not received a rate increase since 2006, except in limited circumstances, such as changes in the statewide minimum wage. Residential care providers (ARM), day programs, and traditional work programs received a three percent rate reduction in February of 2009, which expired in July of 2012. These providers received an additional rate reduction of 1.25 percent in July 2010, which expired in July 2013. Since 2008, providers whose rate is set through negotiations with individual regional centers have had their rates frozen and the rates for new providers were limited to the median rate for the year 2007. These providers were also subject to the three percent and 1.25 percent rate reductions, and subsequent expiration, discussed above. Supported work providers, who rate is set in statute, received a 24 percent increase in 2006, but their rate was subsequently reduced by 10 percent in 2008.

Legislative Analyst's Office. The LAO agrees with most parties that the current rate-setting process is complicated and results in insufficient and uneven rates. The LAO finds the requirement for a rate

maintenance process in the RFP to lack clarity and suggests the Legislature request the department to work with the prospective bidders to include the role of economic and policy changes in rate maintenance activities. Specifically, the LAO recommends that rate maintenance could include:

- Options for how costs can be reduced in recessionary times, while minimizing adverse impacts on consumer outcomes.
- Options for how funding could be restored or a return to a regular rate maintenance schedule following the implementation of cost-saving measures.
- Options for ongoing rate adjustments based on market conditions.
- Options for implementing rate changes associated with minimum wage increases and other labor laws.
- Options for how rates can adjust to policy changes, including recommendations for incorporating flexibility into the rate structure.

Stakeholder Proposals.

The Lanterman Coalition seeks assurances that the state will select a consultant for the rate study who will incorporate the actual costs of delivering quality community services and (1) provide transparency in the process and a continued commitment to keeping the community closely apprised of the study's progress, (2) extensive community input opportunities with a dedicated stakeholder committee to oversee the consultants' work, and (3) that principles for the new rate structure are developed with the disability community

Questions:

For Nancy Bargmann, DDS

- *Briefly describe the status of the rate study.*

For Sonja Petek, LAO

- *Briefly describe your recommendations regarding the rate study.*

Staff Comment and Recommendation. Informational Item. No action is necessary.

ISSUE 25: Regional Center Purchase-of-Services - Update on Previously Actions - Disparities

Background. The department and regional centers are statutorily-required to annually collaborate to compile data in a uniform manner relating to POS authorization, utilization and expenditure by regional center and by specified demographics including: age, race, ethnicity, primary language spoken by consumer, disability, and other data. This information is also to include data on individuals eligible for, but not receiving, regional center services. Regional centers are required to hold public hearings on this data and the department is required to provide oversight, through their contract agreements with the regional centers, by requiring specified activities and establishing annual performance objectives.

Numerous legislative hearings and press accounts have discussed a significant level of disparities in service delivery among racial and ethnic groups and between regional centers. Multiple bills have been signed into law to address these disparities through multiple strategies including, governing board training; data collection and sharing; improved departmental oversight of regional centers; and requirements that regional centers communicate and provide written materials in multiple languages. Despite these efforts, significant disparities remain.

AB 2X 1 provided $11 million General Fund to address pay differentials supporting bilingual service coordinators at regional centers when fluency in the second language helps to address the language needs of the regional center's catchment area; and for implementation of recommendations and plans to help reduce disparities in the purchase-of-service expenditures and to encourage the development and expansion of culturally and linguistically appropriate services. Activities funding may include, but are not limited to, paying differentials supporting direct care bilingual staff of community-based service providers, parent education programs, cultural competency training, and outreach.

On July 26, 2016, the department sent guidelines to regional centers regarding the submission of proposals to obtain funding to address identified areas of disparity. Subsequently, in August 2016, the department held four stakeholder meetings throughout the state to discuss and gather information on disparity issues. Additionally, each regional center was required to consult with stakeholders regarding activities that may be effective in addressing disparities in the receipt of regional center services and the regional center's proposed requests for the above-mentioned funding.

The department approved proposals from all 21 regional centers for activities to promote equity and reduce purchase of services disparities. Of the $11 million, the department approved proposals ranging from $1,500 to $750,000. Activities funded include: electronic interpreter systems, translation of written materials, cultural training, group trainings in native languages, reduced caseloads, cultural competency staff training, cultural brokers and parent mentors, and outreach activities. By mid-March, the department anticipates approving additional regional center proposals that expand on previously approved proposals and/or that address language access issues.

The department will allocate funds in March 2017. Regional centers are statutorily-required to report to the department by May 31, 2016, on the implementation of approved proposals. Pursuant to AB 1606, the department will annually assess disparities data and report annually, beginning in April 2017.

Senate Committee on Human Services Oversight Hearing on Disparities. On Tuesday, March 14, 2017, the Senate will have the opportunity for a more focused discussion on this issue at a Senate Committee on Human Services informational hearing entitled: "Moving Toward Equity: Addressing Disparities in Services Provided by the Regional Center System."

Stakeholder Proposals.

Disability Rights CA and the Association of Regional Center Agencies both argue that ethnically diverse families are more likely to have been impacted by the suspension of services, such as camp and social recreation, and the reduced availability of respite services. They argue restoring camp and social recreation services and lifting the cap on respite may assist in addressing service disparities across racial and ethnic lines.

Questions.

For Nancy Bargmann, DDS

- *Briefly describe the status of the disparities initiatives.*
- *How will the impact of these projects be measured?*
- *Given the struggle this system has encountered in meaningfully reducing disparities over many years of discussion, how does the department view its role in identifying and initiating strategies that have been proven successful?*

For Rick Rollins, ARCA

- *Briefly describe your proposal for funding recreation and respite programs to address the disparities issue.*

For Marty Omoto, California Person Centered Advocacy Partnership

- *What is your perspective on how to best address the disparities issue?*

For Aaron Carruthers, SCDD

- *What is your perspective on how to best address the disparities issue?*

Staff comments and recommendations. Informational Item. No action is necessary.

ISSUE 26: Regional Center Purchase-of-Services - Current Year Adjustments

AB2X 1 Savings. The budget identifies a $14.3 million decrease ($8.4 million General Fund decrease) in estimated expenditures of AB2X 1 funding, consistent with anticipated POS caseload and utilization expenditure decreases.

Purchase-of-Services Savings. The budget identifies a decrease of $38 million ($36.1 million General Fund decrease) due to the net difference of adjustments in all categories based on updated expenditure trends and increased federal reimbursements. The budget further proposes to shift $27.2 million this amount to backfilled for increased developmental center costs.

Stakeholder Proposals.

ARCA proposes these funds instead be used for unmet community needs.

Questions:

For Nancy Bargmann, DDS

- *Briefly describe the current year adjustments.*

For Rick Rollins, ARCA.

- *Briefly describe how ARCA believes these POS saving should be utilized.*

Staff Comment and Recommendation. Hold open pending May Revision.

ISSUE 27: Regional Center Purchase-of-Services - Budget Year Proposals

Updated Caseload and Expenditure Projections. The budget proposes a $290.7 million ($268.2 million General Fund increase) to reflect an increase in all POS budget categories reflecting updated caseload and expenditure projections.

AB2X 1 Full-Year Costs. The budget proposes a $14.3 million increase ($8.4 million General Fund increase) to reflect the full-year costs associated with ABX2 1 implementation.

Best Buddies. The budget proposes a $1 million General Fund decrease due to the removal of this one-time funding provided in the current year.

Minimum Wage Adjustments. The budget proposes a $84.7 million increase ($48 million General Fund increase) to reflect the impact of minimum wage increases, established through AB 10 (Alejo), Chapter 351, Statutes of 2013 and SB 3 (Leno), Chapter 4, Statutes of 2016, on minimum wage community-based workers. The state-mandated hourly minimum wage increased from $10.00 to $10.50, effective January 1, 2017; and will increase to $11.00, effective January 1, 2018. SB 499 (Stone) and AB 279 (Holden) have been introduced to address this issue.

Stakeholder Proposals.

Lanterman Coalition and ARCA support funding required for complying with federal, state, and local mandates, such as a local minimum wage. According to these stakeholders, the state covers some of these costs through often cumbersome and expensive procedures, others go unfunded; and they ask for the adoption of a simple mechanism to make providers whole for these mandated costs.

Questions.

For Nancy Bargmann, DDS

- *Briefly describe the budget year proposal.*

For Steve Miller, Lanterman Coalition

- *Briefly present your proposal regarding federal, state and local mandates.*

Staff comments and recommendations. Hold open pending May Revision.

ISSUE 28: Regional Center Purchase-of-Services - Safety Net Development – Proposed Trailer Bill Language: EBSH and CCH Facilities

Presenters:

Nancy Bargmann, Department of Developmental Services
Kris Cook, Department of Finance

Status of new model development. Over the last few years, the department has been authorized to develop new community models of services intended to address the needs of persons with significant medical and/or behavioral needs, including persons moving from a developmental center, psychiatric facility or Institutions for Mental Disease (IMD). These include:

Enhanced Behavioral Homes. W&I Code Section 4684.80 to 4684.87 provided the department authority to promulgate emergency regulations to develop Enhanced Behavioral Supports Homes. Through 2016-17, the department approved a total of 27 Enhanced Behavioral Supports Homes with Community Placement Plan funding. .

Delayed Egress/Secured Perimeter Homes.
These facilities are not required to be eligible for federal funding, as this model continues to be ineligible under federal regulations. However, the Legislature capped the number of total allowable beds under this model at 150 statewide; required a minimum of 50 beds be available for persons who are designated as incompetent to stand trial (IST) pursuant to Section 1370.1; generally limited the number of beds per home to six, except one half of the facilities serving IST placements may be up to 15 beds.

Community Crisis Homes. The department is authorized to develop facilities with a maximum capacity up to eight beds each. At this time, the department approved the development of 12 four-bed homes using Community Placement Plan funding.

Transitional Homes. The department approved the development of three homes through Community Placement Plan funding.

Adult Residential Facility for Persons With Special Health Care Needs (ARFPSHN) with Behavioral Supports. These are Department of Social Services licensed and Department of Developmental Services certified residential program, in the community, for adults with developmental disabilities who are medically fragile and require 24/7 licensed nursing supports, and also require behavioral supports**.**

Placements of Last Resort. The California Health and Human Services Agency's report entitled "Plan for the Future of Developmental Centers", released in January 2014, made recommendations as to what should be developed to ensure the needs of persons currently living in developmental centers, or those with similar needs, would be met in the community once the developmental centers had closed. Among these recommendations was the development of crisis services to immediately meet the needs of persons in crisis and the availability of "placements of last resort."

WIC 4474.15 requires the department to submit an update at the May Revision on how it will provide crisis service and how the state will maintain its role in providing residential services to those whom

private sector vendors cannot or will not serve. As part of this plan, the department must assess the option of expanding the community state staff program to allow the department's employees to serve as regional crisis management teams that provide assessment, consultation, and resolution for persons with developmental disabilities in crisis in the community.

Proposed Trailer Bill Language – Extend Exemption From Requirement That Facilities Be Eligible For Federal Funding To Enhanced Behavioral Homes (EBSH) And Community Crisis Homes (CCH) That Utilize Delayed Egress/Secured Perimeters.

Proposal**.** The proposed language will amend Welfare and Institutions Code Sections 4648.80(a) and 4698(c)(1), to allow DDS to approve, at the discretion of the director, EBSH and CCHs to be developed with the utilization of delayed egress devices and secured perimeters, thus making them ineligible for federal HCBS funding. Current law caps the size of licensed homes with delayed egress devices and secured perimeters at six beds, with the exception of a limited number of homes for individuals designated as incompetent to stand trial. CCHs, however, may be licensed for up to eight beds. Therefore, the proposed trailer bill language would also create an exception to the Health and Safety Code to allow DDS to approve up to one third of CCHs with delayed egress devices and secured perimeters to exceed the six-bed limit.

Background**:** WIC authorizes the department to develop enhanced behavioral supports homes (EBSH) and community crisis homes (CCH) through the use of Community Placement Plan funding. The department promulgated emergency regulations for EBSH and the permanent regulations are close to becoming final. The department is currently in the process of promulgating emergency regulations to implement the development of CCH.

The department argues that these two models of care are necessary components of the continuum of residential options for individuals with developmental disabilities in California. They will form part of the "safety net", being developed to provide services for individuals with challenging service needs, particularly given the pending closure of state developmental centers. DDS anticipates also serving individuals who would otherwise be placed in institutions for mental disease or out-of-state, both of which are ineligible for federal reimbursements.

The current EBSH and CCH statutory authority requires the services qualify for federal HCBS funding. The majority of the EBSH and CCHs currently being developed statewide will qualify for federal HCBS funding; however, DDS and regional centers recognize a need to develop a limited number of homes with delayed egress devices and secured perimeters to meet the needs of individuals with developmental disabilities with the most complex service needs and serve as an effective option within California's safety net.

Stakeholder Proposals.

Disability Rights CA requests clarity that the proposed trailer bill language does not increase the total cap on delayed egress and secured perimeter facilities and to limit the total number of community crisis homes that can also be delayed egress and secured perimeter homes.

Disability Rights CA also argue that a range of supports, not just crisis services and residential placements, is necessary for a well-functioning safety net system; that services are needed to support consumers who are involved with the criminal justice system; the state should continue its role in operating or overseeing small, time-limited crisis homes.

Questions:

For Nancy Bargmann, DDS

- *Briefly describe your proposed trailer bill.*

- *Given how restrictive settings have been over-utilized historically, how will the department ensure that placements in these facilities are appropriate, that the services and supports provided in these facilities are focused on preparing an individual to move back to the community as soon as appropriate, and that the necessary services and supports are available or being developed to support a move back to the community?*

- *What other resources are being developed as part of the safety net to support persons in the community to prevent placements into these more restrictive settings?*

- *What role will state run settings or services play in the safety net?*

For Kathleen Miller, Sonoma Developmental Center Parent Association

- *What components do you think are important in building a successful safety net and how do these new models address your concerns?*

For Catherine Blakemore, DRC

- *What components do you think are important in building a successful safety net and how do these new models address your concerns? Present your concerns about the proposed trailer bill language.*

Staff Comments and Recommendations: Hold proposed trailer bill language open pending further discussion.

ISSUE 29: Regional Center Purchase-of-Services - Community Placement Plan (CPP) Funding – Proposed Trailer Bill Language: CPP Funds

The budget continues the $68 million ($43 million General Fund) in baseline funding for regular CPP and provides $26 million ($19 million General Fund) for facility-specific CPP.

Background. Since 2002-03, the budget has included funding (regular CPP) for regional centers to develop community services and supports necessary for persons moving from developmental centers and to deflect persons living in the community from developmental center placements. As specific developmental centers have identified for closure, additional funding has been provided specifically to accelerate the development of community resources for persons in those centers.

The chart below shows the status of residential capacity for persons moving from developmental centers using CPP funds, as of January 31, 2017.

Department of Developmental Services

DEVELOPMENT OF RESIDENTIAL CAPACITY FOR CONSUMERS TRANSITIONING FROM DEVELOPMENTAL CENTERS SUBJECT TO CLOSURE
Online Report

TABLE 1A: ALL DEVELOPMENTAL CENTERS

Developmental Center	Total Approved Start-Up Projects [1]		Number of Projects in Each Stage of Development							
			Pre-Acquisition [2]	In Escrow [3]	Acquired and Under Renovation [4]		Pending Licensure [5]		Licensed, Vendored and Certified [6]	
	Projects	Capacity	Projects	Projects	Projects	Capacity	Projects	Capacity	Projects	Capacity
FDC - Fairview	78	285	39	9	16	56	2	8	12	41
PDC - Porterville	34	162	18	10	1	5	1	4	4	18
SDC - Sonoma	119	452	41	5	50	195	4	17	19	57
TOTAL	231	899	98	24	67	256	7	29	35	116

Source: DDS analysis of Regional Center information provided as January 31, 2017. Status reports may lag status changes by 30 to 60 days.
Notes: Homes developed prior to the Community Placement Plan process may have additional capacity for Developmental Center (DC) consumers. Additional capacity in some homes has been encumbered for consumers in the community. Includes 10 Supported Living Services (SLS) projects, which do not have a specific capacity.

[1] All currently active start-up projects related to DC closure.
[2] Projects have been approved and are in the Request for Proposals process or actively searching for a property/site.
[3] Properties are in escrow to purchase a residential development.
[4] Properties have been acquired and are undergoing renovation/rehabilitation.
[5] Properties have completed renovation/rehabilitation and are in the process of obtaining a license, vendor and/or certification.
[6] Properties are completed and currently serving or able to serve consumers.

The chart below identifies the proposed funding for these CPP activities in the budget year.

Community Placement Plan (CPP) 2017-18 Funding Summary

	Sonoma	Fairview	Porterville	Regular CPP	Total
Operations	$3,616,000	$1,212,000	$606,000	$15,265,000	$20,699,000
Purchase of Services					
Start-Up[1]	$0	$0	$0	$27,265,000	$27,265,000
Assessment[2]	$0	$0	$0	$1,500,000	$1,500,00
Number of Consumers	0	0	0	XXX	XXX
Placement[3]	$13,322,000	$4,570,000	$2,352,000	$22,824,000	$$43,068,000
Number of Consumers	71	34	18	145	268
Deflection[4]	$0			$1,000,000	$1,000,000
Number of Consumers	0			XXX	XXX
Total	**$16,938,000**	**$5,782,000**	**$2,958,000**	**$67,854,000**	**$93,532,00**

[1]Start-Up – These expenditures are related to development of new facilities, new programs, and program expansion.
[2]Assessment – These expenditures are for individualized and comprehensive identification of consumer supports and services needed for stabilized community living.
[3]Placement – These expenditures are for the phase-in of consumers to community settings based on consumer-specific information.
[4]Deflection – These expenditures are for related services needed to deflect the admission of individuals into developmental centers.

For the developmental center-specific CPP funding, all start-up and assessment activities will be completed in the current year, resulting in a $53.1 million decrease ($55.3 million General Fund decrease) in the budget year.

Legislative Analyst's Office. The LAO agrees that there may a need for increased community resources for a number of reasons, including changing needs of consumers related to diagnosis and age. However, the LAO believes that consideration of funding these changing needs should be made apart from CPP funding decisions. Further, the LAO argues that when considering community funding needs, the Legislature should evaluate alternative funding mechanisms. Finally, the LAO suggests that the Legislature could require the department to conduct an assessment of where community resources are insufficient prior to requesting additional funding to address these gaps in service.

Proposed Trailer Bill Language – Community Placement Plan Funds.

Proposal. The Administration proposes to amend existing statute to allow regular CPP funds to be used to develop and fund resources in the community for individuals transitioning from other institutional settings or who are already living in the community.

Background. WIC Section 4418.25 requires the department to establish policies and procedures for the development of an annual community placement plan by regional centers. The CPP is designed to enhance the capacity of the community service delivery system and to reduce the reliance on the use of

developmental centers other restrictive living environments by providing funding to the regional centers for the development of a variety of resources. These resources include residential development, initial placement costs, transportation, day program services, and mental health and crisis services.

The CPP provides dedicated funding for comprehensive assessments of developmental center residents, for identified costs of moving individuals from DCs to the community, and for deflection of individuals from developmental center admission. The plans include budget requests for regional center operations, assessments, resource development, and ongoing placement costs.

As the developmental centers move toward closure, the need to develop new specialized resources for these populations will decline. However, as institutional and out-of-state service options become unavailable, there will be an increasing demand for community-based services and supports to meet the needs of consumers already in the community, including those with complex and challenging needs. The proposed language will authorize the use of CPP funds to develop resources for individuals transitioning from institutional settings or are already living in the community.

Stakeholder Proposals.

Disability Rights CA seeks to modify the proposed trailer bill language to give priority to proposals that create resources that help maintain individuals in their current home, such as mobile crisis support, wrap-around services, or enhanced rates or staffing.

Questions.

For Nancy Bargmann, DDS

- *Briefly describe your proposed trailer bill language.*
- *How does the process you describe involve local communities in the identification of unmet needs that these funds could address?*
- *How will the department measure success of funded projects in meeting goals?*

For Sonja Petek, LAO

- *Briefly present your perspective on this proposal.*

For Aaron Carruthers, SCDD

- *The State Council also has funding for community development. Do you see a way that the council's use of their funds, and the use of program development funds can complement each other in identifying new models and addressing unmet needs in the community?*

For Catherine Blakemore, DRC

- *Briefly present your proposal to modify the proposed trailer bill language?*

Staff Comments and Recommendations. Leave open pending further discussions.

PANEL 5: Federal Issues - ISSUE 30
Nancy Bargmann, Department of Developmental Services
Kris Cook, Department of Finance
Sonja Petek, Legislative Analyst's Office
Aaron Carruthers, State Council on Developmental Disabilities
Catherine Blakemore, Disability Rights California

ISSUE 30: Federal Issues

As the nation ushers in a new President and Congress, concerns have been raised as to the impact these changes may have on the amount and nature of federal funding that supports many programs in California and federal rules and regulations that guide how services and supports are provided. The State Council on Developmental Disabilities and Disability Rights California rely almost exclusively on federal funding. Based on the Governor's budget for 2017-18, federal funding provides 39 percent of the community services budget, and 26 percent of the developmental center budget. Receipt of these funds is contingent upon compliance with various federal regulations, including the new HCBS waiver rules discussed earlier in this agenda. New programs, such as the Self-Determination Program, are currently pending federal approval.

Questions:

For DDS, SCDD, DRC

- *If federal rules and regulations are relaxed or eliminated relative to the provision of services and supports, what steps do you see has important to protect the rights and well-being of persons with developmental disabilities in California?*

- *If funding is reduced significantly, what options will need to be considered to best protect the entitlement in California?*

Senate Budget and Fiscal Review—Holly J. Mitchell, Chair
SUBCOMMITTEE NO. 3 **Agenda**

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

Thursday, March 16, 2017
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Part B

Consultant: Peggy Collins

Item Page	Department	Action

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

Issue 1: Overview ..... Informational
Issue 2: Headquarters – Update on Previous Actions ..... Informational
Issue 3: Headquarters - Information Security and Privacy Support BCP- ..... Hold Open
Issue 4: Headquarters – Community Housing Development Oversight BCP ..... Hold Open
Issue 5: Headquarters – Self-Determination Program Implementation Update ..... Informational
Issue 6: Developmental Centers – Overview ..... Informational
Issue 7: Developmental Centers – Revised Estimate Process ..... Informational
Issue 8: Developmental Centers – Update on Previously Actions ..... Informational
Issue 9: Developmental Centers – Current Year Budget Shortfall ..... Hold Open
Issue 10: Developmental Centers – Budget Year Adjustments ..... Hold Open
Issue 11: Developmental Centers – Proposed TBL: Developmental Center Staff Transitioning to Vendor Status ..... Approve (2-0)
Issue 12: Developmental Centers – Capital Outlay Project: Porterville Developmental Center Water System ..... Approve (2-0)
Issue 13: Developmental Centers – Report on GF Savings Associated with Closure ..... Informational
Issue 14: Regional Center Operations Overview ..... Informational
Issue 15: Regional Center Operations – Update on Previous Actions ..... Informational
Issue 16: Regional Center Operations – Current Year Adjustments ..... Hold Open
Issue 17: Regional Center Operations – Budget Year Proposals ..... Hold Open
Issue 18: Regional Center Operations – Proposed TBL: Reporting of Employment Outcomes by Regional Centers ..... Hold Open
Issue 19: Regional Center Purchase-of-Services - Overview ..... Informational

Issue 20: Regional Center Purchase-of-Services – Update on Previous Actions – HCBS Waiver Compliance – Proposed TBL: HCBS Policy Directives……..Hold Open
Issue 21: Regional Center Purchase-of-Services – Update on Previous Actions – Competitive Paid Employment Incentives and Paid Internships – Proposed TBL: Paid Internships for 18 to 22 Year Olds…….….Hold Open
Issue 22: Regional Center Purchase-of-Services – Update on Previous Actions – Special Session Rate Enhancements – Proposed TBL: Service Rate Update……Approve (2-0)
Issue 23: Regional Center Purchase-of-Services – Unanticipated Rate Adjustments and Health and Safety Waiver Requests ……..…..Informational
Issue 24: Regional Center POS – Update on Previous Actions – Rate Study……...Informational
Issue 25: Regional Center POS – Update on Previous Actions – Disparities……Informational
Issue 26: Regional Center Purchase-of-Services - Current Year Adjustments……Hold Open
Issue 27: Regional Center Purchase-of-Services – Budget Year Proposals ……Hold Open
Issue 28: Regional Center Purchase-of-Services – Safety Net Development – Proposed TBL: EBSH and CCH Facilities……Hold Open
Issue 29: Regional Center Purchase-of-Services – Community Placement Plan Funding – Proposed TBL: CPP Funds…….….Hold Open
Issue 30: Potential for Federal Changes……..Informational

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

SUBCOMMITTEE NO. 3 Agenda

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

Thursday, March 23, 2017
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Scott Ogus

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.

4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 1: Overview

Department of Managed Health Care Funding Summary			
Fund Source	**2015-16**	**2016-17**	**2017-18**
	Actual	***Revised***	***Proposed***
0890 – Federal Trust Fund	$560,000	$100,000	$-
0933 – Managed Care Fund	$60,863,000	$73,549,000	$76,753,000
0995 - Reimbursements	$2,362,000	$2,679,000	$171,000
Total Department Funding:	**$63,785,000**	**$76,328,000**	**$76,924,000**
Total Authorized Positions:	**373.9**	**446.0**	**449.2**

Background. The Department of Managed Health Care (DMHC) is the primary regulator of the state's 138 health care service plans, which provide health, mental health, dental, vision, and pharmacy services to more than 25 million Californians. Established in 2000, DMHC enforces the Knox-Keene Health Care Service Plan Act of 1975, which implemented California's robust oversight regime of the managed care system. In fulfilling its regulatory responsibilities under the Act, DMHC conducts medical surveys and financial examinations to ensure health plan compliance and financial stability, provides a 24-hour call center to help consumers resolve health plan complaints, and administers Independent Medical Reviews of services denied by health plans.

Knox-Keene Health Care Service Plan Act of 1975. The Knox-Keene Health Care Service Plan Act of 1975, and subsequent amendments, is one of the most robust regulatory regimes for managed care organizations in any state in the nation. In addition to regulatory requirements related to consumer protections and plans' financial stability, the Knox-Keene Act imposes various network adequacy requirements on health care service plans designed to provide timely access to necessary medical care for those plans' beneficiaries. These requirements generally include the following standards for appointment availability: 1) Urgent care without prior authorization: within 48 hours; 2) Urgent care with prior authorization: within 96 hours; 3) Non-urgent primary care appointments: within 10 business days; 4) Non-urgent specialist appointments: within 15 business days; 5) Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health condition: within 15 business days. The Knox-Keene Act also requires plans to ensure primary care physicians are located within 15 miles or 30 minutes of a beneficiary and there is at least one primary care provider for every 2,000 beneficiaries in a plan's network.

Implementation of Timely Access Standards (SB 964). SB 964 (Hernandez), Chapter 573, Statutes of 2014, required DMHC to implement stricter oversight of health plans' compliance with standards meant to ensure timely access to care. SB 964 was introduced in response to significant expansions of managed care enrollment in both Medi-Cal and Covered California, as well as reports that certain plan products offered "narrow" provider networks that were inadequate to provide timely access to medical care for beneficiaries. SB 964 requires annual review of plans' compliance with Knox-Keene standards for providing timely access to care. DMHC previously reviewed plans' compliance every three years. SB 964 also requires plans to report the following information regarding provider networks:

1. Provider office location
2. Area of specialty
3. Hospitals where providers have admitting privileges, if any
4. Providers with open practices
5. Number of patients assigned to a primary care provider or a provider's capacity to be accessible and available to enrollees
6. Network adequacy and timely access grievances received by the plan

Plans are also required to provide these data separately for Medi-Cal and small group lines of business. DMHC is required to create a standardized methodology for plan reporting on timely access to care by January 2020.

In 2015-16, DMHC received 25 positions and expenditure authority from the Managed Care Fund of $3.8 million to implement the provisions of SB 964. Legal staff and health program analysts in the Office of Plan Licensing were approved to annually review provider networks and ensure compliance with timely access standards. Positions were also approved in the department's Help Center to review enrollee complaints regarding timely access and network adequacy.

In February 2017, DMHC published its timely access report for calendar year 2015. According to DMHC, 90 percent of the timely access compliance reports submitted by plans contained one or more significant inaccuracies including: 1) submission of data for providers not in the plan's network, 2) errors in calculating compliance rates, and 3) omission of compliance data for one or more required provider types. The use of an external vendor by 24 health plans to gather data and prepare compliance reports may have contributed to the submission of erroneous reports, despite 150 comments to health plans by DMHC prior to submission regarding these data issues.

The widespread inaccuracy of the data submissions has made it impossible for DMHC to analyze whether plans were in compliance with timely access standards for 2015. The report notes that plans that submitted inaccurate data are in violation of the Knox-Keene Act and DMHC's Office of Enforcement will be investigating for possible disciplinary action. DMHC also reports it will require the use of a department-approved vendor to monitor data accuracy for the 2016 calendar year submissions. Because of ongoing efforts to prevent submission of inaccurate data for 2016, DMHC reports it plans to extend the compliance report submission deadline by one to two months.

Complete and Accurate Provider Directories (SB 137). SB 137 (Hernandez), Chapter 649, Statutes of 2015, requires a health plan to implement several requirements to ensure its provider directories contain accurate information to allow consumers to access covered health care services. The bill was approved in response to several audits demonstrating health plans' provider directories were riddled with inaccuracies, preventing health care consumers from choosing plans with networks containing their preferred providers. DMHC is required to provide uniform standards for provider directories by December 31, 2016, and plans must begin using the department's provider directory standards for all plan products by July 1, 2017. The department's development of standards is exempt from the Administrative Procedures Act until January 1, 2021, during which time it may revise the standards twice.

Consumer Participation Program. SB 1092 (Sher), Chapter 792, Statutes of 2002, created the Consumer Participation Program (CPP) and authorized the director of DMHC to "award reasonable

advocacy and witness fees to any person or organization that demonstrates that the person or organization represents the interests of consumers and has made a substantial contribution on behalf of consumers to the adoption of any regulation or to an order or decision made by the director if the order or decision has the potential to impact a significant number of enrollees." The CPP has provided funding to organizations to represent consumer interests in a variety of DMHC proceedings. The statute allows DMHC to award a total of $350,000 each fiscal year. In 2016-17, Consumers Union, the Western Center on Law and Poverty, and Health Access California received awards for a combined total of approximately $50,000.

The statutory authority for the CPP is scheduled to sunset on January 1, 2018. The program's sunset date has been extended twice in trailer bill language, in 2007 and 2011. Because this program provides vital consumer representation in regulatory matters governed by DMHC, the Legislature may wish to consider trailer bill language to delete the statutory sunset date.

Subcommittee Staff Comment. This is an informational item.

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

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

2. What types of enforcement actions are available to the department in response to inaccurate data submissions for SB 964 timely access compliance reporting for 2015?

3. What steps is the department taking to ensure accurate data submissions for the 2016 reporting?

4. How is the department monitoring whether plan enrollees are receiving timely access to medical care in the absence of reliable reporting demonstrating plan compliance?

5. What is the status of health plan adoption of the department's uniform provider directory standards required pursuant to SB 137? How will these standards improve the accuracy of provider directories? Are any updates or additional components planned before 2021?

Issue 2: Help Center Case Backlog and Workload

Budget Issue. DMHC requests 11 positions and expenditure authority from the Managed Care Fund of $3.4 million in 2017-18, $3.3 million in 2018-19 and 2019-20, and $2.7 million annually thereafter. If approved, these resources would allow DMHC's Help Center to address increased workload and subsequent backlog attributed to full implementation of the Affordable Care Act and conforming legislation.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0933 – Managed Care Fund	$-	$3,422,000
Total Funding Request:	**$-**	**$3,422,000**
Total Positions Requested:	**11.0**	

Background. DMHC's Help Center provides a range of services to assist consumers with health care issues and ensure managed care patients receive the services to which they are entitled. The Help Center responds to enrollee calls, reviews and resolves complaints, administers Independent Medical Reviews (IMRs), and addresses urgent nurse complaints. The Help Center is composed of several branches that are responsible for supporting this workload.

The Contact Center processes and responds to incoming correspondence and consumer telephone inquiries, educates consumers regarding various health plan issues, provides referrals to other entities or agencies for issues outside of its jurisdiction, and collects demographic and other data to track problems and trends. The Complaint Resolution Branch is responsible for the initial processing of complaints, case creation, and resolution. After certain conditions are met, complaints regarding a health plan's denial of services are eligible for Independent Medical Review (IMR). An IMR is a review of a case by independent physicians that are not part of the health plan that has denied services. The Independent Medical/Clinical Review Branch is responsible for the initial review and analysis of IMRs; referral to an external review organization, which provides the independent physicians that make IMR determinations; and closes the IMR after the determination is made.

In addition to these branches, Help Center staff are assisted by the Legal Affairs and Policy Development Division, which investigates and resolves complex complaints and provides legal counsel, and the Division of Management Support Services, which provides administrative and technical support.

Previous Help Center Budget Augmentations. Since 2014, DMHC has received additional resources for its Help Center in two of the last three fiscal years for workload related to the federal Affordable Care Act. In 2014-15, DMHC received 37 positions and annual expenditure authority from the Managed Care Fund of $4.4 million for increased workload related to the state's expansions of Medi-Cal and coverage in the individual market. Because these expansions significantly increased enrollment of individuals in managed care who had previously been uninsured, DMHC experienced an increase in call and complaint volume from these new consumers, many of whom were unfamiliar with how to use their health care coverage benefits. In 2015-16, DMHC received an additional 7 positions and annual expenditure authority from the Managed Care Fund of $1.1 million after reporting the percentage of new enrollees in a health plan regulated by the department was higher than anticipated.

According to DMHC, total consumer calls to the Help Center increased from 60,809 in 2014 to 92,996 in 2016, an increase of 52.9 percent. During this period, standard complaints increased 74.7 percent (from 9,217 to 16,098) and IMRs increased 157.4 percent (from 3,148 to 8,104). Despite the increase in staff, DMHC is reporting a backlog of complaints and IMRs. In response, the department has implemented mandatory overtime and utilized temporary help resources to support the increased workload and attempt to clear the backlog.

DMHC is requesting the following resources:

1. Contact Center - 2 Staff Services Analysts to respond to increased call volume
2. Complaint Resolution and IMR Branch – 1 Staff Services Manager I and 8 Associate Governmental Program Analysts (5 permanent, 3 from limited-term resources) to screen, process and close complaints and IMRs
3. Legal Affairs and Policy Development Division – 1 Attorney and 3 Senior Legal Analysts (1 permanent, 2 from limited-term resources) to provide legal support for complaint and IMR case processing and closure
4. Management Support Services – 1 Associate Governmental Program Analyst to provide administrative and technical support to Help Center staff

DMHC indicates the request for limited-term resources for three years (equivalent to 5 positions) is intended to clear the complaint and IMR backlog within the three-year period. The department expects the permanent resources in this request to be sufficient to prevent future complaint or IMR backlogs.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 3: Information Technology Resource Request

Budget Issue. DMHC requests two positions and expenditure authority from the Managed Care Fund of $746,000 in 2017-18, $722,000 in 2018-19 and 2019-20, and $289,000 annually thereafter. If approved, these resources would allow DMHC to address information security needs and transition to an efficient information technology (IT) systems architecture and forward looking roadmap to meet business intelligence requirements.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0933 – Managed Care Fund	$-	$746,000
Total Funding Request:	**$-**	**$746,000**
Total Positions Requested:	**2.0**	

Background. DMHC reports significant challenges from increased technological complexity, aging IT infrastructure, and increased security risks. The Office of Technology and Innovation (OTI) maintains the department's outdated infrastructure and supports several in-house developed legacy applications utilized by nearly every departmental division. These legacy applications, while custom designed for DMHC's workload, require customized support and experience interoperability problems with other systems. OTI receives over 2,500 change and service requests each year and currently has a backlog of such requests.

Statewide "Cloud First" Technology Policy. In August 2014, the California Department of Technology (CDT) published Technology Letter 14-04, which outlined the Administration's "Cloud First" policy. CDT's Office of Technology Services (OTech) developed a secure state government-wide private cloud, which offers support for three common cloud service models: Software as a Service (SaaS), Platform as a Service (PaaS), and Infrastructure as a Service (IaaS). The technology letter, as well as addition of Section 4983 to the State Administrative Manual (SAM 4983), directed state entities to shift to the "Cloud First" policy for all new reportable and non-reportable IT projects.

According to DMHC, the resources contained in this budget request will allow it to implement a forward looking IT roadmap, reduce use and continued investments in its legacy applications, and accelerate migration of its systems to the OTech Cloud. One Senior Programmer Analyst would support systems development to consolidate and replace legacy systems and to improve the department's IT processes. One Systems Software Specialist II would be responsible for security enhancements and monitoring of all systems to prevent security breaches. Three-year, limited-term resources equivalent to one Systems Software Specialist II would specialize in updating the department's IT infrastructure to enhance security, deliver high performance network communications and enable migration of applications, servers, and workstations to the OTech Cloud.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 4: Prohibition of Surprise Balance Billing (AB 72)

Budget Issue. DMHC requests 16 positions, limited-term resources (equivalent to 3.75 staff) and expenditure authority from the Managed Care Fund of $3,588,000 in 2017-18, $3,173,000 in 2018-19, $2,963,000 in 2019-20, and $2,251,000 annually thereafter. If approved, these resources would allow DMHC to regulate the elimination of "surprise balance billing" pursuant to the requirements of AB 72 (Bonta), Chapter 492, Statutes of 2016.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0933 – Managed Care Fund	$-	$3,588,000
Total Funding Request:	**$-**	**$3,588,000**
Total Positions Requested:	**16.0**	

Background. AB 72 (Bonta), Chapter 492, Statutes of 2016, establishes a provider reimbursement, reconciliation, and complaint resolution infrastructure to eliminate "surprise balance billing", the practice of billing consumers for health care services delivered by out-of-network (non-contracting) providers at an in-network (contracting) health facility. Specifically, AB 72 establishes a reimbursement rate formula for non-contracting providers, an independent dispute resolution process (IDRP) to resolve claim disputes between non-contracting providers and health plans, and regulatory and reporting requirements for DMHC and the California Department of Insurance. For consumers, AB 72 ensures that consumers are only billed for the in-network cost sharing amounts pursuant to their health care service plan contract when selecting an in-network facility for their care.

DMHC Implementation Requirements. AB 72 requires DMHC to:

1. Establish an IDRP for claim disputes between health care service plans and non-contracting providers by September 1, 2017.
2. Establish uniform written procedures for the submission, receipt, processing and resolution of claim payment disputes.
3. Provide a report to the Governor and the Legislature containing data related to the IDRP, a summary of payments related to AB 72, and findings regarding the impact of the bill on network adequacy by January 1, 2019.
4. Develop a standardized methodology for plans and delegated entities to determine the average contracted rates for services subject to AB 72 by January 1, 2019.
5. Engage stakeholders throughout the development process with a stakeholder meeting no later than July 1, 2017.
6. Review average contracted rates and the policies and procedures for calculating these rates as part of the Office of Financial Review's examination of plans' fiscal and administrative affairs. Plans provide DMHC with the data, methodology and policies and procedures used to determine their average contracted rates for the 2015 calendar year, which is the base year for rate development in 2017 and beyond.

DMHC requests resources to support increased workload in the following programs:

1. Help Center – The requested resources would allow DMHC to respond to increased provider complaint call volume and process IDRP requests

- 1 Associate Governmental Program Analyst
- 1 Attorney
- 1 Legal Secretary
- 1 Office Technician
- Three-year limited-term resources equivalent to 3 staff
- Three-year limited-term resources for IDRP consultant costs.

2. Office of Plan Monitoring – The requested resources would support monitoring of plan compliance with the network adequacy requirements for non-contracting providers implemented by AB 72. In addition, these resources would support review of plans' grievance systems for compliance with AB 72.
   - 2 Associate Health Program Advisers
   - 2 Attorney III
   - 1 Staff Health Care Service Plan Analyst
3. Office of Financial Review The requested resources would support creation of the methodology for determining average contracted rates for providers, review contracted rate submissions, train DMHC staff for review of plan policies used to calculate rates, and develop data format submissions to facilitate the IDRP process.
   - 1 Associate Life Actuary
   - 1 Corporation Examiner
4. Office of Enforcement – The requested resources would support enforcement actions arising from health plan non-compliance with the provisions of AB 72.
   - 1 Attorney III
   - 1 Legal Secretary
5. Office of Administrative Services – The requested resources would provide administrative support related to the new positions.
   - 2 Staff Services Analysts
6. Office of Technology and Innovation – The requested resources would provide IT and technical support related to the new positions.
   - 1 Staff Information Systems Analyst

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. Please describe the process for plans to submit initial rates for July 1, 2017. What guidance has DMHC provided to plans to ensure completeness and accuracy of the submissions?

3. What stakeholder engagement has occurred to date? Has the required meeting been scheduled?

4. Which division is responsible for the January 1, 2019, report to the Governor and Legislature? Are there resources in this request allocated for preparation of the report?

Issue 5: Medi-Cal Interagency Agreement Reduction

Budget Issue and Trailer Bill Language Proposal. The DMHC is requesting a reduction of 18.5 positions and a reduction in expenditure authority of $5.3 million ($3.4 million Managed Care Fund and $1.9 million reimbursements) in 2017-18 and $4.3 million ($2.9 million Managed Care Fund and $1.4 million reimbursements) annually thereafter. If approved, these reductions and the related trailer bill language proposal would reflect the termination of existing interagency agreements between DMHC and the Department of Health Care Services (DHCS).

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0933 – Managed Care Fund	$-	($3,398,000)
0995 – Reimbursements	$-	($1,870,000)
Total Funding Request:	**$-**	**($5,268,000)**
Total Positions Requested:	**(18.5)**	

Background. Since 2010, DMHC has received resources to perform workload focused on Medi-Cal managed care plans on behalf of DHCS. These services are currently provided through four interagency agreements between the two departments. DHCS reimburses DMHC for 50 percent of costs associated with the agreements, and 100 percent of consulting services costs incurred to support the Cal MediConnect Ombudsman Program. The four interagency agreements are as follows:

1115 Waiver Demonstration Project. Beginning in 2010, DMHC conducts medical surveys, medical loss ratio financial examinations, and network adequacy reviews related to the 1115 Waiver, a federal waiver program to enable Medicaid participants to receive benefits through certain providers and permit the State to require certain individuals to receive benefits through managed care providers.

Rural Expansion. AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012, authorized the transition of approximately 400,000 individuals in 28 rural counties from fee-for-service to Medi-Cal managed care plans. AB 1468 (Committee on Budget), Chapter 438, Statutes of 2012, required DHCS to enter into an interagency agreement with DMHC to conduct financial audits, medical surveys, and a review of the provider networks with the expansion of Medi-Cal managed care into the 28 rural counties.

Medi-Cal Dental Managed Care. DHCS began contracting with six Dental Managed Care (DMC) plans in 2013. These dental plans receive a negotiated, monthly capitated reimbursement rate for each Medi-Cal beneficiary enrolled in the plan. Beneficiaries enrolled in the contracted plans receive dental benefits from providers within the plan's provider network. Under the interagency agreement, DMHC conducts financial examinations and medical surveys focused on the Medi-Cal line of business for these six DMC plans.

Coordinated Care Initiative. The Coordinated Care Initiative (CCI) seeks to provide better health outcomes for individuals eligible for both Medicare and Medi-Cal (dual-eligibles) by enrolling them into managed health care plans. SB 1008 (Committee on Budget and Fiscal Review), Chapter 33, Statutes of 2012, required DHCS to enter into an interagency agreement with DMHC to perform health plan

surveys and financial reviews, readiness review activities, and provide consumer assistance to eligible beneficiaries of CCI. The Ombudsman Program conducts outreach and enhances awareness of Ombudsman service availability, investigates and resolves Cal MediConnect enrollees' issues with managed care plans and refers Cal MediConnect enrollees to various resources and assistance programs.

Federal Medicaid Managed Care Regulations. Released in May 2016 by the federal Centers for Medicare and Medicaid Services, Final Rule 2390-P changed Medicaid regulations to align the rules governing Medicaid managed care plans with those of other major sources of coverage, such as Qualified Health Plans and Medicare Advantage. The rule also implements statutory provisions, changes actuarial payment provisions, promotes quality of care, and strengthens efforts to reform delivery systems that serve Medicaid and Children's Health Insurance Program (CHIP) beneficiaries.

The new rulemaking requires DHCS to substantially expand its oversight and monitoring of Medi-Cal managed care plans, county mental health plans, Prepaid Inpatient Hospital Plans (PIHP), and DMC plans by requiring greater detail in oversight activities and verification of information, including data on provider networks according to an expanded range of provider types, cultural and language standards, and quality improvement projects. The new rules also require states to demonstrate their willingness to issue sanctions to plans that repeatedly fail to comply with program requirements. DHCS received 38 positions and $10.4 million ($4.9 million General Fund and $5.4 million federal funds) in 2016-17 and is requesting an additional 15 positions and $8.9 million ($4.5 million General Fund and $4.5 million federal funds) in 2017-18 to manage the new regulatory workload.

According to DHCS and DMHC, the increased monitoring of Medi-Cal managed care plans required by the new rulemaking is more stringent than the surveys, reviews and other regulatory oversight provided by DMHC under the interagency agreements. DHCS reports this workload will be completed by staff in its Managed Care Operations, Managed Care Quality and Management, Capitated Rates, Dental Services, and Audits and Investigations Divisions. As a result, DMHC is proposing to terminate the four interagency agreements with DHCS, which expects to assume this workload within its overall compliance with the requirements of the final rule. The department's proposal includes trailer bill language implementing the termination of the agreements and a reduction in positions and expenditure authority as follows:

1115 Waiver Demonstration Project: Reduction of $2,005,000 and 13.0 Positions

Office of Plan Monitoring - Division of Provider Networks

- 2.0 Health Program Specialist I
- 1.0 Associate Health Program Adviser
- Ongoing consultant costs in the amount of $300,000 to assess and monitor the availability and adequacy of Medi-Cal managed care plans' provider networks.

Office of Plan Monitoring - Division of Plan Surveys

- 1.0 Supervising Health Care Service Plan Analyst
- 4.0 Staff Health Care Service Plan Analysts

Office of Financial Review - Division of Financial Oversight

- 1.0 Corporation Examiner IV (Supervisor)
- 4.0 Corporation Examiners

Rural Expansion: Reduction of $487,000 and 3.5 Positions

Help Center
- 2.0 Consumer Assistance Technicians
- 0.5 Nurse Evaluator II
- 0.5 Associate Governmental Program Analyst

Office of Plan Monitoring - Division of Plan Surveys
- 0.5 Associate Health Care Service Plan Analyst
- Ongoing consultant costs in the amount of $130,000 to assist the DMHC with conducting medical surveys.

Medi-Cal Dental Managed Care: Reduction of $384,000 and 2.0 Positions

Office of Plan Monitoring - Division of Plan Surveys
- 0.5 Health Program Specialist II
- 0.5 Associate Health Care Service Plan Analyst
- Ongoing consultant costs in the amount of $130,000 to assist the DMHC with conducting DMC surveys.

Office of Financial Review - Division of Financial Oversight
- 1.0 Corporation Examiner

Coordinated Care Initiative: Reduction of $522,000 in FY 2017-18

Office of Plan Monitoring - Division of Provider Networks
- Limited-term expenditure authority equivalent to 0.5 Health Program Specialist I until December 31, 2017 to perform this workload.

Help Center
- Limited-term expenditure authority equivalent to 0.5 Associate Governmental Program Analyst until December 31, 2017 to perform this workload.

Short-term consultant costs were provided through December 31, 2017 to partner with California community-based organizations to provide consumers with local, hands-on assistance with enrollment into Cal MediConnect health coverage. This request reflects a reduction in the amount of $400,000 in 2017-18.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending evaluation of the companion proposal from DHCS to assume the responsibilities of the interagency agreements DMHC proposes to terminate.

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

1. Please provide a brief overview of this proposal.

2. If the elimination of the interagency agreements is approved, what regulatory oversight of Medi-Cal managed care plans will still be under the jurisdiction of DMHC?

3. Please describe how DMHC and DHCS will coordinate their oversight and monitoring activities to avoid duplication of efforts.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Overview

Department of Health Care Services Funding Summary				
Fiscal Year:	**2015-16**	**2016-17**	**2017-18**	**BY to CY**
STATE OPERATIONS				
Fund Source	***Actual***	***Revised***	***Proposed***	***Change***
General Fund	$176,186,000	$203,591,000	$202,958,000	($633,000)
Federal Funds[1]	$301,977,000	$374,560,000	$373,879,000	($681,000)
Special Funds/Reimb	$46,230,000	$59,638,000	$52,232,000	($7,406,000)
Total Expenditures	**$524,393,000**	**$637,789,000**	**$629,069,000**	**($8,720,000)**
Total Auth. Positions	**3518.3**	**3835.4**	**3770.7**	**(64.7)**
LOCAL ASSISTANCE				
Fund Source	***Actual***	***Revised***	***Proposed***	***Change***
General Fund	$17,917,490,000	$19,939,167,000	$19,410,746,000	($528,421,000)
Federal Funds[1]	$55,445,670,000	$67,133,809,000	$67,069,323,000	($64,486,000)
Special Funds/Reimb	$9,822,122,000	$15,163,325,000	$18,156,027,000	$2,992,702,000
Total Expenditures	**$83,185,282,000**	**$102,236,301,000**	**$104,636,096,000**	**$2,399,795,000**
[1]*Federal Funds include Funds 0890, 7502, 7503, and 8500*				

Background. The Department of Health Care Services' (DHCS) mission is to protect and improve the health of all Californians by operating and financing programs delivering health care services to eligible individuals. DHCS programs provide services to ensure low-income Californians have access to health care services and that those services are delivered in a cost-effective manner. DHCS programs include:

- ***Medi-Cal.*** DHCS serves as the single state agency for Medi-Cal, California's Medicaid program. Medi-Cal is a health care program for low-income and low-resource individuals and families who meet defined eligibility requirements. Medi-Cal coordinates and directs the delivery of health care services to approximately 14 million qualified individuals, including low-income families, seniors and persons with disabilities, children in families with low-incomes or in foster care, pregnant women, and low-income people with specific diseases. As of January 1, 2014, due to the Affordable Care Act, childless adults up to 138 percent of the federal poverty level are also eligible for services in Medi-Cal.

- ***Children's Medical Services.*** Children's Medical Services coordinates and directs the delivery of health care services to low-income and seriously ill children and adults. Its programs include the Genetically Handicapped Persons Program, California Children's Services Program, and Child Health and Disability Prevention Program.

- ***Primary and Rural Health***. Primary and Rural Health coordinates and directs the delivery of health care to Californians in rural areas and to underserved populations. Its programs include: Indian Health Program, Rural Health Services Development Program, Seasonal Agricultural and Migratory Workers Program, State Office of Rural Health, Medicare Rural Hospital Flexibility Program/Critical Access Hospital Program, Small Rural Hospital Improvement Program, and the J-1 Visa Waiver Program.

- ***Mental Health & Substance Use Disorder Services***. As adopted in the 2011 through 2013 budget acts, DHCS oversees the delivery of community mental health and substance use disorder services, reflecting the elimination of the Departments of Alcohol and Drug Programs and Mental Health.

- ***Other Programs*.** DHCS oversees family planning services, cancer screening services to low-income under-insured or uninsured women, and prostate cancer treatment services to low-income, uninsured men, through the Every Woman Counts Program, the Family Planning Access Care and Treatment Program, and the Prostate Cancer Treatment Program.

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

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

1. Please provide a brief overview of DHCS programs and budget.

Issue 2: November 2016 Medi-Cal Estimate - Overview

Budget Issue. The November 2016 Medi-Cal Local Assistance Estimate includes $100.1 billion ($19.6 billion General Fund, $66.8 billion federal funds, and $13.7 billion special funds and reimbursements) for expenditures in 2016-17, and $102.6 billion ($19.1 billion General Fund, $66.8 billion federal funds, and $16.7 billion special funds and reimbursements) for expenditures in 2017-18.

Medi-Cal Local Assistance Funding Summary			
Fiscal Year:	**2016-17**	**2017-18**	**BY to CY**
Benefits			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$18,580,262,000	$18,118,289,000	($461,973,000)
Federal Funds	$63,114,015,000	$62,976,866,000	($137,149,000)
Special Funds/Reimbursements	$13,681,542,000	$16,693,070,000	$3,011,528,000
Total Expenditures	**$95,375,819,000**	**$97,788,225,000**	**$2,412,406,000**
County Administration			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$859,237,000	$858,771,000	($466,000)
Federal Funds	$3,397,740,000	$3,502,083,000	$104,343,000
Special Funds and Reimbursements	$11,956,000	$11,819,000	($137,000)
Total Expenditures	**$4,268,933,000**	**$4,372,673,000**	**$103,740,000**
Fiscal Intermediary			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$120,524,000	$152,982,000	$32,458,000
Federal Funds	$-	$-	$-
Special Funds and Reimbursements	$-	$-	$-
Total Expenditures	**$120,524,000**	**$152,982,000**	**$32,458,000**
TOTAL MEDI-CAL EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$19,560,023,000	$19,130,042,000	($429,981,000)
Federal Funds	$66,808,522,000	$66,750,097,000	($58,425,000)
Special Funds and Reimbursements	$13,693,498,000	$16,704,889,000	$3,011,391,000
Total Expenditures	**$100,062,043,000**	**$102,585,028,000**	**$2,522,985,000**

Caseload. In 2016-17, the budget assumes annual Medi-Cal caseload of 14 million, a decrease of 0.6 percent compared to assumptions for the 2016 Budget Act. In 2017-18, the budget assumes annual

Medi-Cal caseload of 14.3 million, a 1.8 percent increase compared to the revised caseload estimate for 2016-17.

Significant General Fund Changes. The November 2016 Medi-Cal Local Assistance Estimate includes the following significant General Fund changes:

2016-17 General Fund Deficiency - The budget includes increased expenditures in the Medi-Cal program of approximately $1.8 billion General Fund compared to the 2016 Budget Act. The current year increase is primarily attributable to a one-time retroactive payment of drug rebates to the federal government and miscalculation of costs associated with the Coordinated Care Initiative in prior estimates. (For more information, see Issue 3: Medi-Cal Unanticipated Costs – 2016-17 Deficiency)

Managed Care Organization Tax - The budget includes reduced General Fund expenditures in the Medi-Cal program of approximately $1.1 billion in 2016-17 and $1.6 billion in 2017-18 from the tax on enrollment of managed care organizations authorized by SBX2 2 (Hernandez), Chapter 2, Statutes of 2016.

Coordinated Care Initiative (CCI) - The budget reflects savings of approximately $20 million General Fund from the extension of the duals demonstration pilot project (Cal MediConnect). The Governor's Budget estimate of CCI projects that it will no longer be cost-effective and, consistent with current law, will be discontinued in 2017-18. Based on the lessons learned from the CCI demonstration project, the budget includes the extension of the duals demonstration pilot (Cal MediConnect) for an additional two years, through December 31, 2019.

Optional Expansion of Medi-Cal - The budget includes General Fund expenditures of $888.4 million in 2016-17 and $1.6 billion in 2017-18 for the optional Medi-Cal expansion population. Beginning in 2017, the state assumes a 5 percent share of cost for optional expansion expenditures.

Full-Scope Medi-Cal Coverage for Undocumented Children (SB 75) - The budget includes General Fund expenditures of $279.5 million to provide full-scope benefits to approximately 185,000 children, pursuant to SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015. (For more information, see Issue 6: Undocumented Children Full-Scope Expansion)

Children's Health Insurance Program (CHIP) Reauthorization - The budget assumes Congress will reauthorize the CHIP program, but at the previous federal matching percentage of 65% effective October 1, 2017. The budget includes General Fund costs of $536.1 million to account for the loss in federal funding. (For more information, see Issue 8: Title XXI Federal Match Reduction)

New Qualified Immigrants (NQI) Affordability and Benefits Wrap Program - The budget includes General Fund savings of $48 million from transitioning coverage for NQI adults from Medi-Cal to an Exchange plan. The budget proposes all NQI adults be included in the wrap program January 1, 2018. (For more information, see Issue 7: New Qualified Immigrant Wrap Proposal)

Major Risk Medical Insurance Fund Abolishment – The budget includes reduced General Fund expenditures of $62.3 million offset by a one-time transfer of the remaining fund balance in the Major Risk Medical Insurance Fund. The budget abolishes the fund, and proposes the transfer of the remaining

fund balance to the newly established Health Care Services Plans Fines and Penalties Fund to fund MRMIP and to offset General Fund expenditures in the Medi-Cal program. (For more information, see Issue 10: Elimination of Major Risk Medical Insurance Fund Proposal)

Hospital Quality Assurance Fee Extension - The budget includes General Fund savings of over $1 billion in 2017-18 from the extension of the hospital quality assurance fee. On November 8, 2016, voters passed Proposition 52, which amends the state Constitution to permanently extend the fee.

Drug Medi-Cal Organized Delivery System Waiver - The budget includes $141.6 million General Fund expenditures for a five-year pilot program for participating counties to use an organized delivery system to provide substance use disorder services to eligible Medi-Cal beneficiaries.

Proposition 56 - The budget includes reduced General Fund expenditures of $1.2 billion offset by revenue received from voter approval of Proposition 56, which increased the excise tax rate on cigarettes, tobacco products, and electronic cigarettes. After backfills and specified allocations, Proposition 56 requires 82 percent of the funds remaining be transferred to the Healthcare Treatment Fund for DHCS to increase funding for existing healthcare programs and services by providing improved payments for all healthcare, treatment, and services. Proposition 56 also provided 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".

The Administration has interpreted the statutory provisions of Proposition 56 to allow allocation of revenue to fund growth in 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. According to the Administration, Proposition 56 revenue deposited in the Healthcare Treatment Fund is allocated to the following expenditures in 2017-18:

PC #	PC Title	Amount of New Program Growth Funded by Proposition 56 Compared to 2016 Budget Act Level (Whole Dollars)
96	Two Plan Model	$464,092,000
97	County Organized Health Systems	$166,112,000
99	Geographic Managed Care	$81,150,000
167	Medicare Pmnts.- Buy-In Part A & B Premiums	$37,956,000
168	Medicare Payments - Part D Phased-Down	$285,485,000
102	Regional Model	$16,795,000
104	Pace (Other M/C)	$35,803,000
112	Capitated Rate Adjustment for FY 2017-18	$150,000,000
	Total	**$1,237,393,000**

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open as updated estimates of caseload and expenditures will be provided at the May Revision.

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

1. Please provide a brief overview of the significant General Fund changes in the Medi-Cal program in the 2017-18 fiscal year.

2. Please describe the allocations of Proposition 56 funding in the Medi-Cal budget.

3. Please describe the department's interpretation of the provisions of Proposition 56 allowing revenues to fund growth in program expenditures that would otherwise be funded by General Fund. How do these allocations comply with the non-supplantation language in the Proposition 56 statute governing Medi-Cal expenditures?

Issue 3: Medi-Cal Unanticipated Costs – 2016-17 Deficiency

Budget Issue. The Administration estimates unanticipated increases in Medi-Cal program expenditures in 2016-17 will exceed its 2016 Budget Act appropriation, resulting in a current year General Fund deficiency of approximately $1.8 billion.

Background. The 2016 Budget Act appropriated $17.8 billion of General Fund for the Medi-Cal program in 2016-17. According to DHCS, updated estimates of Medi-Cal expenditures for 2016-17 will be $19.6 billion, an increase of $1.8 billion over the 2016 Budget Act appropriation. DHCS reports this substantial increase in expenditures is primarily due to two factors: 1) a miscalculation of costs related to the Coordinated Care Initiative (CCI), and 2) a one-time repayment to the federal government of pharmacy rebates collected on claims for ACA beneficiaries.

CCI Miscalculation. The budget references a miscalculation in CCI, California's demonstration project for individuals eligible for both Medicare and Medi-Cal (dual-eligibles), that contributed to the significant deficiency in the Medi-Cal program in 2016-17. According to the Administration, the 2016 Budget Act underestimated General Fund resources for CCI by approximately $1.5 billion. Specifically, the 2016 Budget Act:

Underestimated costs for managed care payments for CCI beneficiaries' care	**$573.2 million**
Overestimated savings to fee-for-service system for transition to managed care	**$913.1 million**
TOTAL CCI-Related Deficiency (General Fund):	**$1.486 billion**

Authorized by SB 1008 and SB 1036 (Committee on Budget and Fiscal Review), Chapters 33 and 45, Statutes of 2012, CCI integrates medical, behavioral health, and long-term services and supports for dual-eligible beneficiaries in seven demonstration counties: San Mateo, Santa Clara, Los Angeles, Riverside, San Bernardino, Orange, and San Diego. Dual-eligible beneficiaries were passively enrolled into Cal MediConnect, which coordinates Medicare and Medi-Cal benefits, beginning in 2014. Dual-eligible beneficiaries who opted out of Cal MediConnect and Medi-Cal-only beneficiaries such as seniors and persons with disabilities, were mandatorily enrolled in managed care for Medi-Cal benefits, including long-term services and supports (LTSS) like In-Home Supportive Services (IHSS) and skilled nursing facility care.

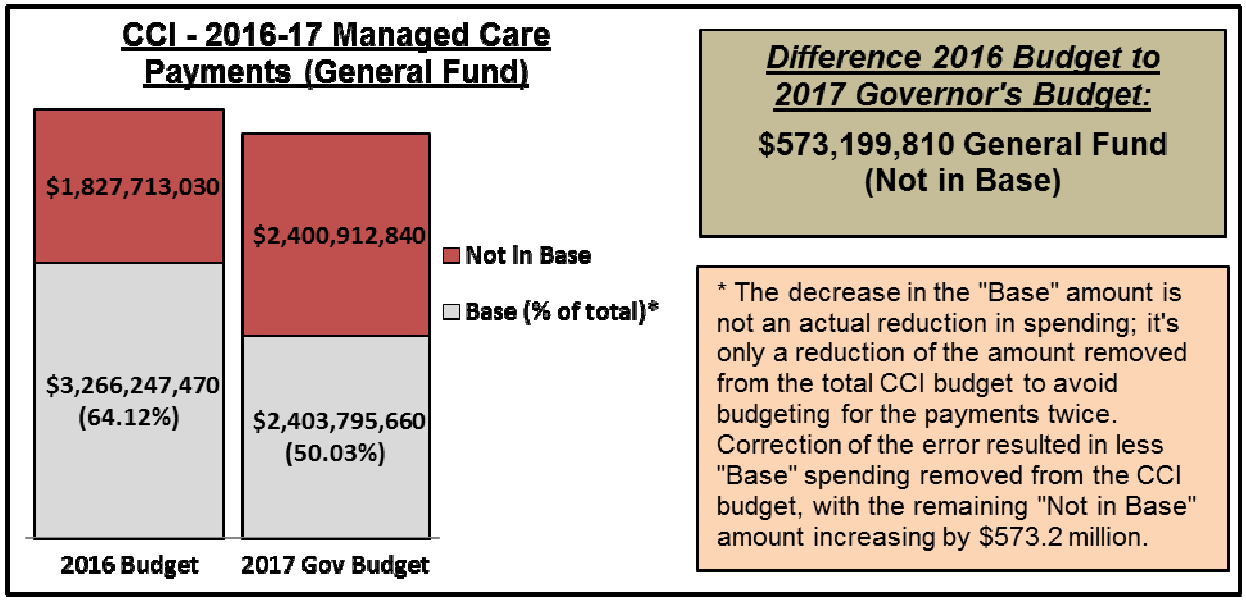
Most Medi-Cal beneficiaries enrolled in CCI already receive a portion of their Medi-Cal benefits through a managed care plan. However, LTSS benefits were previously provided through the fee-for-service delivery system, except in San Mateo and Orange Counties. Because of the integration of LTSS into managed care, the budget for CCI includes two main components:

- Costs for capitation payments to managed care plans for the delivery of benefits, either in Cal MediConnect or in managed care including LTSS.
- Savings in the fee-for-service delivery system from no longer providing LTSS, as beneficiaries transition into managed care for those benefits.

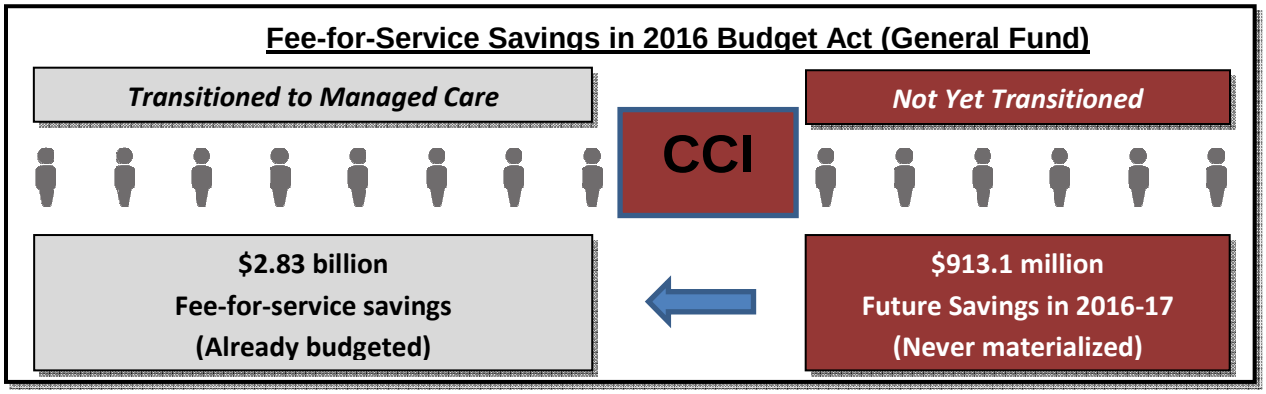
In general, the annual costs for capitation payments and the savings from fee-for-service should be roughly equivalent, since the capitation payments are based on the fee-for-service equivalent costs. The program receives some additional General Fund savings from Cal MediConnect plans that have savings targets built into their rates.

The overall miscalculation was the result of estimation errors in each of these components. Both estimation errors resulted in the inclusion of less General Fund authority in the 2016 Budget Act than needed for the operation of the program, and contributed to the total $1.8 billion current year Medi-Cal deficiency in the 2017 Governor's Budget.

Managed Care Payments. When the Medi-Cal program estimates the budget for managed care payments to CCI plans, there are two components to the estimation. First, DHCS determines the total cost for capitation payments to plans for CCI beneficiaries. Then, because most CCI beneficiaries were already receiving non-LTSS benefits through managed care, DHCS determines what percentage of the total capitation payments are already captured in the program's base trend estimate. The amount captured in the base is removed from the CCI budget to avoid budgeting for the payments twice (once in the base and again in the CCI budget). For the 2016 Budget Act, DHCS miscalculated how much it should have removed from the CCI budget due to a spreadsheet formula error that counted the base amounts from San Mateo and Orange Counties twice. An additional $573.2 million General Fund was necessary to correct the error.



Fee-For-Service Savings. Medi-Cal's estimate for fee-for-service savings in CCI assigned a per-member per-month (PMPM) savings value to each individual transitioning into managed care. This strategy was generally sound for the seven counties that had previously transitioned, because there was a significant population of individuals receiving LTSS in the fee-for-service system. However, by the 2016 Budget Act the only county left to transition was Orange County. Orange County operates a county organized health system (COHS) plan for all Medi-Cal beneficiaries in which LTSS services are already integrated into the managed care capitation payments. Because no care in Orange County is delivered in fee-for-service, no fee-for-service savings would occur from transitioning individuals into managed care. The Medi-Cal estimate for CCI savings in the 2016 Budget Act, however, still assumed a standard PMPM for each individual and built in $913.1 million of savings that never materialized.



Retroactive Federal Recoupment of Pharmacy Rebates. Federal Medicaid law and regulations allow the Medi-Cal program to receive rebates from drug manufacturers for prescriptions provided to beneficiaries. In addition to required federal rebates, Medi-Cal negotiates supplemental state rebates that increase the total amount of rebate received. DHCS collects rebate revenue from manufacturers and reimburses the federal government for the federal matching funds provided for the original claim. Traditional Medi-Cal beneficiaries' claims receive a 50 percent match, Children's Health Insurance Program (former Healthy Families Program) beneficiaries currently receive an 88 percent match, and optional expansion (ACA) beneficiaries currently receive a 95 percent match.

Until April 2016, the department's Rebate Accounting and Information System was unable to identify ACA pharmacy claims. As a result, federal reimbursement was never remitted for drug rebates on claims between April 2015 and June 2016. According to DHCS, these revenues were reported as General Fund savings in the 2015-16 fiscal year and supported additional Medi-Cal expenditures in subsequent fiscal years. The retroactive recoupment owed to the federal government for these claims, funded with state General Fund, is approximately $487.3 million. DHCS reports this payment was made in September 2016.

Supplemental Appropriation. Government Code section 16531.1 provides $1 billion of General Fund loan authority to DHCS in the event of a deficiency in the Medi-Cal budget for the purpose of making payments to Medi-Cal providers. Because the current year General Fund deficiency exceeds the $1 billion loan authority, the program may experience problems with cash flow leading to interruptions in payments to Medi-Cal providers. The Administration reports it is evaluating options for addressing potential cash flow issues, including additional General Fund loan authority or accelerated consideration of supplemental appropriation legislation, and will provide further information on its proposed response in the coming weeks.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended this issue be held open pending further updates to Administration estimates of the 2016-17 deficiency at the May Revision or earlier, further guidance on the scope of the department's cash flow challenges, and the Administration's proposed response to those issues.

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

1. Please provide a brief overview of the deficiency related to the miscalculation for the Coordinated Care Initiative.

2. Please provide a brief overview of the deficiency related to the retroactive federal repayments for pharmacy rebates.

3. Based on current estimates, when does the department expect to exceed its appropriation and loan authority in 2016-17? How would payments be prioritized if this occurs?

Issue 4: County Administration Estimate and Budget Proposals

Budget Issue and Trailer Bill Language Proposal. The budget includes $1.3 billion ($651.3 million General Fund and $651.3 million federal funds) in both 2016-17 and 2017-18 for the base allocation to counties for eligibility determinations for Medi-Cal beneficiaries. The base allocations represent no change from the amounts included in the 2016 Budget Act.

In addition to the base allocation, the budget includes $655.3 million ($327.7 million General Fund and $327.7 million federal funds) for additional county eligibility workload related to implementation of the federal Affordable Care Act. These additional funds also are unchanged from amounts included in the 2016 Budget Act.

DHCS requests expenditure authority of $1.5 million ($731,000 General Fund and $730,000 federal funds) in 2017-18 and 2018-19, and $244,000 ($122,000 General Fund and $122,000 federal funds) in 2019-20. If approved, these resources would allow the department to continue development of a new budgeting methodology for county administrative costs that reflects the impact of the Affordable Care Act, pursuant to the requirements of SB 28 (Hernandez), Chapter 442, Statutes of 2013.

DHCS also requests trailer bill language to clarify legislative intent not to appropriate funds for a cost of living adjustment to counties for Medi-Cal eligibility workload in 2017-18.

County Administration Funding Summary			
Fiscal Year:	**2016-17**	**2017-18**	**BY to CY**
County Administration Base			
Fund Source	***Revised***	***Proposed***	***Change***
0001 – General Fund	$651,341,500	$651,341,500	$-
0890 – Federal Trust Fund	$651,341,500	$651,341,500	$-
Total Expenditures	**$1,302,683,000**	**$1,302,683,000**	**$-**
Implementation of ACA			
Fund Source	***Revised***	***Proposed***	***Change***
0001 – General Fund	$327,655,000	$327,655,000	$-
0890 – Federal Trust Fund	$327,655,000	$327,655,000	$-
Total Expenditures	**$655,310,000**	**$655,310,000**	**$-**

Program Funding Request Summary (Budgeting Methodology BCP)		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	$731,000
0890 – Federal Trust Fund	$-	$730,000
Total Funding Request:	**$-**	**$1,461,000**
Total Positions Requested:	**0.0**	

Background. DHCS provides funding for county staff and support costs to perform administrative activities associated with the Medi-Cal eligibility, enrollment, retention, and redetermination process. Counties have traditionally served as the primary access point for low-income individuals to apply for Medi-Cal coverage and other public assistance programs. Using workload data, expenditure data, and other available information, DHCS determines a base allocation for each county based on estimates of staff costs, support costs, and staff development costs. Two years after development of the base allocation for a fiscal year, DHCS reconciles the budgeted base allocation with a county's actual expenditures, with additional funds provided to counties that spent more than their allocation and repayment to the state of unspent county funds. The budget includes $1.3 billion ($651.3 million General Fund and $651.3 million federal funds) in both 2016-17 and 2017-18 for the base allocation.

Implementation of the federal Affordable Care Act (ACA) significantly changed county Medi-Cal eligibility workload. Changes to the enrollment and redetermination processes designed to simplify beneficiaries' application for the program result in additional complexity. The new process included an interface with the California Healthcare Eligibility, Enrollment and Retention (CalHEERS) system, California's portal for health insurance affordability program applications. System implementation issues with CalHEERS' county interfaces led to significant increases in county eligibility workload and delay in eligibility determinations. In response to these issues, DHCS has provided counties additional funding over their base allocation to account for the increase in workload. The budget includes $655.3 million ($327.7 million General Fund and $327.7 million federal funds) in both 2016-17 and 2017-18 for implementation of the ACA.

In anticipation of the workload changes required by ACA implementation, the Legislature approved SB 28, which requires DHCS to develop and implement a new budgeting methodology for county administration of the Medi-Cal program. The methodology, to be developed in consultation with county stakeholders, is meant to reflect the changes in county operations as a result of implementation of the ACA. In 2014-15, the Legislature approved two limited-term positions and contract funding to begin working on the new methodology. According to DHCS, the approved staff have been engaged in efforts to learn current county processes and spending patterns, research prior efforts to create a new budgeting methodology, and prepare documents required to engage the services of a contractor. DHCS also reports it worked with the County Welfare Directors Association and the Service Employees International Union to develop a scope of work for the contractor to perform time/motion studies and make other estimates of county costs to assist in the development of the new methodology.

DHCS requests limited-term extension of the resources previously approved, as follows:

- Three-year expenditure authority of $244,000 ($122,000 General Fund and $122,000 federal funds) equivalent to one Staff Services Manager I and one Associate Governmental Program Analyst to continue working with counties and the contractor to develop the new budgeting methodology.
- Two-year expenditure authority of $1.2 million ($608,000 General Fund and $607,000 federal funds) to continue funding the contractor to assist in development of the new budgeting methodology.

According to DHCS, the data and other information provided through the contractor's work will inform the development of the new budgeting methodology and determine how it will be implemented. If these resources are approved, DHCS expects implementation no sooner than 2017-18.

County Administration COLA Trailer Bill Language. ABX4 12 (Evans), Chapter 12, Statutes of 2009, prohibits automatic cost of living adjustments (COLAs) to state departments and agencies. However, Welfare and Institutions Code section 14154(c)(1) states legislative intent that counties receive adequate funding, including an annual COLA, for the eligibility work performed on behalf of the Medi-Cal program. Since 2009, the Legislature has approved trailer bill language annually to state legislative intent to not appropriate funds for a COLA for county's eligibility workload in that year. DHCS proposes trailer bill language to add 2017-18 to the list of fiscal years beginning in 2008-09 during which it is the intent of the Legislature not to appropriate funds for a county COLA.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold these issues open as updated estimates of caseload and expenditures will be provided at the May Revision.

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

1. Please provide a brief overview of the local assistance estimate for County Administration.

2. Why are base allocations and ACA implementation funding flat between the 2016-17 and 2017-18 fiscal years?

3. Please provide a brief overview of the budget change proposal for extension of resources related to the new budgeting methodology for county administration costs.

4. How will the implementation of the new MEDS system, pursuant to the request previously heard by the subcommittee, lead to efficiencies in counties' administration of eligibility for the Medi-Cal program? Would these efficiencies be captured by the new budgeting methodology?

Issue 5: Use of CalWORKs Eligibility to Determine Medi-Cal Eligibility

Trailer Bill Language Proposal. DHCS proposes trailer bill language to provide statutory authority to seek federal approval to use determination of eligibility for the California Work Opportunity and Responsibility to Kids (CalWORKs) program as a determination of eligibility for the Medi-Cal program.

Background. DHCS considers a CalWORKs eligibility determination to also confer automatic eligibility for the Medi-Cal program. This consideration is based on an analysis that demonstrates individuals qualifying for CalWORKs, under CalWORKs program rules, would also qualify for Medi-Cal, under Medi-Cal's eligibility rules. Currently when an individual's eligibility for CalWORKs ends, Medi-Cal eligibility continues under the 1931(b) program until the next annual renewal or unless the reason for the CalWORKs discontinuance is also a reason for discontinuance for Medi-Cal. The federal Centers for Medicare and Medicaid Services recently recommended DHCS request federal approval through a state plan amendment to continue using CalWORKs eligibility determination as a basis for eligibility to the Medi-Cal program.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending further updates at May Revision, as well as potential federal actions regarding the status and funding of health coverage in the Medi-Cal program.

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

1. Please provide a brief overview of this proposal.

Issue 6: Undocumented Children Full-Scope Expansion (SB 75)

Budget Issue. The budget includes $292.3 million ($230.4 million General Fund and $61.9 million federal funds) in 2016-17 and $354.4 million ($279.5 million General Fund and $74.8 million federal funds) for the enrollment of undocumented children into full-scope Medi-Cal, pursuant to SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$230,369,000	$279,533,000
0890 – Federal Trust Fund	$61,927,000	$74,825,000
Total Funding Request:	**$292,296,000**	**$354,358,000**

Background. SB 75 expands eligibility for full-scope Medi-Cal to all income-eligible children under age 19, regardless of immigration status. Undocumented children were previously eligible for restricted-scope Medi-Cal coverage, which includes emergency and pregnancy related services only. Services provided under restricted-scope Medi-Cal receive a 50 percent federal match, while the additional non-emergency services provided under the full-scope expansion are funded entirely by state General Fund. DHCS estimates there are 250,000 undocumented children under age 19 covered under the expansion of eligibility, which includes two distinct populations:

1. **Restricted-Scope Medi-Cal Beneficiaries** – DHCS estimates there were 119,076 undocumented children previously enrolled in restricted-scope Medi-Cal coverage. All of these children completed the transition into full-scope Medi-Cal coverage between May and September 2016.
2. **Not Currently Enrolled.** DHCS estimates there are 130,924 undocumented children that were eligible for, but not enrolled in, restricted-scope Medi-Cal. These children must undergo eligibility determinations through the ordinary Medi-Cal application process. The department estimates that 50 percent of these children will enroll in coverage over the 12 month period beginning in May 2016. As of March 2, 2017, 61,917 children in this category were enrolled in full-scope benefits, or 47.3 percent of the estimated population of undocumented children not currently enrolled. Based on these trends, enrollment is likely to exceed the department's estimate of 50 percent of this population.

Immigration Enforcement Concerns from Beneficiaries. Various stakeholders have reported an increase in inquiries from parents of undocumented children considering disenrollment from Medi-Cal, citing concerns about immigration enforcement actions by the new federal administration. The department does not capture information on the reasons for disenrollment, but has observed a slowdown in enrollment in recent months.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending further updates in caseload and expenditures at May Revision.

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

1. Please provide an update on the progress of enrollment for undocumented children, both for those transitioning from restricted-scope coverage and those not previously enrolled.

Issue 7: New Qualified Immigrant Wrap Proposal

Budget Issue and Trailer Bill Language. The budget includes savings of $120.8 million ($48 million General Fund and $72.8 million federal funds) to implement the transition of New Qualified Immigrants (NQIs) into the New Qualified Immigrant Affordability and Benefit Program (NQI Wrap)

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	($48,035,000)
0890 – Federal Trust Fund	$-	($72,775,000)
Total Funding Request:	**$-**	**($120,810,000)**

Background. The federal Personal Responsibility and Work Opportunity Act prohibits federal financial participation for full-scope Medi-Cal services provided to qualified, nonexempt immigrants who have resided in the United States for less than five years. These individuals, known as New Qualified Immigrants (NQIs), are still eligible for restricted-scope Medi-Cal for emergency and pregnancy related services, for which the federal match is available. California provides full-scope Medi-Cal coverage for NQIs, with the nonemergency services funded with 100 percent state General Fund. The budget assumes $707 million of additional General Fund expenditures for full-scope coverage of this population in 2016-17.

Existing Transition of NQI Adults Without Children. SBX1 1 (Hernandez), Chapter 4, Statutes of 2013, provides for the transition of NQIs over age 21 without children into an individual market health plan through the Covered California health benefit exchange. The bill requires Medi-Cal to cover the beneficiary's premium costs, minus the advance premium tax credit provided by federal law, as well as any cost-sharing charges. This coverage and payment structure is referred to as the NQI Wrap.

The 2016 Governor's Budget assumed savings of $83.9 million ($31.8 million General Fund and $52.1 million federal funds) for implementation of the NQI Wrap transition in January 1, 2017. However, by the May Revision the Administration requested a delay of one year (from January 1, 2017 to January 1, 2018) for the transition.

DHCS Proposal Expands Wrap to NQIs With Children. DHCS is proposing trailer bill language to expand the transition of NQI adults to include those with children, in addition to the current population of NQI childless adults. DHCS contends that the state's full-scope Medi-Cal coverage for NQIs does not meet federal minimum essential coverage (MEC) requirements. Individuals that do not maintain MEC are required to pay a federal tax penalty under the Affordable Care Act's individual mandate.

The proposed trailer bill language also makes changes to income eligibility requirements to address differences between eligibility rules in Medi-Cal compared to Covered California.

The budget includes savings of $120.8 million ($48 million General Fund and $72.8 million federal funds) for implementation of its expanded NQI Wrap proposal. However, DHCS reports these savings figures only account for transition of the existing population of NQI childless adults, with no budgeted savings for the expansion to NQI adults with children. The Administration expects to include additional savings attributed to this population in the May Revision.

Minimum Essential Coverage Designation. According to the federal Centers for Medicare and Medicaid Services (CMS), final regulations (45 CFR 156.604) promulgated under the Affordable Care Act (ACA) outline a process by which other types of coverage not statutorily specified and not designated through regulation as MEC may apply to be recognized as MEC. Such plans or policies must meet substantially all of the coverage and consumer protection requirements of Title I of the ACA.

In general, full-scope Medi-Cal coverage for NQIs meets the requirements to be recognized as MEC, as this coverage is identical to that received by other Medi-Cal beneficiaries. However, this program is not statutorily specified or designated through regulation as MEC and DHCS has never applied to the federal government for an MEC designation. According to DHCS, the only barrier to designation of the full-scope NQI program as MEC is for the department to apply for, and CMS to approve, the designation. Given the uncertainty of federal policy regarding both health care and immigration issues, it is unclear whether an application for an MEC designation for the NQI program would be approved by the new federal administration.

Immigrant Rights and Health Consumer Advocates Have Raised Concerns. A coalition of immigrant rights and health consumer advocacy organizations has expressed their opposition to implementation of the existing NQI Wrap proposal, as well as its expansion to NQI adults with children. The coalition notes that, although most NQIs eligible for Medi-Cal are not required to file income taxes, transition to coverage in the Covered California exchange would require tax filing to determine eligibility for federal advance premium tax credits. NQIs would also be required to navigate the different enrollment requirements for both Medi-Cal and the Covered California exchange, potentially leading to coverage disruptions for beneficiaries. The coalition includes the California Pan-Ethnic Health Network, the California Immigrant Policy Center, Health Access California, the National Immigration Law Center, and the Western Center on Law and Poverty.

Health Plans May Not Be Ready for Implementation. The California Association of Health Plans (CAHP) has also expressed its opposition to the department's proposal, indicating that the planned implementation of the NQI Wrap on January 1, 2018 does not allow sufficient time to address technical and operational aspects related to the transition. CAHP reports there has been no agreement between Covered California and DHCS on the design of a plan to maintain zero cost-sharing for NQI beneficiaries under the wrap. According to Blue Shield of California, depending on the design of the product, plans could be required to process claims multiple times in order to comply with state and federal rules and maintain federal cost-sharing reduction and advance premium tax credit subsidies.

According to DHCS, no plans have submitted the required product filings with Covered California to provide coverage under an NQI Wrap program. Product filings for the provision of exchange coverage in the 2018 calendar year are due in early May 2017.

Panel Discussion. The subcommittee has requested the following panelists, in addition to the Department of Health Care Services and the Department of Finance, to provide comments on this proposal:

- **Christopher Galeano**, Policy Associate, California Immigrant Policy Center
- **Kimberly Chen**, Government Affairs Manager, California Pan-Ethnic Health Network
- **Jennifer Alley**, Legislative Advocate, California Association of Health Plans

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending further discussions about the implementation readiness of health plans, stakeholder and beneficiary concerns, and potential changes to the availability of federal funding.

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

1. Please provide a brief overview of the existing transition populations and the expanded populations covered under this proposal.

2. Has DHCS provided plans with sufficient information on the geographic distribution of this population to allow for appropriate plan and product filings?

3. How many plans have submitted product filings to Covered California that would support implementation of this proposal? How would the proposal move forward if there are no qualifying products?

Issue 8: Title XXI Federal Match Reduction

Budget Issue. The budget includes an increase of $536.1 million General Fund, which assumes a reduction of the federal matching percentage for the Children's Health Insurance Program (CHIP) from 88 percent to 65 percent. Unless reauthorized by Congress, CHIP is scheduled to expire on October 1, 2017.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	$536,059,190
0890 – Federal Trust Fund	$-	($592,024,190)
Total Funding Request:	**$-**	**($55,965,000)**

Background. Title XXI of the Social Security Act, known as the Children's Health Insurance Program (CHIP), permits states to provide health care services to children up to 250 percent of the Federal Poverty Level. CHIP allows states to integrate these children into an existing state Medicaid program, or to create a stand-alone program. California originally chose the latter option, establishing the Healthy Families Program administered by the Managed Risk Medical Insurance Board to provide health, dental and vision coverage to eligible children. The 2012 Budget Act, as part of a package of budget-balancing solutions, eliminated the Healthy Families Program, transferring its beneficiaries to Medi-Cal over a 12 month period. The new program for these beneficiaries is known as the Optional Targeted Low-Income Children Program (OTLICP). The budget assumes OTLICP caseload of approximately 1 million children in 2017-18.

Enhanced Federal Match and Maintenance of Effort. Title XXI provides an enhanced federal match for states' CHIP expenditures. California's traditional matching percentage for Title XXI spending has been 65 percent.

Approval of the federal Affordable Care Act (ACA) made two significant changes to the state-federal requirements and fiscal relationship regarding CHIP:

1. **Enhanced Match to 88 Percent --** ACA provided for an increase in the enhanced match for CHIP to 88 percent effective October 1, 2015 until September 30, 2019.
2. **Maintenance of Effort –** ACA also required states to maintain eligibility levels and requirements for children in both Medicaid and CHIP until September 30, 2019.

Despite the enhanced federal match for CHIP contained in the ACA statute, the CHIP program and its funding is scheduled to expire on October 1, 2017. It is unclear how expiration of the CHIP statute in 2017 would impact states' requirements to maintain eligibility levels for children pursuant to the ACA until 2019. According to DHCS, under a scenario in which CHIP is allowed to expire while the ACA maintenance of effort requirements remain, the state would likely receive a 50 percent match for expenditures for OTLICP beneficiaries.

There is significant uncertainty regarding how federal actions related to CHIP or the ACA would interact to affect the state's OTLICP. Under various scenarios, the federal matching percentage could range from zero to 88 percent. For the purposes of the Medi-Cal budget, DHCS assumes that CHIP will

be reauthorized, but at the previous enhanced matching rate of 65 percent. This assumption results in an increase of $536.1 million General Fund expenditures in 2017-18 to account for the loss of federal funding. Alternatively, if CHIP were reauthorized at the existing 88 percent federal match, the state would realize General Fund savings of that amount in 2017-18.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending further monitoring and evaluation of efforts to secure Congressional reauthorization of CHIP and associated changes in funding levels.

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

1. Please provide a brief overview of Medi-Cal expenditures supported by Title XXI funding.

2. What is the underlying rationale for assuming reauthorization with a 65 percent federal match?

3. What are the fiscal and programmatic consequences to Medi-Cal if Congress fails to reauthorize CHIP?

Issue 9: Denti-Cal

Dental Services for Medi-Cal Beneficiaries. The budget includes $992.2 million ($310.6 million General Fund and $681.6 million federal funds) in 2016-17 and $1.2 billion ($430.7 million General Fund and $816.9 million federal funds) in 2017-18 for base fee-for-service expenditures for dental services in the Medi-Cal Dental Program, known as Denti-Cal.

The budget also includes $132.5 million ($49.8 million General Fund and $82.8 million federal funds) in 2016-17 and $147.6 million ($56.4 million General Fund and $91.2 million federal funds) in 2017-18 for base dental services provided through dental managed care (DMC) plans.

Dental Services Funding Summary			
Fiscal Year:	**2016-17**	**2017-18**	**BY to CY**
Denti-Cal Fee-for-Service			
Fund Source	***Revised***	***Proposed***	***Change***
0001 – General Fund	$310,636,300	$430,696,140	$120,059,840
0890 – Federal Trust Fund	$681,597,700	$816,853,860	$135,256,160
Total Expenditures	**$992,234,000**	**$1,247,550,000**	**$255,316,000**
Dental Managed Care (DMC)			
Fund Source	***Revised***	***Proposed***	***Change***
0001 – General Fund	$49,754,390	$56,443,760	$6,689,370
0890 – Federal Trust Fund	$82,764,610	$91,154,240	$8,389,630
Total Expenditures	**$132,519,000**	**$147,598,000**	**$15,079,000**

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, while adults receive a more limited set of services.

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 current contract requires Delta to provide dental fiscal intermediary (FI) services including claims processing, provider enrollment, beneficiary outreach, and underwriting.
2. Dental Managed Care (DMC) - The department contracts with six DMC plans that provide dental care to approximately 932,000 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.

Partial 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. According to DHCS, the 2017-18 cost to restore all of the remaining adult dental services would be $190.7 million ($69.5 million General Fund and $121.2 million federal funds).

2014 Audit Findings. 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.

As of February 2016, the Auditor reported DHCS had fully implemented 15 of the recommendations, 8 recommendations were still pending, and 1 will not be implemented.

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 July 2016 for the 2014-15 fiscal year. The report found that in 2013-14 Denti-Cal paid an overall average between 65.5 and 129.2 percent of New York, Illinois, Florida, and Texas' Medicaid Programs' dental fee schedule. For 2014-15 the overall average was between 64.8 and 105.8 percent. The report also found a decrease in providers rendering Denti-Cal services, from 9,527 in calendar year 2008 to 8,001 in calendar year 2015.

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 contract renewal, 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.
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.
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.
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.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending further updates in caseload and expenditures at May Revision.

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

1. Please provide a brief overview of the Denti-Cal program and budget.

2. Please describe the department's dental outreach activities, particularly to children, and any resulting improvements in dental utilization.

3. Please describe the findings and any conclusions contained in the department's annual rate review.

4. Please provide a brief overview of the four domains of the Medi-Cal 2020 Waiver's Dental Transformation Initiative.

Issue 10: Elimination of Major Risk Medical Insurance Fund Proposal

Budget Issue and Trailer Bill Language Proposal. DHCS proposes budget actions and trailer bill language to abolish the Major Risk Medical Insurance Fund, transfer its $68.9 million fund balance to a new Health Care Services Plans Fines and Penalties Fund, redirect existing health plan administrative fines and penalties transfers to the new fund, and allow the fund to support expenditures in the Major Risk Medical Insurance Program and to offset General Fund spending in the Medi-Cal program.

Program Funding Request Summary		
Fund Source - Revenues	**2016-17**	**2017-18**
0313 – Major Risk Medical Insurance Fund	$-	($68,866,000)
3133 – Managed Care Admin Fines & Penalties Fund (DMHC)	$-	($6,000,000)
3311 – Health Care Services Plans Fines and Penalties Fund[1]	$-	$74,866,000
Fund Source – State Operations Expenditures	**2016-17**	**2017-18**
0313 – Major Risk Medical Insurance Fund	$-	($1,334,000)
3311 – Health Care Services Plans Fines and Penalties Fund	$-	$1,334,000
Fund Source – Local Assistance Expenditures	**2016-17**	**2017-18**
0001 – General Fund[2]	$-	($62,293,000)
0313 – Major Risk Medical Insurance Fund	$-	($11,237,000)
3311 – Health Care Services Plans Fines and Penalties Fund	$-	$73,530,000
Total Funding Request (Expenditures)	**$-**	**$-**
[1]*Fund 3311: $68,866,000 transfer from Fund 0313 balance and statutory $6,000,000 transfer from Fund 3133*		
[2]*General Fund: $62,293,000 GF expenditures in Medi-Cal offset by expenditures from Fund 3311*		

Background. The Major Risk Medical Insurance Program (MRMIP) was established in 1991 to provide health care coverage to individuals denied private health coverage due to a pre-existing medical condition. Prior to provisions of the federal Affordable Care Act (ACA) prohibiting coverage denials based on pre-existing conditions, MRMIP served as California's high-risk pool insurance program to provide coverage to individuals considered uninsurable. MRMIP coverage contains several limitations that have since been abolished in the private health insurance market, including annual and lifetime benefit caps. Beneficiaries pay premiums, which are subsidized by the state so they are equivalent to the market rate for comparable coverage.

Since 2014, MRMIP caseload has declined significantly as previously uninsurable individuals were able to find affordable coverage in the private market. However, the program still retains approximately 1,300 beneficiaries that have been unable to obtain coverage for a variety of reasons. MRMIP was previously funded by a combination of Proposition 99 tobacco tax revenue and administrative fines and penalties levied on health care service plans by the Department of Managed Health Care (DMHC). Since the decline in caseload, the program is supported exclusively by the fines and penalties revenues.

SB 1379 (Ducheny), Chapter 607, Statutes of 2008, established the Managed Care Administrative Fines and Penalties Fund, administered by DMHC. SB 1379 provided for the transfer of the first $1 million of fines and penalties deposited in the fund to the Office of Statewide Health Planning and Development (OSHPD) to fund the Steven M. Thompson Physician Corps Loan Repayment Program. Any revenue

remaining after the $1 million transfer to OSHPD is transferred to the Major Risk Medical Insurance Fund, now administered by the Department of Health Care Services, to fund MRMIP.

Significant Fund Balance. Since 2014 the Major Risk Medical Insurance Fund no longer receives transfers from Proposition 99 tobacco tax revenues. However, because of the decline in MRMIP caseload and expenditures, the fund has a significant remaining balance and its transfers from health plan administrative fines and penalties largely fund current health care expenditures. In recent budgets, the Legislature has reallocated these funds to the following purposes:

2014-15

1. **Robert F. Kennedy Health Plan - $3.2 million** in one-time funds to the Robert F. Kennedy Health Plan, a self-funded, self-insured plan for farmworkers. The funds were provided for the Plan to purchase stop-loss insurance to allow compliance with ACA requirements regarding annual and lifetime coverage limits.

2. **Electronic Health Records - $3.8 million** of one-time funds to provide the non-federal share for a federal Electronic Health Records (EHR) Meaningful Use grant. The American Recovery and Reinvestment Act of 2009 established the EHR Incentive Program for Medicaid and Medicare providers. Under the program, which provided a 90 percent federal match for eligible expenditures, Medi-Cal providers received incentive payments to assist in purchasing, installing, and using electronic health records in their practices.

2015-16

1. **Robert F. Kennedy Health Plan - $2.5 million** of one-time funds to the Robert F. Kennedy Health Plan for purposes of continuing its purchase of stop-loss insurance.

2. **Lifelong Community Clinic - $2 million** in one-time funds to the Lifelong Community Clinic in Contra Costa County to support extended hours for urgent care services. The clinic supported care for individuals previously served by Doctor's Medical Center, which closed on April 20th of that year due to unsustainable operating losses.

2016-17

1. **Medi-Cal Funding - $2 million** in one-time funds to DHCS to offset General Fund expenditures in the Medi-Cal program. The Administration had proposed trailer bill language to prospectively transfer managed care administrative fines and penalties revenue over $1 million to offset General Fund expenditures in the Medi-Cal program. The Legislature rejected the Administration's trailer bill proposal, but allocated the requested funding on a one-time basis.

Stability of MRMIP Funding. As previously stated, the transfer of health care service plan fines and penalties revenue is the only remaining funding source exclusively allocated for expenditures in MRMIP. The Administration's trailer bill proposal abolishes the Major Risk Medical Insurance Fund, transfers the remaining fund balance and redirects health care service plan fines and penalties revenue to the new Health Care Services Plans Fines and Penalties Fund. The proposal also allows funds to be spent on both MRMIP and to offset General Fund expenditures in the Medi-Cal program. Although the

Administration has indicated MRMIP expenditures would be fully funded prior to any allocation to Medi-Cal, the proposed language is not clear on the priority for expenditures from the new fund.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open to allow continued discussion with the Administration to clarify whether expenditures in MRMIP would be fully funded prior to any allocation to the Medi-Cal program. The Administration has indicated this priority of expenditures is consistent with the intent of its trailer bill proposal and its budgetary allocations.

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

1. Please provide a brief overview of this proposal.

2. Will the funding deposited in the new Health Care Services Plans Fines and Penalties Fund be allocated to fund MRMIP prior to allocation to any Medi-Cal expenditures?

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

SUBCOMMITTEE NO. 3 Agenda

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

Thursday, March 30, 2017
9:30 a.m., or Upon Adjournment of Floor Session
State Capitol, Room 4203
PART A

Consultant: Theresa Pena

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5175 DEPARTMENT OF CHILD SUPPORT SERVICES (DCSS)

Issue 1: Overview

The Department of Child Support Services (DCSS) is the single state agency designated to administer the federal Title IV-D mandated Child Support Program (CSP). California's Child Support Program seeks to enhance the well-being of children and families' self-sufficiency by providing professional services to locate parents, establish paternity, and establish and enforce orders for financial and medical support. DCSS estimates that there are approximately 1.2 million child support cases in California.

Administration and funding. The Child Support Program is locally administered and funded through federal and state funds, 66 percent and 34 percent, respectively. The program earns federal incentive funds based on the state's performance in the five federal performance measures (to be discussed below). Eligibility for federal Temporary Assistance to Needy Families (TANF) Block Grant funding is also contingent upon continuously providing federally-required child support services.

Service delivery. Local and regional child support agencies deliver services, which are available to all California residents. Families may be referred to CSP through public assistance programs. Non-aided families may apply for services at an office or online, and support is passed directly to the custodial party. After the initial application or referral, the family proceeds to case intake.

Collections. Basic collections represent the ongoing efforts of Local Child Support Agencies (LCSAs) to collect child support payments from parents paying support. Basic collections are collected from the following sources: wage assignments; federal and state tax refund intercepts; unemployment insurance benefit intercepts; lien intercepts; bank levies; and, direct payments from parents paying support. Collections made on behalf of non-assistance families are forwarded directly to custodial parties; while collections for families receiving assistance are retained and serve as recoupment of past welfare costs.

Total Collections Received, by source (FY 2015-16)	
Wage Withholding	$1.62 billion
IRS federal income tax refund	$147 million
FTB state income tax refund	$36 million
Unemployment Insurance Benefits	$40 million
Collections from other IV-D states	$96 million
Non-custodial parents regular payments	$345 million
Other sources* (Liens, workers' compensation, disability insurance benefits offset, California insurance intercepts, and full collections program without wage levies)	$105 million

Total child support distributed collections have grown from $2.4 billion (fiscal year 2015-16) to a projected $2.5 billion for the budget year ($2.1 billion non-assistance payments; $403 million assistance payments). According to the Administration, wage withholding continues to be the most effective way to collect child support, constituting 68 percent ($1.6 billion) of the total collections received. For more information about total collections received by source, please see the department's chart above.

Disregard payments to families. In addition to the California Work Opportunity and Responsibility to Kids (CalWORKs) grant, the custodial party receiving support also receives the first $50 of the current month's child support payment collected from the non-custodial parent. Forwarding the disregard portion of the collection to the family, instead of retaining it as revenue, results in reduced collection revenues for state and federal governments.

Automation System. Federal law requires each state to create a single statewide child support automation system that meets federal certification standards. There are two components of the California Child Support Automation System—Child Support Enforcement (CSE) and State Disbursement Unit (SDU).

- Child Support Enforcement. The CSE system contains tools to manage the accounts of child support recipients and to locate and intercept assets from non-custodial parents who are delinquent in their child support payments. In addition, it funds the local electronic data processing maintenance and operation costs.

- State Disbursement Unit. The SDU provides services to collect child support payments from non-custodial parents and to disburse these payments to custodial parties. The SDU complements the CSE system by providing services to collect and distribute child support obligation payments for both the IV-D and non- IV-D populations[1], and to prepare collection payment transactions for processing by the CSE system.

The California Child Support Automation System (CCSAS) was implemented in 2008, and received its federal certification as the statewide automation system shortly thereafter. The program's cost was approximately $1.5 billion dollars, and implementation took around eight years. DCSS must maintain the automation system, and is responsible for ensuring that LCSAs can access the system. Ongoing annual costs for the CCSAS are approximately $122 million ($107 million Child Support Enforcement; $15 million State Disbursement Unit).

The following chart displays the total CCSAS CSE actual and projected costs through 2017-18.

TASKS	ACTUAL 2003/04 - 2013/14	BUDGET SFY 2014/15	BUDGET SFY 2015/16	BUDGET SFY 2016/17	BUDGET SFY 2017/18	TOTAL
Development	902,073,292	-	-	-	-	$ 902,073,292
Operations	555,629,865	69,810,366	71,072,440	71,860,440	71,858,440	$ 840,231,551
Local Technical Support	671,403,274	35,007,994	35,007,994	35,007,994	35,007,994	$ 811,435,250
TOTAL CSE Costs	$ 2,129,106,431	$ 104,818,360	$ 106,080,434	$ 106,868,434	$ 106,866,434	$ 2,553,740,093

[1] Title IV-D of the Social Security Act is a federally required program providing parentage and support establishment and support enforcement services.

2013 Federal Performance Measures. Federal incentive payments are based on the state's annual data reliability compliance and its performance in five measures, which were established by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), and the Child Support Performance and Incentive Act of 1998. The five performance measures are:

1. **Statewide Paternity Establishment Percentage (PEP)** measures the number of children born out-of-wedlock for whom paternity was acknowledged or established in the fiscal year compared to the total number of children in the state born out-of-wedlock during the preceding fiscal year. California measured 98.6 percent in FFY 2016. The federal minimum performance level is 50 percent.

2. **Cases with Support Orders Established** measures cases with support orders as compared to total caseload. California measured 90.4 percent for FFY 2016, an increase of one percentage points over FFY 2015. The federal minimum performance level is 50 percent.

3. **Collections on Current Support** measures the current amount of support collected as compared to the total amount of current support owed. California measured 67 percent for FFY 2016, an increase of 0.5 percentage points from the previous year. The federal minimum performance level is 40 percent.

4. **Cases with Collections on Arrears** measures the number of cases with child support arrearage collections as compared with the number of cases owing arrearages during the federal fiscal year. California measured 66.7 percent for FFY 2016, an increase of 0.5 percentage points from the previous year. The federal minimum performance level is 40 percent.

5. **Cost Effectiveness for California** compares the total amount of distributed collections to the total amount of expenditures for the fiscal year, expressed as distributed collections per dollar of expenditures. California measured $2.51 for FFY 2016, unchanged from the previous year. The federal minimum performance level is $2.00.

DCSS estimates that California will be entitled to $41.6 million in federal incentive funds for fiscal year 2015-16 and $42.4 million in the budget year.

On December 11, 2014, the department issued Child Support Services letter 14-12, which outlines how the department will shift from evaluating statewide and local performance improvement efforts exclusively by the five federal performance measures to a more "customer-oriented, family-centered approach." Performance management plans will be reviewed within the context of practice improvement indicators, as provided by the department; and, regional administrators will monitor LCSA implementation.

DCSS has since developed a set of measures called practice indicators to track other key metrics that are important to our customers and to the performance of the program. These measures are meant help to inform strategies and practices that the LCSAs adopt and include in their annual performance improvement plans. Some key practice indicators the percentage of orders that result from collaborative negotiations with both parties that result in stipulation orders, the timeliness of service provided, the reliability of child support payments and the accuracy of child support orders.

Update on Local Child Support Agency Revenue Stabilization. Since July 1, 2009, the state provides $18.7 million ($6.4 million General Fund) for the 49 LCSAs to stabilize caseworker staffing, and to avoid a loss in child support collections. To receive an allocation of revenue stabilization funds, DCSS requires that revenue stabilization funds are distributed to counties based on their performance on two key federal performance measures—1) collections on current support and 2) cases with collections on arrears. According to 2015-16 data, DCSS found that revenue stabilization funds maintained statewide child support collections. Specifically, the stabilization funds have assisted in retaining:

- 210 child support caseworkers
- $135.3 million in total distributed collections.
- $15.2 million in net total assistance collections.
- $7.2 million GF share of assistance collections.
- $120.1 million in total non-assistance collections.

Uniform Interstate Family Support Act (UIFSA). The UIFSA governs the establishment, enforcement, and modification of interstate child and spousal support orders by providing jurisdictional standards and rules for determining which state's order is controlling and whether a tribunal of this state may exercise continuing, exclusive jurisdiction over a support proceeding. The UIFSA was first developed by the National Conference of Commissioners on Uniform State Laws in 1992, was amended in 1996, 2001, and 2008. All states were required to enact UIFSA in 1998 as a condition to receive federal funds for family support enforcement. As a result, UIFSA is currently state law in all 50 states and jurisdictions.

The UIFSA 2008: 1) allows states to redirect support payments to a new state when all parties have left the state that originally issued a support order; 2) requires courts to permit out-of-state parties to appear telephonically in proceedings to establish, modify, or enforce a support order; and, 3) allows for the provision of child support services to residents of other countries pursuant to the 2007 Hague Convention on the International Recovery of Child Support and Other Forms of Maintenance.

On September 29, 2014, the President signed the Preventing Sex Trafficking and Strengthening Families Act (Public Law (P.L.) 113-183), which, among its provisions requires the adoption of the UIFSA 2008 by the end of each state's 2015 legislative session, as a condition of federal child support program funding. The key changes from the 1996 version to the 2008 version include:

- Allowing California to redirect support payments to a new state when all parties have left the state that originally issued a support order;
- Requiring courts to permit out-of-state parties to appear telephonically in proceedings to establish, modify, or enforce a support order; and
- An expansion for provision of child support services to residents of other countries pursuant to the Hague Convention on the International Recovery of Child Support and Other Forms of Maintenance (Convention).

Office of Child Support Enforcement (OCSE) Final Rule. On December 20, 2016, the federal OCSE published The Flexibility, Efficiency, and Modernization in Child Support Programs Final Rule (Final Rule). Effective January 19, 2017, the final rule makes changes to the child support program intended to increase the effectiveness of the program for all families, states, territories and tribal programs and to ensure that child support services are accessible to families and delivered in a fair and transparent

manner. Some of the changes include: clarifying and streamlining regulations to improve the efficiency of child support programs; clarifying the variables that should be considered or included when calculating a child support order amount in order to improve the fairness and accuracy of child support orders; expands criteria for closing child support cases; and expands the types of services for which federal financial participation is available. DCSS, in collaboration with the LCSAs, is in the process of conducting an in depth review of the Final Rule in order to determine how this impacts California's Child Support Program. In addition, DCSS will work with the Judicial Council of California (JCC) to see how the provisions pertaining to child support order setting guidelines will impact California's child support guidelines. The JCC is currently in progress of conducting a quadrennial review of the state's child support guidelines.

Staff Comment and Recommendation. Informational only. No action required.

Questions.

1. Please provide a brief overview of the department and its services.

Issue 2: TBL – Extend Suspension of Improved Performance Incentives

Governor's Proposal. The Administration proposes to extend the suspension of Improved Performance Incentives for DCSS through 2017-18.

Background. The Improved Performance Incentives program provides that the ten LCSAs with the best performance standards will receive an additional five percent of the state's share of those counties' collections that are used to reduce or repay aid that is paid under the CalWORKs program, and that these funds be used for specified child support-related activities. The incentives are paid for with 100 percent General Fund. However, this law was only operative for one year and has been suspended since 2002-03 due to fiscal restraints.

The department notes that they are currently evaluating how this program should be restructured to better direct incentives towards specific reforms or innovations that could improve collections, the reliability of child support payments owed by non-custodial parties, and increase the pool of eligible LCSAs.

Staff Comment and Recommendation. Hold open. No concerns have been raised to subcommittee staff at this time.

Questions.

1. Please provide a summary of the proposal.

Issue 3: TBL – Repeal Health Insurance Incentives Program

Governor's Proposal. The Administration proposes to repeal the Health Insurance Incentives Program.

Background. The Health Insurance Incentives Program requires that DCSS provide payments to the LCSA of $50 per case for obtaining third-party health coverage or insurance of Medi-Cal beneficiaries, to the extent that funds are appropriated in the budget act. However, this program was only operative for one year and these payments have been suspended since 2003-04. This incentive was originally suspended due to a decline in General Fund revenues and subsequently suspended due to ongoing budget constraints.

The department notes that this suspension was extended from 2015-16 through 2016-17, in order for DCSS to reevaluate the incentive program and determine its relevance. DCSS states that federal and state laws already require the enforcement of medical support. LCSAs are already required to find alternatives to Medi-Cal without these incentives. Also, the implementation of the Affordable Care Act has further improved health care coverage for children. Because the payment to LCSAs has already been suspended for several years, there would be no impact to counties as this is the status quo.

Staff Comment and Recommendation. Hold open. No concerns have been raised to subcommittee staff at this time.

Questions.

1. Please provide a summary of the proposal.

5180 DEPARTMENT OF SOCIAL SERVICES – CHILD WELFARE SERVICES (CWS)

Issue 1: Overview

The CWS system includes child abuse prevention, emergency response to allegations of abuse and neglect, supports for family maintenance and reunification, and out-of-home foster care. The total funding for CWS is estimated to be approximately $6 billion for 2016-17, and $6.2 billion for 2017-18. The core of CWS is made up of four components:

- Emergency Response: Investigations of cases where there is sufficient evidence to suspect that a child is being abused or neglected.
- Family Maintenance: A child remains in the home, and social workers provide services to prevent or remedy abuse or neglect.
- Family Reunification: A child is placed in foster care, and services are provided to the family with the goal of ultimately returning the child to the home.
- Other Placements: Provides permanency services to a child who is unable to return home and offers an alternative family structure, such as legal guardianship or independent living.

Caseload trends. There has been a significant decline in the foster care caseload over the last 10 years. Caseload has declined more than 39 percent from 71,662 in 2006-07, to 43,356 in 2015-16. The department attributes part of the caseload decline to prevention efforts for out-of-home care and back-end efforts for permanency placements.

Demographics of children in foster care. Research documents how children and youth, who experience foster care and those who emancipate from care, are at risk for challenges related to education, health, and mental health. As of October 1, 2016, across all placement types, 38 percent of youth have been in care for less than 12 months, 23 percent have been in care between 12 and 23 months, and 21 percent have been in care between 24 and 47 months, and 18 percent have been in care for more than 48 months.

The following table, based on October 2016 data from U.C. Berkeley[2] displays the percentage of ethnic or racial representation of a child in foster care by placement type.

Placement Type	Black	White	Latino	Asian/Pacific Islander	Native American
Pre-Adopt	18.3%	21.9%	57.0%	1.6%	1.1%
Kin	20.4%	20.8%	55.4%	1.9%	1.6%
Foster	20.2%	26.5%	50.3%	1.9%	1.2%
FFA	19.0%	23.9%	54.1%	2.0%	1.0%
Court Specified Home	16.4%	38.5%	41.0%	3.1%	1.0%
Group	32.3%	25.4%	39.3%	2.1%	1.0%
Shelter	18.2%	39.4%	34.3%	4.0%	4.0%
Non-FC	28.4%	21.2%	47.8%	2.2%	0.4%
Transitional Housing	32.0%	25.3%	38.9%	2.7%	1.1%
Guardian-Dependent	41.5%	11.8%	44.3%	1.5%	0.9%
Guardian-Other	29.4%	24.9%	40.6%	2.3%	2.9%
Runaway	24.5%	23.4%	48.8%	1.3%	2.0%
Trial Home Visit	12.0%	24.6%	58.3%	3.9%	1.2%
SILP	25.2%	22.7%	47.6%	3.3%	1.2%
Other	26.2%	23.0%	47.1%	1.6%	2.1%

Temporary placement types. Traditionally, there have been three major temporary placement types — a foster family home (FFH), foster family agency (FFA), or group homes:

- FFHs are licensed residences that provide for care up to six children. This placement type also includes relative caregivers. Under the Continuum of Care Reform (CCR), these families are known resource families.

[2] http://cssr.berkeley.edu/ucb_childwelfare/

- FFAs are private, nonprofit corporations intended to provide treatment and certify placement homes for children with higher level treatment needs. Under CCR, FFAs are also considered resource families.

- Group homes are licensed to provide 24-hour non-medical residential care in a group setting to foster youth from both the dependency and delinquency jurisdictions.

Under CCR, however, group homes are being phased out and Short-Term Residential Treatment Placements (STRTPs) replace them. As of January 1, 2017, group homes are no longer a placement option (subject to case-by-case exceptions that may allow them to continue to operate for a period of time). STRTPs will provide care, supervision, and expanded services and supports.

Additionally, FFAs and STRTPs will be required to ensure access to specialty mental health services and strengthen their permanency placement services by approving families for adoption, providing services to help families reunify, and giving follow-up support to families after a child has transitioned to a less restrictive placement. AB 403 (Stone), Chapter 773, Statutes of 2015, also requires FFAs and STRTPs to make educational, health, and social supports available.

Duration in placement and placement movements. According to the department's 2015-16 CWS Realignment Report, for the largest age group category, 13-17 years old, of the 4,737 children, the majority (45 percent) move out of group home placements in less than 12 months; longer stays (12-36 or more months) comprise the remaining 55 percent (2,619).

The foster youth in group home care will transition to alternative placements. In 2017-18, the department assumes that 115 group home placements will move to an intensive services foster care placement; 345 group home placements will move to an STRTP placement; and 515 group home placements will move to a family-based setting. The remaining 4,630 group home placements will not yet transition.

Below is a table for 2017-18, based on data from DSS, which shows caseload movement from group homes.

Table 3. HBFC Rate Caseload - Child Welfare Group Home Caseoad Movements.

		FY 2016-17 Caseload	FY 2017-18 Caseload	FY 2018-19 Caseload	FY 2019-20 Caseload	FY 2020-21 Caseload	Assumed Final Distribution
Total Child Welfare GH Caseload		3,637	3,638	3,637	3,637	3,638	
Total Current GH 1-9	*390*						
GH RCL 1-9 Shifting to TFC		-	-	17	19	19	9%
GH RCL 1-9 Shifting to STRTP		-	-	-	-	-	0%
GH RCL 1-9 Shifting to FFA		10	27	83	193	195	92%
GH RCL 1-9 Shifting to FFH/Relative		-	18	66	173	176	83%
GH not Shifting		380	345	224	5	-	0%
Total Current GH 10-12	*2,902*						
GH RCL 10-12 Shifting to TFC		-	67	247	430	435	28%
GH RCL 10-12 Shifting to STRTP		37	200	371	573	580	37%
GH RCL 10-12 Shifting to FFA		-	133	371	1,003	1,016	65%
GH RCL 10-12 Shifting to FFH/Relative		-	133	494	860	871	55%
GH not Shifting		2,865	2,369	1,419	36	-	0%
Total Current GH 14	*346*						
GH RCL 14 Shifting to TFC		-	8	15	51	52	28%
GH RCL 14 Shifting to STRTP		2	24	59	103	104	56%
GH RCL 14 Shifting to FFA		-	16	44	119	121	65%
GH RCL 14 Shifting to FFH/Relative		-	8	44	68	69	37%
GH not Shifting		343	290	183	4	-	0%

*Caseload values are rounded.

Licensing. The Community Care Licensing Division licenses facilities, including foster family homes, foster family agencies (who, in turn, certify individual foster families), and group homes. All facilities must meet minimum licensing standards, as specified in California's Health and Safety Code and Title 22 Regulations. Among those requirements, group homes must provide youth with direct care and supervision, daily planned activities, food, shelter, transportation to medical appointments and school, and at least a monthly consultation and assessment by the group home's social worker and mental health professional, if necessary, for each child. Currently, the department must visit all homes and facilities at least once every five years, with an additional random sample of 30 percent of homes and facilities each year. The 2015-16 Governor's budget included resources to improve regulatory oversight by increasing the frequency of inspections of Community Care licensed facilities throughout the state. Changes to inspection frequency for Children's Residential will go into effect in two stages. During Stage 1, beginning in January 2017, all children's residential homes and facilities will be inspected once every three years with an additional random sample of 30 percent of facilities. During the final stage, beginning in January 2018, all children's residential homes and facilities will be inspected once every two years with an additional random sample of 20 percent of facilities.

Performance measures and accountability. The federal Administration for Children and Families (ACF) conducts Child & Family Services Reviews (CFSRs) of states' child welfare systems, which include measures of outcomes related to the safety, permanency, and well-being experienced by children and families served. Round 2 of the CFSR was conducted in 2008 with the Program Improvement Plan (PIP) that was successfully completed in 2012. The state is currently in Round 3 of the CFSR. The statewide assessment was submitted in March of 2016. ACF issued the final report outlining their findings from the most recent review in January of 2017, and the report indicated that California did not meet any of the required outcome measures, and five of the seven systemic factors were not met. California is required to enter into a three-year PIP to address all areas of deficiency.

The Child Welfare System Improvement and Accountability Act also created a statewide accountability system that became effective in 2004. It includes 14 performance indicators monitored at the county-specific level and a process for counties to develop System Improvement Plans (SIPs).

Realignment. The 2011 public safety realignment and subsequent related legislation realigned child welfare services and adoptions programs to the counties, transferring nonfederal funding responsibility for foster care to the counties. In addition, over the last several years, the state increased monthly care and supervision rates paid to group homes, foster family homes, and foster family agency-certified homes, as a result of litigation.

Prior to the 2011 realignment, DSS estimated the costs associated with meeting federal and state requirements for the estimated numbers of children and families to be served as part of the annual budget process. Under the 2011 realignment, the total funding for CWS is instead determined by the amount available from designated funding sources (a specified percent of the state sales and use tax and established growth allocations) that are directed to the counties and corresponding matching funds. Both before and after realignment, certain CWS expenditures, including payment rates for care providers that are statutorily established, are provided on an entitlement basis.

Trailer bill provisions in 2012-13 additionally established programmatic flexibility that allows counties, through action by boards of supervisors after publicly-noticed discussion, to discontinue some programs or services that were previously funded with only General Fund, including clothing allowance and specialized care increments added to provider rates and Kinship Support Services programs.

Roles of the state and counties. DSS is responsible for oversight, statewide policy and regulation development, technical assistance, and ensuring federal compliance. Prior to realignment, the state was also at risk for the full costs of any federally-imposed penalties stemming from federal CFSRs. Under realignment, counties, whose performance contributed to an applicable penalty, must pay a share of the penalty if realignment revenues were adequate to fully fund the 2011 base, and if they did not spend a minimum amount of allocated funding on CWS.

Required reporting on realignment. Pursuant to SB 1013 (Budget and Fiscal Review Committee), Chapter 35, Statutes of 2012, DSS must report annually to the Legislature on April 15 outcome and expenditure data, as well as impacts of CWS and Adult Protective Services program realignment. Reports must also be posted on the department's website. The 2016 Child Welfare Services Realignment Report[3] found the following:

- Child welfare practices of investigating referrals within policy timeframe continue to remain above state standards.

- There has been a significant decline in the foster care caseload. Caseload has declined more than 47 percent from 108,159 in 2000 to 57,266 in 2015.

- Between 2010 and 2015, the number of children for whom the first placement is with a relative/kin increased from 18 percent to 26 percent, while the proportion of children placed in group homes decreased from 16 percent to 13 percent.

- The proportion of children who entered foster care and subsequently exited to permanency due to guardianship, adoption or reunification within 12 months dropped from 40.9 percent in 2010 to 35.5 percent in 2014.

- The proportion of children re-entering foster care within a year increased form 11.1 percent in 2008 to 11.9 percent in 2013.

The department, which is currently drafting the 2017 Realignment Report, has shared that preliminary review of expenditure data for 2015-16 shows an increase in spending in both Transitional Housing Program (THP) and THP-Plus, whereas in prior years spending in these programs has decreased. Otherwise, they maintain that child welfare outcome indicator results remain consistent with previous reports.

Reports of Child Near-Fatalities. The federal Child Abuse Prevention and Treatment Act (CAPTA) requires that states receiving funds under CAPTA must disclose to the public findings and information about child abuse and neglect cases that result in fatalities or near fatalities. On December 8, 2015, the federal Administration for Children, Youth, and Families (ACYF) notified DSS of non-compliance with federal guidelines regarding public disclosure procedures in cases where a child dies or nearly dies as the result of abuse or neglect.

[3] The full report can be accessed here:
http://www.dss.cahwnet.gov/cdssweb/entres/pdf/legislature/2016RealignmentReportOAB.pdf

California complied with these new requirements by enacting AB 1625 (Committee on Budget), Chapter 320, Statutes of 2016. Starting January 1, 2017, in addition to all fatalities, counties must both report the near fatality to DSS and publicly disclose a combination of case file documents and a case summary on the details of the near fatality and any child welfare services provided to the victim or the victim's family.

Recent policy and budget actions. Several policies and budget actions lay the groundwork for child welfare reform, including:

- **Extended foster care.** AB 12 (Beall), Chapter 559, Statutes of 2010, enacted the "California Fostering Connections to Success Act of 2010," which provides an extension for foster youth, under specified circumstance, to remain in care until age 21; increases support for kinship care (opportunities for youth to live with family members); improves education stability; coordinated health care services; provides direct child welfare; and, expands federal resources to train caregivers, child welfare staff, attorneys, and more.

- **Katie A.** The Katie A. vs. Bonta case was first filed on July 18, 2002 as a class action suit on behalf of children who were not given adequate services by both the child protective system and the mental health system in California. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. Outcomes from the settlement agreement and implementation plan include the creation of the Core Practice Model; and the provision of Intensive Care Coordination, Intensive Home-Based Services, and Therapeutic Foster Care to eligible children.

- **Title IV-E Waiver.** Title IV-E is the major federal funding source for child welfare and related probation services. These funds, which were previously restricted to pay for board-and-care costs and child welfare administration, can be used to provide direct services and supports under the waiver extension. Since Title IV-E funding is based solely on actual cost of care, if a county's preventative services are effective and fewer children enter or stay in the foster care system, the county's Title IV-E funding is reduced. Thus, the county is penalized for reducing foster care placements, even though such a reduction is the most desirable outcome. The 2014-15 budget authorized the waiver extension for five years, beginning October 1, 2014. The nine participating counties include: Alameda, Butte, Lake, Los Angeles, Sacramento, San Diego, San Francisco, Santa Clara, and Sonoma.

- **Commercial Sexual Exploitation of Children (CSEC) Program.** SB 855 (Budget and Fiscal Review Committee), Chapter 29, Statutes of 2014, established the state CSEC program to enable county child welfare agencies to provide services to child victims of commercial sexual exploitation. The CSEC program was established as a county opt-in program. Shortly after the state program was enacted, federal CSEC legislation was enacted with statewide requirements.

  Last year, the Legislature provided an additional $5 million General Fund, for a total of $19 million for the CSEC program. These funds are being used to train county workers to better work with CSEC youth, develop interagency protocol to serve CSEC, provide prevention and intervention activities, and services such as training foster youth to recognize and avoid commercial sexual exploitation and engaging survivors, submitting county plans, and collecting data.

- **Relative Caregiver Funding.** Effective January 1, 2015, counties, who opt-in to the Approved Relative Caregiver (ARC) Funding Program, must pay an approved relative caregiver a per child, per month rate, in return for the care and supervision of a federally-ineligible Aid to Families with Dependent Children-Foster Care (AFDC-FC) child placed with the relative caregiver, equal to the base rate paid to foster care providers for a federally-eligible AFDC-FC child. To date, a total of 48 counties have opted in.

  With the CCR, however, ARC payment rates will be equal to the home-based family care rate basic level.

- **Bringing Families Home (BFH).** Created by AB 1603 (Chapter 25, Statutes of 2016), the BFH program is intended to reduce the number of families in the child welfare system experiencing homelessness, to increase family reunification, and prevent foster care placement. It is an optional state-funded program with a dollar-for-dollar county match requirement. County programs must utilize a Housing First model, including Rapid Rehousing or Supportive Housing. The 2016-17 Budget Act allocated $10 million that is available through June of 2019. DSS received interest from 23 counties with a total of $18.7 million requested to implement local BFH programs. Counties with the strongest BFH program plans will be contacted and asked to submit more detailed program information by early April 2017, and the funds will be allocated in mid-May.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the program, services, caseload trends, and proposed budget.

2. Please briefly discuss California's Round 3 Child & Family Services Review and Program Improvement Plan.

3. Please provide an update on the CSEC program and discuss how additional funds from last year are being spent.

Issue 2: Budget Change Proposal: Full-year Costs for CWS Near-Fatality Case Reviews

Governor's Proposal. The Administration requests one permanent Staff Services Manager I and three Associate Governmental Program Analyst positions to address workload associated with the federal Child Abuse Prevention Treatment Act (CAPTA) requirements to review and disclose information relating to child near fatalities, and AB 1625(Committee on Budget), Chapter 320, Statutes of 2016.

Background. The federal CAPTA requires that states receiving funds under CAPTA must disclose to the public findings and information about child abuse and neglect cases that result in fatalities or near fatalities. CAPTA provides approximately $5 million funds annually for child abuse prevention activities. On December 8, 2015, the federal Administration for Children, Youth, and Families (ACYF) notified DSS of non-compliance with federal guidelines regarding public disclosure procedures in cases where a child dies or nearly dies as the result of abuse or neglect.

California was then required to submit a Program Improvement Plan (PIP) to comply with the new CAPTA requirements. Last year, the Legislature enacted AB 1625 which lays out the procedure for public disclosure of near fatalities, and satisfies the PIP requirement. However, the department notes that this legislation doubles the annual number of near fatalities cases reported to DSS, and requires additional staff time to review each incident. Currently, DSS has six staff performing this work for fatalities.

The department notes that these new resources will ensure compliance with the continued receipt of federal CAPTA funds, and will allow the department to analyze specific cases resulting in a child near fatality and identify specific areas where the county and state need to focus improvement strategies.

Staff Comment and Recommendation. Hold open. Staff notes that the request for staff to complete the work on near fatalities appears reasonable, and no concerns have been raised at this time.

Questions.

1. Please provide an overview of the proposal.

Issue 3: TBL – Approved Relative Caregiver (ARC) Program

Governor's Proposal. The Administration proposes to modify the ARC program consistent with implementation of the CCR.

Background. The ARC program allows counties to opt in to provide payments to federally ineligible relative caregivers of an amount equal to the foster care basic rate received by federally eligible relative caregivers of dependent children. Approved relatives in these counties receive a grant payment which consists of funds from CalWORKs, the state General Fund, and the county, if necessary. A total of 48 counties opted in and currently participate in the ARC program.

AB 1603 (Committee on the Budget) Chapter 25, Statutes of 2016, effective January 1, 2017, allows all relatives who are approved under the Resource Family Approval process in the CCR to receive an amount equal to the resource family basic rate, regardless of federal eligibility.

The department notes that this TBL will result in a cost of approximately $21.4 million General Fund for 2016-17, and $25.2 million for 2017-18.

Some advocates have pointed out that TBL should include funding for the dual agency rate and the infant supplement rate. These payments affect some of the most vulnerable foster youth populations: disabled youth ages 0-3 who also receive services from regional centers, and parenting teens and their infants, living with relatives. The department has been consistent in its message that ARC rates are meant to be equal among all categories, and it would make sense that these two rates, which appear to have been inadvertently left out, would be included in this TBL or in the May Revision. Advocates are currently in discussions with the department regarding these two rates, as well as a few other technical suggestions.

Staff Comment and Recommendation. Hold open. Staff recommends that the department work with advocates to address dual agency rate and infant supplement rate, as well as their technical suggestions, and expects hear back on these issues by the May Revision.

Questions.

1. Please provide an overview of the proposal.

2. Please discuss why the dual agency rate and infant supplement rate were not included last year, and whether the department intends to include them in this year's TBL.

Issue 3: Proposals for Investment

The subcommittee has received the following CWS-related proposals for investment.

- Child Care for Foster Children

Budget Issue. Los Angeles County, the County Welfare Directors Association, and others request $31 million to increase access to child care and enable a larger pool of families to become foster parents. Advocates cite the inability to access child care as a top barrier to finding placement for children removed from their parents due to abuse and neglect. This proposal includes three pieces: (1) Any resource family needing child care for children ages 0 through 3, would receive an immediate, time-limited voucher to pay for child care for up to six months following a child's placement at a cost of $22 million. (2) Funding of $4 million to support child care navigators through the county resource and referral agencies who work with the resource family to facilitate the use of the emergency voucher to ensure a foster child's immediate access to child care and continue to work with the family to facilitate placement. (3) Inclusion of $5 million to provide appropriate trauma-informed training for child care providers, with a trainer to cover every county.

Staff Comment and Recommendation. Hold open.

- Grants for Extracurricular Activities

Budget Issue. Assemblymember Acosta requests $15.3 million General Fund to provide grants of $500 or less to qualified foster youth to participate in extracurricular enrichment activities. The amount represents an estimate of 30,500 eligible foster youth receiving a maximum grant award.

Staff Comment and Recommendation. Hold open.

- Additional Foster Care Public Health Nurses (PHNs)

Budget Issue. SEIU requests $3.8 million General Fund (75% Federal Match for $15.4 million Total Funds) to hire an additional 96 PHNs to provide for the necessary oversight on foster youth on psychotropic medications. Last year's budget provided for an additional $6.6 million for PHNs; however SEIU claims this was not enough and PHN caseloads in some counties are still above the recommended amount of 200 foster youth to one nurse.

Staff Comment and Recommendation. Hold open.

- Funding for Medical Review of Psychotropic Medication Authorizations for Foster Youth

Budget Issue. National Center for Youth Law requests $80,025 General Fund (75% Federal Match for $320,100 Total Funds) to provide a centralized medical review service (through contracted services) of requests for authorizations of psychotropic medications for foster youth. Currently only 40% of counties have a process for reviewing authorizations. The position would be housed within the Department of Social Services.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – CHILD WELFARE SERVICES (CWS)

Issue 1: Oversight – Continuum of Care Reform (CCR) Implementation

Governor's Proposal. The budget includes approximately $107.9 million General Fund in 2016-17, and $121.9 million General Fund in 2017-18 to implement various components of the Continuum of Care Reform (CCR) enacted by AB 403.

Below is a breakdown of this funding:

Continuum of Care Reform (CCR) Summary*

The CCR has costs listed in several sections in the budget tables. This chart provides a consolidated view of all of the costs included in the budget tables for FY 2016-17 and FY 2017-18 for the CCR.

(in 000's)	2017-18 Governor's Budget					
	FY 2016-17			FY 2017-18		
Item	Total	Federal[1]	Non-Federal	Total	Federal[1]	Non-Federal
Home-Based Family Care Rate	$22,212	$1,117	$21,095[2]	$10,574	-	$10,574[3]
Foster Family Agency – Social Worker Rate Increase	$3,786	-	$3,786	-	-	-
Accreditation	$2,827	$1,414	$1,413	$2,827	$1,414	$1,413
Contracts	$10,485	$4,929	$5,556	$11,925	$5,650	$6,275
Second Level Administration Review	$29	$6	$23	$62	$12	$50
Child and Family Teams	$27,441	$5,423	$22,018	$54,399	$10,643	$43,756
Foster Parent Recruitment, Retention and Support	$54,729	$11,469	$43,260	$57,080	$13,913	$43,167
Automation	$500	$250	$250	-	-	-
RFA	$12,042	$4,012	$8,030	$24,904	$8,169	$16,735
SAWS	$6,101	$3,550	$2,551	-	-	-
CDSS Local Assistance Total	**$140,152**	**$32,170**	**$107,982**	**$161,771**	**$39,801**	**$121,970**

Note:
1 Federal Title IV-E funds are not included for the CDSS Title IV-E California Well-Being Project Counties, as federal funds for the Project are capped.
2 Includes $34,000 of county funds for Kin-GAP cases.
3 Includes $94,000 of county funds for Kin-GAP cases.

The table below provides a high-level summary of changes between the 2016-17 Budget Act and the 2017-18 Governor's budget:

Continuum of Care Reform (CCR)

Funding (In Millions)	FY 2016-17 Appropriation	FY 2016-17 Revised Budget	FY 2017-18 Governor's Budget	FY 2016-17 Change From Appropriation	FY 2017-18 Change From Appropriation
Total	$152.7	$140.2	$161.8	-$12.5	$9.1
Federal	$33.3	$32.2	$39.8	-$1.1	$6.5
State	$119.3	$107.9	$121.9	-$11.4	$2.6
County (Reimb.)	$0.1	$0.1	$0.1	$0	$0

Background. Significant research documents the poor outcomes of children and youth in group homes, such as higher re-entry rates into foster care, low high school graduation rates, and increased risk of arrest. These group homes are generally more expensive than family placements. The CCR began by trying to find solutions to these problems, but eventually broadened the effort into a more comprehensive set of system changes for the whole foster care system.

In 2012, the Legislature passed SB 1013 (Budget and Fiscal Review Committee), Chapter 35, Statutes of 2012, which authorized the department to develop recommendations related to the state's current rate setting system, and to services and programs that serve children and families in the continuum of Aid to Families with Dependent Children-Foster Care (AFDC-FC) eligible placement settings. In January 2015, the department released the report "California's Child Welfare Continuum of Care Reform", which listed recommendations to improve assessment of child and families to make more appropriate initial placement decisions; emphasize home-based family care; support placement with available services; change the goals for group home care placement; and, increase transparency for child outcomes. The Legislature subsequently passed AB 403, to implement the CCR, which codified the recommendations. Some of the main components of AB 403 are:

- Creation of Short-Term Residential Treatment Placements (STRTPs), which are intended to provided short term, therapeutic services to stabilize children so that they may quickly return to a home-based family care setting.

- Foster Family Agencies (FFAs) and STRTPs will be required to ensure access to specialty mental health services and strengthen their permanency placement services.

- Additional integration between child welfare and mental health services.

- FFAs and STRTPs are required to obtain and maintain accreditation from a nationally-recognized body in order to improve quality and oversight. CCR also calls for the development of publicly available FFA and STRTP performance measures.

- Resource Family Approval (RFA) is a new, streamlined assessment that replaces the existing multiple approval, licensing, and certification processes for home-based family caregivers.

- The required use of child and family teams (CFTs) in decision-making.

- The creation of a new, comprehensive strengths and needs assessment upon entering the child welfare system in order to improve placement decisions and ensure prompt access to supportive services.

- New Home-Based Family Care rate structure, which is based on child need, which is based on a Level of Care (LOC) tool.

Placement costs

Prior to CCR, group home facilities were organized under a system of rate classification levels (RCLs) ranging from 1-14 that are based on levels of staff training and ratios. In practice, a majority of group homes were RCL 10 and above, with nearly 50 percent of groups homes at RCL 12. As of 2015-16, group home placements constituted 13 percent of foster care placement and represented 48 percent of total foster care costs. Group home rates were based on the level of care and services provided, ranging from $2,332 to $9,879 per month.

Reimbursement rates for 14 separate group home levels will be replaced by a new set of rates that is based on the needs of the child, which will be determined by a still-in-development assessment tool to be used by county social workers and child and family teams, unlike the previous structure which centered around the age of the child. These new rates are intended to reflect the expanded set of responsibilities of STRTPs and FFAs under CCR.

With the passage of the 2016-17 budget, the Legislature approved the Administration's proposed Home-Based Family Care (HBFC) Rate structure on an interim basis shown below:

Continuum of Care Reform (CCR) Summary*

Home-Based Family Care Rate Structure

Based on Level of Care (LOC)

	Basic Level	LOC-2	LOC-3	LOC-4
A Pay to Resource Family for Basic Rate				
Basic Rate	$889	$989	$1,089	$1,189
B Pay to Foster Family Agency				
Basic Rate	$889	$989	$1,089	$1,189
Social Worker	$340	$340	$340	$340
Social Services & Support	$156	$200	$244	$323
RFA	$48	$48	$48	$48
Administration	$672	$672	$672	$672
Total	**$2,105**	**$2,249**	**$2,393**	**$2,572**

C Pay to Resource Family for Intensive Services FC (ISFC)	
ISFC Rate	$2,321
Pay to Foster Family Agency including ISFC Administration	
ISFC Administration	$3,482
ISFC Social Services & Support	$200
Total	**$6,003**
D Pay to Short-Term Residential Therapeutic Program (STRTP)	
STRTP Rate	$12,036

E Pay to Foster Family Agency or Community Based Organizations for Services Only	
Total Rate	**$771**

The FFA rate is separated into two components. The first goes to the family caregiver as an assistance payment, and the second goes to the FFA for administrative and social work activities. Similarly, the Therapeutic Foster Care (TFC) model divides the TFC rate into two components, one of which is paid to the TFC caregiver and the second which is paid to the FFA for administrative and supportive services.

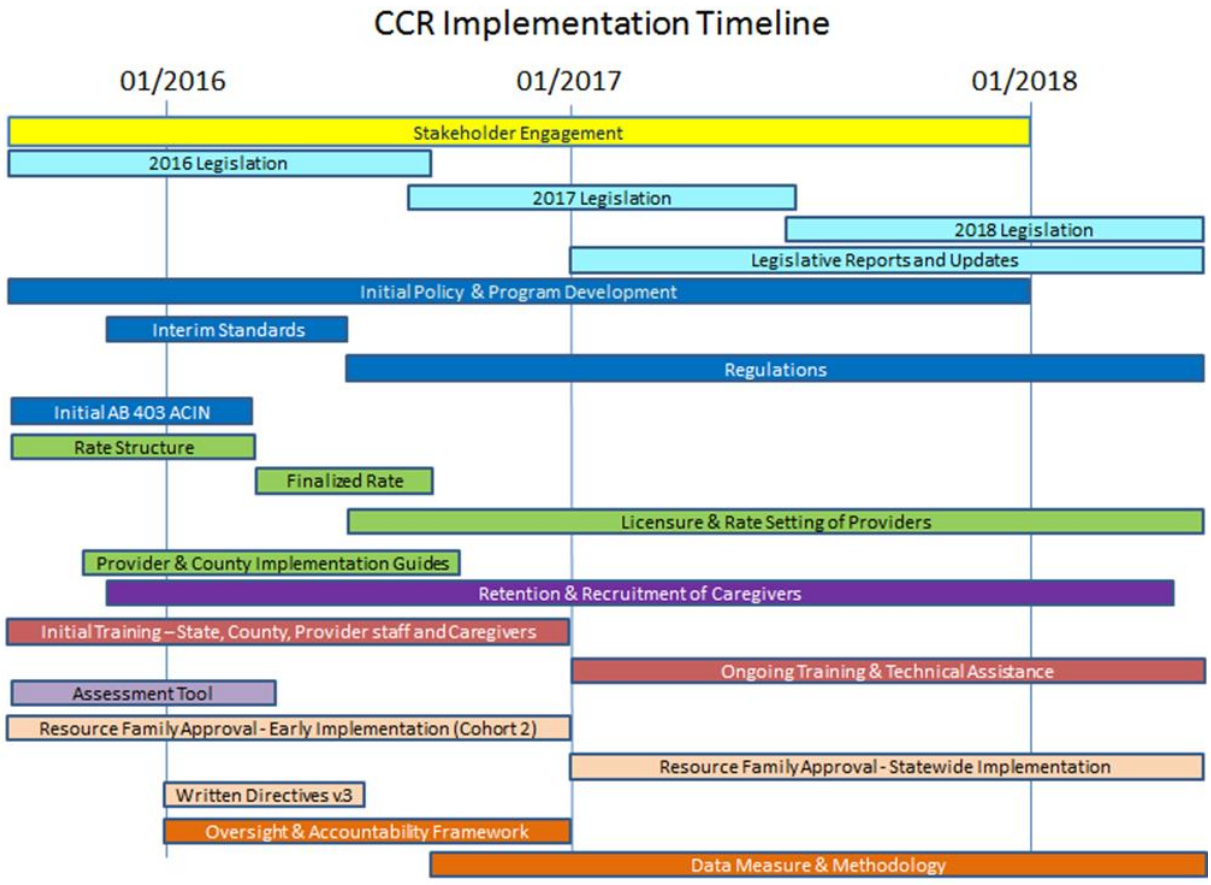
CCR also allows counties to pay FFAs to provide services to children who are not placed in FFAs, allowing children in relative and county-approved homes to access supportive services if the county chooses to provide funding. The rates paid to FFAs to provide these services are called the FFA services only rates.

Implementation Update.

Several components of CCR were implemented on July 1, 2015, including the foster family agency social worker rate increase and foster parent recruitment, retention, and support activities for resource families and foster parents. Accreditation of STRTPs and FFAs, and the RFA process in thirteen counties, began on July 1, 2016.

Other implementation activities of the CCR have been split into Phase I and Phase II. Phase I began to implement January 1, 2017, and includes the basic level of the rate paid to families and the series and supports components of the FFA payment, the utilization of CFTs, and the remainder of counties beginning to use the RFA process. Phase II is slated to implement on July 1, 2017, and includes all LOCs of the HBFC rate structure.

However, implementation is an ongoing, evolving effort that will take at least several years to fully and successfully roll out all components. The department has provided the following timeline of implementation activities:



The department, in accordance with supplementary reporting language included in the 2016 Budget Act, has been providing Legislative staff with monthly, and now quarterly updates, on the progress of CCR implementation. Below are the latest updates on the various CCR components:

- The CFT Process. CFT tracking will add documentation functionality in the Child Welfare Services/Case Management System by Spring/Summer 2017. The functionality will allow social workers and probation officers to enter the name of the lead agency, CFT meeting frequency, team membership, key roles, and other pertinent information. These fields become mandatory when the CFT has been selected as a service type. The additional CCR funded CFTs began January 1, 2017. DSS is also working with CFT specialists to develop a state approved CFT curriculum, has developed brochures on the CFT process to inform youth, parents, and professionals, and has partnered with the Resource Center for Family-Focused Practice at UC Davis to conduct statewide trainings for social workers, probation officers, behavioral health staff, and educators.

- Assessment Tool Pilot. The department is piloting two different assessment tools: TOP and CANS. TOP is being piloted in Los Angeles, Tuolomne, San Diego, Fresno, and San Joaquin. CANS is being piloted in San Francisco, Shasta, and Humboldt. A four-month evaluation of these pilots is scheduled to begin in March and will be completed by June. The department has built in costs in the budget for whichever assessment tool is ultimately chosen.

- LOC Protocol. The Foster Care Audits and Rates Bureau is continuing to work with stakeholders in developing a LOC protocol tool which is designed to assist rate determinations and placement decisions, and to be paired with the assessment tool.

- RFA. The RFA program was enacted into law as a pilot program and was reauthorized as an early implementation program with statewide implementation in 2012. In 2015, RFA was expanded and mandated for all counties as part of CCR implementation effective January 1, 2017.

  Families who have gone through the RFA process in the early implementing counties were invited to participate in a satisfaction survey. Generally, respondents were satisfied with the RFA process, but many identified the length of the process as an issue. Through conversations with counties and case file reviews by DSS, the department has determined that many factors affect the timeframes to approve resource families, and have begun the process of ameliorating these along with counties to provide technical assistance to reduce delays.

- Foster Parent Recruitment Retention and Support (FPPRS). From January 1, 2016 to June 30, 2106, the department notes that 2,295 new non-relative foster caregivers were contacted and engaged; 7,195 potential relative/non-relative extended family members were identified by counties; approximately 3,177 children were affected by FPPRS activities and assisted in placing children in less-restrictive settings, and/or stepping down children from group homes to family-like placements; and approximately 1,487 children were assisted in achieving permanency by FPPRS activities. Below is a chart showing the top ten uses for FPPRs funds for counties in 2015-16.

ALL (CW/PROB)	CHILD WELFARE	PROBATION
1. Caregiver Support	1. Caregiver Support	1. Caregiver Support
2. Caregiver Training	2. Recruitment Outreach	2. Caregiver Training
3. Placement Support Staff	3. Caregiver Training	3. Recruitment & Outreach
4. Recruitment & Outreach	4. Initial Placement Support	4. Wraparound
5. Initial Placement Support	5. Placement Support Staff	5. Initial Placement Support
6. Family Finding Support & Staff	6. Concrete Support	6. Concrete Support
7. Family Finding & Other Databases	7. Marketing	7. Family Finding Support & Staff
8. Concrete Support	8. Family Finding & Other Databases	8. Staff Training
9. Marketing	9. Normalizing Activities	9. Normalizing Activities
10. Normalizing Activities	10. Respite care	10. Family Finding & Other Databases

- Mental Health. DSS and DHCS have committed to work together to develop a "road map" for accessing Specialty Mental Health Services (SMHS) through county Mental Health Plans, and non-specialty services through Managed Care Plans or the Fee-For-Service system. DSS and DHCS are also working together to produce reports on SMHS utilization on a quarterly basis, which includes status updates on the capacity of all involved providers to provide mental health services. The Subcommittee has requested that the departments provide a high level narrative of the roles of DSS and DHCS in the CCR processes related to mental health, and a timeline of what goals and benchmarks both departments are considering as important to the success of CCR as implementation continues.

Automation. Various changes to the Child Welfare Services/Case Management System (CWS/CMS) and licensing systems are required to implement CCR, including what is necessary for the automation of foster care payments. These changes will be discussed in more detail in the Subcommittee No.3 hearing on April 20, 2017. Below is a chart reflecting these changes.

System	Current Status	Next Step	Next Step Due Date	Completion
CWS/CMS	Business requirements are being developed for an expedited release April 1 which will add the four levels of home based family care rates into the system as well as information for general documentation of CFTs	Concurrently working on the sizing for a July 2017 released	April 1, 2017	
LIS/FAS	Working on items that were not priority for Jan 1, 2017	Preparing for the addition of the Temporary Care Shelter Facility; cleaning up minor issues	April 1, 2017	
FFA web app	In production. Made four additional changes requested for the Web app. A warning page was added to alert people to be make the correct choice between resource family home and county licensed home.	Cleaning up minor issues;		
SAWS	Phase 1 has been completed and implemented in all three of the SAWS	Workgroups are ongoing to finalize the policy for Phase 2 automation and implementation. All SAWS are working to program the system changes	December 2017	
LAARS	County and other user testing of the updated database is occurring and will continue through late February.	An ACIN is in development regarding the new policies for uploading RFA Notice of Actions	April 1, 2017	
Administrator Certification System	New program type was added to demographics. 95% done with the coding	Currently testing	March 15, 2017	

Advocate Concerns. Some stakeholders have raised concerns that the interim rates for FFAs as proposed to be implemented in Phase II are inadequate to provide the core services required by AB 403, and that there is an overall lack of funding to support the permanency goals of the CCR.

Panel. The Subcommittee has requested the following panelists, in addition to the Department of Social Services, the Department of Health Care Services, the Department of Finance, and the Legislative Analyst's Office, to provide comment on the implementation of the CCR and discuss concerns raised by advocates:

- Cathy Senderling, County Welfare Directors Association of California
- Kirsten Barlow, County Behavioral Health Directors Association of California
- Susanna Kniffen, Children Now
- Carol Schroeder, California Alliance of Child and Family Services

Staff Comment and Recommendation. Hold open. Given the split of implementation of the rates into Phase I and Phase II and how early we are in implementation of other components of the reforms, it is still too soon to have a full picture of just how CCR is implementing and whether it is achieving its goals. Despite the delay, it would seem that the department is taking its time to ensure that current implementation is going smoothly in the meantime, and quarterly briefings to the legislative staff are helpful. However, concerns that stakeholders raise may be valid, and may require more time to evaluate. The Legislature should continue to monitor and oversee CCR as it implements more fully. In particular, access to mental health services is critical to the success of the CCR, and DSS and DHCS should continue to work closely together in order to provide the smoothest transition for foster youth and deliver on the promises of CCR.

Questions.

1. Please provide a brief overview of CCR and an update on current implementation.

2. Please discuss the delay in full implementation of the rate structure and why implementation has been split into two phases.

3. How are implementation activities affecting caseload and budgeting assumptions moving forward?

4. Please provide an update on the development of the Level-of-Care tool, and walk through how it will work with the rate structure. When can the Legislature expect to see a final tool?

5. How will the department take into consideration stakeholder concerns about rates? Will there be a more formal conversation on permanent rates if there is enough concern about interim rates once implemented, and how will the Legislature and stakeholders be included?

6. When do you anticipate having more information on CCR related costs and savings, as outlined in SRL?

7. Please provide an update on how mental health is integrating with CWS under CCR. How is DHCS tracking whether mental health services are being provided to all children who need these services?

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

SUBCOMMITTEE NO. 3 Agenda

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

Thursday, March 30, 2017
9:30 a.m., or Upon Adjournment of Floor Session
State Capitol, Room 4203
PART A

OUTCOMES

Consultant: Theresa Pena

Item	Department	Action
5175	**Department of Child Support Services**	
Issue 1	Overview	Informational
Issue 2	TBL – Extend Suspension of Improved Performance Incentives	Hold Open
Issue 3	TBL – Repeal Health Insurance Incentives Program	Hold Open
5180	**Department of Social Services – Child Welfare Services**	
Issue 1	Overview	Hold Open
Issue 2	Budget Change Proposal: Full-year Costs for CWS Near-Fatality Case Reviews	Hold Open
Issue 3	TBL – ARC	Hold Open
Issue 4	Proposals for Investment	Hold Open
5180	**Department of Social Services – Child Welfare Services**	
4260	**Department of Health Care Services**	
Issue 1	Oversight: Continuum of Care Reform Implementation	Hold Open

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

SUBCOMMITTEE NO. 3 Agenda

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

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

PART B

Consultant: Scott Ogus

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.

4260 DEPARTMENT OF HEALTH CARE SERVICES
5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: Pathways to Well-Being: Implementation of *Katie A. vs. Bonta* Requirements

Implementation Update. *Katie A. vs. Diana Bonta* was a class action lawsuit filed on behalf of a number of foster children in California asserting the Medi-Cal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program requires the provision of "wraparound" and "therapeutic foster care" mental health services to children in foster care or at risk of foster care placement. On July 15, 2011, the parties agreed to a settlement which outlined a series of actions to transform the way children and youth who are in foster care, or who are at risk of foster care placement, receive access to mental health services.

Under the Settlement Agreement, beneficiaries meeting medical necessity criteria may receive existing services in a more intensive and effective manner. These services are referred to as Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), and Therapeutic Foster Care (TFC). These three services are to be delivered consistent with a Core Practice Model (CPM) that creates a coherent and all-inclusive approach to service planning and delivery. The Settlement Agreement also specified that children and youth who meet *Katie A.* subclass criteria are eligible to receive ICC, IHBS, and TFC. County Mental Health Plans (MHPs) are obligated to provide ICC and IHBS through the EPSDT benefit to all children and youth under the age of 21 who are eligible for full scope Medi-Cal benefits and who meet medical necessity criteria for these services. MHPs provide ICC and IHBS and claim federal reimbursement through the Short-Doyle/Medi-Cal (SDMC) claiming system.

Intensive Care Coordination. Intensive Care Coordination (ICC) is a targeted case management service that facilitates assessment of, care planning for and coordination of services, including urgent services for members of the *Katie A.* subclass. ICC services are provided within the Child and Family Team (CFT) and in accordance with the Core Practice Model (CPM). ICC service components include: assessment, service planning and implementation, monitoring and adapting, and transition. ICC services are provided to all members of the *Katie A.* subclass.

The CFT is comprised of the child and family and all ancillary individuals who work together to develop and implement the client plan and are responsible for supporting the child and family in attaining their goals. There must be an ICC coordinator who:

- Ensures that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized and culturally and linguistically competent manner, and that services and supports are guided by the needs of the child.
- Facilitates a collaborative relationship among the child, family and involved child-serving systems.
- Supports the parent or caregiver in meeting their child's needs.
- Helps establish the CFT and provides ongoing support.
- Organizes and matches care across providers and child-serving systems to allow the child to be served in the community.

Intensive Home-Based Services. Intensive Home Based Services (IHBS) are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child's functioning, and help the child and the child's family build skills necessary for successful functioning in the home and community. IHBS services are provided within the Child and Family Team (CFT) and in accordance with the Core Practice Model (CPM). Service activities may include assessment, plan development, therapy, rehabilitation and collateral services. IHBS is provided to members of the *Katie A.* subclass as determined medically necessary.

ICC and IHBS Implementation. County mental health plans began billing for ICC and IHBS services for dates of service starting January 1, 2013. To implement billing and collection of data on services provided to the *Katie A.* subclass, DHCS implemented changes to the SDMC claiming system. These changes included submission of ICC and IHBS claims with a Demonstration Project Identifier code of "KTA" and procedure codes for ICC (T1017, HK) and IHBS (T2015, HK).

According to the department's latest 12-month rolling report of *Katie A.* subclass SMHS services:

- The number of subclass members is 16,249 (statewide).
- Total approved amount to date is $139,450,030 (statewide).
- The total amount of ICC minutes provided to subclass members to date is 17,875,164 (statewide).
- The total amount of IHBS minutes provided to subclass members to date is 19,891,355 (statewide).
- The number of subclass members that have received ICC to date is 11,431 (statewide).
- The number of subclass members that have received IHBS to date is 8,386 (statewide).
- The total number of counties with approved claims for ICC and/or IHBS is 51.
- The total number of counties using the KTA Demonstration Project Identifier is 50.
- Not all counties have implemented the KTA identifier, which may have resulted in under-reporting of claims and members for the subclass.

Therapeutic Foster Care Implementation. The Therapeutic Foster Care (TFC) service model is a short-term, intensive, highly coordinated, trauma-informed, and individualized rehabilitative service covered under Medi-Cal. TFC is provided to children up to age 21 with complex emotional and behavioral needs who are placed with trained and intensely supervised and supported TFC parents. The TFC parents serve as key participants in the therapeutic treatment process of the child. TFC services assist the child in achieving client plan goals and objectives, improve functioning and well-being, and help the child to remain in community settings.

The TFC service model is intended for children and youth who require intensive and frequent mental health support in a one-on-one environment. The TFC service model allows for the provision of certain Medi-Cal Specialty Mental Health Services (SMHS) components available under the ESPDT benefit as a home-based alternative to high-level care in institutional settings such as group homes and, in the future, as an alternative to Short Term Residential Therapeutic Programs (STRTPs). TFC homes may also serve as a step down from STRTPs. The TFC service model is one service option in the continuum of care for eligible children.

According to DHCS, the TFC services model had a target implementation date of January 1, 2017. However, no TFC services are being provided as DHCS, the Department of Social Services (DSS), and

state and county stakeholders are still developing the details of the TFC service model and its modes of delivery. The department reports that specialty mental health providers are receiving information regarding TFC in recently developed training materials.

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

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

1. Please provide a brief overview of DHCS and county mental health program actions completed to date implementing the provisions of the *Katie A.* Settlement Agreement.

2. Please describe how TFC providers are recruited and trained, and how this benefit is delivered.

3. How long will children be placed with TFC providers? Under what circumstances would a child be considered for a longer-term compared to a shorter-term placement with a TFC provider?

Issue 2: Oversight: Foster Youth and Psychotropic Medications

Background. Studies have shown that age, gender, and placement type impacts the prevalence of psychotropic drug use.[1] Pertaining to placement type, studies find that children in the most restrictive placement setting are the most likely to receive psychotropic medications or multiple medications. In group or residential homes, nearly half of the young people are taking at least one psychotropic drug.

Related Legislation. The Legislature has been following this issue for close to a decade. The Senate has held a series of hearings and passed various bills to ameliorate the issue:

SB 238 (Mitchell), Chapter 534, Statutes of 2015, requires data sharing agreements between DHCS and DSS, as well as between the state and county placing agencies to provide information about children and foster youth taking psychotropic medications. It requires DSS, in consultation with DHCS and stakeholders, to develop and distribute a monthly report to each county placing agency. Additionally, SB 238 requires a system to alert social workers about situations that may warrant additional follow-up. SB 238 requires robust data sharing agreements between DHCS and DSS and county placing agencies in a three-way arrangement known as the Global Interagency Agreement (GIA). Under the GIA, DHCS provides DSS with both medical and pharmacy claims level detail. DSS matches this claims data with their foster care-specific data. The combined, matched data is then provided to each county's foster care placing agency. According to the latest report from DSS, 21 of the 58 counties had data sharing agreements, and two others had separate data use agreements.

SB 484 (Beall), Chapter 540, Statutes of 2015, mandates additional review and increased standards of psychotropic medication usage in group homes, and creates new data collection and notification requirements for the Community Care Licensing Division (CCLD) within DSS in order to identify and mitigate inappropriate levels of psychotropic medication use by children in foster care residing in group homes.

SB 319 (Beall), Chapter 535, Statutes of 2015, authorizes a foster care public health nurse to monitor and oversee a child's use of psychotropic medications, and authorizes the release of health information. It also requires a foster care public health nurse to assist a non-minor dependent to make informed decisions about health care.

SB 1291 (Beall), Chapter 844, Statutes of 2016, requires annual mental health plan reviews to be conducted by an external quality review organization (EQRO) and, commencing July 1, 2018, requires those reviews to include specific data for Medi-Cal eligible minor and non-minor dependents in foster care, including the number served each year. The bill requires DHCS to share data with county boards of supervisors, including data that will assist in the development of mental health service plans and performance outcome system data and metrics. The bill also requires any corrective action plan to be posted on the county's website.

[1] Raghavan, R; Zima, BT; Anderson, RM; Leibowitz, AA; Schuster, MA; & Landsverk, J. (2005). Psychotropic medication use in a national probability sample of children in the child welfare system. Journal of child and adolescent psychopharmacology. 15(1):97.

SB 1174 (McGuire) Chapter 840, Statutes of 2016, requires DHCS and DSS, under a specified data-sharing agreement, to provide the Medical Board of California with information regarding Medi-Cal physicians and their prescribing patterns of psychotropic medications and related services for specified children and minors placed in foster care using data provided by the two departments.

The 2016 Budget Act included $1.7 million General Fund (with an assumed federal match of $5 million) to fund the hiring of additional public health nurses to improve the monitoring of psychotropic drug use in foster care. The 2016 Budget Act also included:

1. DHCS: One full-time permanent research position and expenditure authority of $134,000 ($67,000 General Fund and $67,000 federal funds) in 2016-17, and $125,000 ($63,000 General Fund and $63,000 federal funds) annually thereafter, to implement the requirements of SB 238.
2. DSS: Expenditure authority of $149,000 ($100,000 General Fund) in contract funding to develop monthly, county-specific reports for children in foster care who are prescribed psychotropic medications through Medi-Cal.
3. DSS: Two-year, limited-term expenditure authority of $833,000 ($684,000 General Fund) to support approximately five positions (three Licensing Program Analysts, 0.5 Licensing Program Manager I, 0.5 Office Assistant, and one Associate Governmental Program Analyst), both to implement the requirements of SB 238 and SB 484.

Audit. The Senate held a hearing in the fall of 2016 in response to a requested audit. Overall, the Bureau of State Audits found that about one in eight foster youth in California is prescribed psychotropic medication, or nearly 9,500 of the 79,000 foster youth in the study. In reviews of 80 individual case files in four counties, the auditor found nearly one-third of children prescribed psychotropic medications did not receive recommended follow-up visits and a significant number did not appear to have received appropriate mental health services. Nearly a quarter of the children whose files were reviewed were authorized to take medication in dosages that exceeded the state's recommended maximum and one in three did not have evidence of required court authorization for the medications. The auditor also criticized the state's fragmented oversight system and identified a lack of communication among departments, specifically between county social services and mental health departments, as a significant gap in the system. However, the auditor acknowledged that various recent efforts are in early stages of implementation to improve oversight of the use of psychotropic medications by foster youth.

Update on State Agencies Data Sharing Agreements. DHCS currently has an interagency agreement (IA) with DSS, effective April 2015, to share information regarding the oversight and monitoring of psychotropic medication prescribing within the child foster care population. In an effort to address foster youth psychotropic medication prescribing from the provider perspective, the Medical Board of California (MBC) also entered into a data use agreement (DUA) with DHCS in April 2015.

Update on State and County Data Sharing Agreements. Additionally, DHCS has encouraged and signed DUAs with individual counties who want to monitor psychotropic medication use in their specific foster care population. In addition to these currently established DUAs, SB 238 requires more robust data sharing agreements between DHCS and DSS and county placing agencies in a three-way arrangement known as the Global Interagency Agreement (GIA). Under the GIA, DHCS will provide DSS with both medical and pharmacy claims level detail, which DSS will match with their foster care specific data. This combined, matched data will then be provided to each county's foster care placing

agency. Over time, the parameters of the data sharing under the GIA are expected to change as counties develop ways to analyze the data, which will necessitate changes in how the data is pulled and compiled by both DHCS and DSS.

SB 238 creates a mandate for DHCS and DSS to ensure foster care data is shared with all 58 county placing agencies. According to DHCS, this mandate eliminates the existing, voluntary nature of the DUAs and will result in increased research and data programming to ensure all 58 counties are represented and receiving the required foster care data. See below for information on which counties have DUAs and GIAs.

Individual County DUAs	**Global DUAs (GIA)**
Los Angeles	Alameda
Riverside	Butte
	Contra Costa
	El Dorado
	Humboldt
	Kern
	Lake
	Madera
	Mendocino
	Placer
	Sacramento
	San Diego
	San Francisco
	San Luis Obispo
	San Mateo
	Santa Clara
	Shasta
	Sonoma
	Ventura
	Yolo
	Yuba

SB 484 mandates additional review and increased standards regarding psychotropic medication usage in group homes, and creates new data collection and notification requirements for the Community Care Licensing Division (CCLD) within DSS in order to identify and mitigate inappropriate levels of psychotropic medication use by children in foster care residing in group homes.

Quality Improvement Project: Improving the Use of Psychotropic Medication among Children and Youth in Foster Care. DHCS and DSS have convened a statewide quality improvement project to design, pilot, and evaluate effective practices to improve psychotropic medication use among children and youth in foster care. In order to meet the goals of the quality improvement project, three workgroups have been created. These include the Clinical Workgroup, the Data and Technology Workgroup, and the Youth, Family, and Education Workgroup.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. DHCS and DSS: Please provide an update on the implementation of the enacted legislation listed in this agenda.

2. DHCS and DSS: Why don't all counties have DUAs or GIAs? How are DHCS and DSS working with counties to get these established?

3. DHCS and DSS: Do parents and social workers get a notice of action when there is a denial of services for a foster youth?

4. DHCS and DSS: Please provide an update on the "Quality Improvement Project: Improving the Use of Psychotropic Medication among Children and Youth in Foster Care."

5. DHCS and DSS: How are the two departments monitoring the usage of psychotropic drugs among foster care children?

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Out-of-County Foster Care Presumptive Transfer Regulations Delay

Trailer Bill Language Proposal. DHCS proposes trailer bill language to extend its deadline to adopt out-of-county foster care presumptive transfer regulations from July 1, 2019, to July 1, 2020.

Background. AB 1299 (Ridley-Thomas), Chapter 603, Statutes of 2016, requires DHCS to develop regulatory procedures for transferring the financial responsibility and provision of Medi-Cal Specialty Mental Health Services (SMHS) when a foster child is placed outside of their county of original jurisdiction. These regulatory procedures are described as "presumptive transfer." DHCS has worked in consultation with stakeholders including the California Department of Social Services, County Behavioral Health Directors Association of California, Child Welfare Directors Association of California, Chief Probation Officers of California, County Mental Health Plans, and the California Child Welfare Council, to develop the required procedures to allow foster children in host counties to receive medically necessary and timely SMHS. Specifically, AB 1299 requires DHCS to do the following:

1. By July 1, 2017, issue policy guidance concerning the conditions for, and exceptions to presumptive transfer. The policy guidance must ensure that:
    a. The transfer improves access to SMHS consistent with the child's mental health needs.
    b. The transfer does not disrupt continuity of care.
    c. Conditions and exceptions are applied consistently statewide with consideration of varying capabilities of small, medium, and large counties.
    d. Waivers are only granted with an individualized determination that an exception applies.
    e. Parties who disagree with an exception determination may seek judicial review.
    f. There is a procedure for expedited transfer within 48 hours of out-of-county placement.
2. By July 1, 2019, adopt regulations to implement the required transfer procedures. Until regulations are adopted, DHCS may implement and administer the new procedures through all county letters or information notices.

Implementation Timeline. According to DHCS, it has been engaging stakeholders in the development process for the new presumptive transfer procedures for several months. The department expects to have a draft of its guidance implementing the new procedures by April. After review by stakeholders, DHCS plans to issue the final guidance by the July 1, 2017, deadline contained in the statute.

AB 1299 Fiscal Estimate for Regulatory Development. According to the Senate Appropriations Committee analysis of AB 1299, the department would incur ongoing administrative costs of about $300,000 ($150,000 General Fund and $150,000 federal funds) annually to develop policies, adopt regulations, monitor disputes between counties, and monitor the provision of services under the bill. DHCS has not provided an update of expected state operations costs to implement the regulations.

DHCS proposes trailer bill language to extend its deadline to adopt the presumptive transfer regulations required by AB 1299 from July 1, 2019, to July 1, 2020; a delay of one year. AB 1299 authorizes DHCS to implement and administer its presumptive transfer procedures through all county letters or other guidance until the adoption of regulations. As noted above, the final guidance implementing the presumptive transfer procedures is expected to be released by July 1, 2017. Therefore, a delay in

promulgation of final regulations should not delay implementation of the presumptive transfer procedures at the county level.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. What resources would DHCS need to complete the regulations by the current deadline of July 1, 2019?

Issue 2: Assisted Outpatient Treatment Evaluation Report (Laura's Law) Delay

Trailer Bill Language Proposal. DHCS proposes trailer bill language to allow for a one year delay of its annual reporting requirements under the Assisted Outpatient Treatment (AOT) Program, also known as Laura's Law. The proposal would delay the report due July 1, 2017, until July 1, 2018.

Background. AB 1421 (Thomson), Chapter 1017, Statutes of 2002, established the Assisted Outpatient Treatment Demonstration Project Act of 2002, known as Laura's Law. Laura's Law was named after Laura Wilcox, a 19 year old Nevada County college student killed by an individual with severe mental illness who was not complying with prescribed mental health treatment. The law established an option for counties to utilize the courts, probation, and the mental health system to address the needs of individuals unable to participate on their own in mental health treatment programs. The former Department of Mental Health (now absorbed into DHCS) issued guidance to counties in 2003 specifying the submission requirements for implementation of an AOT program. For many years, Nevada County was the only county that implemented an AOT, known as the Turning Point Providence Center, as Laura's Law did not require counties to implement an AOT program and did not appropriate any additional implementation funding.

SB 585 (Steinberg), Chapter 288, Statutes of 2013, authorized counties to utilize Mental Health Services Act (MHSA) funding from Proposition 63 (2004) revenues to support implementation and operation of AOT programs. According to DHCS, since the passage of SB 585, the following counties have implemented or are planning to implement new AOT programs: Contra Costa, Los Angeles, Mendocino, Orange, Placer, San Diego, San Francisco, and Yolo.

The department reports one of its analysts is partially allocated to preparing the annual evaluation report required by Laura's Law. Because only one county had established an AOT program, these staff resources were sufficient to manage the collection and evaluation of data, and the preparation of the report. According to DHCS, the addition of eight new county AOT programs will add significantly to the workload required to prepare the annual evaluation report and it is unable to absorb this workload. Therefore, DHCS is proposing to delay the preparation of the report by one year, until July 1, 2018.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. What additional staff resources are needed for the increased workload related to including the eight new AOT programs in the annual report?

Issue 3: Community Mental Health - Overview

Background. California has a decentralized public mental health system with most direct services provided through the county mental health system. Counties (i.e., county mental health plans) have the primary funding and programmatic responsibility for the majority of local mental health programs. See table below for a summary of county community mental health funding.

Community Mental Health Funding Summary			
Fund Source	**2015-16**	**2016-17**	**2017-18**
	Total	**Total**	**Total**
1991 Realignment			
Mental Health Subaccount (base and growth)*	$128,837,000	$157,643,000	$200,561,000
2011 Realignment			
Mental Subaccount Health Account (base and growth)*	$1,127,247,000	$1,127,864,000	$1,129,876,000
Behavioral Health Subaccount (base)**	$1,168,395,000	$1,235,358,000	$1,308,486,000
Behavioral Health Growth Account	$66,964,000	$73,127,000	$93,254,000
Realignment Total	**$ 2,491,443,000**	**$2,593,992,000**	**$ 2,732,177,000**
Medi-Cal Specialty Mental Health Federal Funds	**$2,279,073,000**	**$2,450,457,000**	**$2,700,176,000**
Medi-Cal Specialty Mental Health General Fund	**$ 151,199,000**	**$136,520,000**	**$187,983,000**
Mental Health Services Act Local Expenditures	**$1,418,778,000**	**$1,340,000,000**	**$1,340,000,000**
Total Funds	**$ 6,340,493,000**	**$6,520,969,000**	**$6,960,336,000**

*2011 Realignment changed the distribution of 1991 Realignment funds in that the funds that would have been deposited into the 1991 Realignment Mental Health Subaccount, a maximum of $1.12 billion, are now deposited into the 1991 Realignment CalWORKs MOE Subaccount. Consequently, 2011 Realignment deposits $1.12 billion into the 2011 Realignment Mental Health Account.

**Reflects $5.1 million allocation to Women and Children's Residential Treatment Services. Includes Drug Medi-Cal.

Medi-Cal Mental Health. There are three systems that provide mental health services to Medi-Cal beneficiaries:

1. **County Mental Health Plans (MHPs) -** California provides Medi-Cal specialty mental health services (SMHS) under a waiver that includes outpatient SMHS, such as clinic outpatient providers, psychiatrists, psychologists and some nursing services, as well as psychiatric inpatient hospital services. Children's SMHS is provided under the federal requirements of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for persons under age 21. County mental health plans are the responsible entity that ensures SMHS is provided. Medi-Cal enrollees must obtain SMHS through the county. SMHS is a Medi-Cal entitlement for adults and children

that meet medical necessity criteria, which consist of having a specific covered diagnosis, functional impairment, and meeting intervention criteria.

2. **Managed care plans –** SBX1 1 (Hernandez), Chapter 4, Statutes of 2013, expanded the scope of Medi-Cal mental health benefits and required these services to be provided by Medi-Cal managed care plans excluding those benefits provided by county mental health plans under the SMHS waiver. Generally these are mental health services to those with mild to moderate levels of impairment. The mental health services provided by managed care plans include:
    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
    - Outpatient services for the purposes of monitoring drug therapy
    - Outpatient laboratory, drugs, supplies and supplements
    - Psychiatric consultation

3. **Fee-For-Service Provider System -** Effective January 1, 2014 the mental health services listed below are also available through the fee-for-service provider system:
    - Individual and group mental health evaluation and treatment (psychotherapy)
    - Psychological testing when clinically indicated and medically necessary to evaluate a mental health condition
    - Outpatient services for the purposes of monitoring drug therapy
    - Outpatient laboratory, drugs, supplies and supplements
    - Psychiatric consultation

Mental Health Services Act (Proposition 63, Statutes of 2004). The Mental Health Services Act (MHSA) imposes a one percent income tax on personal income in excess of $1 million. These tax receipts are reconciled and deposited into the MHSA Fund on a "cash basis" (cash transfers) to reflect funds actually received in the fiscal year. The MHSA provides for a continuous appropriation of funds for local assistance.

The purpose of the MHSA is to expand mental health services to children, youth, adults, and older adults who have severe mental illnesses or severe mental health disorders and whose service needs are not being met through other funding sources (i.e., funds are to supplement and not supplant existing resources).

Most MHSA funding is to be expended by county mental health departments for mental health services consistent with their approved local plans (three-year plans with annual updates) and the required five components, as required by MHSA. The following is a brief description of the five components:

- **Community Services and Supports for Adult and Children's Systems of Care.** This component funds the existing adult and children's systems of care established by the Bronzan-McCorquodale Act (1991). County mental health departments are to establish, through a stakeholder process, a listing of programs for which these funds would be used. Of total annual revenues, 80 percent is allocated to this component.

- **Prevention and Early Intervention.** This component supports the design of programs to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for unserved and underserved populations. Of total annual revenues, 20 percent is allocated to this component.

- **Innovation.** The goal of this component is to develop and implement promising practices designed to increase access to services by underserved groups, increase the quality of services, improve outcomes, and promote interagency collaboration. This is funded from five percent of the Community Services and Supports funds and five percent of the Prevention and Early Intervention funds.

- **Workforce Education and Training.** This component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illness. In 2005-06, 2006-07, and 2007-08, 10 percent of total revenues were allocated to this component, for a total of $460.8 million. Counties have 10 years to spend these funds.

- **Capital Facilities and Technological Needs.** This component addresses the capital infrastructure needed to support implementation of the Community Services and Supports, and Prevention and Early Intervention programs. It includes funding to improve or replace existing technology systems and for capital projects to meet program infrastructure needs. In 2005-06, 2006-07, and 2007-08, 10 percent of total revenues were allocated to this component, for a total of $460.8 million. Counties have 10 years to spend these funds.

Counties are required to submit annual expenditure and revenue reports to DHCS and the Mental Health Services Oversight and Accountability Commission (MHSOAC). DHCS monitors county's use of MHSA funds to ensure that the county meets the MHSA and MHSA Fund requirements.

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

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

1. Please provide an overview of community mental health programs overseen by DHCS.

Issue 4: Specialty Mental Health Services – Performance Outcomes System

Budget Issue. The budget includes $10.2 million ($5.1 million General Fund and $5.1 million federal funds) in 2016-17 and $13.7 million ($6.8 million General Fund and $6.8 million federal funds) in 2017-18 for costs to reimburse mental health plans for the costs of capturing and reporting functional assessment data as part of the Performance Outcomes System (POS) for EPSDT mental health services.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$5,087,000	$6,818,500
0890 – Federal Trust Fund	$5,087,000	$6,818,500
Total Funding Request:	**$10,174,000**	**$13,637,000**

Background. SB 1009 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2012, required DHCS to convene stakeholders to develop a plan for a POS for EPSDT mental health services provided to Medi-Cal eligible children. The department was required to consider the following objectives: 1) enables provision of high quality and accessible EPSDT services for eligible children and youth; 2) collects information that improves practice at the individual, program, and system levels; 3) minimizes costs by building on existing resources; and 4) generates reliable data that are collected and analyzed in a timely fashion. AB 82 (Committee on Budget), Chapter 23, Statutes of 2013, implemented the following additional requirements for the department:

- Convene a stakeholder advisory committee to develop methods to routinely measure, assess, and communicate program information regarding informing, identifying, screening, assessing, referring, and linking Medi-Cal eligible beneficiaries to mental health services.
- The committee reviews health plan screenings for mental health illness, health plan referrals to Medi-Cal fee-for-service providers, and health plan referrals to county mental health plans. This information is to be included in the POS implemented by the department.
- Propose how to implement the updated POS plan no later than January 10, 2015.

The department's implementation plan for the POS includes the following elements:

1. Establish the POS methodology – The department is required to develop a clear methodology for specifying the purpose of the project, stakeholder and partner involvement, the target population, data availability, data limitations or strengths, reporting elements and timelines, and other relevant details necessary for implementation and development of the POS. The department has focused the methodology first on its reporting requirements from existing DHCS databases, with further development of data collection protocols expected in the future.

2. Report performance outcomes from existing DHCS databases – The department is required to utilize existing DHCS data systems to evaluate performance outcomes on a preliminary basis. The systems used are as follows:
   a. *Short Doyle/Medi-Cal (SD/MC) Claiming System* – Provides information from county mental health plans about who is receiving services, how often the services are received, and the amount claimed for federal reimbursement of services to Medi-Cal beneficiaries.

b. *Client and Services Information System* -- Collects data pertaining to mental health clients and the services they receive at the county level including information about non-Medi-Cal mental health services, Medi-Cal SMHS, client demographics, diagnoses, living arrangement, service strategy, race/ethnicity, employment, and education level.
c. *Web-Based Data Collection Reporting System - Consumer Perception Surveys* – Provides information about the client or family member's perception of satisfaction with regards to services including general satisfaction, access, quality or appropriateness of care, social connectedness, client functioning, criminal justice, and quality of life. Other data include perceived impacts to quality of life including general life satisfaction, living situation, daily activities and functioning, family and social relations, finances, legal and safety, and health.
d. *Data Collection and Reporting System* – Collects data pertaining to any client enrolled in an MHSA funded Full Service Partnership program. Data includes residential status, education, criminal justice, legal designations, co-occurring disorders, source of financial support, and emergency intervention.
e. *Management Information System/Decision Support System* – Provides data pertaining to claims and encounter data (mental health Medi-Cal, Drug Medi-Cal, managed care, pharmacy, fee-for-service Medi-Cal), Medi-Cal eligibility data, provider data, and other reference data such as National External Norms and Benchmarks.

Using existing data between 2011-12 and 2014-15, the department has produced several data reports including a statewide aggregate report and county-specific reports (for small, medium, large and rural counties). A county-level aggregate report is still in development. The reports include the following data elements: 1) unique counts of children and youth receiving SMHS; 2) penetration rates of services compared to eligible population; 3) utilization; 4) arrivals, continuance, and exiting of services; and 5) time to step down. Many of these elements are organized in the aggregate, as well as by race, age group, and gender.

3. Comprehensive Data Collection and Reporting – The department, in partnership with stakeholders and academic researchers, is developing a functional assessment tool to assess client clinical and functional status over time. This tool will be deployed at the county level to collect the data needed to assess outcomes in the POS. According to DHCS, the tool is expected to be approved within the next few weeks and provided to county stakeholders in Spring 2017. The department expects additional costs for purchasing the new tool and training 14,614 county clinical staff in its use.

4. Continuous Quality Improvement Using POS Reports – The department plans to utilize existing processes to develop a quality assurance and improvement process. This process is intended to ensure consistent, high-quality, and fiscally effective services are delivered to children and their families to improve school performance, the home environment, child safety, and involvement with the juvenile justice system.

5. Tracking Continuum of Care Screenings and Referrals – The department has required managed care plans to report data on mental health screenings and referrals to specialty mental health services since May 2014. According to DHCS, however, this data is not adequate to evaluate the linkages between managed care and the SMHS system, as required

by statute. The department is attempting to evaluate the data needed to appropriately track these linkages.

Resources Approved for Implementation. The 2015 Budget Act approved three permanent positions and annual expenditure authority of $350,000 ($175,000 General Fund and $175,000 federal funds) to implement the data collection, analysis and IT functions of the POS. Prior to these resources, existing staff were redirected from other divisions to manage the workload.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending updates at the May Revision.

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

1. Please provide an update on the development of the functional assessment tool. When will the tool be released?

2. How will county clinical staff be trained to use the new tool? What types of information will be collected and how will this assist with quality improvement?

3. What is the status of the department's quality improvement process? What conclusions has the department reached, if any, from the existing data reports on potential improvements in the delivery of SMHS or other services?

Issue 5: Drug Medi-Cal Estimate - Overview

Budget Issue. The budget includes $251.8 million ($6.1 million General Fund, $178.1 million federal funds, and $67.5 million county funds) in 2016-17 and $984.6 million ($147.3 million General Fund, $684.2 million federal funds, and $153.1 million county funds) in 2017-18 for Drug Medi-Cal.

2016-17 Drug Medi-Cal Program Funding Summary (dollars in thousands)

Service Description	2016-17				
	Total Funds	General Fund	Federal Funds	County Funds	Case-load
Narcotic Treatment Program	$183,293	$1,522	$130,461	$51,310	45,674
Outpatient Drug Free Treatment Services	$23,621	$150	$17,114	$6,357	32,097
Intensive Outpatient Treatment Services	$6,502	$1,350	$4,867	$285	3,696
Residential Treatment Services	$1,833	$7	$1,113	$713	410
Organized Delivery System Waiver	$23,669	$3,115	$16,749	$3,805	-
Drug Medi-Cal Cost Settlement	$3,429	$-	$3,036	$393	-
Annual Rate Adjustment	$-	$-	$-	$-	-
Drug Medi-Cal County Administration	$9,180	$-	$4,590	$4,590	-
County Utilization Review/Quality Assurance	$300	$-	$206	$94	-
TOTAL	**$251,827**	**$6,144**	**$178,136**	**$67,547**	**81,874**
Regular Total	$238,341	$6,129	$170,782	$61,430	80,469
Perinatal Total	$4,006	$15	$2,558	$1,433	1,405
Other Total	$9,480	$-	$4,796	$4,684	-

2017-18 Drug Medi-Cal Program Funding Summary (dollars in thousands)

Service Description	2017-18				
	Total Funds	General Fund	Federal Funds	County Funds	Case-load
Narcotic Treatment Program	$188,472	$3,917	$131,807	$52,748	46,487
Outpatient Drug Free Treatment Services	$23,731	$379	$16,998	$6,354	32,097
Intensive Outpatient Treatment Services	$6,568	$1,389	$4,893	$286	3,706
Residential Treatment Services	$1,730	$17	$1,040	$673	410
Organized Delivery System Waiver	$748,960	$141,606	$520,251	$87,103	-
Drug Medi-Cal Cost Settlement	$-	$-	$-	$-	-
Annual Rate Adjustment	$-	$-	$-	$-	-
Drug Medi-Cal County Administration	$6,502	$-	$3,251	$3,251	-
County Utilization Review/Quality Assurance	$8,656	$-	$5,951	$2,705	-
TOTAL	**$984,619**	**$147,308**	**$684,191**	**$153,120**	**82,700**
Regular Total	$955,495	$147,151	$666,615	$141,729	81,295
Perinatal Total	$13,966	$157	$8,374	$5,435	1,405
Other Total	$15,158	$-	$9,202	$5,956	-

Background. Established in 1980, the Drug Medi-Cal program provides medically necessary substance use disorder (SUD) treatment services to eligible Medi-Cal beneficiaries for specific, approved services.

Beginning in 2011, administration of the Drug Medi-Cal program was transferred from the Department of Alcohol and Drug Programs (DADP) to DHCS and the program was realigned to the counties as part of 2011 Realignment. Drug Medi-Cal had previously been funded with General Fund and federal funds. 2011 Realignment redirected funding for both Drug Medi-Cal and discretionary substance use disorder programs, including those supported by the Substance Abuse Prevention and Treatment block grant, to the counties. Counties provide the non-federal share of expenditures, which are matched with federal funds, for Drug Medi-Cal services as they existed in 2011 and for individuals eligible for Drug Medi-Cal under 2011 Medi-Cal eligibility rules in place before implementation of the optional Medi-Cal expansion under provisions of the federal Affordable Care Act (ACA). Because implementation of the expansion is considered optional and Proposition 30 requires state requirements imposed after September 2012 be funded by the state, DHCS is responsible for the non-federal share of expenditures for Drug Medi-Cal services provided to individuals in the expansion population.

Both DHCS and counties have specific oversight requirements for Drug Medi-Cal. DHCS is tasked with administrative and fiscal oversight, monitoring, auditing and utilization review. Counties can contract for Drug Medi-Cal services directly, or contract with DHCS, which then directly contracts with providers to deliver Drug Medi-Cal services. Counties that elect to contract with DHCS to provide services are required to maintain a system of fiscal disbursement and controls, monitor to ensure that billing is within established rates, and process claims for reimbursement. DHCS is also implementing a new Drug Medi-Cal Organized Delivery System Waiver, a pilot project to test organized delivery of an expanded benefit package for substance use disorder services. (See Issue 8: Drug Medi-Cal – Organized Delivery System Waiver)

Drug Medi-Cal is delivered through four base modalities:

- **Narcotic Treatment Program (NTP)** – An outpatient service that provides methadone maintenance services directed at stabilization and rehabilitation of persons with opioid dependency and substance use disorder diagnoses. This service includes daily medication dosing, a medical evaluation, treatment planning, and a minimum of fifty minutes per month of face-to-face counseling sessions.

  The budget includes $183.3 million ($1.5 million General Fund, $130.5 million federal funds, and $51.3 million county funds) in 2016-17 and $188.5 million ($3.9 million General Fund, $131.8 million federal funds, and $52.7 million county funds) in 2017-18 for NTP services. In 2016-17, NTP caseload is expected to be 45,674, an increase of 2,554 (5.9 percent) compared to the 2016 Budget Act. In 2017-18, NTP caseload is expected to be 46,487, an increase of 813 (1.8 percent) compared to the revised 2016-17 caseload estimate.

- **Outpatient Drug Free (ODF) Treatment Services** – Outpatient services are designed to stabilize and rehabilitate Medi-Cal beneficiaries with a substance abuse diagnosis in an outpatient setting. Participants receive at least two group, face-to-face counseling sessions per month. Additional counseling and rehabilitation services include admission physical

examinations, intake, medical necessity establishment, medication services, treatment and discharge planning, crisis intervention, collateral services, and individual and group counseling. The budget includes $23.6 million ($150,000 General Fund, $17.1 million federal funds, and $6.4 million county funds) in 2016-17 and $23.7 million ($379,000 General Fund, $17 million federal funds, and $6.4 million county funds) in 2017-18 for ODF services. In 2016-17, ODF caseload is expected to be 32,097, an increase of 1,415 (4.6 percent) compared to the 2016 Budget Act. In 2017-18, ODF caseload is expected to be 32,097, unchanged compared to the revised 2016-17 caseload estimate.

- **Intensive Outpatient Treatment (IOT) Services** –Outpatient counseling and rehabilitation services provided at least three hours per day, three days per week, including admission physical examinations, intake, treatment planning, individual and group counseling, parenting education, medication services, collateral services and crisis intervention.

  The budget includes $6.5 million ($1.4 million General Fund, $4.9 million federal funds, and $285,000 million county funds) in 2016-17 and $6.6 million ($1.4 million General Fund, $4.9 million federal funds, and $286,000 county funds) in 2017-18 for IOT services. In 2016-17, IOT caseload is expected to be 3,696, an increase of 264 (7.7 percent) compared to the 2016 Budget Act. In 2017-18, IOT caseload is expected to be 3,706, an increase of 13 (0.4 percent) compared to the revised 2016-17 caseload estimate.

- **Residential Treatment Services (RTS)** – Rehabilitation services to beneficiaries with a substance use disorder diagnosis in a non-institutional, non-medical residential setting. Beneficiaries live on the premises and are supported to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Services include mother/child habilitative and rehabilitative services, service access including transportation, education to reduce the harmful effects of alcohol and drugs on mother or fetus/infants, and coordination of ancillary services.

  The budget includes $1.8 million ($7,000 General Fund, $1.1 million federal funds, and $713,000 million county funds) in 2016-17 and $1.7 million ($17,000 General Fund, $1 million federal funds, and $673,000 county funds) in 2017-18 for RTS services. In 2016-17, RTS caseload is expected to be 410, an increase of 130 (46.4 percent) compared to the 2016 Budget Act. In 2017-18, RTS caseload is expected to be 410, unchanged compared to the revised 2016-17 caseload estimate.

Other Medi-Cal Substance Use Disorder benefits, that are not included in Drug Medi-Cal, include:

- **Medication-Assisted Treatment** – This service includes medications (e.g., buprenorphine and Vivitrol) that are intended for use in medication-assisted treatment of substance use disorders in outpatient settings. These medications are provided via Medi-Cal managed care or Medi-Cal fee-for-service, depending on the medication.

- **Medically Necessary Voluntary Inpatient Detoxification** – This service includes medically necessary, voluntary inpatient detoxification and is available to the general population. This service is provided via Medi-Cal fee-for-service.

- **Screening and Brief Intervention** – This service is available to the Medi-Cal adult population for alcohol misuse and, if threshold levels indicate, a brief intervention is covered. This service is provided in primary care settings via Medi-Cal managed care or Medi-Cal fee-for-service, depending on the delivery system in which the patient is enrolled.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending further updates in caseload and expenditures at May Revision.

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

1. Please provide a brief overview of the caseload and expenditure changes in the base Drug Medi-Cal estimate.

Issue 6: Drug Medi-Cal – Organized Delivery System Waiver

Budget Issue. The budget includes $23.7 million ($3.1 million General Fund, $16.7 million federal funds, and $3.8 million county funds) in 2016-17 and $749 million ($141.6 million General Fund, $520.3 million federal funds, and $87.1 million county funds) in 2017-18 for the implementation of the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver. The Waiver authorizes a pilot project to test organized delivery of an expanded benefit package for substance use disorder services.

2016-17 DMC-ODS Waiver Program Funding Summary (dollars in thousands)				
Service Description	**2016-17**			
	Total Funds	**General Fund**	**Federal Funds**	**County Funds**
Organized Delivery System Waiver	$23,669	$3,115	$16,749	$3,805
TOTAL	**$23,669**	**$3,115**	**$16,749**	**$3,805**
Regular Total	$23,396	$3,114	$16,583	$3,699
Perinatal Total	$273	$15	$166	$106

2017-18 DMC-ODS Waiver Program Funding Summary (dollars in thousands)				
Service Description	**2017-18**			
	Total Funds	**General Fund**	**Federal Funds**	**County Funds**
Organized Delivery System Waiver	$748,960	$141,606	$520,251	$87,103
TOTAL	**$748,960**	**$141,606**	**$520,251**	**$87,103**
Regular Total	$738,399	$141,483	$513,923	$82,993
Perinatal Total	$10,561	$123	$6,328	$4,110

Background. The Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver is a voluntary pilot program that offers California counties the opportunity to expand access to high-quality care for Medi-Cal enrollees with substance use disorders (SUD). The goal of the DMC-ODS Waiver is to demonstrate how organized SUD care improves beneficiary health outcomes, while decreasing system-wide health care costs. Counties that choose to participate in the DMC-ODS Waiver are required to provide access to a full continuum of SUD benefits modeled after criteria developed by the American Society of Addiction Medicine (ASAM). Counties are required to submit implementation plans and proposed interim rates for all county-covered SUD services, except NTP rates, which are set by DHCS.

To receive services through the DMC-ODS Waiver, beneficiaries must meet the following criteria:

1. The beneficiary must be enrolled in Medi-Cal
2. The beneficiary must reside in a county that is participating in the DMC-ODS Waiver
3. The beneficiary must have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with certain exceptions, or for youth under 21, be assessed as "at-risk" for developing a SUD
4. The beneficiary must meet the ASAM Criteria definition of medical necessity for services (or ASAM adolescent treatment criteria for youth under 21).

The standard Drug Medi-Cal program covers outpatient services, intensive outpatient services, limited perinatal residential services, and narcotic treatment program services. Optional participation in the DMC-ODS Waiver allows counties to cover an expanded array of SUD services for Medi-Cal beneficiaries. The benefits offered under the DMC-ODS Waiver are as follows:

1. Existing Drug Medi-Cal Services
   - Non-perinatal Residential Treatment Services
   - Withdrawal Management
     - ASAM Criteria Level 1.0 – Ambulatory, without extended on-site monitoring
     - ASAM Criteria Level 2.0 – Ambulatory, with extended on-site monitoring
     - ASAM Criteria Level 3.2 – Clinically managed residential withdrawal management
   - Recovery Services
   - Case Management
   - Physician Consultation
   - Expanded Medication Assisted Treatment (MAT) (buprenorphine, naloxone, and disulfiram)

2. Expanded Services Available in ODS Waiver
   - Additional MAT (non-NTP providers)
   - Partial Hospitalization
   - Withdrawal Management
     - ASAM Criteria Level 3.7 – Medically monitored inpatient
     - ASAM Criteria Level 4.0 – Medically managed intensive inpatient

According to DHCS, six counties are expected to begin providing services under the DMC-ODS Waiver in 2016-17: San Mateo, Santa Cruz, Riverside, Santa Clara, Marin, and San Francisco. An additional ten counties are expected to begin providing services in 2017-18. The department reports a total of 20 counties, representing approximately 73 percent of the state's population, are participating or planning to participate in the DMC-ODS Waiver. DHCS expects additional counties to opt in over the coming months.

Resources Approved for DMC-ODS Implementation. The 2016 Budget Act approved eight permanent positions and expenditure authority of $946,000 ($473,000 General Fund and $473,000 federal funds) over two years to support fiscal oversight and programmatic monitoring requirements of the DMC-ODS Waiver.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide an update on the implementation of the DMC-ODS Waiver.

2. How many counties have opted in to the waiver to date? Which ten counties are expected to provide services in 2017-18?

3. How have the counties that recently began offering services under the Waiver implemented the delivery of the services not previously available under Drug Medi-Cal?

4. Please describe the evaluation process for determining whether outcomes are improving under the DMC-ODS Waiver.

Issue 7: Substance Use Disorders Licensing Workload

Budget Issue. DHCS requests 20 permanent positions (conversion of six limited-term positions and 14 new positions) and expenditure authority of $2.5 million ($290,000 Narcotic Treatment Program Licensing Trust Fund, $1.7 million Residential and Outpatient Program Licensing Fund, and $531,000 reimbursements). If approved, these resources would support increased licensing, monitoring, and complaint investigation workload as a result of expansion of services under the federal Affordable Care Act and the Drug Medi-Cal Organized Delivery System Waiver.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0243 – Narcotic Treatment Program Licensing Trust Fund	$-	$290,000
3113 – Residential and Outpatient Program Licensing Fund	$-	$1,726,000
0995 – Reimbursements	$-	$531,000
0890 – Federal Trust Fund [non-add]	$-	[$1,046,000]
Total Funding Request:	**$-**	**$2,547,000**

Background. According to DHCS, there has been substantial growth in facilities seeking licensure and the department expects this growth will continue over the next several years. In particular, the department has seen increased licensing and monitoring workload related to facilities in counties participating in the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver.

Licensing Workload. DHCS is required to license and certify all California facilities that provide 24-hour residential and outpatient alcohol and other drug (AOD) treatment, detoxification, or recovery services to adults. The department processes initial and renewal applications for residential, outpatient, detoxification, adolescent waivers, incidental medical services; American Society of Addiction Medicine (ASAM) designations; and conducts site visits for each initial and renewal application. DHCS also monitors compliance with state, federal and local laws, regulations and statutes by conducting reviews every two years.

DHCS currently licenses or certifies 1,777 facilities, including 356 residential facilities, 560 residential/AOD facilities, and 861 AOD outpatient facilities.

Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver. The Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver is a voluntary pilot program that offers California counties the opportunity to expand access to high-quality care for Medi-Cal enrollees with substance use disorders (SUD). Counties that choose to participate in the DMC-ODS Waiver are required to provide licensed Narcotic Treatment Program (NTP) services, resulting in expected increases in new program applications, licensing and monitoring. Existing NTPs in opt-in counties are also required to order, prescribe, and administer three new medications: buprenorphine, disulfiram and naloxone, in addition to optionally utilizing vivitrol. This requirement will result in regulatory amendments, revised or amended protocols from all existing NTPs utilizing the new medications, staff training and subsequent development of tracking and monitoring tools as well as additional on-site inspection policies and procedures.

The federal Centers for Medicare and Medicaid Services requires all residential providers to meet ASAM requirements and obtain a DHCS issued ASAM designation as part of their participation in the DMC-ODS Waiver. DHCS is currently implementing the ASAM Designation process, which includes the provisional and final Level 3.1, 3.3 and 3.5 designation, collection of fees and fines, and provision of technical assistance to facilities.

DHCS reports an increase in licensing workload, ASAM designation, and monitoring as a result of these expansions and new requirements. According to DHCS, insufficient staff resources has led to a backlog of 265 initial applications for providers to obtain licensure or certification and 150 renewal applications for licensure or certification. Since 2015, due to the increasing licensing backlog, the department redirected five Associate Governmental Program Analysts (AGPAs) to manage the increased workload.

Complaints Investigation. DHCS is responsible for investigating complaints brought against licensed residential treatment programs, outpatient programs, unlicensed programs, and registered or certified counselors employed by one of these programs. Unusual incidents and client deaths are reported to the department from programs statewide. Investigations may result in one of three classes of deficiencies when a program fails to comply with any provisions of state and federal laws and regulations. Class A deficiencies represent an imminent danger to a resident of a facility, in which death or physical injury is a likely consequence. Class B deficiencies relate to the operation or maintenance of the facility which has a direct or immediate relationship to the physical health, mental health, or safety of facility residents. Class C deficiencies are those relating to the operation or maintenance of the facility which DHCS determines has only a minimal relationship to the health or safety of residents. DHCS is reporting an increase in complaints workload and a subsequent backlog resulting from the expansions of services under the DMC-ODS Waiver.

DHCS is requesting the following positions:

Licensing and Certification Section - 14 positions (Six permanent, eight from limited-term resources) to address the increased licensing application workload and to clear the current application backlog

- **Five permanent AGPAs** to respond to calls and e-mail inquiries from applicants, providers, and county program representatives related to program requirements, the licensure process, and status of applications; develop and complete provider trainings and outreach on program requirements, conduct county outreach, and provide trainings to programs regarding the standards and licensure requirements.
- **One permanent Office Technician** responsible for administrative support of the AGPA staff.
- **Five-Year Limited-Term Funding** equivalent to:
    1. One Staff Services Manager I to supervise staff engaged in the oversight, analysis, and evaluation of current policy and procedures to bring the program into compliance with state and federal laws and program integrity protections.
    2. One Health Program Specialist I to assist in promulgation of regulations, act as liaison regarding bill analyses and ongoing legislation, write and analyze bills, update the AOD Certification Standards, assist in the preparation of memos and other public correspondence, update processes, conduct studies of licensing statistics, and perform data analysis.
    3. Two AGPAs responsible for assisting in the elimination of the application backlog.

- **Two-Year Limited-Term Funding** equivalent to:
  1. Four AGPAs designated for workload related to Los Angeles County specific increases in licensing applications.

Narcotic Treatment Programs Section – Four permanent positions for NTP licensing workload.

- **One permanent Staff Services Manager I** to supervise NTP staff including planning, organizing and managing field operations, leading and assisting with review of initial applications, temporary suspension orders, license revocations, and directing investigations of complex and politically sensitive complaints and patient deaths.
- **Two permanent AGPAs** responsible for reviewing initial applications, conducting annual and follow-up inspections of NTPs for compliance with State and federal laws and regulations, reviewing exceptions, and conducting complaint investigations, death investigations, and special incident investigations.
- **One permanent Office Technician** responsible for administrative support of NTP licensing activities.

Complaints Section – Ten permanent positions to address the ongoing and increasing complaints workload, including the current backlog.

1. **Nine permanent AGPAs** (five converted from limited-term) to conduct investigations of complaints brought against licensed residential treatment facilities, certified outpatient programs, unlicensed residential treatment programs, unusual incidents and allegations of counselor misconduct at programs, as well as follow-up site visits to verify that deficiencies have been corrected.
2. **One permanent Staff Services Manager I** (converted from limited-term) to supervise and review the work of staff, lead and assist with service of temporary suspension orders and inspection warrants, license revocations and directing investigations of complex and politically sensitive complaints and patient deaths.

Residential and Outpatient Program Licensing Fund (ROPLF). Health and Safety Code Section 11833.02 requires DHCS to charge fees for licensure and certification of all residential AOD recovery or treatment facilities and for certification of outpatient AOD programs. The Residential Outpatient Program Licensing Fund (ROPLF) collects all fines, fees, and penalties assessed to licensed and certified AOD providers, which are deposited and made available upon appropriation by the Legislature for supporting the licensing and certification activities of residential and outpatient facilities.

DHCS is requesting expenditure authority from the Narcotic Treatment Program Licensing Fund, the ROPLF, and reimbursements to fund this request.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 8: SAPT Block Grant – HIV Early Intervention Services Set-Aside Elimination

Background. The Substance Abuse Prevention and Treatment (SAPT) Block Grant Program provides funds to states to plan, carry out, and evaluate activities to prevent and treat substance abuse. The program is administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) and represents the largest source of non-Medicaid federal funding to states for the prevention and treatment of substance use disorders. It constitutes a substantial amount of all states' budgets for substance abuse programming and serves an average of two million individuals each year nationwide. States have flexibility in determining how funds should be allocated to address local needs; however, to receive funding, states must meet specific set-aside and maintenance of effort (MOE) requirements and conduct activities designed to achieve 17 legislative goals of the program.

HIV Early Intervention Services Set-Aside. The SAPT Block Grant Program includes a set-aside program intended to allocate five percent of block grant funding for HIV early intervention services in states with a higher burden of HIV or AIDS cases. Known as the HIV Early Intervention Services (EIS) Set-Aside, the program includes a threshold for designation as an HIV EIS state of 10 or more AIDS cases per 100,000 individuals annually.

According to a report by the California HIV/AIDS Policy Research Centers, HIV EIS Set-Aside funding was used in two primary ways: 1) to integrate substance use counseling and education efforts into HIV and primary care settings, and 2) provide HIV and Hepatitis C virus (HCV) education, testing, and linkage to care through substance use services and programs. County grants supported the ability to provide substance use and behavioral health services to those at high risk for HIV, especially in rural areas. In addition, because Drug Medi-Cal does not reimburse drug treatment programs for HIV or HCV testing, the HIV EIS set-aside provided funding for testing for drug treatment clients likely to be at high risk for HIV.

Due to a variety of factors including aggressive public health strategies, increased utilization of anti-retroviral therapies, and development of pre-exposure prophylaxis medications, California has experienced a drop in HIV and AIDS cases. While the decrease in HIV/AIDS incidence is a positive public health achievement, the state is now below the threshold for designation as an HIV EIS state. Therefore, the SAPT Block Grant funding provided to counties for these purposes is no longer available. California's final year of funding for the set-aside was federal fiscal year 2015 and it received approximately $12.5 million. Pursuant to the terms of the block grant, other SAPT funding may not be allocated to these purposes once a state is no longer designated as an HIV EIS state.

Potential Alternative Sources of Funding. The SAPT Block Grant funding for integrated substance use disorder counseling in HIV settings and increased testing and linkage to care is likely to have contributed to the state's reduced incidence of HIV and AIDS, as the targeted population is at high-risk of infection. The HIV Alliance proposes funding the programs previously funded by the HIV EIS Set-Aside with a $12.5 million General Fund allocation. The California HIV/AIDS Policy Research Centers report also suggests the state evaluate whether it could use funding from the federal 21st Century Cures Act, which allocates $1 billion to states for substance use disorders. It is also unclear how the funds that had previously been allocated to the HIV EIS Set-Aside are currently being spent. The Legislature may wish to consider identifying an alternative funding source to reinvest in these programs.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. What are the restrictions on counties' use of SAPT Block Grant funding that prevents expenditures for the purposes previously supported by the HIV EIS Set-Aside?

2. How are the HIV EIS Set-Aside funds reallocated to the remaining SAPT Block Grant programs?

3. Has DHCS considered alternative funding strategies to continue to support these services at the county level? What other funding is available for this purpose?

4260 DEPARTMENT OF HEALTH CARE SERVICES
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Mental Health Services Act Fiscal Reversion

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

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

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

3. *Innovation:* Up to 5 percent of MHSA funds received for CSS and PEI may be used for innovative programs that develop, test and implement promising practices that have not yet demonstrated their effectiveness.

MHSA also required counties to spend a portion of their revenues on two additional components to build the infrastructure to support mental health programs. Since 2008-09, counties have the option of using a portion of their CSS funding in these areas or to build up a prudent reserve:

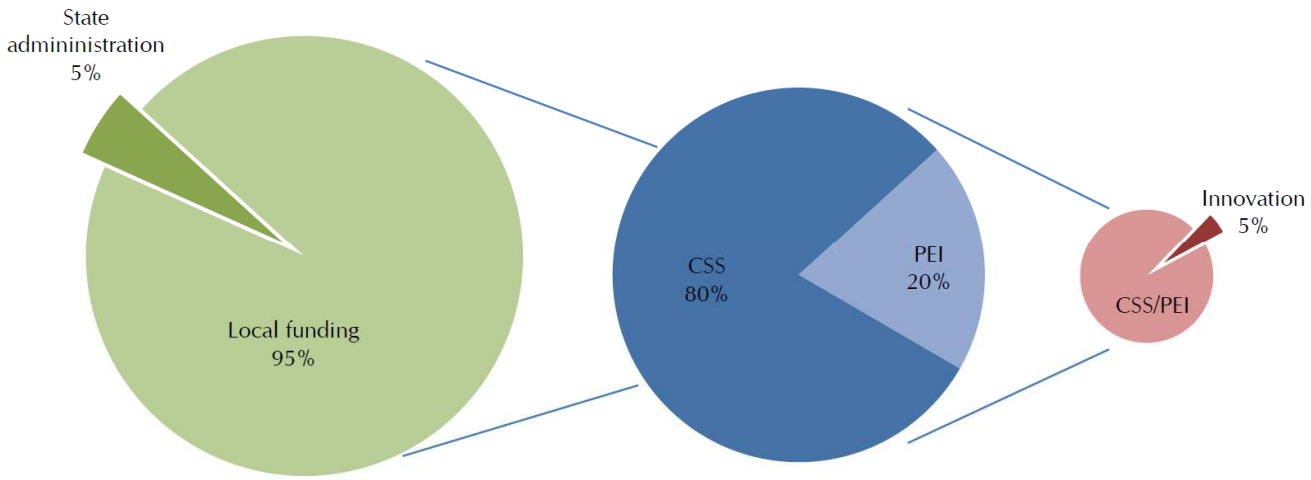
4. *Workforce Education and Training:* This component aims to train more people to remedy the shortage of qualified individuals who provide services to address severe mental illness. Counties may use funds to promote employment of mental health clients and their family members in the mental health system and increase the cultural competency of staff and workforce development programs.

5. *Capital Facilities and Technological Needs:* This component finances necessary capital and infrastructure to support implementation of other MHSA programs. It includes funding to improve or replace technology systems and other capital projects.

MHSA funds are allocated to counties through a formula that weighs each county's need for mental health services, the size of its population most likely to apply for services, and the prevalence of mental illness in the county. Adjustments are made for the cost of living and other available funding resources. The formula also provides a minimum allocation to rural counties for the CSS and PEI components.

State Administration Funds. MHSA authorizes the use of up to five percent of annual revenues for state administration and specifies that these funds are to be used by state agencies to "implement all duties pursuant to the [MHSA] programs." This includes ensuring adequate research and evaluation regarding the effectiveness and outcomes of MHSA services and programs.

Apportionment of Mental Health Services Act Funds.



Source: Little Hoover Commission Report #225: *Promises to Keep: A Decade of the Mental Health Services Act* (Jan. 2015)

Reversion Requirements for Unspent County Funds. MHSA requires the reversion of unspent county funds to the state. According to Welfare and Institutions Code section 5892 (h), "any funds allocated to a county which have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other counties in future years". However, DHCS has not reverted unspent county funds since 2008.

Concerns About Reversion Policies. Mental health advocates have expressed concerns that counties are retaining MHSA funds that could be reverted and reallocated to the provision of additional mental health services. However, counties have reported various challenges with accurate reporting of funds subject to reversion, including limitations on reporting forms from DHCS, inadequate identification of funds owed, and unclear policies for reversion.

MHSOAC Recommendations. In March 2017, MHSOAC released a discussion draft for consideration by Commission members titled *Mental Health Services Act Fiscal Reversion Policy Reconsidered: Challenges and Opportunities*. The draft identified many of the long-standing issues preventing appropriate reversion of unspent MHSA funds and made several recommendations for MHSOAC, DHCS and the Legislature. These included:

1. **"Reset" Reversion Policies** – MHSOAC recommended DHCS continue to update its fiscal reporting requirements to take effect in 2017-18 and beyond. For prior years, MHSOAC recommends three options for the Legislature to consider regarding the identification, reporting or reversion of unspent MHSA funds:
    - Hold counties harmless for reversion prior to 2017-18
    - Allow counties to retain a portion of reverted funds

- Hold counties harmless for reversion prior to 2012-13, when responsibilities were transferred from the former Department of Mental Health to DHCS.

2. **Extend Reversion Period from Three to Five Years for Small Counties** – Because small counties experience greater challenges in funding and sustaining mental health services programs with limited MHSA allocations, MHSOAC recommends the Legislature allow small counties to apply for state approval to extend the reversion timeline for funds subject to the three year limit.
3. **Allow Counties to Revise Annual Revenue and Expenditure Reports** – MHSOAC recommends DHCS clarify whether and how counties may amend their annual revenue and expenditure reports with updated, more complete, or audited information.
4. **Establish an MHSA Reversion Fund** – MHSOAC recommends establishing an MHSA Reversion Fund to receive unspent county MHSA funds. This fund would highlight the level of unspent funds reverted to the state, enhance incentives for counties to spend MHSA allocations, and allow the Legislature to reallocate this funding to unmet mental health services needs in the state.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending further discussions about improving policies regarding reversion of MHSA funds and ensuring unspent funds are reallocated in a timely manner to their intended support of mental health services programs.

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

1. DHCS: Please describe the challenges that have led to the extensive delay in fiscal reversion of MHSA funds.

2. DHCS: What is the current plan, if any, and expected timeframe for reversion of unspent MHSA funds?

3. DHCS: What is the status of the requirement from AB 1618, Chapter 43, Statutes of 2016 that requires DHCS to post the three-year program and expenditure plans submitted by every county?

4. MHSOAC: Please describe the recommendations in your discussion draft: "Mental Health Services Act Fiscal Reversion Policy Reconsidered: Challenges and Opportunities".

5. MHSOAC and DHCS: What is the scope of unspent funds statewide that might be available for reversion and reallocation? How would the reallocation occur?

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Overview

Mental Health Services Oversight and Accountability Commission Three-Year Funding Summary			
Fund Source	**2015-16**	**2016-17**	**2017-18**
	Actual	***Revised***	***Proposed***
0995 - Reimbursements	$-	$22,000,000	$22,000,000
3085 – Mental Health Services Fund	$48,002,000	$56,344,000	$45,146,000
Total Department Funding:	**$48,002,000**	**$78,344,000**	**$67,146,000**
Total Authorized Positions:	**26.6**	**26.2**	**29.2**

Mental Health Services Act (Proposition 63; 2004). The Mental Health Services Act (MHSA) imposes a one percent income tax on personal income in excess of $1 million. The purpose of the MHSA is to expand mental health services to children, youth, adults, and older adults who have severe mental illnesses or severe mental health disorders and whose service needs are not being met through other funding sources (i.e., funds are to supplement and not supplant existing resources).

Mental Health Services Oversight and Accountability Commission. The Mental Health Services Oversight and Accountability Commission (MHSOAC) was established in 2005 and is composed of 16 voting members. These members include:

Elected Officials:

- Attorney General
- Superintendent of Public Instruction
- Senator selected by the President pro Tem
- Assemblymember selected by the Speaker

12 members appointed by the Governor:

- Two persons with a severe mental illness
- A family member of an adult or senior with a severe mental illness
- A family member of a child who has or has had a severe mental illness
- A physician specializing in alcohol and drug treatment
- A mental health professional
- A county sheriff
- A superintendent of a school district
- A representative of a labor organization
- A representative of an employer with less than 500 employees
- A representative of an employer with more than 500 employees
- A representative of a health care services plan or insurer

In making appointments, the Governor shall seek individuals who have had personal or family experience with mental illness.

MHSOAC's responsibilities are as follows:

Review of MHSA Programs

- The MHSOAC oversees the MHSA funded programs and services through the counties' annual updates. Counties submit updates every year to reflect the status of programs and services in their counties.

Evaluations

- The MHSOAC has a statutory mandate to evaluate how MHSA funding has been used, what outcomes have resulted, and how to improve services and programs.

Research

- The MHSOAC supports collaborative research efforts to develop and implement improved tools and methods for program improvement and evaluation statewide.

Triage

- County triage personnel provide linkages and services to what may be the first mental health contact for someone in crisis. Crisis services are provided at shelters, jails, clinics and hospital emergency rooms to help link a person to appropriate services.

Stakeholder Contracts

- Statewide stakeholder advocacy contracts are focused on supporting the mental health needs of consumers, children and transition aged youth, veterans, racial and ethnic minority communities and their families through education, advocacy, and outreach efforts.

Commission Projects

- The MHSOAC selects special project topics and under the direction of a subcommittee of Commissioners, conducts research through discussion, review of academic literature, and interviews with those closely affected by the topic to formulate recommendations for administrative or legislative changes.

Technical Assistance & Training

- The MHSOAC offers technical assistance and training to counties, providers, clients and family members, and other stakeholders to support the goals of the MHSA and specific responsibilities of the Commission, such as review of counties' MHSA-funded Innovative Program plans.

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

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

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

Issue 2: Contract Administration

Budget Issue. MHSOAC requests one position and expenditure authority from the Mental Health Services Fund of $157,000 annually. If approved, these resources would support MHSOAC's ability to implement new and expanded contracting obligations authorized by the 2016 Budget Act.

Program Funding Request Summary (Budgeting Methodology BCP)		
Fund Source	**2016-17**	**2017-18**
3085 – Mental Health Services Fund	$-	$157,000
Total Funding Request:	**$-**	**$157,000**
Total Positions Requested:	**1.0**	

Stakeholder Contract Administration. MHSOAC oversees the activities of statewide stakeholder advocacy contracts funded under Welfare and Institutions Code Section 5892(d). These contracts support the needs of mental health clients, family members, children, transition-aged youth, veterans, the LGBTQ community and organizations working to reduce racial and ethnic disparities through education, outreach and advocacy efforts. The contracts had previously been awarded on a sole source basis under the former Department of Mental Health (DMH). After the dissolution of DMH in 2011, responsibility for awarding the stakeholder advocacy contracts transferred to MHSOAC. Historically, the amount allocated for stakeholder contracts ranged from $300,000 to $669,000 per year, for a total of approximately $2 million per year, distributed between the following four populations: clients or consumers, children and youth, transition-aged youth, and families of clients or consumers. After a series of budgetary and legislative augmentations, funding for each of the seven mental health advocacy contracts is now $670,000, or a total of approximately $4.7 million in contracted funds per year.

MHSOAC reports it is working to enhance the stakeholder advocacy contract process. It has moved from a sole source strategy to a competitive process. In 2016, MHSOAC released requests for proposal (RFP) for six of the contracts. 13 proposals were submitted in response to the RFPs. Of those proposals, three did not meet the technical qualifications and only one surpassed the minimum qualifying threshold for consideration. MHSOAC is revisiting the contracting process, working with the various stakeholder communities to encourage interest in submitting advocacy proposals, and will reissue RFPs for these contracts in 2017.

Children's Crisis Services Grant Program. The 2016 Budget Act allocated $3 million of MHSA funds to support a competitive grant program for crisis services for children. In particular, $1.5 million of the grants are meant to add triage personnel who would be available at various points of access, such as clinics and schools. These personnel would provide the following services: coordination, referral, monitoring of service delivery, and placement service assistance. The remaining $1.5 million of the grants are meant to add family support services training designed to help families participate in the planning process, access services, and navigate programs. These grants were part of a package of local public safety investments included in the 2016 Budget Act to reduce people's involvement in the criminal justice system. The total investment in children's crisis services was $31 million ($17 million General Fund and $14 million MHSA funds). The budget proposes to revert the General Fund portion of the funding. (See California Health Facilities Financing Authority Issue 3: Reversion of Children's Crisis Capacity Infrastructure Grant Funding)

MHSOAC is requesting one position and expenditure authority from the Mental Health Services Fund of $157,000 annually. If approved, MHSOAC would hire one Associate Governmental Program Analyst to assist ongoing efforts to conduct outreach and more effectively administer stakeholder advocacy contracts. In addition the analyst would support administration of children's crisis contract funds through a competitive grant process.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 3: Prevention and Early Intervention Plan Reviews

Budget Issue. MHSOAC requests two positions and expenditure authority from the Mental Health Services Fund of $309,000 annually. If approved, these resources would allow MHSOAC to implement regulations for Prevention and Early Intervention (PEI) and Innovation programs pursuant to AB 82 (Committee on Budget), Chapter 23, Statutes of 2013.

Program Funding Request Summary (Budgeting Methodology BCP)		
Fund Source	**2016-17**	**2017-18**
3085 – Mental Health Services Fund	$-	$309,000
Total Funding Request:	**$-**	**$309,000**
Total Positions Requested:	**2.0**	

Background. AB 82 modified the Mental Health Services Act (MHSA) and directed MHSOAC to adopt regulations for programs and expenditures under both the Prevention and Early Intervention (PEI) component and the Innovation component and to continue providing technical assistance to counties to improve public mental health programs. MHSOAC adopted regulations in the summer of 2015, specifying data collection and reporting requirements for the counties under MHSA. In 2015, counties began planning to collect newly required outcome performance measurements and must begin annual and periodic PEI reporting in 2017. These new regulatory requirements have increased the need for technical assistance and training to counties to ensure compliance.

Existing Technical Assistance Resources. MHSOAC currently provides consultation on a case-by-case basis in response to requests for technical assistance. One Consulting Psychologist is dedicated to reviewing innovation plans and providing technical assistance on innovation programs. One Health Program Manager II supervises one Staff Mental Health Specialist and two Health Program Specialist I working on innovation plan reviews, as well as other county plan reviews, contract monitoring, and the development of outreach and community forums. The 2016 Budget Act approved two Health Program Specialist I/II and one Research Program Specialist I/II to work with the Consulting Psychologist and Health Program Manager II to implement the Innovation program. However, current staff resources are being redirected to provide support to the PEI program.

MHSOAC requests two positions and expenditure authority from the Mental Health Services Fund of $309,000 annually:

- One Health Program Specialist II to provide subject matter expertise and leadership in PEI program review, serve as primary point of contact and administrative lead for MHSOAC's monitoring and oversight efforts of county programs, and provide technical assistance and training consultation to counties.
- One Associate Governmental Program Analyst to provide program support to the PEI team, serve as staff analytic lead in the preparation of reviews of county PEI programs, serve as subject matter expert and project lead, and serve as staff analytic lead in preparation of technical assistance materials.

If approved, these positions under the supervision of the Health Program Manager II and in close collaboration with the Consulting Psychologist, the Innovation program unit, and existing staff, would

allow MHSOAC to develop an integrated approach to guiding, monitoring and reporting on the impact of MHSA on California's mental health system.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. Have the counties been consulted and what is their response to this proposal?

0977 CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY

Issue 1: Overview

Background. The California Health Facilities Financing Authority (CHFFA) was established in 1979 to help nonprofit and public health facilities reduce their cost of capital and promote health care improvement and cost containment objectives. CHFFA achieves these goals by providing cost-effective tax-exempt bond, low-cost loan, and direct grant programs. The Authority is governed by nine members, including the State Treasurer, the State Controller, the Director of Finance, two members appointed by the Senate Rules Committee, two members appointed by the Speaker of the Assembly, and two members appointed by the Governor subject to confirmation by the Senate. Of the members appointed by the Senate, one member must be a licensed physician and surgeon, and one must be a current or former health facility executive. Of the members appointed by the Assembly, one member must be trained in investment or finance and one member represents the general public. The members appointed by the Governor also represent the general public. Appointed members serve for four years.

California Health Facilities Financing Authority Three-Year Funding Summary			
Fund Source	**2015-16**	**2016-17**	**2017-18**
	Actual	***Revised***	***Proposed***
0001 – General Fund	$44,744,000	$-	$-
0904 – CHFFA Fund	$4,454,000	$8,986,000	$8,985,000
0995 – Reimbursements	$-	$2,800,000	$2,800,000
3085 – Mental Health Services Fund	$3,999,000	$15,000,000	$4,000,000
6046 – Children's Hospital Fund	$68,128,000	$40,359,000	$40,359,000
6079 – Children's Hosp. Bond Act Fund	$99,443,000	$75,178,000	$75,358,000
8073 – CHAMP Acct, CHFFA Fund	$-	$400,000	$400,000
Total Department Funding:	**$220,768,000**	**$142,723,000**	**$131,902,000**
Total Authorized Positions:	**14.9**	**17.5**	**17.5**

California Health Facilities Financing Authority Comparison to 2016 Budget Act			
Fund Source	**2016-17**	**2016-17**	**2016-17**
	Appropriation	***Revised***	***Difference***
0001 – General Fund	$84,539,000	$-	($84,539,000)
0904 – CHFFA Fund	$9,223,000	$8,986,000	($237,000)
0995 – Reimbursements	$2,800,000	$2,800,000	$-
3085 – Mental Health Services Fund	$15,000,000	$15,000,000	$-
6046 – Children's Hospital Fund	$40,357,000	$40,359,000	$2,000
6079 – Children's Hosp. Bond Act Fund	$75,178,000	$75,178,000	$-
8073 – CHAMP Acct, CHFFA Fund	$400,000	$400,000	$-
Total Department Funding:	**$227,497,000**	**$142,723,000**	**($84,774,000)**
Total Authorized Positions:	**17.5**	**17.5**	**-**

California Health Facilities Financing Authority Comparison 2016-17 (Rev) to 2017-18			
Fund Source	**2016-17**	**2017-18**	**2017-18**
	Revised	***Proposed***	***Difference***
0001 – General Fund	$-	$-	$-
0904 – CHFFA Fund	$8,986,000	$8,985,000	($1,000)
0995 – Reimbursements	$2,800,000	$2,800,000	$-
3085 – Mental Health Services Fund	$15,000,000	$4,000,000	($11,000,000)
6046 – Children's Hospital Fund	$40,359,000	$40,359,000	$-
6079 – Children's Hosp. Bond Act Fund	$75,178,000	$75,358,000	$180,000
8073 – CHAMP Acct, CHFFA Fund	$400,000	$400,000	$-
Total Department Funding:	**$142,723,000**	**$131,902,000**	**($10,821,000)**
Total Authorized Positions:	**17.5**	**17.5**	**-**

CHFFA was created to be the state's vehicle for providing financial assistance to public and non-profit health care providers in California through loans funded by the issuance of tax-exempt bonds. CHFFA has financed a wide range of providers and programs throughout the state and administers the following six major programs: 1) Children's Hospital Program, 2) Tax-Exempt Bond Program, 3) Clinic Grant Program, 4) Healthcare Expansion Loan Program (HELP II), 5) California Health Access Model Program (CHAMP), and 6) Investment in Mental Health Wellness Act of 2013.

Children's Hospital Program. In 2004, California voters approved Proposition 61, which authorized the issuance of $750 million in general obligation bonds and established the Children's Hospital Program. In 2008, Proposition 3 authorized the issuance of an additional $980 million in general obligation bonds. The purpose of both programs is to improve the health and welfare of California's critically ill children by providing a stable source of funds for capital improvement projects for children's hospitals. Eight private, non-profit children's hospitals are each eligible for $172 million and five University of California Children's Hospitals are eligible for $69.2 million each through Proposition 61 and Proposition 3 combined. As of December 2016, the following grants have been approved under Proposition 61 and Proposition 3:

- Children's Hospital and Research Center Oakland
  - Prop. 61: $73.9 million (six completed projects)
  - Prop. 3: $97.4 million (four completed projects)
- Valley Children's Health Care (formerly Children's Hospital Central California)
  - Prop. 61: $73.9 million (six completed projects)
  - Prop. 3: $59.4 million (six completed projects; $38.3 million remaining to be disbursed)
- Children's Hospital Los Angeles
  - Prop. 61: $72.2 million (one completed project)
  - Prop. 3: $97.4 million (one completed project)
- Children's Hospital Orange County
  - Prop. 61: $73.9 million (five completed projects)
  - Prop. 3: $97.4 million (one completed project)
- Earl and Loraine Miller Children's Hospital Long Beach

  - Prop. 61: $74 million (one completed project)
  - Prop. 3: $26.7 million (one completed project; one project in progress; $15.6 million remaining to be disbursed)
- Loma Linda University Children's Hospital
  - Prop. 61: $26.1 million (two completed projects; one project in progress; $47.9 million remaining to be disbursed)
  - Prop. 3: $- (one project in progress; $97.4 million remaining to be disbursed)
- Lucile Salter Packard Children's Hospital at Stanford
  - Prop. 61: $73.6 million (one completed project)
  - Prop. 3: $97.4 million (one project in progress)
- Rady Children's Hospital San Diego
  - Prop. 61: $73.9 million (three completed projects)
  - Prop. 3: $72.2 million (four completed projects; two projects in progress)
- Mattel Children's Hospital at UCLA
  - Prop. 61: $29.8 million (one completed project)
  - Prop. 3: $24.9 million (one completed project)
- UC Davis Children's Hospital
  - Prop. 61: $29.8 million (three completed projects)
  - Prop. 3: $18.7 million (two completed projects)
- University Children's Hospital at UC Irvine
  - Prop. 61: $29.8 million (one completed project)
  - Prop. 3: $- (no project applications received; $39.2 million remaining to be disbursed)
- UC San Diego Children's Hospital
  - Prop. 61: $29.8 million (one completed project)
  - Prop. 3: $39 million (one project in progress)
- UC San Francisco Children's Hospital
  - Prop. 61: $29.8 million (one completed project)
  - Prop. 3: $39 million (one project in progress)

Tax-Exempt Bond Program. CHFFA established the Tax-Exempt Bond Program to provide health facilities with access to tax-exempt, fixed rate financing for their equipment purchases. A borrower under the program may fund qualifying equipment purchases of $500,000 or more. The maturity of the loan must be related to the useful life of the equipment to be financed. Notes issued through the program are collateralized by the equipment that is purchased. Funds may be used to purchase or reimburse all types of qualifying equipment by an eligible health facility, including but not limited to medical and diagnostic equipment, computers, and telecommunications equipment. Funds may also be used to finance minor equipment installation costs. To qualify for funding, the proposed project must be a health facility, operated by a private nonprofit corporation or association, city, city and county, county, or hospital district.

Clinic Grant Programs. AB 2875 (Cedillo), Chapter 99, Statutes of 2000, established the Cedillo-Alarcon Community Clinic Investment Act of 2000 and allocated $50 million to CHFFA for the purpose of awarding grants to eligible primary care clinics for capital outlay projects. In 2004, as part of the Anthem-Well Point merger, $35 million dollars was allocated to CHFFA for the purpose of awarding grants to eligible health care facilities providing service to underserved communities throughout California. To qualify for funding, the proposed project must be a health facility, operated by a private,

non-profit corporation or association, city, city and county, county, or hospital district. Approximately 150 non-profit community clinics received grants for infrastructure improvement.

Healthcare Expansion Loan Program II (HELP II). CHFFA established HELP II in 1995 to assist small and rural health facilities in obtaining financing for their capital needs. Health facilities eligible for financing under HELP II must meet one of the following conditions:

- Receive no more than $30 million in annual gross revenues.
- Located in a rural Medical Service Study Area as defined by the California Workforce Policy Commission.
- A district hospital.

Eligible facilities must be non-profit or publicly operated, have been in existence for at least three years performing the same types of services, and demonstrate evidence of fiscal soundness and ability to meet the terms of the loan. Eligible health facilities may receive loans under the following general terms:

- Two percent fixed interest rate for property acquisition, construction, renovation (maximum 20 year repayment period).
- Two percent fixed interest rate for equipment (maximum five year repayment period).
- Three percent fixed interest for loan refinancing (maximum 15 year repayment period).
- Loan amounts between $25,000 and $1,500,000.

California Health Access Model Program (CHAMP). AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012, authorized CHAMP, a one-time grant program to support innovative methods of health care service delivery and improve health outcomes for vulnerable populations by bringing services to individuals where they live or congregate. These health care services include medical, mental health, or dental services for the diagnosis, care, prevention, and treatment of illness or individuals with physical, mental, or developmental disabilities. In 2014, CHAMP approved a demonstration project grant for the San Francisco Health Plan (SFHP) for up to $1.5 million. SFHP's proposed project aims to expand and evaluate an existing pilot program for high-risk, high-cost patients to improve their health outcomes and experience of care, as well as to lower costs. CHFFA is reviewing options for additional CHAMP funding rounds. If demonstration projects that receive initial grants are successful at developing new methods of delivering high-quality, cost-effective health care services in community settings that result in: 1) increased access to quality health care and preventive services, 2) improved health care outcomes for vulnerable populations or communities, or both, CHFFA is authorized to implement a second grant program that awards recipients up to an additional $5 million.

Investment in Mental Health Wellness Grant Program. SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013, provided $142.5 million in one-time General Fund, $4 million in ongoing Mental Health Services Act (MHSA) funding, and $2.8 million in federal matching funds (reimbursements) to provide grants for community-based mental health crisis support. Known as the Investment in Mental Health Wellness Act of 2013, SB 82 authorized CHFFA to disburse funds to California counties or their nonprofit or public agency designates to develop mental health crisis support programs. The one-time General Fund grants support capital projects to increase capacity for crisis intervention, crisis stabilization, crisis residential treatment, and rehabilitative mental health services. The MHSA and federal funds grants support personnel costs associated with operation of mobile crisis support teams. The grants support capital improvement, expansion and limited start-up costs.

CHFFA conducted five funding rounds for competitive grant awards between November 2013, and May 2016. After completion of all five rounds, the program approved a total of 56 grants for the benefit of 41 counties. Approximately $136.5 million of capital funding (General Fund) and $4 million of MHSA funding for mobile crisis support team personnel has been encumbered. As of June 30, 2016, $37.9 million of total funding has been disbursed to 22 counties. Once projects are completed, these grants will add the following mental health crisis support resources:

- 76 mobile crisis vehicles
  - Status (Sept 2016): 61 purchased; additional 15 expected by the end of 2017
- 58.25 mobile crisis personnel
  - Status (Sept 2016): 55.65 individuals hired
- 1,185 crisis stabilization and crisis residential treatment beds
  - Status (Sept 2016):
    - 63 crisis stabilization beds added; additional 228 expected by the end of 2017
    - 56 crisis residential treatment beds added; additional 838 expected by the end of 2017
- 18 peer respite beds
  - Status (Sept 2016): None added; 18 expected by the end of 2017

Approximately 41 beds will be dedicated to youth individuals.

After the fifth and final funding round, $7 million of General Fund capital funding remained to revert back to the General Fund. The 2016 Budget Act reappropriated these funds and authorized a total augmentation of $31 million ($17 million General Fund, $14 million MHSA funds) in 2016-17 for additional expansion of community-based mental health crisis support specifically for children under 21 years of age. The budget includes a current year reversion of the $17 million General Fund previously allocated for this purpose, while preserving availability of the MHSA funding. (See Issue 3: Reversion of Children's Crisis Capacity Infrastructure Grant Funding)

Subcommittee Staff Comment. This is an informational item.

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

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

2. How does CHFFA monitor progress on the grants it awards through its various funding programs?

3. Please provide a status update on the progress of mental health crisis capacity expansion funded by the Investment in Mental Health Wellness Program.

Issue 2: Reversion of Community Infrastructure Grant Funding

Budget Issue. The Administration requests reversion of $67.5 million General Fund in 2016-17. These funds were approved in the 2016 Budget Act for infrastructure grant funding to assist communities in providing mental health or substance use disorder treatment. This augmentation was part of a package of General Fund investments designed to reduce people's involvement in the criminal justice system. If the proposed reversion is approved, the Administration would reallocate this funding to other budgetary expenditures and the previously approved community infrastructure grant program would be eliminated.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	($67,500,000)	$-
Total Funding Request:	**($67,500,000)**	**$-**
Total Positions Requested:	**0.0**	

Background. The 2016 Budget Act appropriated $67.5 million to CHFFA and approved trailer bill language to establish a competitive infrastructure grant program to promote criminal justice diversion programs and services. The grant program would have achieved these goals by supporting expansion of capacity in mental health treatment facilities, substance use disorder treatment facilities, and trauma-centered service facilities.

These grants were part of a package of local public safety investments included in the 2016 Budget Act to reduce people's involvement in the criminal justice system. The $67.5 million one-time funding was intended to provide infrastructure grants to cities and counties for land purchase, construction, repairs, and upgrades to increase the local infrastructure for providing transitional housing, mental health and substance abuse treatment, services for victims of human trafficking and domestic violence, and other supportive services needs identified by the county or city.

The budget proposes to revert the $67.5 million General Fund allocation for the competitive infrastructure grant program. This proposal is one of several reductions in one-time spending commitments included in the budget to address the state's General Fund deficit. If approved, the proposed reversion of these funds is permanent and the grant program would be eliminated.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending updates to the state's General Fund condition at the May Revision.

Questions. The subcommittee has requested Department of Finance to respond to the following:

1. Please provide a brief overview of this proposal.

2. Please describe the Administration's rationale for reversion of these previously approved funds and elimination of the community infrastructure grant program.

3. Please describe any expected future impact on expenditures in the criminal justice system as a result of reduced availability of diversion programs and services.

Issue 3: Reversion of Children's Crisis Capacity Infrastructure Grant Funding

Budget Issue and Trailer Bill Language Proposal. The Administration requests reversion of $17 million General Fund in 2016-17. These funds were approved in the 2016 Budget Act to increase the number of facilities providing a continuum of crisis services for children. If the proposed reversion and accompanying trailer bill language are approved, the Administration would reallocate this funding to other budgetary expenditures and the grant program would be limited to the previously allocated MHSA funds.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	($17,039,000)	$-
Total Funding Request:	**($17,039,000)**	**$-**
Total Positions Requested:	**0.0**	

Background. The 2016 Budget Act appropriated a total of $17 million to CHFFA and approved trailer bill language to establish a competitive grant program to provide a continuum of crisis services to children under 21 years of age with the following objectives:

1. Provide for early intervention and treatment services to improve the client experience, achieve recovery and wellness, and reduce costs.
2. Expand community-based services to address crisis intervention, crisis stabilization, and crisis residential treatment needs that are wellness-, resiliency, and recovery-oriented.
3. Add at least 200 mobile crisis support teams.
4. Add at least 120 crisis stabilization and crisis residential treatment beds.
5. Add triage personnel to provide intensive case management and linkage to services for individuals with mental health disorders in community-based service points, such as homeless shelters, schools, and clinics.
6. Expand family respite care.
7. Expand family supportive training.
8. Reduce unnecessary hospitalizations and inpatient days.
9. Reduce recidivism and unnecessary local law enforcement expenditures.
10. Provide local communities with increased financial resources to leverage public and private funding sources to improve networks of care for children and youth with mental health disorders.

These grants were part of a package of local public safety investments included in the 2016 Budget Act to reduce people's involvement in the criminal justice system. The total investment in children's crisis services was $31 million ($17 million General Fund and $14 million MHSA funds). The General Fund was composed of approximately $7 million reappropriated from unspent funds previously allocated to the Investment in Mental Health Wellness Grant Program and $10 million of new General Fund resources.

The budget proposes to revert the $17 million General Fund portion of the funding. This proposal is one of several reductions in one-time spending commitments included in the budget to address the state's General Fund deficit. According to the Administration's arguments in support of this proposal, these

funds were at an early stage of development and remained uncommitted. The remaining MHSA funds are still available for competitive grants to fulfill the objectives of the original allocation.

Trailer Bill Language Proposal. The Administration is also proposing accompanying trailer bill language to amend the statutory provisions of the grant program as follows:

1. Implements the program "[t]o the extent funds are available" and deletes references to the 2016 Budget Act allocation.
2. Removes the required numbers of mobile crisis support teams and crisis stabilization and crisis residential treatment beds.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold these issues open pending updates to the state's General Fund condition at the May Revision.

Questions. The subcommittee has requested Department of Finance to respond to the following:

1. Please provide a brief overview of this proposal.

2. Please describe the Administration's rationale for reversion of these previously approved funds and reduction of the scope of the children's crisis services grant program.

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

SUBCOMMITTEE NO. 3 Agenda

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

April 20, 2017
9:30 a.m., or Upon Adjournment of Floor Session
Room 4203, State Capitol

Consultant: Theresa Pena

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.

0530 – HEALTH AND HUMAN SERVICES AGENCY, OFFICE OF SYSTEMS INTEGRATION
5180 – DEPARTMENT OF SOCIAL SERVICES

Issue 1: Overview: Office of Systems Integration and Automation Projects

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

OSI currently oversees a number human services projects for the Department of Social Services (DSS), including:

Appeals Case Management System (ACMS). ACMS supports the work of the State Hearings Division (SHD), which is responsible for ensuring due process for individuals who wish to appeal administrative decisions about benefits for public assistance programs, including Medi-Cal, Covered California, CalWORKs, CalFresh, and In-Home Supportive Services (IHSS). Currently ACMS, along with 21 ad-hoc applications, is collectively known as the State Hearings System (SHS). The SHS tracks, schedules, and manages appeals requests received from all 58 counties. OSI will help procure system integration services to assist the design, development and implementation of a hearings appeals system that will assist the recipients of public social service programs seeking fair hearings, DSS stakeholders, and state and local government entities. The ACMS will create a single case management system that will combine intake, scheduling and reporting functions into a single workflow; streamline current manual processes and reduce errors caused by data entry. The 2016 Budget Act approved an increase of $237,000 in OSI spending authority for the ACMS project and the conversion of seven existing state positions from limited-term to permanent.

Case Management Information and Payrolling Systems (CMIPS II). CMIPS II is an automated statewide system that performs case management and payroll functions for all IHSS providers and recipients. DSS contracts with OSI for project management and vendor contract oversight services to maintain and operate CMIPS II. After a statewide transition in 2013 from the legacy CMIPS system to a new system, CMIPS II, the project is currently in the maintenance and operations (M&O) phase. The CMIPS II Post Implementation Evaluation Report was approved by the California Department of Technology (CDT) on July 29, 2016. The existing prime vendor contract ends on March 31, 2018, and OSI is conducting a competitive procurement to award a new prime vendor contract for M&O.

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

and design/development approach, where an Request for Proposal (RFP) is broken into a set of smaller modules that can be delivered in a short period of time, and a separate vendor is selected for each module.

Child Welfare Services/Case Management System (CWS/CMS). The CWS/CMS is a statewide tool that currently supports the Child Welfare System of services. The CWS/CMS provides information to service workers to improve case work services, reduces repetitive manual workload, provides policy makers with information to design and manage services, and fulfills state and federal legislative requirements. However, this system is outdated in a number of ways and will be replaced by the CWS-NS.

Electronic Benefit Transfer (EBT) Project. EBT is the system used in California for the delivery, redemption, and reconciliation of public assistance benefits, such as CalFresh, California Food Assistance Program, and cash aid benefits. Recipients of public assistance in California access their benefits with the Golden State Advantage EBT card. The new EBT services contract was executed on June 6, 2016, and the transition to the new California EBT system and other EBT-related services was initiated. The transition is scheduled to be completed no later than January 2018.

Statewide Automated Welfare System (SAWS). The Statewide Automated Welfare System (SAWS) Consortia is made up of multiple systems which support such functions as eligibility and benefit determination, enrollment, and case maintenance at the county level for some of the state's major health and human services programs, including CalWORKs and CalFresh. The Consortia includes the Los Angeles Eligibility, Automated Determination, Evaluation, and Reporting (LEADER) system, which is now being replaced by the LEADER Replacement System (LRS), the Welfare Client Data System (CalWIN), and Consortium IV (C-IV), which are managed by the Office of Systems Integration (OSI).

Welfare Data Tracking Implementation Project (WDTIP). WDTIP provides counties with the automated functionality required to conform to the statewide tracking of time-on-aid requirements, and tracks the 48 and 60-month assistance clock, the 24-month services clock, and WTW exemptions and sanctions. WDTIP is the interface system within the existing county SAWS consortia.

Staff Comment and Recommendation. No action required. This is an informational item only.

Issue 2: Overview: Child Welfare Services – New System (CWS-NS) Update

Budget issue. The Governor's budget includes $58.3 million total funds ($29.2 million General Fund) for the CWS-NS Project in the current year and $178.7 million total funds ($89.4 million General Fund).

Background. Child Welfare Services/Case Management System (CWS/CMS) was fully implemented and transitioned to its operational phase in 1998. DSS has overall responsibility for the system, including providing project and program direction to OSI. OSI provides information technology expertise and is responsible for implementation and day-to-day operations of the system. Currently, the CWS/CMS does not meet the Statewide Automated Child Welfare Information System (SACWIS) requirements.

The CWS-NS Project will replace the aging CWS/CMS with a new solution that meets current CWS business practices, as well as SACWIS requirements necessary to retain federal funding. The CWS-NS Project is intended to bring the system into compliance with state and federal laws and regulations, make the system easier to use for CWS workers, result in enhanced data reliability and availability, allow user mobility, and automate system interfaces with other state partners to enable data sharing. In November 2015, DSS and OSI announced that the CWS-NS Project will use an Agile procurement and design/development approach, instead of building a monolithic, one-time solution, where the implementation of the IT system does not begin until all phases of the project are complete. Under the Agile approach, a RFP is broken into a set of smaller modules that can be delivered in a short period of time. Analysis, design, coding, and testing continue for each module until the entire IT system is complete. Instead of contracting with a single vendor, a separate vendor is selected for each model.

The following table shows total estimated one-time project costs, expenditures to date (July 2013 through March 2017) and the remaining budget balance:

Project Costs

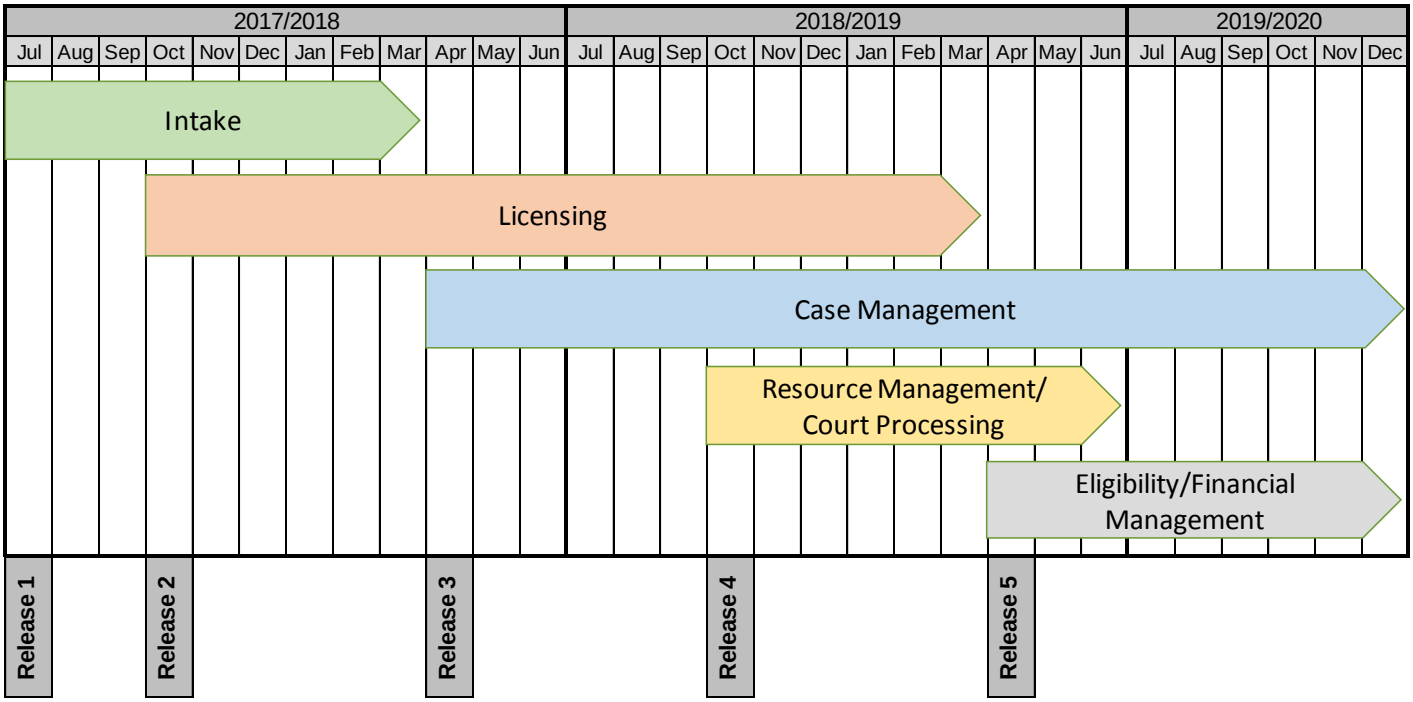
Total Estimated One-Time Cost	Expenditures Through March 17	Remaining Balance
$397,918,393	$39,836,909	$358,081,484

Compared to continuing to operate the current system and making necessary changes to it, however, the Administration estimated that the state will realize savings by completing the CWS-NS system because of its reduced maintenance and operations costs.

Total project expenditures through March 2017 are as follows:

2013-14: $5,711,858 - Planning
2014-15: $10,194,001 - Planning
2015-16: $10,622,214 – Procurement (Pivot to Agile)
2016-17: $13,308,836 ($43,293,395 projected through June 2017) – Design and Development of Intake and Certification, Approval, and Licensing Services (CALS)
Total: $69,821,46

The new timeline for the CWS New System Project is below:



DSS and OSI are required to provide monthly project updates to the Legislature and stakeholders. DSS and OSI have fulfilled this reporting requirement through a combination of written reports and in-person briefings.

Legislative Analyst's Office (LAO) Comments. While the LAO did not have any new publications on CWS-NS this year, their publication "The 2016-17 Budget: Child Welfare Services – New System" makes relevant points about the potential benefits and risks of the Agile approach that are still applicable:

- Agile implementation is much more flexible than the traditional implementation approach because it provides IT projects with the opportunity to address challenges with one module without compromising other aspects of the IT project. This flexibility allows for functions to be completed and deployed to users more quickly.

- Where in a traditional implementation, system users would have to adapt to changes only once, in agile implementation, system users have to adapt to changes as each module is implemented.

- The Agile approach may increase vendor interest and participation, since there are a limited number of vendors with the expertise to design and implement IT systems for large projects that are implemented under the traditional approach.

- At the conclusion of the project, all modules must work together to fully meet the objectives of the project. Since there are likely multiple vendors for the various modules, this will require increased coordination.

Implementation Update. Release 1 (R1) creates a bridge between the legacy system and the new system, and establishes a foundation for future work across the entire platform. R1 was launched in March in six core counties. Selected users in these counties will have access to live, statewide data in the legacy database with enhanced search capabilities.

CWDS, in partnership with the Department of Technology, continue to work together on a refresh of the Agile Development Pre-Qualified Vendor Pool (ADPQ). On February 6, 2017, a Request for Information was released to increase the current pool of 11 Agile vendors up to 30.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please summarize the current CWS-NS timeline and overall project costs.

2. Please explain how OSI is adapting to Agile approach, and what you have learned about the Agile process in the past year.

Issue 3: Oversight: SAWS Single System

Budget Issue. The budget includes approximately $238.8 million ($91.5 million General Fund) for Local Assistance costs in SAWS in 2016-17 and $234.4 million ($93.2 million General Fund) in 2017-18.

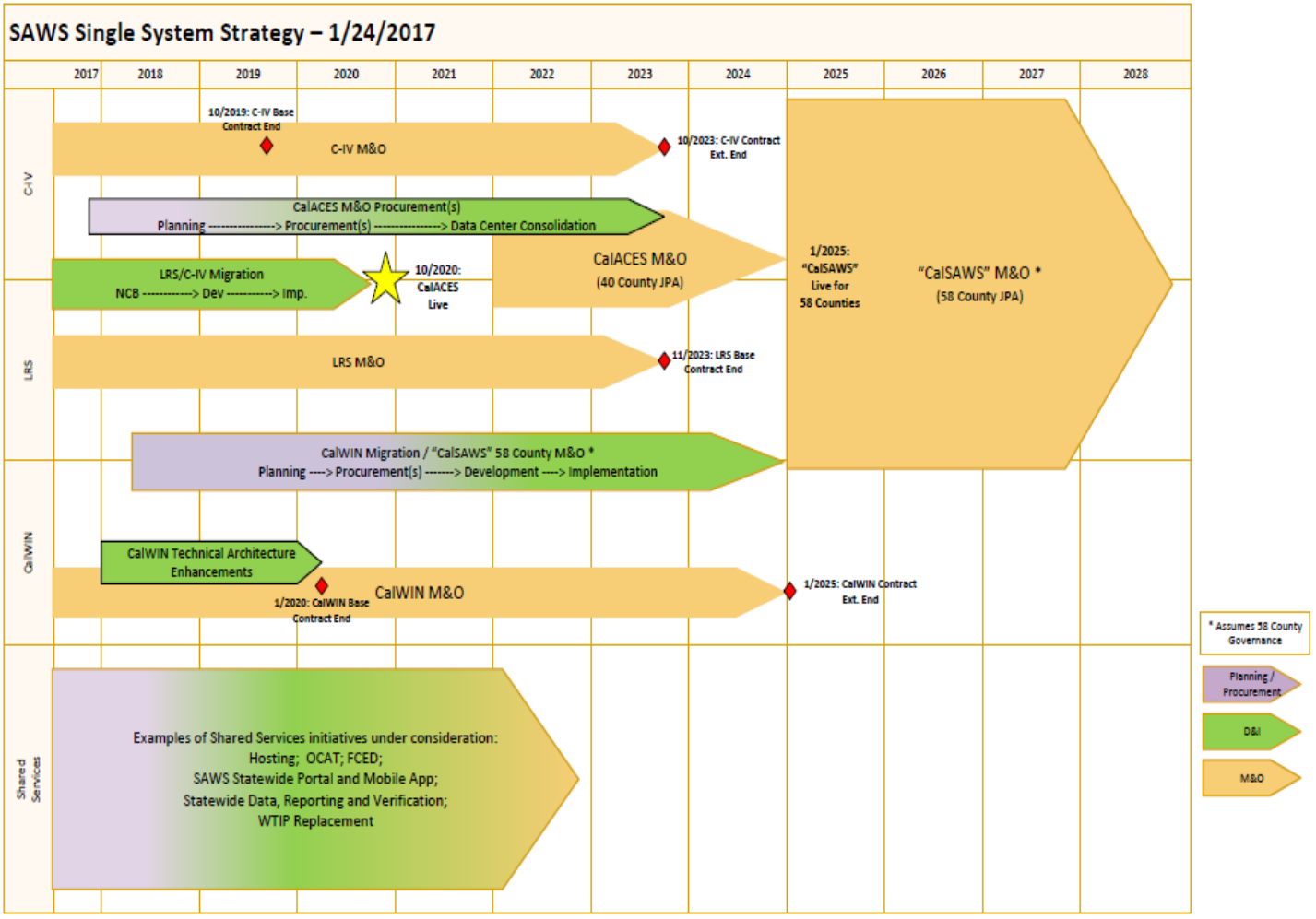
Background. The SAWS Consortia is made up of multiple systems which support such functions as eligibility and benefit determination, enrollment, and case maintenance at the county level for some of the state's major health and human services programs, including CalWORKs and CalFresh. The Consortia includes the Los Angeles Eligibility, Automated Determination, Evaluation, and Reporting (LEADER) system, which is now being replaced by the LEADER Replacement System (LRS), the Welfare Client Data System (CalWIN), and Consortium IV (C-IV), which are managed by the Office of Systems Integration (OSI). SAWS is undergoing a variety of changes, including:

Horizontal Integration of SAWS and CalHEERS. The goal of the Horizontal Integration effort between the Covered California system (CalHEERS) and SAWS is to allow an applicant applying for health coverage online through Covered California to submit their CalWORKs or CalFresh application online at that time without having to re-respond to some of the questions already asked. Horizontal Integration was implemented in July 2016, and in the first seven months of implementation, over 25,000 individuals had initiated the CalFresh or CalWORKs applications through this process.

C-IV Migration into LRS. In September 2015, Los Angeles County began to rollout LRS, their new eligibility determination system. As of November 2016, the LRS Project has successfully completed countywide implementation for the Department of Public Social Services and the Department of Children and Family Services. In addition, C-IV counties (which is another system in the SAWS consortia, and includes 39 counties), will begin migrating over to the LRS system. This migration is expected to be complete in 2020, and together the systems will be known as CalACES. The LRS Project is in Phase II - Performance and Verification, a six-month period from November 2016 to May 2017 to confirm that LRS meets the required functional and performance standards. OSI notes that by May 2017, all Phase I and Phase II defects will be resolved.

Single System. Since 2011, the federal Centers for Medicaid Services (CMS) and the Food and Nutrition Services (FNS) have asked California for a long-term strategy for a centralized SAWS system, as opposed to the multiple systems in the SAWS Consortia. Finally, in December 2016, CMS and FNS have officially made it a requirement for SAWS to be a single system by 2023 in order to receive federal funds. Going forward, the state will work to implement this single SAWS system, to be known as CalSAWS. The state has asked the federal government for an extension on the single system to January 2025.

The state must take several steps before consolidating the consortia into one system. The migration of C-IV and into LRS to become CalACES must first be achieved, and CalWIN must undergo Technical Architecture Enhancements (TAE). The state must obtain federal approval of this approach and CalWIN TAE, complete CalACES negotiations, and complete LRS performance verification. A joint county and state planning effort for a single SAWS system strategy, including a discussion of shared services and what a governance body would look like, must commence. Below is a timeline for implementing the SAWS single system:



Staff Comment and Recommendation. No action required. Item included for oversight and discussion purposes. OSI and DSS provide quarterly updates to legislative staff.

Questions.

1. Please discuss the current status of the SAWS system.

2. Please discuss the shift to a single system.

3. Does the department anticipate that additional costs for SAWS will arise due to the shift to a single system?

4. When does the department expect to hear from the federal government regarding its request for an extension to 2025 for the single system?

Issue 4: Budget Change Proposal: Child Welfare Digital Services Adjustment

Governor's Proposal. The Administration requests a total of 57 positions and reclassification of 10 positions and an overall increase of $51.0 million ($25.5 million General Fund) for 2017-18 to continue activities related to delivering the CWS-NS solution and to reflect the project's recent adoption of the agile approach. This request operates within the established overall total cost for the CWS-NS project. Specifically, the 57 positions requested are:

- 1 Office Technician
- 9 Staff Information Systems Analysts
- 15 Senior Information System Analysts
- 4 System Software Specialist IIs
- 4 DP Manager IIs
- 1 DP Manager III
- 6 Associate Information System Analysts
- 2 System Software Specialist IIs
- 3 System Software Specialist IIIs
- 2 Associate Programmer Analysts
- 2 Staff Programmer Analysts
- 1 Senior Programmer Analyst
- 1 Senior Programmer Analyst Supervisor
- 1 System Software Specialist I
- 2 Staff Services Manager IIIs
- 1 Associate Personnel Analyst
- 1 Staff Services Analyst
- 1 Management Services Technician
- 1 Senior Legal Analyst

Background. CWS-NS replaces the previous CWS/CMS which had fallen out of compliance with state and federal law. CWS-NS is intended to make the system easier to use for CWS workers, result in enhanced data reliability and availability, allow user mobility, automate system interfaces with other state partners to enable data sharing, and ultimately to reduce ongoing maintenance and operations costs. In November 2015, DSS and OSI announced that the CWS-NS Project will use an Agile procurement and design/development approach, which will release functionality incrementally over the next few years.

DSS and OSI point out that the project has identified emerging resource gaps in several key areas, including: project management, procurements, key performance data and analysis, implementation, training, platform technology, development, testing, program policy, and administration. The requested positions are meant to address these gaps and mitigate the risk and schedule delays that would ensue if this BCP were not approved. DSS and OSI are also looking to build the state's technical capacity in the long run so that the project can reduce dependency on vendors, develop a pool of qualified state resources, allow the state to be more flexible in the enhancements of future services, and eventually lower the operational costs.

OSI maintains that the CWS-NS Project will budget on an annual basis. Last year when they submitted their 2016-17 Spring Finance Letter, the Agile approach to the project was still very new, and OSI states they did not have the capacity at that time to forecast their needs clearly enough for 2017-18. Going forward, OSI estimates that the CWS-NS project will forecast on a 12-18 month timeline of the work that is required into the future. They also project they will have a request for additional state resources along these lines in 2018-19, but that some of the need will decline by 2019-20.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please briefly summarize the proposal.

2. Please explain how these positions are overall critical to the success of the CWS-NS project.

3. Please discuss how this request fits in to the overall costs already budgeted for the CWS-NS project and how future requests may or may not fit into the budgeted amount. How should the Legislature consider funding and providing staffing for the CWS-NS project differently under the Agile approach than it has in the past?

Issue 5: Budget Change Proposal: CMIPS II – Implementation of Paid Sick Leave for IHSS Providers (SB 3)

Governor's Proposal. The Office of Systems Integration requests a one-time increase of $4.8 million in spending authority to implement paid sick leave for IHSS and Waiver Personal Care Services providers, beginning July 1, 2018. The Department of Social Services requests a corresponding one-time increase of $4.8 million General Fund in local assistance authority to increase contract service costs with OSI.

Background. CMIPS II in an automated statewide system that performs case management and payroll functions for all IHSS providers and recipients. DSS contracts with OSI for project management and vendor contract oversight services to maintain and operate CMIPS II.

SB 3 (Leno), Chapter 4, Statutes of 2016 entitles IHSS providers to paid sick days. Implementation of this functionality is scheduled to be deployed in a phased approach, beginning July 2018. The BCP notes that half of the $4.8 million is for application changes, business interface process changes, training of county staff, and provider help desk resources. The CMIPS II application changes will implement functionality to calculate, accrue, and track sick leave hours required to support variable yearly sick leave caps and accrual rates at both the state and county levels. The remaining half of the $4.8 million is to provide four statewide mass mailings informing recipients and providers about the SB 3 changes to the IHSS program.

Staff Comment and Recommendation. Hold open. No concerns have been raised to subcommittee staff at this time.

Questions.

1. Please briefly summarize the proposal.

Issue 6: Budget Change Proposal: CMIPS II – Vendor Contract Transitional Activities

Governor's Proposal. OSI requests a one-time increase of $8.9 million in spending authority to support potential prime vendor contract transition activities related to CMIPS II. DSS requests a corresponding one-time increase of $8.9 million General Fund local assistance authority and corresponding budget bill provisional language.

Background. CMIPS II in an automated statewide system that performs case management and payroll functions for all IHSS providers and recipients. DSS contracts with OSI for project management and vendor contract oversight services to maintain and operate CMIPS II.

As of January 2014, CMIPS II transitioned from the Design, Development and Implementation phase to the ongoing Maintenance and Operations phase. The existing prime vendor contract ends March 31, 2018. OSI is conducting a competitive procurement to award a new prime vendor contract for maintenance and operations services in August 2017. If a contract is awarded to a new prime vendor, there will be an eight-month transition period during which the incumbent prime vendor, which is currently Hewlett-Packard, winds down operations and the new prime vendor ramps up activities.

Budget bill language (BBL) will be necessary to implement this BCP if approved. The BBL would be triggered if there is a funding need for transition activities for a new vendor. Should the incumbent vendor be awarded the contract, an assessment of transition activity costs will be performed to determine an appropriate level of transition activity funding associated with new contract requirements. The actual cost of transition will not be known until the public cost opening, which is planned in late June 2017.

Staff Comment and Recommendation. Hold open. No concerns have been raised to subcommittee staff at this time.

Questions.

1. Please briefly summarize the proposal.

Issue 7: Budget Change Proposal: Horizontal Integration Office: Transfer to Office of Systems Integration

Governor's Proposal. The Administration requests to move the Horizontal Integration (HI) Office and its three existing staff and associated funding with DSS to OSI. This is a cost-neutral proposal.

Background. The HI Office has interactions with various departments and programs under the purview of the Health and Human Services Agency (Agency). The Office of the Agency Information Officer (AIO), which is currently housed in OSI under Agency, already has the responsibility of looking across issues under the entirety of Agency, which aligns closely to HI's mission.

While the HI Office was specifically created in 2013 to bridge a critical divide between DSS and Affordable Care Act (ACA) related activities, they have since become a cross-programmatic and cross-departmental team. The Administration notes that this shift of HI to OSI will further integration efforts among departments and systems, as Agency programs operate some of the most complex, interconnected systems in state government. Being positioned at the Agency level rather than the department level provides a greater degree of oversight, and demonstrates to staff throughout the Agency that this effort is a priority of the Agency – and not just a project within DSS. Teaming up with the Enterprise Architecture Office within the AIO, the HI team can implement standards, best practices, and other enterprise wide improvements that can drive horizontal integration across the entire Agency.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please briefly summarize the proposal.

5180 DEPARTMENT OF SOCIAL SERVICES – STATE HEARINGS DIVISION (SHD)

Issue 1: Overview: State Hearings Division

Background. State hearings, which are adjudicated by Administrative Law Judges (ALJs) employed through DSS, are used to provide due process to recipients of, and applicants for, many of California's health and human services' programs, including Medi-Cal, CalWORKs, CalFresh, and In-Home Supportive Services. When a recipient disagrees with a decision made by their local county welfare department, they are legally entitled to request a hearing to contest the decision. The *King v. McMahon* and *Ball v. Swoap* court decisions mandate that DSS provides recipients with timely due process for the adjudication of appeals hearings. Additionally, these court orders impose financial penalties on DSS for failing to adjudicate decisions within specified timeframes. The penalties are paid to the prevailing claimant. Federal mandates require that all requests for hearings be adjudicated within 90 days, or 60 days for CalFresh, of a recipient's request.

Penalty Structure. Under the court orders, the minimum daily penalty amount is $5.00 per day, or a minimum of $50, whichever is greater. However, if 95 percent of all decisions are not issued within the required deadlines in a given month, the daily penalty rate for that programmatic category increases by $2.50 over the penalty rate being paid to claimants the previous month. In contrast, if 95 percent of all decisions related to that particular program are issued on time in a given month, the corresponding daily penalty rate decreases by $2.50 from the penalty rate being paid the previous month. The maximum daily rate under the court orders is $100 per day.

Recent Caseload Growth. The SHD has seen an increased workload, resulting primarily from the implementation of the Affordable Care Act (ACA). ACA workload is expected to increase the amount of hearing decisions by over 10,400; a 55 percent increase over the FY 2012-13 workload. This growth is due to the increase hearing requests in Scope of Benefits and Medi-Cal redetermination appeals. The overall total is projected to increase from approximately 89, 200 hearing requests and 19,000 decisions in 2012-13 to 120,100 hearing requests and 27,500 decisions by the end of FY 2016-17.

As a result of the allocation of permanent general jurisdiction resources in 2012-13 and ACA resources in 2014-15, the SHD has seen a significant drop in penalties from $4.4 million in 2012-13 to an estimated $299,995 for 2016-17. The penalty rate per day of a late decision was $65.00 for Medi-Cal, $25.00 for CalWORKs, $5.00 for CalFresh, and $70.00 for IHSS.

According to DSS, recent processing times, average penalties, and total penalties paid by program are listed below:

Program	Timeliness Requirement (In Days)	Average Processing Time of Late Cases (In Days)	Average Days Late	Average Penalty
CalFresh	60	67	7	$50.00
CalWORKs	90	0	0	0
IHSS	90	155.81	65.18	$4,725.00
Medi-Cal	90	171.20	81.20	$5,481.00

State Hearing Penalties by Program for the Last 5 Fiscal Years

Total Penalties Paid by Program					
FY	**CalWORKs**	**CalFresh**	**Medi-Cal**	**IHSS**	**Total**
FY 12/13	$290,248	$54,175	$3,533,700	$541,717	$4,419,840
FY 13/14	$91,952	$8,807	$423,363	$71,133	$595,255
FY 14/15	$17,253	$5,080	$150,175	$68,295	$240,803
FY 15/16	$7,427	$2,830	$95,490	$82,387	$188,135
FY 16/17*	$17,112	$4,250	$110,302	$131,967	$299,995

IHSS Pilot Project. The IHSS Pilot project is the outcome of an assessment initiated by SHD in 2015 which determined that the time needed to prepare for an IHSS hearing appeared significantly longer than other types of cases. The department convened a workgroup that included many stakeholders, and reviewed SHD's initial draft of recommendations developed during 2016 and provided recommendations on identified best practices, training needs, and the development of informational documentation for IHSS applicants and recipients. The department developed evaluation tools to track and test whether efficiency and due process improved, and the IHSS Pilot Project will test these best practices in Yolo and San Diego beginning May 1, 2017. It is anticipated that statistical deliverables should be available sometime in late January 2018.

Staff Comment and Recommendation. No action needed. This is an informational item only.

Questions.

1. Please briefly provide an overview of the function of the state hearings division and the structure of the timeliness requirements and penalties for not meeting them.

5180 DEPARTMENT OF SOCIAL SERVICES - CALWORKS

Issue 2: Overview: CalWORKs

Governor's Proposal. The revised 2016-17 budget includes $5.2 billion in federal, state and local funds for the program, and estimates an average monthly caseload of 463,540 (a decline 6.5 percent from the previous estimate). The 2017-18 budget includes $5.1 billion in federal, state, and local funds for the program, and estimates an average monthly caseload of 459,173 families. The Governor's budget for CalWORKs does not propose any major policy changes.

Background. California Work Opportunities and Responsibilities to Kids (CalWORKs), the state's version of the federal Temporary Assistance for Needy Families (TANF) program, provides cash assistance and welfare-to-work services to eligible low-income families with children.

CalWORKs is funded through a combination of the federal TANF block grant (to receive $3.7 billion in TANF funds, California must provide a maintenance-of-effort of $2.9 billion annually), the state General Fund, other various funding allocations from the state, realignment funds, and other county funds. Below is a table summarizing these various funding sources and the changes from 2016-17.

CalWORKs Funding Sources

(Dollars in Millions)

	2016-17 Revised	2017-18 Proposed	Change From 2016-17 Amount	Change From 2016-17 Percent
Federal TANF block grant funds	$2,428	$2,297	-$131	-5%
General Fund	682	450	-232	-34
Realignment funds from local indigent health savings	586	812	226	39
Realignment funds dedicated to grant increases	319	331	12	4
Other county/realignment funds	1,188	1,186	-2	__[a]
Totals	**$5,203**	**$5,076**	**-$127**	**-2%**

[a]Negligible amount.

TANF = Temporary Assistance for Needy Families.

(http://www.lao.ca.gov/Publications/Report/3576/1)

The Child Poverty and Family Supplemental Support Subaccount provides funding for the grant impact of prior CalWORKs Maximum Aid Payment (MAP) increases, including last year's 1.43 percent MAP increase and now the repeal of the Maximum Family Grant (MFG) rule, in addition to any subsequent grant increases when sufficient revenues are available. Prior year base funding is available to the counties immediately. The FY 2016-17 and FY 2017-18 growth funding requires adequate upfront General Fund authority in the DSS budget until subaccount funds are available directly to the counties.

In the *Child Poverty and Family Supplemental Support Subaccount - Growth*, $32.9 million will be available in 2015-16 and $49 million will be available in 2016-17. In the *Child Poverty and Family Supplemental Support Subaccount - Base*, $285.9 million will be available in 2015-16 and $281.6 million will be available in 2016-17.

Another important source of state funding is the Single Allocation. The Governor's budget provides approximately $1.7 billion for the Single Allocation in both 2016-17 and 2017-18. Within the Single Allocation, different categories of funding for various purposes such as employment services, eligibility and administration, and Stage 1 Child Care are included. Funding for each category within the Single Allocation is based on different methodologies that adjust funding from prior years based on caseload projections and assumed costs per case.

Demographics of CalWORKs Recipients.[1] Around three-quarters of all CalWORKs recipients are children. Nearly half of those children are under the age of six. Ninety-two percent of heads of CalWORKs recipient households are women. Two-thirds of these households are headed by single women. Nearly half have an 11th grade or less level of education, and ten to 28 percent are estimated to have learning disabilities. Around 80 percent of these adults report experiencing domestic abuse at some point.

Caseload and Spending Trends. Prior to federal welfare reform in the mid-1990s, California's welfare program aided more than 900,000 families. By 2000, the caseload had declined to 500,000 families. During the recent recession the caseload grew; but at an estimated 563,500 families in 2012-13, it was not anywhere close to the levels of the early 1990s. Most recently, the caseload declined 6.2 percent in 2015-16, and from there is expected to continually decrease in 2016-17, and 2017-18 (to a projected 459,173 families).

Federal Context and Work Participation Rate. Federal funding for CalWORKs is part of the TANF block grant program. TANF currently requires states to meet a work participation rate (WPR) for all aided families, or face a penalty of a portion of their block grant. States can, however, reduce or eliminate penalties by disputing them, demonstrating reasonable cause or extraordinary circumstances, or planning for corrective compliance. It is also important to note that federal formulas for calculating a state's WPR have been the subject of much criticism. For example, the federal government does not give credit for a significant number of families who are partially, but not fully, meeting hourly requirements.

California did not meet the WPR requirements in 2007-2015, and was assessed $1.8 billion in penalties. California has successfully completed corrective compliance plans (CCPs) that address the WPR shortfalls of 2008-2011, eliminating $587.1 million in penalties for those years. And because penalties are contingent upon the previous year's penalty amount, the penalties will be resent to a 2012 penalty amount and recalculated. The anticipated penalties assessed for 2012-2015 are projected to decrease by $1.1 billion due to continued achievement of the overall WPR rate; however, California did fail to meet the two-parent rate. The department is in the process of disputing the two-parent penalty amount for

[1] Context information comes from sample data collected by the Department of Social Services (DSS) and from studies in single or multiple counties, as summarized in *Understanding CalWORKs: A Primer for Service Providers and Policymakers*, by Kate Karpilow and Diane Reed. Published in April 2010; available online.

2015, and will likely submit a CCP if the dispute is unsuccessful, leaving approximately $138 million outstanding related to two-parent penalties.

At a joint Senate Human Services and Senate Budget and Fiscal Review Subcommittee No.3 hearing on March 10, 2014, an expert from the Center on Budget and Policy Priorities testified that no other state has ever been required to pay penalties.

Welfare-to-Work (WTW) Program and the 24-month clock. Adults eligible for CalWORKs are subject to a lifetime limit of 48 months of assistance. Unless exempt for reasons, such as disability or caregiving for an ill family member, adults must participate in work and other welfare-to-work (e.g., educational) activities. Depending on family composition, these activities are required for 20, 30, or 35 hours per week. The program also offers supportive services, such as childcare and housing support. Effective January 1, 2013, clients are under the WTW 24-month clock, which provides 24 months of additional flexibility around how to meet work requirements, but after the initial 24-months, imposes stricter work requirements to receive assistance and a limit on the number of recipients who can.

SB 1041 (Budget and Fiscal Review Committee), Chapter 47, Statutes of 2012 made significant changes to CalWORKs' welfare-to-work rules, including:

- Creation of a 24-month time limit with more flexible welfare-to-work activities (including employment, vocational education; job search; job readiness; job skills training; adult basic education; secondary school; or barrier removal activities) before the time limit has been reached, and stricter requirements afterward (up to 48 total months).

- A two-year phase-out of temporary exemptions from welfare-to-work requirements for parents of one child from 12 to 24 months old or 2 or more children under age 6, along with a new, once in a lifetime exemption for parents with children under 24 months.

- Changes to conform state law to the number of hours of work participation (20, 30, or 35, depending on family composition) required to comply with federal work requirements.

Counties may provide extensions of the more flexible rules for up to six months for up to 20 percent of participants. This 20 percent extender is not a cap, but a target.

Child-Only Caseload. In more than half of CalWORKs cases (called "child-only" cases), the state provides cash assistance on behalf of children only and does not provide adults with cash aid or welfare-to-work services. There is no time limit on aid for minors. In most child-only cases, a parent is in the household, but ineligible for assistance due to receipt of Supplemental Security Income, sanction for non-participation in welfare-to-work, time limits, or immigration status. In the remaining cases, no parent is present, and the child is residing with a relative or other adult with legal guardianship or custody.

CalWORKs child care. CalWORKs participants are eligible for child care if they are employed or participating in WTW activities. CalWORKs child care is administered in three stages:

- Stage 1. Provides care to CalWORKs families when first engaged in work or WTW activities, and is provided by DSS.

- Stage 2. Once counties deem the family "stable," CalWORKs families move to this program. Families remain in Stage 2 until they have not received assistance for two years. The California Department of Education (CDE) administers this program.

- Stage 3. Families transition to this program after Stage 2. CDE also administers this program.

Stages 1 and 2 services are considered entitlements, whereas Stage 3 services are available based on funding levels. Families receiving CalWORKs assistance, those considered "safety net," or families who are sanctioned are not required to pay family fees.

Early Engagement Strategies. SB 1041 also required DSS to convene stakeholder workgroups to inform the implementation of the above changes, as well as the following three strategies intended to help recipients to engage with the WTW component, particularly given the new time limits and rule changes:

- Expansion of subsidized employment. Under subsidized employment, counties form partnerships with employers, non-profits, and public agencies to match recipients with jobs. Wages are fully or partially subsidized for six months to a year.

- Family stabilization. Family stabilization (FS) is intended to increase client success during the flexible WTW 24-Month Time Clock period by ensuring a basic level of stability for clients who are especially in crisis, including intensive case management and barrier removal services. Clients must have a "Stabilization Plan" with no minimum hourly participation requirements. Six months of clock-stopping is available, if good cause is determined.

- Online CalWORKs Appraisal Tool (OCAT). OCAT is a standardized statewide WTW appraisal tool that provides an in-depth assessment of a client's strengths and barriers, including: employment history, interests, and skills; educational history; housing status and stability; language barriers; child health and well-being; and, physical and behavioral health, including, but not limited to, mental health and substance abuse issues.

Eligibility for individuals with previous felony drug convictions. SB 855 (Budget and Fiscal Review), Chapter 29, Statutes of 2014 expanded eligibility for adults who were previously ineligible for benefits due to a prior felony drug conviction, and implemented on April 1, 2015.

Housing and homeless assistance. In the last several budgets, housing and homeless assistance has received more attention and funding as people have become more aware that the lack of affordable housing impacts many CalWORKs recipients.

- The CalWORKs Housing Support Program (HSP) was established in 2014 to provide evidence-based interventions (such as rapid-rehousing) to CalWORKs families that are homeless or at risk of homelessness. Other core components of HSP include housing identification, rent and moving assistance, and focused case management. HSP was augmented in the last two budget cycles.

- The Homeless Assistance Program (HAP) provides a once-in-a-lifetime payment to meet the reasonable costs of obtaining permanent housing, and/or temporary shelter while seeking permanent housing. A typical family is eligible to receive benefits of up to $65 per night for 16 consecutive days of temporary shelter while searching for permanent housing. Families may also be eligible to receive up to two months of rental assistance in order to obtain permanent housing or two months of rental arrearages to prevent eviction. The 2016-17 budget eliminated the HAP the once-in-a-lifetime ban and allows a family to receive HAP assistance once in a 12 month period while maintaining existing exceptions for domestic violence and when existing housing becomes uninhabitable.

Maximum Family Grant (MFG) Repeal. The 2016-17 budget repealed the Maximum Family Grant rule, which stipulated that a family's maximum aid payment would not be increased for any child born into a family that had received CalWORKs for ten months prior to the birth of a child. Now, cash grants will be increased to include any child who was not receiving cash assistance because of the MFG. The repeal of the MFG is funded both through revenues in the Child Poverty and Family Supplemental Support Subaccount, which also funds MAP increases, and the General Fund.

Monitoring results and outcomes. In July 2014, the RAND Corporation launched a multiyear, evaluation to explore if CalWORKs programmatic reforms achieve desired objectives and report on any unintended consequences. The final report should be completed by early 2018. Initial findings, presented in December 2016, suggest that while the flexibility of SB 1041 changes is generally viewed as positive, CalWORKs participants and welfare staff still struggle to understand the complexities of the 24-month time clock. Findings also indicate that full implementation of SB 1041 components is still underway.

Summary of Major CalWORKs Changes
2009-2016

2009-10

- ➢ Suspend COLA
- ➢ Eliminate statutory basis for future COLAs
- ➢ Four percent grant cut

2011-12

- ➢ Reduce adults' lifetime limit from 60 to 48 months
- ➢ Eight percent grant cut
- ➢ Suspend CalLearn intensive case management for teen parents
- ➢ Decrease earned income disregard form $225 to $112

2012-13

- ➢ Create 24-mo. flexible participation period with stricter federal requirements after 24 mo.
- ➢ Phase-in funding for CalLearn case management

2013-14

- ➢ Five percent MAP increase, effective March 1, 2014
- ➢ Restore earned income disregard to $225

2014-15

- ➢ WINS starts Jan. 1, 2014
- ➢ Increase vehicle asset limit
- ➢ Five percent MAP increase, effective April 1, 2015
- ➢ Housing Support enacted

2015-16

- ➢ Expand eligibility to include former drug offenders

2016-17

- ➢ 1.43 percent MAP increase
- ➢ Repeal Maximum Family Grant rule

Policy considerations. The Legislature may wish to examine the following issues related to CalWORKs programs:

- Grant levels. In 1996-97, a maximum grant for a family of three was $594, or 55 percent of federal poverty level (FPL). By comparison, in 2016-17, a maximum grant for a family of three is projected to be $714 or 42 percent of FPL.

- Impact of the 24-month clock. The department, citing that fewer than 100 clients have exhausted the 24-month clock since implementation and have subsequently been removed from aid, there are no tangible savings. However, it appears that the number of CalWORKs recipients who will have months tick off their clock or exhaust their clock will likely increase in the next year. The department estimates that 430 average monthly cases will be removed from aid in 2016-17 and 740 will be removed from aid in 2017-18.

- Program goals and measures. What measures, besides the WPR, does the state use or plan to use to determine the success of CalWORKs? As early engagement components of the CalWORKs program begin to see a return of data and increased utilization, the Legislature may wish to consider the best way to use this data, and what outcomes they would like to see, to improve CalWORKs overall.

Staff Comment and Recommendation. Hold open. As this year's CalWORKs budget is largely caseload driven and proposes no new program changes, staff recommends that caseload-related funding decisions be made after the May Revision.

Questions.

1. Please briefly summarize the CalWORKs program, including funding sources, average grant amounts, recent legislative and policy changes, and caseload trends.

2. Please provide an update on the most recent 24-month clock data, including the number of families that will time out of the 24-month clock and the number who might be sanctioned for not meeting WTW requirements.

3. Please discuss efforts the department is making to help families who are meeting the WPR but receiving sanctions.

4. Given the flexibility of the activities under the 24-month clock, it was expected that participation would increase in adult education or vocational training. Has this occurred? Why or why not?

Issue 3: Oversight: Early Engagement Strategies

Background. AB 74 (Budget and Fiscal Review Committee), Chapter 21, Statues of 2013, enacted several provisions meant to engage CalWORKs families earlier and more extensively, and by doing so to eliminate some of the obstacles to long term self-sufficiency. Specifically, AB 74 enacted Expanded Subsidized Employment (ESE), the Online CalWORKs Appraisal Tool (OCAT), and Family Stabilization (FS). Funding for these programs in 2016-17 and 2017-18 is as follows:

Funding	FY 16-17	FY 17-18
Expanded Subsidized Employment (ESE)	$95.8 million Total Funds	$95.8 million Total Funds
Online CalWORKs Appraisal Tool (OCAT)	$12.0 million Total Funds	$12.0 million Total Funds
Family Stabilization (FS)	$39.9 million Total Funds	$39.9 million Total Funds

*Total Funds includes a mix of TANF and General Fund

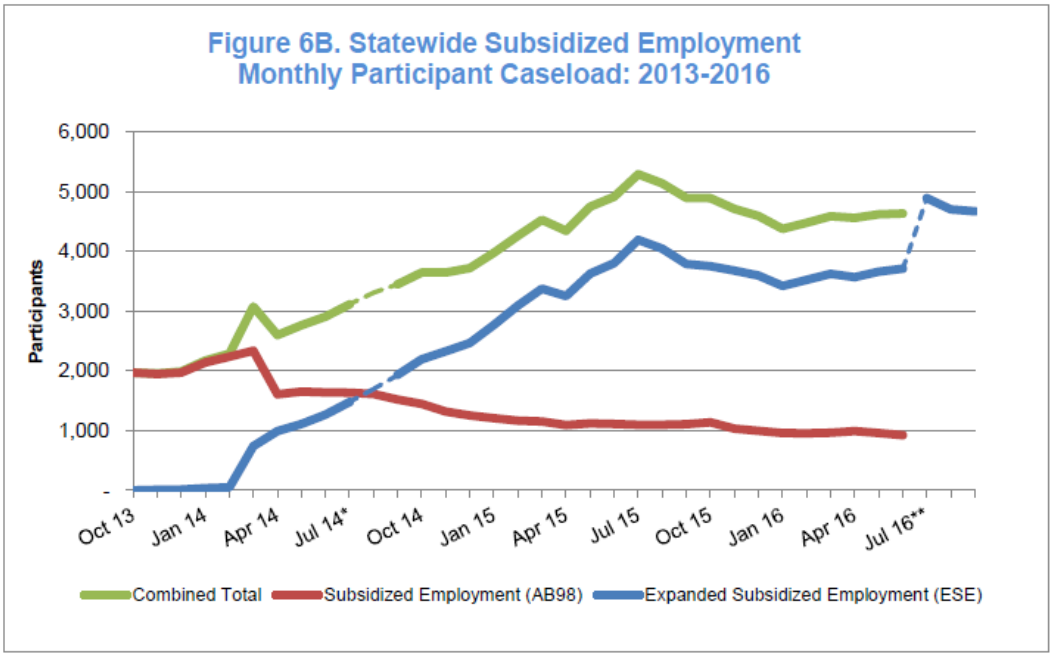
Expanded Subsidized Employment. Under subsidized employment, counties form partnerships with employers, non-profits, and public agencies to match recipients with jobs. Wages are fully or partially subsidized for six months to a year. While in an ESE placement, the CalWORKs recipient obtains specific skills and experience with the goal of obtaining permanent unsubsidized employment with the participating employer. Wages average $3,300 per month, and the majority earn between $10.00 and $13.00 per hour.

The monthly cost-per-slot is estimated at $1,355 and includes subsidized wages and benefits, non-wage employer costs such as worker's compensation. Grant savings resulting from employment earnings are reinvested into the ESE Program.

$138 million ($134 million for ESE and $4 million due to the elimination of AB 98 subsidized employment) was allocated to 56 counties in 2016-17, and DSS projects that around 8,000 new jobs were anticipated for the same time period. Proposed funding for this program in 2017-18 is $134 million.

As of December 2016, 51 counties are participating in the program. 2014-15 saw the participation of 7,798 new participants, and increased to 8,265 in 2015-16.

The following figures shows participants in subsidized employment programs, and shows an upward trend for subsidized employment activities.



Data Source: Participant data is based on monthly county transmissions.

Online CalWORKs Appraisal Tool (OCAT). OCAT is a standardized statewide WTW appraisal tool that provides an in-depth assessment of a client's strengths and barriers, including: employment history, interests, and skills; educational history; housing status and stability; language barriers; child health and well-being; and, physical and behavioral health, including, but not limited to, mental health and substance abuse issues. The department indicates that OCAT has been implemented in all 58 counties.

Between July 1, 2015, and June 30, 2016, 73,444 OCAT appraisals had been completed with recommendations for supportive services:

- 36,442 recommendations for mental health services.
- 18,401 recommendations related to domestic abuse.
- 5,967 recommendations related to substance abuse.
- 54,273 clients indicated they were not working at the time of appraisal.
- 10,130 clients were enrolled in education or training programs at the time of appraisal.

The following table shows the growth in the utilization of OCAT:

Table 6D. OCAT Appraisals by Month: FY 2015-16

Month	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
# of OCAT Appraisals	1,316	2,977	5,208	6,494	6,420	7,408	6,949	6,562	6,999	10,017	6,345	6,823

Data Source: OCAT Helpdesk Technical Assistance Reports

As more data is provided by OCAT through continued use and enhanced reports, DSS anticipates that additional programs that are used by CalWORKs clients may benefit from the recommendation data, and that the data may be used to determine how to address unmet needs for services statewide and at the local level. However, OCAT needs to be integrated into the larger SAWS system in order for OCAT data to be utilized effectively to this end. Integrating OCAT into SAWS was not funded in the Governor's budget.

Family stabilization (FS). FS is intended to increase client success during the flexible WTW 24-Month Time Clock period by ensuring a basic level of stability for clients who are especially in crisis, including intensive case management and barrier removal services for both adults and children. Clients must have a "Stabilization Plan" with no minimum hourly participation requirements. Six months of clock-stopping is available, if good cause is determined. Family Stabilization is a voluntary program, and counties were given flexibility to determine the services that are provided and individual program components. All 58 counties had fully implemented their FS programs as of June 2015.

CalWORKs Family Stabilization (FS) Status Report[1] Fiscal Year 2015-16 (July 2015 vs. June 2016 comparison)		
July 2015	June 2016	Participation
2,307	**2,833**	**Open FS cases.**
1,246	1,443	FS cases active in FS only.
240	295	FS cases that transitioned to a WTW plan.
821	1,095	FS cases that participated concurrently in WTW activities.
770	**763**	**FS cases that received good cause.**
		Services
2,148	**2,560**	**Total adults who received services.**
854	**1,422**	**Total children who received services.**
509	584	Domestic Abuse
1,256	1,488	Mental Health
218	397	Substance Abuse
1,405	1,919	Other [2]
		Housing Support/Services
726	**903**	**Total Homeless services provided.**
4,114	**5,291**	**Total FS services provided.**

Open cases have increased from 2,400 in December 2015 to 2,833 in June 2016. 3,982 individuals received domestic abuse services, mental health services, substance abuse services, or other services in June 2016, and 903 cases received homeless support or services in June 2016. Nearly 4,400 individuals successfully transitioned from an FS plan back to Welfare-to-Work between July 2014 and June 2016.

Staff Comment and Recommendation. Hold open. As OCAT continues to provide more information, the Legislature may wish to closely monitor what this data is revealing about the assessed needs of CalWORKs recipients, and how programs such as Family Stabilization or Expanded Subsidized Employment can be used to further the goals of the CalWORKs program. It is important to note that evaluation of this data may be dependent on the OCAT integration into SAWS.

Questions.

1. Please provide an overview of early engagement strategies, and continued implementation of these strategies.

2. How many subsidized employment placements have led to long-term, living-wage employment?

3. What are some new and different services that Family Stabilization funding provides?

4. Please discuss the automation of OCAT, and an update on initial data that OCAT has provided.

Issue 4: Oversight: Housing Support Program

Budget Issue. The Budget Act of 2016 appropriates $47 million for Homeless and Housing Support Services, and the Administration proposes the same level of funding for 2017-18. This breaks down to approximately $31 million in Federal Funds and $16 million General Fund.

Background. The CalWORKs Housing Support Program (HSP) was established in 2014 to provide evidence-based interventions to CalWORKs families that are homeless or at risk of homelessness. This funding allows County Welfare Departments to assist homeless families to quickly obtain permanent housing and provide wrap-around supports. Counties have the flexibility to design their own county-specific HSP plan to serve the needs of the community, but are required to use evidence-based models. It is anticipated that 49 counties will implement or expand an existing Housing Support Program in both 2016-17 and 2017-18.

The HSP recognizes rapid re-housing and targeted homelessness prevention programs as cost-effective strategies to help families exit or avoid homelessness and retain permanent housing. Other core components of a HSP include comprehensive and coordinated entry with community partners along a continuum of care, housing identification, rent and moving assistance, and focused case management. Examples of services provided are landlord outreach and engagement, housing search and placement, housing barrier assessment, legal services and credit repair.

Caseload. Statute allows all CalWORKs families to be eligible for HSP services, regardless of their asset or income levels, when a county finds that the family is experiencing homelessness or housing instability. Between September 2014 and December 2016, over 6,500 families were moved from homelessness to permanent housing. Statewide, nearly 4,000 families were receiving services and/or financial assistance through this program during the month of December 2016. The majority of families housed are ready to exit the program after receiving rental subsidies for six months or less.

Staff Comment and Recommendation. No action required, informational item only.

Questions.

1. Please provide an overview of the program and services it provides.

2. What is the identified need for CalWORKs families who are homeless or at risk of homelessness? Given the additional resources the program received for the current year, does the program currently meet this need?

Issue 5: Trailer Bill Language: Expand Use of Local Family Support Account Funds

Governor's Proposal. The Administration proposes to allow funds in a county's family support subaccount to be used to fund a portion of the CalWORKs Single Allocation in lieu of using General Fund.

The department notes that thirteen counties realized additional indigent health care savings in 2014-15 ($265.9 million) compared to initial estimate; this proposal will allow counties to redirect these savings.

Background. AB 85 (Committee on Budget), Chapter 24, Statutes of 2013 requires counties to establish a family support account in their local health and welfare trust accounts, which receives 1991 Realignment revenues from sales tax and vehicle license fees from the state-level Family Support Subaccounts.

Actual expenditure data reported by counties indicates that 13 counties realized additional combined indigent health savings of $265.9 million in 2014-15 above the previously estimated savings level. Currently, the 1991 Realignment revenues deposited into a county's local family support subaccount can only be used to fund CalWORKs grant costs; however, the state has maximized the amount of 1991 Realignment funds that can be used for this purpose. This proposal would be a one-time cost shift to allow the extra savings to be redirected towards the CalWORKs Single Allocation.

Staff Comment and Recommendation. Hold open.

Question.

1. Please summarize the proposal.

Issue 6: Proposals for Investment

The subcommittee has received the following advocate requests related to the CalWORKs program:

- Unsanction CalWORKs recipients who meet the federal WPR

Budget Issue. The Coalition of California Welfare Rights Organization (CCWRO) requests that CalWORKs recipients who meet the federal WPR be unsanctioned and provided with supportive services. The estimate for this proposal is $4 million General Fund and would require trailer bill language.

Background. Current law provides that if a CalWORKs recipient has been sanctioned, and the only way that sanction can be set aside is if the participant performs the activity that they failed were sanctioned for. The major reason for sanctions is generally failure to attend orientation and appraisal, and this is usually because recipients do not have transportation or child care at that point. However, many recipients who are sanctioned find a job on their own, and start working to meet the federal WPR. To cure the sanction and be able to receive supportive services, the CalWORKs recipient would now have to take a day off from their new job to go through orientation or appraisal, and perhaps jeopardize their employment.

Staff Comment and Recommendation. Hold open.

- Simplify postsecondary educational participation for WTW

Budget Issue. The CCWRO requests that (1) parents enrolled in a publicly funded educational or postsecondary educational activity be deemed to be meeting their WTW participation requirements as it does for WIOA participation, (2) such educational participation shall be deemed to be an extension of the 24-month clock, (3) provide an allowance of ancillary services, and (4) simplify access to childcare. CCWRO estimates that this could save approximately $100,000 General Fund annually and would require TBL.

Background. After the passage of SB 1041, it was expected that there would be an increase in referrals to education, given the flexibility in activities afforded by the bill. However, this has not occurred. One of the reasons for this may be that education only meets the federal WPR for one year.

Staff Comment and Recommendation. Hold open.

- Revise Single Allocation budgeting methodology and establish outcome and accountability system

Budget Issue. The County Welfare Director's Association (CWDA) requests that DSS be required to work with CWDA on the revision of the Single Allocation budgeting methodology, and the establishment of a new outcomes and accountability review system to foster continuous quality improvement in the program.

Background. The Single Allocation of CalWORKs funding provided to counties has historically fluctuated with caseload, although it funds both fixed and flexible work. Most recently, due to a trend of decreasing caseload, counties have underspent their Single Allocation funds. However, come 2017-18, the Single Allocation will be reduced by $198 million. This type of dramatic swing makes it difficult for counties to ramp up quickly in years when caseload and funding increases, as well as when they have to make rapid cuts when caseload and funding drops. CWDA points out that while many welfare-to-work services are easily scaleable, baseline administrative work is often not. And oftentimes when caseload decreases, the families left on CalWORKs are the ones most in need of increased services and supports.

The CalWORKs program offers a variety of different services, including job search and employment placement assistance, crisis resolution, mental health treatment, housing, child care, and educational opportunities. However, the only official measure of success is the federal WPR, which only looks at whether an individual was present in a "countable activity" for the required number of hours each month. This narrow measure does not tell us anything about broader measures of success, such as families finding and keeping living wage work or how children are faring.

Staff Comment and Recommendation. Hold open.

- Provide funding to integrate OCAT into SAWS

Budget Issue. CWDA requests trailer bill language and $3.7 million in funding to integrate the OCAT as a service within the SAWS system.

Background. Currently, OCAT is a standalone system that requires county staff to do duplicate data entry, and the lack of integration within SAWS impedes outcome tracking. DSS and CWDA have been working together over the past year to evaluate costs and options for the OCAT-SAWS integration; however, the Governor's budget did not include funding for these purposes.

Staff Comment and Recommendation. Hold open.

- Increase maximum CalWORKs grants and reinstate COLA and Earned Income Disregard

Budget Issue. The Western Center on Law and Poverty (WCLP) requests that the maximum grant by family size be increased to at least 50 percent of the FPL, and reinstatement of the COLA, as well as an increase to the Earned Income Disregard so that it has the same purchasing power as it did in 1997.

Background. Current maximum grant levels for a family of three on CalWORKs is just 42 percent of the FPL. Nearly 600,000 children live in deep poverty, most while enrolled in the CalWORKs program.

Staff Comment and Recommendation. Hold open.

- Create voluntary CalWORKs home visiting program

Budget Issue. California Latinas for Reproductive Justice, the Children's Defense Fund, Black Women for Wellness, and others request the creation of a voluntary home visiting program (the CalWORKs Baby Wellness and Family Support Home Visiting Program) for pregnant women and families with very young children served in the CalWORKs program. Home visiting would be evidence-based under the criteria of the Maternal, Infant, and Early Childhood Home Visiting program and provided by trained nurses or social workers.

Background. Much research has been done that points to the benefits of early home visiting. Some of these benefits include healthy child development beginning in the prenatal period, increased school readiness, enhanced parenting skills, and improved family economic self-sufficiency. This request is also addressed in AB 992 (Arambula) which is currently pending in the Assembly Appropriations Committee.

Staff Comment and Recommendation. Hold open.

Issue 7: Overview: CalFresh

Governor's Proposal. The Governor's budget includes $1.9 billion ($657.9 million General Fund) for CalFresh administration in 2017-18, a $136.6 million ($35.2 million General Fund) decrease from the 2016-17 appropriation. This increase is largely attributable to revised caseload projections. The CalFresh caseload is projected to decrease 2.8 percent in the current year and an additional 0.7 percent in 2017-18. The final CalFresh caseload, which is adjusted for caseload impacts not reflected in the base trend, is projected to reach an average of 1.8 million households in 2016-17 and 2017-18.

Background. CalFresh is California's name for the national Supplemental Nutrition Assistance Program (SNAP). As the largest food assistance program in the nation, SNAP aims to prevent hunger and to improve nutrition and health by helping low-income households buy the food they need for a nutritionally adequate diet. CalFresh food benefits are funded nearly exclusively by the federal government. Californians are expected to receive $7.2 billion (all federal funds) in CalFresh benefits in 2016-17, and $7.1 billion in 2017-18.

CalFresh benefits are provided on electronic benefit transfer (EBT) cards, and participants may use them to purchase food at participating retailers, including most grocery stores, convenience stores, and farmers' markets. In an average month in 2015-16, approximately $611 million in CalFresh food assistance was disbursed to around 4.4 million Californians. The current average monthly benefit per household is around $292 ($141 per person). Since 1997, California has also funded the California Food Assistance Program (CFAP), a corresponding program for legal permanent non-citizens, who are ineligible for federal nutrition assistance due to their immigration status. The proposed CFAP budget includes $62.8 million General Fund for food benefits, with an expected average monthly caseload of around 21,000 households (with about 48,000 recipients).

Eligibility and benefits. CalFresh households, except those with a member who is aged or has a disability, or where all members receive cash assistance, must meet gross and net income tests. Most CalFresh recipients must have gross incomes at or below 200 percent of the federal poverty level (which translates to approximately $3,360 per month for a family of three) and net incomes of no more than 100 percent of the federal poverty level ($1,680 per month for a family of three), after specified adjustments. The average monthly benefit per household is around $292 ($141 per person).

Efforts to improve participation. In FFY 2013, the most recent period for which official measures are available[2], the participation rate for the working low-income population was 74 percent nationally. California's participation rate for the working low-income population was the lowest in the nation at an estimated 52 percent. California's overall participation rate was the third lowest in the nation at an estimated 66 percent while the national rate was 85 percent.[3] Reasons offered for California's poor

[2] *Reaching Those in Need: Estimates of State Supplemental Nutrition Assistance Program Participation Rates in 2013,* USDA, February 2016 (http://www.fns.usda.gov/sites/default/files/ops/Reaching2013.pdf)

[3] DSS has noted that the federal government does not count the state's "cash-out" policy for SSI/SSP recipients (whereby those individuals receive a small food assistance benefit through SSP and are not eligible for additional CalFresh benefits) in its participation rate. The Department estimates that the state's participation rate could be a few percentage points higher if many those individuals who would otherwise be eligible for CalFresh were counted as participating. The state would still have among the lowest participation rates in the nation.

performance with respect to CalFresh participation include, among others, a lack of knowledge regarding eligibility among individuals who are eligible, frustration with application processes, concerns about stigma associated with receiving assistance, and misconceptions in immigrant communities about the impacts of accessing benefits.

Efforts to increase participation include outreach to communities, in reach to families served by other nutrition and anti-poverty programs (like the Women, Infants and Children (WIC) program) and streamlining customer service with more on-line and telephone access. In February 2016, California was recognized for these efforts and won a most improved Program Access Index award from the USDA for FFY 2014[4].

The department has continued to work on improving participation, most recently focusing on targeted populations:

Outreach to children. California has among the highest percentage of its children receiving CalFresh in the nation. The 2016 budget invested in a Children's Nutrition Initiative. The first project of the Initiative is a partnership between DSS CalFresh and the Department of Public Health WIC program to measure if children ages zero to five were receiving one, both, or neither of the two nutrition supports. Phase 1 consisted of a cross-department data match, and the result found that approximately 150,000 young children are participating in WIC but not CalFresh, even though they appear eligible. More analysis by geography, age, and language is under way. Phase 2 consists of site visits in spring 2017 to local WIC and CalFresh offices, to understand client and worker barriers and opportunities. Phase 3 will produce resources with proven practices for local providers and recommendations for state and federal policy, to help eligible young children receive both WIC and CalFresh. Upcoming projects of the initiative include continued expansion of modern customer service (including mobile and text tools) that are especially user-friendly for young parents.

Outreach to seniors. California's senior population has historically been underserved by CalFresh. Seniors made up approximately seven percent of the caseload in 2015, despite those 65 and over being 10 percent of the population in poverty in California. The state is engaging in a set of strategies to increase participation among currently eligible seniors and persons with disabilities: 1) on October 1, 2017 implementing a USDA "Elderly Simplified Application Project" to provide seniors with no earnings a three year-certification period; all electronic verifications at application; and no interview at recertification, unless requested; 2) also on October 1, 2017 implementing a USDA "Standard Medical Deduction demonstration project" to increase benefits of those with high medical expenses, which often includes seniors; 3) engaging the Behavioral Insights Team to test and design user-friendly application experiences and assistance for seniors; and 4) engaging the Benefits Data Trust to develop an enrollment and application assistance campaign for seniors. DSS will be convening a broad group of nutrition and senior stakeholders in summer 2017 to plan and coordinate this work and supporting partnerships.

[4] Program Access Index is the number of CalFresh participants divided by the estimated number of eligible people in California. The full USDA report, *Calculating the Supplemental Nutrition Assistance Program (SNAP) Program Access Index: A Step-by-Step Guide for 2014*, can be found at http://www.fns.usda.gov/sites/default/files/ops/PAI2014.pdf

Several recently enacted program changes seek to improve CalFresh program participation. Some of those program changes include:

1. Elimination of fingerprint imaging requirement. AB 6 (Fuentes), Chapter 501, Statutes of 2011, eliminated the fingerprinting requirement, which was intended to prevent duplicate receipt of aid. However, fingerprint imaging created the perception of stigma and other measures were already in place to prevent duplicative receipt.

2. Semiannual reporting. Evidence suggested that a number of CalFresh households may leave the caseload after failing to correctly submit regular reports, only to reapply a few months later. AB 6 also amended the reporting requirement from three quarterly reports in a certification period to one report in a certification period.

3. Face-to-face interview waiver. All counties offer telephone interview in lieu of a face-to-face interview for intake and recertification appointments for CalFresh-only clients.

4. Drug and Fleeing Felon Eligibility. Effective April 1, 2015, the lifetime ban on CalFresh benefits for those convicted of certain drug felonies was lifted. In September 2015 the Food and Nutrition Service of the United States Department of Agriculture published new rules on the definition of fleeing felon that allow a majority of previously ineligible adults to become eligible for CalFresh benefits and were implemented in California on December 1, 2015.

Drought Food Assistance Program (DFAP) and CalFood (formerly State Emergency Food Assistance Program (SEFAP) update. The DFAP is a temporary program. The 2016-17 appropriation included $18.4 million General Fund to operate the program. The department notes that this funding will be sufficient to see the program through December 2017, and there is no proposed funding for 2017-18. The CalFood program, formerly known as SEFAP, which provides additional flexibility to food banks, received a one-time $2 million General Fund augmentation in 2016-17; the Governor's budget does not provide additional funding for 2017-18.

Expiration of Federal ABAWD Waiver. When Congress created the SNAP program, they also created a time limit for unemployed childless adults between the ages of 18 and 49 years old, referred to as ABAWDs (Able-Bodied Adult Without Dependents). For ABAWDs, the receipt of SNAP benefits is limited to three months in a 36-month period unless they are working at least 80 hours per month, participating in qualifying education and training activities at least 80 hours per month, or complying with a workfare program. However, the ABAWD waiver California is operating under, which is based on the state's unemployment rate, allows for these individuals to continue receiving CalFresh benefits without the time limit. The statewide ABAWD waiver expires on August 31, 2018, and because California's overall unemployment rate is improving, it will likely not be renewed at a statewide level. The ABAWD waiver will still operate on a county by county basis, depending on that county's unemployment rate. When the waiver expires, certain counties and regions within California will lose waiver eligibility due to their declining unemployment rates. Those counties will then be required to implement the ABAWD time limit, putting likely hundreds of thousands of individuals at risk for not receiving CalFresh benefits. DSS is currently holding five workgroups and running monthly meetings to

help mitigate issues related to the expiration of the waiver and to fully prepare those counties that are at risk of losing the waiver.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the program and current caseload trends.

2. Please summarize efforts to improve participation and results of current outreach efforts.

3. Please discuss the expiration of the federal ABAWD waiver, impacts it may have and efforts the department is making to mitigate any negative effects.

Issue 8: Proposals for Investment

The subcommittee received the following requests for investment:

- Protect ABAWDs from expiring federal waiver

Budget Issue. WCLP requests TBL to (1) remove the ability of a county board of supervisors to opt out of accepting a federal waiver, (2) authorize self-initiated volunteer work to be performed in order to qualify for the ABAWDs exemption to the maximum extent permitted by federal law; and (3) requires the state to maximize federal exemptions to the ABAWD limit for homeless Californians.

Background. Under SNAP regulations, a state can qualify for a 12-month statewide ABAWD waiver if it is determined that the unemployment level is below a certain amount. However, the current ABAWD waiver is set to expire in 2018. Counties are still eligible for a waiver under federal law; however, current state law requires the state to seek a federal waiver for all counties eligible for a waiver unless the county board of supervisors send DSS a letter stating their intent to opt-out.

Staff Comment and Recommendation. Hold open.

- Additional funding for CalFood

Budget Issue. The California Association of Food Banks requests funding CalFood (formerly the State Emergency Food Assistance Program, or SEFAP) at $17.5 million General Fund in the 2017-18 budget.

Background. CalFood funds provide additional flexibility to food banks, as they can purchase the items that they need to complement the types of foods that are currently available to them. Advocates estimate that these funds would provide approximately 87.5 million meals. Last year, the Legislature approved a one-time $2 million General Fund augmentation to SEFAP.

Staff Comment and Recommendation. Hold open.

- Enact pilot to aid CalFresh families impacted by unsafe drinking water

Budget Issue. California Food Policy Advocates requests $5 million in the 2017-18 budget for a three-county supplemental nutrition benefit pilot to bring relief to CalFresh families impacted by unsafe drinking water.

Background. The State Water Board has previously estimated that roughly 400 disadvantage communities in the state receive water from a public water system that does not meet drinking water standards. In 2015, 27 counties have water systems with arsenic and nitrate/nitrite contaminations that made water unsafe to drink; more than 1.9 million CalFresh families reside in these counties.

Staff Comment and Recommendation. Hold open.

5180 – DEPARTMENT OF SOCIAL SERVICES – IMMIGRATION BRANCH

Issue 9: Update: Immigration Services Programs

Background. The 2016 Budget Act included $30 million General Fund for the Immigration Services Program. Through this program, qualified nonprofits who meet specific criteria and guidelines may apply for grants to provide education, outreach, and application assistance to immigrant community members eligible for either deferred action programs or naturalized citizenship.

DSS has awarded contracts to qualified nonprofit organizations that will provide services under one or more of the following service categories: (1) Services to Assist Applicants seeking Deferred Action for Childhood Arrivals (DACA); (2) Services to Assist Applicants seeking Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA); (3) Services to Assist Applicants seeking Naturalization; (4) Services to Assist Applicants seeking Other Immigration Remedies; (5) Legal Training and Technical Assistance Services; and (6) Education and Outreach Activities.

In 2015-16, 78 applications were received and 61 organizations were awarded funding. In 2016-17, 96 applications were received and 80 organizations were awarded funding. Contracts awarded in 2015-16 run from January 1, 2016 through June 30, 2017; while 2016-17 contracts run from January 1, 2017 through December 31, 2017.

Below is a chart that shows what activities were funded and at what level:

Service	Amount	% of Total
DACA	$1,081,200.00	4%
DAPA	0	0%
Other Immigration Remedies	$11,006,000.00	37%
Naturalization	$11,412,000.00	38%
Education and Outreach	$3,269,800.00	11%
LTTA	$976,000.00	3%
Capacity Award	$1,250,000.00	4%
AAPI	$250,000.00	1%
State Operations	$755,000	3%

National discussions of federal immigration policy have impacted demand and need, and the department has adjusted contract deliverables with individual contractors to reflect capacity, demand, need, and other factors.

Regions served include: Statewide (serving multiple regions), Central Valley (Butte, Colusa, Fresno, Glenn, Kern, Kings, Madera, Merced, Placer, San Joaquin, Sacramento, Shasta, Stanislaus, Sutter, Tehama, Tulare, Yolo, Yuba), Bay Area (Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, Sonoma), Central Coast (Monterey, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz), Inland Empire (Riverside, San Bernardino, Inyo), Los Angeles (Los Angeles),

Orange County (Orange, Ventura), and San Diego (Imperial, San Diego). Below is a chart with a breakout of regional allocations.

REGION	FY 2015-16 AWARD	FY 2016-17 AWARD
Statewide	$2,862,150	$8,134,830
Northern California	Included in Central Valley Region	$356,900
Central Valley	$2,508,100	$3,022,570
Bay Area	$2,695,550	$4,138,740
Central Coast	$382,590	$603,280
Los Angeles	$3,696,940	$8,447,270
Orange County	$869,660	$1,082,500
San Diego	$708,310	$706,860
Inland Empire	$736,700	$1,252,050

Organizations in the greater Los Angeles area and the Bay Area have the most capacity, and can serve greater numbers of immigrants, while other areas may have more limited capacity.

API Capacity Project update. The API Capacity Project is one of several projects seeking to improve immigration benefit outcomes for underserved immigrant populations in California. The department is making a two-year investment in the Los Angeles area to increase the number of API undocumented immigrants apply for relief including DACA and U Visas, and to identify best practices to improve outcomes for this community.

The API community is the fastest growing undocumented population in California and undersubscribes immigration relief programs. The Migration Policy Institute reports that nationally only 16 percent of Korean eligible immigrants applied for DACA, compared to 81 percent of immigrants from Mexico and El Salvador. The department will work with contractors with the relevant linguistic and cultural competency to promote immigration remedies, improve utilization and identify outreach and education best practices. This contract term is January 1, 2017 through December 31, 2018.

Reporting Requirements. DSS conducts site visits of contractors and reviews service performance on a quarterly basis. The department notes that outcomes for education and outreach are the most difficult to track.

Unaccompanied Undocumented Minors (UUM). DSS oversees $3 million legal services funding for the UUM program. The department awards contracts to qualified nonprofit legal services organizations that will provide legal representation for UUMs in the filing of, preparation for and representation in administrative and/or judicial proceedings for the following immigration statuses: asylum, T-Visa, U-Visa, and/or Special Immigrant Juvenile Status (SIJS). The legal services include culturally and linguistically appropriate services provided by attorneys, paralegals, interpreters and other support staff for state court proceedings, federal immigration proceedings, and any appeals arising from those proceedings. Services began on December 19, 2014.

The UUM fee-per-case was increased in 2015-16 from $4,000 per case to $5,000 per case to adequately compensate legal services organizations for the contracted UUM services. A departmental survey and research of costs associated with providing UUM legal services ranged from $2,000 to $12,000, depending on the case type. Invoicing records show that the majority of cases that contractors are handling involve Asylum and Special Immigrant Juvenile Status, which have the greatest expense.

The average wait time to secure a court decision for a UUM client is 1,071 days (2.9 years). All UUM contractors have until June 30, 2021 to close out all active cases and submit final invoices.

Below is a chart showing clients served to date with UUM program funding:

Fiscal Year	**2014-15**	**2015-16**	**2016-17**[5]
Clients to be Served	725	580*	580
Clients Completed (Adjudicated)	254	83	2
Final Case Outcomes			
Asylum	183	76	2
T-Visa	2	0	0
U-Visa	2	0	0
SIJS	65	7	0
Other (Citizenship)	2	0	0

DSS has awarded $8.7 million in funding through June 30, 2017 to non-profit legal services providers to provide legal services to 1,885 UUMs. The UUM program has funded an average of 20 non-profit organizations during each of its three cycles.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please briefly summarize the program and services, and provide an update on how current year funds are being spent.

2. Please provide an update on the API Capacity Project.

3. Please provide an update on UUM.

[5] Contracts were executed in November 2016 and invoices were submitted beginning January 2017. 184 have been served through January. The contract end date is June, 2017.

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

SUBCOMMITTEE NO. 3 Agenda

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

April 20, 2017
9:30 a.m., or Upon Adjournment of Floor Session
Room 4203, State Capitol

Consultant: Theresa Pena

OUTCOMES

Item	Department	Action
0530	**Health and Human Services Agency, Office of Systems Integration**	
5180	**Department of Social Services**	
Issue 1	Overview: Office of Systems Integration and Automation Projects	Informational
Issue 2	Update: Child Welfare Services – New System	Hold Open
Issue 3	Oversight: SAWS Single System	Informational
Issue 4	Budget Change Proposal: Child Welfare Digital Services Adjustment	Hold Open
Issue 5	Budget Change Proposal: CMIPS II – Implementation of Paid Sick Leave for IHSS Providers (SB 3)	Hold Open
Issue 6	Budget Change Proposal: CMIPS II – Vendor Contract Transitional Activities	Hold Open
Issue 7	Budget Change Proposal: Horizontal Integration Office: Transfer to Office of Systems Integration	Hold Open
5180	**Department of Social Services – State Hearings Division**	
Issue 1	Overview: State Hearings Division	Informational
5180	**Department of Social Services – CalWORKs**	
Issue 2	Overview: CalWORKs	Hold Open
Issue 3	Oversight: Early Engagement Strategies	Hold Open
Issue 4	Update: Housing Support Program	Informational
Issue 5	Trailer Bill Language: Expand Use of Local Family Support Account Funds	Hold Open
Issue 6	Proposals for Investment	Hold Open

Item	Department	Action
5180	**Department of Social Services – CalFresh**	
Issue 7	Overview: CalFresh	Hold Open
Issue 8	Proposals for Investment	Hold Open
5180	**Department of Social Services – Immigration Branch**	
Issue 9	Update: Immigration Services Programs	Hold Open

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 27, 2017
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Scott Ogus

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.

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: Overview

Office of Statewide Health Planning and Development - *Three-Year Funding Summary*			
Fund Source	**2015-16**	**2016-17**	**2017-18**
	Actual	***Revised***	***Proposed***
0001 – General Fund	$-	$-	$-
0121 – Hospital Building Fund	$53,298,000	$60,501,000	$61,726,000
0143 – CA Health Data & Planning Fund	$31,203,000	$35,930,000	$30,447,000
0181 – Registered Nurse Ed. Fund	$2,081,000	$2,180,000	$2,172,000
0518 – Hlth. Fac. Const. Loan Ins. Fund	$5,891,000	$4,882,000	$4,807,000
0829 – Health Professions Ed. Fund	$9,536,000	$10,855,000	$1,070,000
0890 – Federal Trust Fund	$1,444,000	$1,554,000	$1,447,000
0995 – Reimbursements	$5,096,000	$7,120,000	$863,000
3064 – Mental Hlth. Practitioner Ed. Fund	$391,000	$397,000	$394,000
3068 – Vocational Nurse Ed. Fund	$218,000	$229,000	$224,000
3085 – Mental Health Services Fund	$31,473,000	$49,482,000	$26,023,000
8073 – Med. Underserved Acct., HPE Fund	$2,255,000	$2,302,000	$2,302,000
Total Department Funding:	**$142,886,000**	**$175,432,000**	**$131,475,000**
Total Authorized Positions:	**443.7**	**449.0**	**447.0**

Office of Statewide Health Planning and Development - *Comparison to 2016 Budget Act*			
Fund Source	**2016-17**	**2016-17**	**2016-17**
	Appropriation	***Revised***	***Difference***
0001 – General Fund	$33,334,000	$-	($33,334,000)
0121 – Hospital Building Fund	$60,872,000	$60,501,000	($371,000)
0143 – CA Health Data & Planning Fund	$33,912,000	$35,930,000	$2,018,000
0181 – Registered Nurse Ed. Fund	$2,186,000	$2,180,000	($6,000)
0518 – Hlth. Fac. Const. Loan Ins. Fund	$5,029,000	$4,882,000	($147,000)
0829 – Health Professions Ed. Fund	$10,640,000	$10,855,000	$215,000
0890 – Federal Trust Fund	$1,443,000	$1,554,000	$111,000
0995 – Reimbursements	$4,071,000	$7,120,000	$3,049,000
3064 – Mental Hlth. Practitioner Ed. Fund	$400,000	$397,000	($3,000)
3068 – Vocational Nurse Ed. Fund	$233,000	$229,000	($4,000)
3085 – Mental Health Services Fund	$44,570,000	$49,482,000	$4,912,000
8073 – Med. Underserved Acct., HPE Fund	$2,303,000	$2,302,000	($1,000)
Total Department Funding:	**$198,993,000**	**$175,432,000**	**($23,561,000)**
Total Authorized Positions:	**449.0**	**449.0**	**-**

Office of Statewide Health Planning and Development - *Comparison 2016-17 (Rev) to 2017-18*			
Fund Source	**2016-17**	**2017-18**	**2017-18**
	Revised	***Proposed***	***Difference***
0001 – General Fund	$-	$-	$-
0121 – Hospital Building Fund	$60,501,000	$61,726,000	1,225,000
0143 – CA Health Data & Planning Fund	$35,930,000	$30,447,000	($5,483,000)
0181 – Registered Nurse Ed. Fund	$2,180,000	$2,172,000	($8,000)
0518 – Hlth. Fac. Const. Loan Ins. Fund	$4,882,000	$4,807,000	($75,000)
0829 – Health Professions Ed. Fund	$10,855,000	$1,070,000	($9,785,000)
0890 – Federal Trust Fund	$1,554,000	$1,447,000	($107,000)
0995 – Reimbursements	$7,120,000	$863,000	($6,257,000)
3064 – Mental Hlth. Practitioner Ed. Fund	$397,000	$394,000	($3,000)
3068 – Vocational Nurse Ed. Fund	$229,000	$224,000	($5,000)
3085 – Mental Health Services Fund	$49,482,000	$26,023,000	($23,459,000)
8073 – Med. Underserved Acct., HPE Fund	$2,302,000	$2,302,000	$-
Total Department Funding:	**$175,432,000**	**$131,475,000**	**($43,957,000)**
Total Authorized Positions:	**449.0**	**447.0**	**(2.0)**

Background. The Office of Statewide Health Planning and Development (OSHPD) collects and disseminates information about California's healthcare infrastructure, promotes an equitably distributed healthcare workforce, and publishes information about healthcare outcomes. OSHPD also monitors the construction, renovation, and seismic safety of hospitals and skilled nursing facilities and provides loan insurance to facilitate the capital needs of California's not-for-profit healthcare facilities.

Health Care Workforce Program. OSHPD administers programs designed to increase access to healthcare to underserved populations and provide a culturally competent healthcare workforce. Specifically, OSHPD encourages demographically underrepresented groups to pursue healthcare careers, incentivizes primary care and mental health professionals to work in underserved communities, evaluates new and expanded roles for health professionals and new health delivery alternatives, designates health professional shortage areas, and serves as the state's central repository of health education and workforce data.

OSHPD awards scholarships and loan repayments to aspiring health professionals and graduate students who agree to provide direct patient care in medically underserved areas for one to four years. OSHPD serves as California's Primary Care Office supporting the state's healthcare workforce through pipeline development, training and placement, financial incentives, systems redesign, and research and policy with a focus on underserved and diverse communities.

Health Professions Career Opportunity Program – Mini Grants. The Mini Grants program seeks to fund programs that encourage underrepresented and disadvantaged groups to pursue health careers to develop a more culturally and linguistically competent health care workforce for Californians. Mini

Grants fund activities focused on various categories, including health career conferences and workshops, and health career exploration.

Song-Brown Program. The Song-Brown Health Care Workforce Training Act (Song-Brown Program) was established in 1973 to increase the number of family physicians to provide needed medical services to the people of California. The program encourages universities and primary care health professionals to provide healthcare in medically underserved areas and provides financial support to family medicine, internal medicine, OB/GYN, and pediatric residency programs, family nurse practitioner, physician assistant, and registered nurse education programs throughout California. The Song-Brown program is aided by the California Healthcare Workforce Policy Commission (CHWPC), a 15-member citizen advisory board that provides expert guidance and statewide perspectives on health professional education issues, reviews applications, and recommends contract awards.

State Loan Repayment Program. The State Loan Repayment Program (SLRP) is a federally funded, state-run program that provides student loan repayment funding to healthcare professionals who commit to practicing in Health Professional Shortage Areas (HPSAs) in California. Professionals eligible for awards under SLRP include physicians (M.D. and D.O.), psychiatric nurse specialists, dentists, mental health counselors, registered dental hygienists, health service psychologists, nurse practitioners (primary care), licensed clinical social workers, physician assistants (primary care), licensed professional counselors, certified nurse midwives, marriage and family therapists, and pharmacists. Recipients must also, among other requirements, commit to a two-year (four-year, if half-time) initial service obligation at a SLRP Certified Eligible Site (CES) in one of the areas designated as an HPSA.

Facilities Development Division – Hospital Seismic Safety. In 1971, the Sylmar earthquake struck the northeast San Fernando Valley, killing 64 people and causing significant damage to structures. In particular, the San Fernando Veterans Administration Hospital in Sylmar, constructed in 1926 with unreinforced concrete, collapsed, resulting in the deaths of 44 individuals trapped inside the building. In addition, a more recently constructed psychiatric ward at Sylmar's Olive View Community Hospital collapsed during the quake, resulting in three deaths and the evacuation of more than 1,000 patients. In response to these tragic events, the Legislature approved the Alfred E. Alquist Hospital Facilities Seismic Safety Act, which required hospitals to meet stringent construction standards to ensure they are reasonably capable of providing services to the public after a disaster. In 1983, the act was amended to transfer all hospital construction plan review responsibility from local governments to OSHPD, creating the state's largest building department, the Facilities Development Division.

In 1994, the Northridge earthquake struck the San Fernando Valley again, resulting in major structural damage to many hospitals constructed prior to the Alquist Act, many of which were evacuated. In contrast, hospitals constructed in compliance with Alquist Act standards resisted the Northridge earthquake, suffering very little structural damage. In response, the Legislature approved SB 1953 (Alquist), Chapter 740, Statutes of 1994, which amended the Alquist Act to require hospitals to evaluate and rate all their general acute care hospital buildings for seismic resistance according to standards developed by OSHPD to measure a building's ability to withstand a major earthquake. SB 1953 and subsequent OSHPD regulations also require hospitals to submit plans to either retrofit or relocate acute care operations according to specific timeframes. According to OSHPD, there are approximately 470 general acute care hospital facilities comprised of 2,673 hospital buildings covered by the seismic safety provisions of SB 1953. In addition to oversight of seismic safety compliance for acute care hospitals,

OSHPD is responsible for ensuring seismic and building safety compliance for psychiatric hospitals, skilled nursing facilities, and intermediate care facilities.

Cal-Mortgage. OSHPD's Cal-Mortgage Division administers the California Health Facility Construction Loan Insurance Program. Cal-Mortgage provides credit enhancement for eligible health care facilities when they borrow money for capital needs. Cal-Mortgage insured loans are guaranteed by the "full faith and credit" of California, which permits borrowers to obtain lower interest rates. Eligible health facilities must be owned and operated by private, nonprofit public benefit corporations or political subdivisions such as cities, counties, healthcare districts or joint powers authorities. Health facilities eligible for Cal-Mortgage include hospitals, skilled nursing facilities, intermediate care facilities, public health centers, clinics, outpatient facilities, multi-level facilities, laboratories, community mental health centers, facilities for the treatment of chemical dependency, child day care facilities (in conjunction with a health facility), adult day health centers, group homes, facilities for individuals with developmental disabilities, and office or central service facilities (in conjunction with a health facility). As of January 31, 2017, Cal-Mortgage insures 89 loans with a total value of approximately $1.7 billion.

Health Care Information and Quality Analysis. The Healthcare Information Division (HID) collects and disseminates timely and accurate healthcare quality, outcome, financial, and utilization data, and produces data analyses and other products.

Data Collection. The division collects and publicly discloses facility level data from more than 6,000 licensed healthcare facilities including hospitals, long-term care facilities, clinics, home health agencies, and hospices. These data include financial, utilization, patient characteristics, and services information. In addition, approximately 450 hospitals report demographic and utilization data on approximately 16 million inpatient, emergency department, ambulatory surgery patients, and by physician, about heart surgery patients.

Data Products. The division produces more than 100 data products, including maps and graphs, summarizing rates, trends, and the geographic distribution of services. Risk-adjusted hospital and physician quality and outcome ratings for heart surgery and other procedures are also published. The division conducts a wide range of special studies on such topics as preventable hospital admissions and readmission, trends in care, and racial or ethnic disparities. The division also provides information to the public on non-profit hospital and community benefits, and hospital prices and discount policies.

Technical Assistance. The division provides assistance to the members of the public seeking to use OSHPD data and, upon request, can produce customized data sets or analyses for policymakers, news media, other state departments and stakeholders.

Subcommittee Staff Comment. This is an informational item.

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

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

2. Please describe the ongoing effort to reorganize data collection and IT functions within OSHPD? How will this reorganization benefit stakeholders, policy makers and the public?

Issue 2: Reversion of Health Care Workforce Funding

Budget Issue. The Administration requests reversion of $33.3 million General Fund in 2016-17. These funds are the first year of a three-year, $100 million General Fund allocation approved in the 2016 Budget Act for augmentation of health care workforce initiatives at OSHPD. If the reversion is approved, the Administration would reallocate this funding to other budgetary expenditures and the previously approved health care workforce initiative augmentations would be permanently eliminated.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	($33,334,000)	$-
Total Funding Request:	**($33,334,000)**	**$-**

Background. The 2016 Budget Act appropriated $33.3 million to OSHPD and approved budget bill language to augment existing health care workforce initiatives as follows:

- **$18.7 million** – Grant awards for existing primary care residency slots
- **$3.3 million** – New primary care residency slots at existing residency programs
- **$5.7 million** – Song-Brown Program primary care residency slots for teaching health centers
- **$3.3 million** – Newly accredited primary care residency programs
- **$333,000** – State Loan Repayment Program
- **$2 million** – OSHPD state operations costs for administering the Song-Brown Program

These funds were the first installment of a three-year, $100 million General Fund allocation for these purposes, which included budget bill language to make funds available for expenditure and encumbrance until June 30, 2022. The funds were approved, in part because of reductions in federal and private funding for healthcare workforce development, including the expiration of one-time funding from the California Endowment, the federal Health Resources and Services Administration, and the federal Teaching Health Centers Graduate Medical Education program.

The budget proposes to revert the $33.3 million General Fund allocation for health care workforce initiatives approved in the 2016 Budget Act. The budget also does not include the second-year installment of $33.3 million for health care workforce initiatives and notes that no additional funding is included for this purpose in the future. This proposal is one of several reductions in one-time spending commitments included in the budget to address the state's General Fund deficit. If approved, reversion of these funds would be permanent and the three-year allocation for these initiatives eliminated.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending updates to the state's General Fund condition at the May Revision.

Questions. The subcommittee has requested Department of Finance to respond to the following:

1. Please provide a brief overview of this proposal.

2. Please describe the Administration's rationale for reversion of these previously approved funds and elimination of the health care workforce augmentations.

Issue 3: Health Care Workforce Recruitment Legislation (AB 2024 and AB 2048)

Budget Issue. OSHPD requests expenditure authority from the California Health Data and Planning Fund of $400,000 in 2017-18, $250,000 in 2018-19 and 2019-20, and $70,000 in 2020-21 through 2023-24. If approved, these resources would allow OSHPD to implement health care workforce requirements pursuant to AB 2024 (Wood), Chapter 496, Statutes of 2016, and AB 2048 (Gray), Chapter 454, Statutes of 2016.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0143 – CA Health Data & Planning Fund	$-	$400,000
Total Funding Request:	**$-**	**$400,000**
Total Positions Requested:	**0.0**	

Critical Access Hospitals. The federal Centers for Medicare and Medicaid Services (CMS) certifies certain rural, general acute care hospitals as Critical Access Hospitals (CAHs), which allows for cost-based reimbursement from Medicare instead of the standard, fixed reimbursement rates. This reimbursement structure is intended to enhance the financial performance of small, rural hospitals and reduce hospital closures. To be designated by CMS as a CAH, a hospital must: 1) have no more than 25 beds, 2) be located in a rural area, and 3) be over 35 miles from another hospital (15 miles in mountainous terrain or areas with only secondary roads). According to OSHPD, there are currently 34 CAHs operating in California:

Hospital Name	County
Banner Lassen Medical	Lassen
Bear Valley Cmty. Hosp.	San Bernardino
Biggs-Gridley Memorial	Butte
Catalina Island Medical Center	Los Angeles
Colorado River Medical Center	San Bernardino
Eastern Plumas Hosp. Portola	Plumas
Fairchild Medical	Siskiyou
Frank R Howard Memorial	Mendocino
Glenn Medical	Glenn
Healdsburg District Hospital	Sonoma
J. Phelps Community Hospital	Humboldt
John C Fremont Healthcare	Mariposa
Kern Valley Healthcare	Kern
Mammoth Hospital	Mono
Mark Twain St Joseph's	Calaveras
Mayers Memorial	Shasta
Mendocino Coast Dist. Hospital	Mendocino

Hospital Name	County
Mercy Medical Center	Siskiyou
Modoc Medical Center	Modoc
Mountains Cmty. Hospital	San Bernardino
Northern Inyo	Inyo
Ojai Valley Cmty. Hospital	Ventura
Plumas District Hospital	Plumas
Redwood Memorial	Humboldt
Ridgecrest Hospital	Kern
Santa Ynez Vly. Cottage Hosp.	Santa Barbara
Seneca Healthcare District	Plumas
Southern Inyo Hospital	Inyo
St Helena Hospital, Clearlake	Lake
Surprise Valley Cmty. Hospital	Modoc
Sutter Hospital	Lake
Tahoe Forest Hospital	Nevada
Tehachapi Hospital	Kern
Trinity Hospital	Trinity

AB 2024 Allows CAHs to Directly Employ Medical Professionals. AB 2024 establishes an exemption from the ban on the corporate practice of medicine by authorizing CAHs to directly employ medical professionals and charge for professional services when the following conditions are met:

1) The medical staff concur by an affirmative vote that the employment of the medical professional is in the best interest of the communities served by the hospital.
2) The hospital does not interfere with, control, or otherwise direct the professional judgment of a physician or surgeon.

The exemption is operative until January 1, 2024.

AB 2024 requires OSHPD to provide a report to the Legislature, on or before July 1, 2023, regarding the impact of the exemption on CAHs and their ability to recruit and retain physicians and surgeons. The bill also requires CAHs to annually submit a report to OSHPD containing data it would need to prepare the required legislative report.

OSHPD requests expenditure authority of $200,000 from the California Health Planning and Data Fund in 2017-18 and $70,000 in 2018-19 through 2023-24 to meet AB 2024 reporting requirements. According to OSHPD, these limited-term resources would support development of research methods and protocols, systems development, CAH site coordination, responding to technical questions regarding research requirements, data collection and data analysis, and legislative report preparation. OSHPD plans to develop a web-based data collection process for receipt of information from CAHs to develop the required legislative report.

State Loan Repayment Program. The State Loan Repayment Program (SLRP) is a federally funded, state-run program that provides student loan repayment funding to healthcare professionals who commit to practicing in Health Professional Shortage Areas (HPSAs) in California. Professionals eligible for awards under SLRP include physicians (M.D. and D.O.), psychiatric nurse specialists, dentists, mental health counselors, registered dental hygienists, health service psychologists, nurse practitioners (primary care), licensed clinical social workers, physician assistants (primary care), licensed professional counselors, certified nurse midwives, marriage and family therapists, and pharmacists. Recipients must also, among other requirements, commit to a two-year (four-year, if half-time) initial service obligation at a SLRP Certified Eligible Site (CES) in one of the areas designated as an HPSA.

AB 2048 Adds FQHCs to Eligible Sites for State Loan Repayment Program. AB 2048 requires OSHPD to include all federally qualified health centers located in California in the SLRP CES list. According to OSHPD, there are currently 415 healthcare facilities on the CES list. AB 2048 requires the inclusion of approximately 2,500 additional FQHC sites, a six-fold increase. SLRP currently receives an average of 3,500 technical assistance inquires per year. OSHPD believes the addition of 2,500 practice sites on the CES list would increase the number of technical assistance calls exponentially.

OSHPD requests expenditure authority of $200,000 from the California Health Planning and Data Fund in 2017-18 and $180,000 in 2018-19 and 2019-20 to process additional SLRP applications and provide technical assistance to the additional applicants.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 4: Elective Percutaneous Coronary Interventions Reporting

Budget Issue. OSHPD requests two positions (conversion of limited-term to permanent) and expenditure authority from the California Health Data and Planning Fund of $358,000 annually. If approved, these resources would allow OSHPD to continue to collect data and analyze clinical outcomes for the Elective Percutaneous Coronary Interventions (PCI) program authorized by SB 906 (Correa), Chapter 368, Statutes of 2014.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0143 – CA Health Data & Planning Fund	$-	$358,000
Total Funding Request:	**$-**	**$358,000**
Total Positions Requested:	**2.0**	

Background. SB 906 established the Elective PCI program, which allows certified hospitals without on-site surgical backup to perform elective PCIs. Previously, a hospital could only perform elective PCIs if it operated a surgical cardiac unit within the same facility. SB 906 also requires OSHPD to produce an annual report of performance outcomes for all certified hospitals' elective PCI programs including patient mortality, stroke, and emergency coronary artery bypass graft (CABG) surgery.

The California Department of Public Health (CDPH) certifies hospitals participating in the Elective PCI program. These hospitals must submit performance outcomes data to the American College of Cardiology's National Cardiovascular Data Registry (NCDR). OSHPD obtains the data from NCDR to prepare its annual risk-adjusted outcomes report on mortality, post-operative stroke, and post-operative CABG for certified hospitals. SB 906 also authorizes CDPH to establish an advisory oversight committee to analyze the public outcomes report produced by OSHPD and make recommendations for changing the data analysis or risk-adjustment methods and possible outcomes to add in future reports.

Limited-Term Resources Approved in 2015 Budget Act. The 2015 Budget Act approved two limited-term positions, a Research Scientist III and a Research Program Specialist I, to fulfill OSHPD's SB 906 annual reporting requirements. According to OSHPD, these positions have been developing a work plan and gaining knowledge and understanding of the clinical and quality aspects of the data that will be used to develop accurate risk-adjustment models and outcome reports. Hospitals began submitting applications to participate in the Elective PCI Program in the fall of 2015 and CDPH reviewed and started certifying hospitals later that year. Consequently, the first data from hospitals certified to participate in the program are currently being submitted to NCDR. OSHPD obtained initial NCDR data beginning in September 2016.

The previously approved positions will expire on June 30, 2017. OSHPD requests conversion of these two positions from limited-term to permanent. If approved, these positions would continue to perform ongoing workload related to the annual outcomes reporting for the Elective PCI program.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. What are the clinical outcomes that will be included in the report?

Issue 5: Relocation Rent Adjustment

Budget Issue. OSHPD requests expenditure authority from special funds of $1.2 million annually. If approved, these resources would support rent increases associated with OSHPD's planned relocation of its Sacramento headquarters and Los Angeles location due to expiring lease agreements.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0121 – Hospital Building Fund	**$-**	$733,000
0143 – CA Health Data & Planning Fund	**$-**	$402,000
0518 – Health Facility Construction Loan Insurance Fund	**$-**	$72,000
0829 – Health Professions Education Fund	**$-**	($11,000)
3085 – Mental Health Services Fund	$-	$4,000
Total Funding Request:	**$-**	**$1,200,000**

Background. OSHPD leases office space for its Sacramento headquarters from the California Public Employees' Retirement System (CalPERS). The Sacramento headquarters houses multiple OSHPD programs and more than 400 employees. OSHPD also leases space in Los Angeles from the Metropolitan Water District (MWD), primarily for the Facilities Development Division.

CalPERS provided OSHPD and the Department of General Services (DGS), serving as OSHPD's real estate agent, notification that it would not renew the Sacramento lease, which expires on November 30, 2020. OSHPD has identified a new location for its headquarters in Natomas and plans to relocate in the Spring of 2017.

MWD also provided OSHPD and DGS notification that it would not renew the Los Angeles lease, which expires on May 31, 2017. MWD is conducting seismic retrofitting of its current building and needs the space occupied by OSHPD to relocate its own staff. OSHPD is currently working with DGS to secure a new location and expects to complete its Los Angeles relocation in late 2017.

As a result of these relocations, the new leases will result in increased rent costs of $1.2 million annually beginning in 2017-18. Approximately $1 million is attributable to the Sacramento headquarters relocation and $200,000 is attributable to the LA relocation.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Medi-Cal 2020 Waiver Implementation Update

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 program 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) – 14 Projects
v. Million Hearts Initiative (optional) – 17 Projects
vi. Cancer Screening and Follow-up (optional) – 14 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) – 5 Projects
  v. Transition to Integrated Care: Post-Incarceration (optional) – 3 Projects
  vi. Chronic Non-Malignant Pain Management (optional) – 13 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 – 9 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 financeing 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 $2.6 billion ($1.3 billion intergovernmental transfers and $1.3 billion federal funds) in 2016-17 and $1.6 billion ($800 million intergovernmental transfers and $800 million federal funds) in 2017-18 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 2016-17 and $2.3 billion ($1.2 billion intergovernmental transfers and $1.2 billion federal funds) in 2017-18 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 are 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
Contra Costa Health Services	52,500	$203,958,160
Kern Medical Center	2,000	$157,346,500
L.A. County Department of Health Services	137,700	$900,000,000
Monterey County Health Department	500	$26,834,630
Napa County	800	$22,686,030
County of Orange Health Care Agency	8,098	$23,500,000
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
County of San Diego, Health and Human Services Agency	1,049	$43,619,950
San Francisco Department of Public Health	10,720	$118,000,000
San Joaquin County Health Care Services Agency	2,130	$17,500,000
San Mateo County Health System	5,000	$165,367,710
Santa Clara Valley Health and Hospital System	10,000	$225,715,295
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	2,000	$97,837,690

A second round of WPC Pilot applications were scheduled to be submitted by March 1, 2017. The budget includes $480 million ($240 million intergovernmental transfers and $240 million federal funds) in 2016-17 and $720 million ($360 million intergovernmental transfers and $360 million federal funds) in 2017-18 for funding WPC Pilots.

Dental Transformation Initiative (DTI). The DTI is intended to improve the quality of care and increase utilization of dental services. DHCS is implementing the following four dental domains to accomplish this goal:

- **Domain 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 ten 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.
- **Domain 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.
- **Domain 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.
- **Domain 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.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of implementation progress for each of the four components of the Medi-Cal 2020 Waiver.

Issue 2: Medi-Cal 2020 Waiver Contract Resources

Budget Issue. DHCS requests expenditure authority of $2 million ($980,000 federal funds and $980,000 reimbursements) in 2017-18 through 2020-21 and $460,000 ($230,000 federal funds and $230,000 reimbursements) in 2021-22. If approved, these resources would fund contracts to facilitate learning collaboratives, provide technical assistance, and conduct an independent evaluation for components of the state's Section 1115 Medicaid Waiver, known as Medi-Cal 2020.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0890 – Federal Trust Fund	$-	$980,000
0995 – Reimbursements	$-	$980,000
Total Funding Request:	**$-**	**$1,960,000**
Total Positions Requested:	**0.0**	

Background. California's 1115 Waiver renewal, called "Medi-Cal 2020", was approved by the federal Centers for Medicare and Medicaid Services on December 30, 2015. Medi-Cal 2020 will guide DHCS through the next five years as DHCS works to transform the way Medi-Cal provides services to its more than 14 million members, and improve quality of care, access, and efficiency. The Waiver contains four primary components:

i. Public Hospital Redesign and Incentives in Medi-Cal (PRIME) – A program that partners with public hospitals to implement projects to improve care delivery systems in hospitals.
ii. Global Payment Program – A statewide pool of health care funding for the remaining uninsured
iii. Whole Person Care Regional (WPC) Pilots – Pilot projects to 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
iv. Dental Transformation Initiative (DTI) – An initiative with various programs and incentives to improve the quality of care and increase utilization of dental services.

PRIME and WPC Pilots Learning Collaboratives. As a condition of approval of the Waiver, the department must support regular learning collaboratives and ongoing required quality improvement activities, including development of data collection and analysis systems for external evaluation and providing technical assistance to PRIME entities on program evaluation requirements. DHCS received $500,000 ($250,000 General Fund and $250,000 federal funds) in 2016-17 for a contractor to comply with the Waiver requirements in the PRIME program. In addition, the Waiver approval requires the department to convene learning collaboratives for public entities participating in WPC Pilot programs.

DTI Evaluation Requirements. The Waiver approval requires an evaluation of the DTI, which must meet all standards of leading academic institutions and academic journal peer review, including standards for the evaluation design, conduct, interpretation, and reporting of findings. According to DHCS, the evaluation is required to determine the causal impacts of the DTI demonstration domains and will include a description of the quantitative and qualitative study design, a rationale for the design selected, descriptive statistics that reflect the socioeconomic status and demographic composition of

those served by the demonstration, and a consideration of the impact of the demonstration on socioeconomic and demographic subgroups.

DHCS Requests Limited-Term Contract Resources. DHCS requests expenditure authority of $2 million ($980,000 federal funds and $980,000 reimbursements) in 2017-18 through 2020-21 and $460,000 ($230,000 federal funds and $230,000 reimbursements) in 2021-22. If approved, these resources would fund contracts to facilitate the required learning collaboratives and provide technical assistance for the PRIME and WPC Pilot participants. These resources would also fund a contract to conduct the required evaluation for DTI. Because the non-federal share of funding for these Waiver programs are provided by intergovernmental transfers (IGTs), these contracts would be funded by a combination of IGTs and federal funds. The annual costs for each contract over four years (five years for DTI) are as follows:

Contract Activity	Reimb. (IGTs)	Federal Funds
PRIME Learning Collaboratives/Tech. Assistance	$250,000	$250,000
WPC Pilot Learning Collaboratives	$500,000	$500,000
DTI Evaluation	$460,000	$460,000
TOTAL EXPENDITURES	**$980,000**	**$980,000**

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 3: Affordable Care Act – Optional Expansion of Medi-Cal

Background. The federal Patient Protection and Affordable Care Act (ACA) authorizes states to expand their Medicaid programs to previously uninsured individuals. ABX1 1 (Perez) and SBX1 1 (Hernandez), Chapters 3 and 4, Statutes of 2013, authorized California's Optional Expansion of the Medi-Cal program. The Optional Expansion, effective January 1, 2014, expanded eligibility for previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level. Optional Expansion beneficiaries are mandatorily enrolled in managed care for their Medi-Cal benefits.

For states that expanded Medicaid, the ACA authorized federal matching funds of 100 percent for services provided to this population until January 1, 2017. After that date, states receive a federal match of 95 percent for calendar year 2017, 94 percent for calendar year 2018, 93 percent for calendar year 2019, and 90 percent for calendar year 2020 and beyond. Medi-Cal assumed a five percent General Fund share for the Optional Expansion population beginning January 1, 2017. In addition, the share of capitation payments for abortion-related services offered by Medi-Cal managed care has been borne by the state's General Fund since 2014, as federal funding is not available for this purpose.

The budget includes $20.1 billion ($888.4 million General Fund and $19.2 billion federal funds) in 2016-17 and $18.9 billion ($1.6 billion General Fund and $17.3 billion federal funds) in 2017-18 for coverage of the Optional Expansion population. The department estimates Optional Expansion enrollment of approximately 4 million beneficiaries in 2016-17 and 4.1 million beneficiaries in 2017-18.

Federal Health Care Proposals Create Significant Fiscal Uncertainty. The new federal Administration and leaders in Congress have proposed significant changes to the Affordable Care Act, including the provisions authorizing the expansion of Medicaid. DHCS and the Department of Finance reviewed the legislation developed by leadership in the U.S. House of Representatives, known as the American Health Care Act (AHCA), and identified significant programmatic and fiscal concerns. The review highlighted AHCA's significant shift of costs from the federal government to states, which would result in nearly $6 billion in costs to California in 2020, growing to $24.3 billion by 2027. The General Fund share of these costs would be $4.3 billion in 2020, increasing to $18.6 billion in 2027.

Subcommittee Staff Comment—This is an informational item.

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

1. Please provide a brief overview of caseload and enrollment trends in the Optional Expansion.

2. Please provide a brief overview of the department's analysis of the American Health Care Act's impact on the Medi-Cal program.

Issue 4: Coordinated Care Initiative – Continuation of Cal MediConnect and MLTSS

Budget Issue and Trailer Bill Language Proposal. The budget includes a certification that the Coordinated Care Initiative does not result in General Fund savings and the program will be eliminated effective January 1, 2018, pursuant to SB 94 (Committee on Budget and Fiscal Review), Chapter 37, Statutes of 2013. However, the Administration proposes trailer bill language to continue the duals demonstration project, continue the mandatory enrollment of individuals in managed care for long-term services and supports (MLTSS), except In-Home Supportive Services (IHSS), but eliminate the maintenance-of-effort (MoE) and Statewide Authority for IHSS. The budget includes $626.2 million of General Fund savings in 2017-18 in the Department of Social Services' (DSS) budget from the elimination of the MoE and approximately $20 million of General Fund savings in the DHCS budget from continuation of the demonstration. In addition to the continuation of the Coordinated Care Initiative programs, the proposed trailer bill language repeals four interagency agreements with the Department of Managed Health Care (DMHC) the department reports are unnecessary due to its new oversight and monitoring responsibilities pursuant to new federal regulations governing Medi-Cal managed care plans.

Background. The 2012 Governor's Budget proposed a demonstration project to better integrate the health care delivery system for individuals dually eligible for Medicare and Medi-Cal ("dual-eligibles"). SB 1008 and SB 1036 (Committee on Budget and Fiscal Review), Chapters 33 and 45, Statutes of 2012, and later SB 94, implemented the proposal, known as the Coordinated Care Initiative (CCI). This new program passively enrolled dual-eligibles into an integrated managed care plan for both Medicare and Medi-Cal benefits, known as Cal MediConnect, in seven counties. All other Medi-Cal beneficiaries in those counties, including those that opted out of Cal MediConnect, were mandatorily enrolled in managed care for their Medi-Cal benefits, including long-term services and supports like In-Home Supportive Services (IHSS) and skilled nursing facilities. The program also established a county maintenance-of-effort (MoE) requirement for IHSS, which froze counties' share of costs based on fiscal year 2011-12 expenditures, and established a Statewide Authority, which assumed responsibility for bargaining IHSS workers' wages in the seven demonstration counties. Passive enrollment began in March 2014 and was completed in all seven counties in August 2016. As of March 1, 2017, enrollment in Cal MediConnect plans was 115,613, with 28 percent of eligible beneficiaries enrolled statewide.

SB 94 Provisions Require Statewide General Fund Savings for CCI. SB 94 included a provision requiring the Director of Finance to certify the program results in General Fund savings and, if it did not, the program would be eliminated. The budget includes a certification that the program does not result in General Fund savings and the program will be eliminated effective January 1, 2018. However, the budget proposes to continue the duals demonstration project, continue the mandatory enrollment of individuals in managed care for long-term services and supports, except IHSS, but eliminate the MoE and Statewide Authority for IHSS. The budget includes $626.2 million of General Fund savings in 2017-18 in the Department of Social Services' (DSS) budget from the elimination of the MoE and approximately $20 million of General Fund savings in the Department of Health Care Services' (DHCS) budget from continuation of the demonstration.

Duals Demonstration and MLTSS Continuation Proposal. According to DHCS, based on lessons learned, the budget proposes to continue the Cal MediConnect program, continue mandatory enrollment

of dual eligibles, and integrate long-term services and supports (except IHSS) into managed care. If approved, the department's proposed trailer bill language would result in the following:

1) The duals demonstration would continue in the seven CCI counties, with no change in the beneficiary's experience. Cal MediConnect would continue for those that opt in and integration of MLTSS into managed care would continue for all other beneficiaries in those counties. However, the payments for IHSS services would no longer be accounted for through managed care capitation payments. Despite this change in the flow of funds, the IHSS program experience for beneficiaries would remain nearly identical. The budget assumes approximately $20 million of General Fund savings in 2017-18 from continuation of the demonstration in the DHCS budget.
2) The Statewide Authority would be eliminated. Responsibility for bargaining IHSS workers' wages would return to the counties.
3) The counties' 35 percent share of cost for IHSS would resume and the MoE eliminated. This would result in additional costs for counties, and concomitant reductions in General Fund expenditures in the DSS budget, of $626.2 million in 2017-18.

Repeal of Interagency Agreements with DMHC. DMHC has submitted a request, heard at the subcommittee's March 23 hearing, for a reduction of 18 positions and resources. This request is associated with DHCS' companion request for resources for compliance with the new federal Medi-Cal managed care regulations (See *Issue 6: Federal Medi-Cal Managed Care Regulations*). The two departments report that workload DMHC performs on behalf of DHCS pursuant to four interagency agreements is subsumed by the workload DHCS will accomplish to comply with the new federal regulations. DHCS proposes trailer bill language to repeal the statutory authority for these interagency agreements. These provisions are included in the trailer bill language provided by the Administration for continuation of CCI-related programs.

LTSS Workgroup Proposal - Amendments to Trailer Bill Language. The Assembly Aging and Long-Term Care Committee's Long-Term Services and Supports workgroup, a coalition of advocacy organizations, proposes several amendments to the Administration's proposed trailer bill language. These proposed amendments include the following provisoins:

1) Require counties to coordinate delivery of IHSS services to enable expedited enrollment and reassessment for both Cal MediConnect and MLTSS beneficiaries.
2) Require the development of standardized functional and cognitive assessment elements and guidelines for developing care plans for use by Cal MediConnect and MLTSS plans.
3) Require enforcement of new federal regulations coordinating required LTSS benefits and application to Cal MediConnect and MLTSS beneficiaries.
4) Develop additional data to show availability and quantity of home- and community-based services on a statewide and county-by-county basis.
5) Provide enrollment options for Programs for All-Inclusive Care for the Elderly (PACE) for individuals eligible for both Cal MediConnect and MLTSS.
6) Require the state develop a plan setting priorities for, and measuring progress of, California's integrated service delivery system, along with transition plan timelines.
7) Delete references to lock-in provisions and clarify 12-month continuity of care provisions.

Health Plans Proposal – Amendments to Trailer Bill Language. The California Association of Health Plans also proposes amendments to the Administration's proposed trailer bill language to remove

language referencing the grievance process for Care Plan Option services provided by participating plans.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. Please describe the changes to the program proposed in the trailer bill language compared to the current operation of the program.

Issue 5: Federal Medi-Cal Managed Care Regulations

Budget Issue. DHCS requests 15 positions and expenditure authority of $8.9 million ($4.5 million General Fund and $4.5 million federal funds) in 2017-18 through 2020-21 and $2.6 million ($1.3 million General Fund and $1.3 million federal funds) in 2021-22. If approved, these positions and resources would support compliance with new federal rules governing Medi-Cal managed care plans, dental managed care plans, county mental health plans, and Drug Medi-Cal organized delivery system waiver providers.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	$4,460,000
0890 – Federal Trust Fund	$-	$4,460,000
Total Funding Request:	**$-**	**$8,920,000**
Total Positions Requested:	**15.0**	

Background. Medi-Cal beneficiaries receive health care services through one of two separate delivery systems: fee-for-service and managed care. The managed care delivery system provides services to more than 78 percent of Medi-Cal beneficiaries through 22 Medi-Cal managed care plans. Each plan maintains its own network of providers and is paid a monthly capitation payment for each beneficiary based on rates calculated annually for each plan, county, and the beneficiary's category of aid. Rate development is based on actual encounter and claims data and is required to be certified as actuarially sound by the department's contracted actuary, Mercer.

Counties have adopted four primary models of managed care systems: two plan model, county organized health systems, geographic managed care, and the regional model. In recent years, several large populations of beneficiaries have transitioned into the managed care delivery system, making it the primary mode of service delivery in the Medi-Cal program. Certain services, however, have been exempted from delivery through managed care, particularly for sensitive populations and services.

In addition to Medi-Cal managed care plans, DHCS contracts with 56 county mental health plans, two primary care case management plans and six dental managed care plans. The county mental health plans provide realigned specialty mental health services to Medi-Cal beneficiaries under the terms of a waiver with the federal government. The two primary care case management plans are AIDS Healthcare Foundation and Family Mosaic, which provide services to specific populations in Los Angeles and San Francisco, respectively. The dental managed care plans provide dental services in two counties: Sacramento and Los Angeles. Enrollment in dental managed care is mandatory in Sacramento and voluntary in Los Angeles.

Medicaid Managed Care Regulations. In May 2016, the federal Centers for Medicare and Medicaid Services (CMS) released a final rulemaking for state Medicaid programs with beneficiaries served by managed care organizations. One of the most significant changes imposed by the regulations is the requirement that capitation rates be set at a single rate, rather than in a range. Another significant change is a restriction on directing payments by managed care plans to specified providers. Both of these new rules could potentially undermine several safety net financing mechanisms, such as the

hospital quality assurance fee and intergovernmental transfers, which DHCS uses to draw down additional federal funding for various health care services.

In addition to capitation rate development rules that complicate existing safety net financing programs, the rules require California's network adequacy standards be expanded from one provider type (primary care) to an additional six provider types; collection of quality data to be used to improve the managed care program; enhanced beneficiary supports; and monthly, rather than semi-annual, updates of provider directories.

The new managed care regulations apply to several different types of managed care providers in Medi-Cal. The regulations apply to the four primary models of managed care systems, mental health plans, primary care case management plans, and dental managed care plans. In addition to these plans, the regulations will apply to county programs participating in the Drug Medi-Cal Organized Delivery System Waiver.

Actuarially Sound Capitation Rates and Prospective Rate-Setting. Federal Medicaid law requires that no federal matching funds be paid to a state for capitation payments to a managed care plan unless, among other requirements, the "prepaid payments to the [plan] are made on an actuarially sound basis". Federal Medicaid regulations further define actuarially sound capitation rates as rates that:

1) Have been developed in accordance with generally accepted actuarial principles and practices.
2) Are appropriate for the populations to be covered and the services to be furnished under the contract.
3) Have been certified, as meeting these requirements, by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

DHCS develops capitation rates in consultation with the department's contracted actuary, Mercer. Once rates have been developed, Mercer provides the actuarial soundness certification required by federal regulations. Historically, the rate development process has resulted in a rate range, which represents the minimum and the maximum actuarially sound capitation payment that can be supported by encounter and claims data. The department typically pays the minimum rate in the range, which allows local government entities to provide additional non-federal dollars through intergovernmental transfers (IGTs) up to the maximum of the rate range to draw down additional federal matching funds.

The new managed care regulations prohibit the certification of a rate range, but instead require certification of a single rate. The single rate requirement has led the department to move to a prospective rate-setting process, in which the department and Mercer estimate reasonable, appropriate, and attainable costs under the managed care contract for the rating period. This process includes projecting enrollment and accounting for expected IGTs provided by local government entities, as well as other sources of the non-federal share for higher capitation rates, such as the Hospital Quality Assurance Fee.

Compliance-Related Resources Received in 2016-17. The 2016 Budget Act approved 38 positions and expenditure authority of $10.4 million ($5 million General Fund and $5.4 million federal funds) to complete the workload required to comply with the new regulations. These resources were approved

primarily to begin work on compliance for the 22 Medi-Cal managed care plans. This workload included: monitoring network adequacy, more frequent updates of provider directories, quality measurement, plan technical assistance, new rate development requirements, auditing of plan operations, and legal and research activities.

Additional Compliance Resources Requested in 2017-18. DHCS requests 15 positions and expenditure authority of $8.9 million ($4.5 million General Fund and $4.5 million federal funds) in 2017-18 through 2020-21 and $2.6 million ($1.3 million General Fund and $1.3 million federal funds) in 2021-22. In addition to the 15 permanent positions, the four-year, limited–term expenditure authority is equivalent to 40 additional positions. The request also includes contract funding for external quality review, language accessibility compliance, and technical infrastructure and assistance. The programmatic requests are as follows:

Managed Care Quality and Monitoring Division
Limited-term resources equivalent to four positions: One Research Manager III, one Research Program Specialist II, and two Associate Governmental Program Analysts (AGPAs) would manage increased managed care compliance with the new regulations due to the addition of two new managed care plans. These activities would include monitoring network adequacy and performance, and ensuring quality of data submitted by plans.

Managed Care Operations Division
Limited-term resources equivalent to seven positions: Four AGPAs, one Staff Services Manager II, one Research Program Specialist II and one Health Program Specialist II would manage contract changes, ensure monthly updates to provider directories and consistent enrollee communications, and implement payment system control changes.

Medi-Cal Dental Services Division
Limited-term resources equivalent to seven positions: Three AGPAs, one Staff Services Manager I, one Health Program Specialist II, one Research Program Specialist I and one Office Technician would manage compliance with the new managed care regulations for dental managed care plans. These positions would collect and report data, monitor network adequacy, promulgate necessary regulations, ensure program integrity, and implement quality improvement strategies.

Enterprise Innovation and Technology Services
Limited-term resources equivalent to five positions: One Data Processing Manager II, two Senior Programmer Analysts and two Staff Programmer Analysts would manage required data reporting to the federal government. The required data elements, which must be reported monthly, must be retrieved from several departmental systems with approximately 1,000 data fields.

Information Management Division
Limited-term resources equivalent to two positions: One Research Scientist III and one Research Scientist II would work with staff in the Enterprise Innovation and Technology Services division to collect, report, analyze, and manage data to be reported to the federal government.

Office of HIPAA Compliance
Limited-term resources equivalent to five positions: One Data Processing Manager II, two Senior Information Systems Analysts, and two Staff Information Systems Analysts would be responsible for ensuring HIPAA compliance, quality and integrity of the data being reported to the federal government under the reporting requirements of the new managed care rule.

Office of Legal Services
Limited-Term resources equivalent to two positions: Two Attorney III positions would provide legal support to compliance activities associated with dental managed care plans and mental health plans.

Mental Health Services Division
11 permanent positions and limited-term resources equivalent to three positions: One Staff Services Manager III, one Staff Services Manager II, one Staff Services Manager I, one Health Program Specialist II, two Health Program Specialist I positions, seven AGPAs (four permanent, three limited-term), and one Staff Services Analyst would manage workload related to county mental health plan compliance with the federal managed care regulations. Medi-Cal managed care plans, which are regulated by the Department of Managed Health Care, already have some level of compliance with many of the provisions of the new regulations. However, no such oversight has traditionally been applied to county mental health plans. These positions would manage implementation of new regulations governing provider network adequacy, monitoring and certifying compliance with these requirements, and manage other required quality and regulatory compliance activities for county mental health plans.

Substance Use Disorder – Program, Policy and Fiscal Division
Four permanent positions and limited-term resources equivalent to one position: One Staff Services Manager III, one Staff Services Manager II, and three AGPAs (two permanent, one limited-term) would manage reporting, quality assurance, monitoring, technical assistance, and network adequacy requirements related to the new Drug Medi-Cal Organized Delivery System waiver plans. These plans are categorized as prepaid inpatient hospital plans and are subject to requirements of the new federal managed care regulations.

Negative Position Request from Department of Managed Health Care (DMHC). DMHC has submitted a request, heard at the subcommittee's March 23 hearing, for a reduction of 18 positions and resources associated with this DHCS request. The two departments report that workload DMHC performs on behalf of DHCS pursuant to four interagency agreements is subsumed by the workload DHCS will accomplish to comply with the new federal regulations. These four interagency agreements, which are eliminated in DHCS' trailer bill language proposal for the Coordinated Care Initiative, are as follows:

1115 Waiver Demonstration Project. Beginning in 2010, DMHC conducts medical surveys, medical loss ratio financial examinations, and network adequacy reviews related to the 1115 Waiver, a federal waiver program to enable Medicaid participants to receive benefits through certain providers and permit the State to require certain individuals to receive benefits through managed care providers.

Rural Expansion. AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012, authorized the transition of approximately 400,000 individuals in 28 rural counties from fee-for-service to Medi-Cal

managed care plans. AB 1468 (Committee on Budget), Chapter 438, Statutes of 2012, required DHCS to enter into an interagency agreement with DMHC to conduct financial audits, medical surveys, and a review of the provider networks with the expansion of Medi-Cal managed care into the 28 rural counties.

Medi-Cal Dental Managed Care. DHCS began contracting with six dental managed care (DMC) plans in 2013. These dental plans receive a negotiated, monthly capitated reimbursement rate for each Medi-Cal beneficiary enrolled in the plan. Beneficiaries enrolled in the contracted plans receive dental benefits from providers within the plan's provider network. Under the interagency agreement, DMHC conducts financial examinations and medical surveys focused on the Medi-Cal line of business for these six DMC plans.

Coordinated Care Initiative. The Coordinated Care Initiative (CCI) seeks to provide better health outcomes for individuals eligible for both Medicare and Medi-Cal (dual-eligibles) by enrolling them into managed health care plans. SB 1008 (Committee on Budget and Fiscal Review), Chapter 33, Statutes of 2012, required DHCS to enter into an interagency agreement with DMHC to perform health plan surveys and financial reviews, readiness review activities, and provide consumer assistance to eligible beneficiaries of CCI. The Ombudsman Program conducts outreach and enhances awareness of Ombudsman service availability, investigates and resolves Cal MediConnect enrollees' issues with managed care plans and refers Cal MediConnect enrollees to various resources and assistance programs.

Managed Care Rate-Setting and Network Adequacy - Overview and Discussion. The subcommittee has requested DHCS to provide an overview of the rate-setting process for Medi-Cal managed care, particularly regarding ensuring adequate provider networks for Medi-Cal beneficiaries.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. Please describe the divisions and positions that will manage the workload previously performed by DMHC pursuant to the four interagency agreements.

3. Will all of the federal regulatory requirements be recapitulated in state regulations? If not, which provisions will be excluded and why?

4. Please provide a brief overview of the prospective rate-setting process and the department's progress implementing this process.

Issue 6: Medi-Cal Managed Care Ombudsman Staffing

Budget Issue. DHCS requests 15 positions (nine converted from limited-term and six new, permanent positions) and expenditure authority of $1.8 million ($895,000 General Fund and $894,000 federal funds). If approved, these resources would allow the department to continue managing increased call volume and consumer assistance activities in the Office of Ombudsman.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	$895,000
0890 – Federal Trust Fund	$-	$894,000
Total Funding Request:	**$-**	**$1,789,000**
Total Positions Requested:	**15.0**	

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.

According to DHCS, from December 2015 through September 2016 there has been a 24.5 percent increase in cases handled by the Ombudsman. This trend is expected to grow based on the following increases in managed care caseload and managed care transitions:

- Affordable Care Act optional expansion enrollment
- Implementation of the Whole-Child Model for California Children's Services
- Full-scope Medi-Cal benefits to all children under age 19, regardless of immigration status
- Geographic Managed Care expansion in Sacramento and San Diego

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.

According to DHCS, call volume data support that OMB is unable to successfully operate its call center with less than the current number of staff. DHCS proposes to make the nine limited-term positions permanent and add six new positions to allow redirected contract staff from Health Care Options to return to their original workload.

Stakeholder Proposal for Reporting of Ombudsman Complaint Data. The California Pan-Ethnic Health Network proposes trailer bill language to accompany the department's request. If approved, the proposed language would require quarterly reporting on calls received by the Ombudsman, including:

1) Number and type of contacts received

2) Wait time for callers or average speed to answer
3) Number of calls abandoned
4) Result of contacts, including destination of referred calls and time to resolution of complaint or grievance.

The collected data would include demographic, coverage and complaint-related information, in coordination with the Office of Patient Advocate, which reports on consumer managed care complaints at four state reporting entities. The proposed language would also require the reports be posted on the department's website and compiled into an annual report that also includes training protocols for staff, including cultural and linguistic competency; an assessment of trends; and protocols for call or complaint referrals.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. What information is currently collected by the Office of the Ombudsman and reported to the Office of Patient Advocate? Does the reported data include demographic information, such as language spoken, race, or ethnicity?

Issue 7: Provider Panel - Barriers Preventing Access to Care for Medi-Cal Beneficiaries

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 most recent monitoring plan was completed in September 2016 and is available on the DHCS website. The budget includes savings of $570.8 million ($188.3 million General Fund and $382.5 million federal funds) in 2016-17 and $565.4 million ($191.1 million General Fund and $374.3 million federal funds) in 2017-18.

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.

Provider Panel. The subcommittee has asked the following speakers to address the topic of barriers preventing access to care for Medi-Cal beneficiaries:

- **John D. Stobo, M.D.** – Executive Vice President, UC Health
- **Naomi Fuchs –** Chief Executive Officer, Santa Rosa Community Health Centers
- **Dr. John Luther –** Chief Dental Officer, Western Dental and Orthodontics
- **Stuart Thompson –** Associate Dir. Governmental Relations, California Medical Association
- **Amber Kemp –** Vice President, Health Care Coverage, California Hospital Association

Subcommittee Staff Comment—This is an informational item.

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

1. Please describe how the department monitors access to necessary medical care for Medi-Cal beneficiaries pursuant to its agreement with the federal government.

2. What metrics does the department utilize to determine whether access is sufficient for a particular provider type?

Issue 8: 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. Various budget and legislative actions have restored some adult dental services and acupuncture services.

Costs to Restore Remaining Optional Benefits. According to DHCS, the costs to restore each of the previously discontinued optional benefits in 2017-18 are as follows:

Optional Benefits	FFS	Managed Care	TF	GF
Audiology	$4,454,000	$9,444,000	$13,898,000	$4,372,000
Chiropractic	$557,000	$1,181,000	$1,738,000	$547,000
Incontinence Creams/Washes	$8,197,000	$20,084,000	$28,281,000	$8,856,000
Optician/Optical Lab	$11,051,000	$56,902,000	$67,953,000	$20,879,000
Podiatry	$2,459,000	$5,214,000	$7,673,000	$2,414,000
Speech Therapy	$283,000	$600,000	$883,000	$278,000
Dental	$175,430,000	$15,255,000	$190,685,000	$69,458,000
Grand Total	**$202,431,000**	**$108,680,000**	**$311,111,000**	**$106,804,000**

Various stakeholders have proposed restoration of previously discontinued optional benefits. These proposals may be found in *Issue 9: Allocation of Proposition 56 Tobacco Tax Funding – Proposals for Investment*.

Subcommittee Staff Comment and Recommendation—Hold Open.

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.

2. How do Medi-Cal beneficiaries typically access these services, when needed, outside of their Medi-Cal coverage?

Issue 9: Allocation of Proposition 56 Tobacco Tax Funding – Proposals for Investment

Background. The budget includes reduced General Fund expenditures of $1.2 billion offset by revenue received from voter approval of Proposition 56, which increased the excise tax rate on cigarettes, tobacco products, and electronic cigarettes. After backfills and specified allocations, Proposition 56 requires 82 percent of the funds remaining be transferred to the Healthcare Treatment Fund for DHCS to increase funding for existing healthcare programs and services by providing improved payments for all healthcare, treatment, and services. Proposition 56 also provided 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".

The Administration has interpreted the statutory provisions of Proposition 56 to allow allocation of revenue to fund growth in 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. According to the Administration, Proposition 56 revenue deposited in the Healthcare Treatment Fund is allocated to the following program growth expenditures in 2017-18:

PC #	PC Title	Amount of New Program Growth Funded by Proposition 56 Compared to 2016 Budget Act Level (Whole Dollars)
96	Two Plan Model	$464,092,000
97	County Organized Health Systems	$166,112,000
99	Geographic Managed Care	$81,150,000
167	Medicare Pmnts.- Buy-In Part A & B Premiums	$37,956,000
168	Medicare Payments - Part D Phased-Down	$285,485,000
102	Regional Model	$16,795,000
104	Pace (Other M/C)	$35,803,000
112	Capitated Rate Adjustment for FY 2017-18	$150,000,000
	Total	**$1,237,393,000**

Stakeholder Proposals for Investment of Proposition 56 Funding. Various stakeholders have proposed the following alternative 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

Supplemental Payments to Physicians and Dentists for Medi-Cal Access. The California Medical Association and the California Dental Association request approximately $900 million in Proposition 56 revenue to provide incentive-based supplemental payments to physicians and dentists based on the number of Medi-Cal patients served.

Expand Full-Scope Medi-Cal Up to Age 26 Regardless of Immigration Status. Health Access, the California Immigrant Policy Center, and others request approximately $90 million in Proposition 56 revenue to fund expansion of full-scope Medi-Cal services to young adults up to age 26 regardless of immigration status.

Restore Full-Dental Benefits to Adult Medi-Cal Beneficiaries. The California Pan-Ethnic Health Network, Health Access, and others request $69.5 million Proposition 56 revenue and $121.2 million federal funds to restore remaining dental benefits to adult Medi-Cal beneficiaries that were eliminated in 2009.

General Fund Investments

Restore Vision Benefits to Medi-Cal Beneficiaries. VSP Vision Care requests $68 million ($20.9 million General Fund and $47.1 million federal funds) and accompanying trailer bill language to restore optician and optical lab services in Medi-Cal. These benefits were eliminated in 2009 pursuant to ABX3 5. The proposed statutory changes are also contained in AB 1092 (Cooley), pending in the Assembly.

Clinical Laboratories Recoupment Forgiveness and Rate Restoration. The California Clinical Laboratory Association requests $39 million General Fund to restore AB 97 reductions for clinical laboratory providers and forgive retroactive recoupment of reductions implemented pursuant to AB 1494 (Committee on Budget), Chapter 28, Statutes of 2012.

Supplemental Payments to In-Home Pediatric Care for Medi-Cal Beneficiaries. Asm. Maienschein and Sen. Bates request $20 million General Fund and $20 million federal funds to provide incentive-based supplemental payments to in-home pediatric care providers in the Medi-Cal program.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold these proposals for investment 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 10: Nursing Facility/Acute Hospital Waiver Implementation

Waiver Renewal and Trailer Bill Language Proposal. DHCS proposes to renew its Nursing Facility/Acute Hospital Transition and Diversion waiver agreement with the federal government. The department proposes to codify the provisions of its proposed waiver renewal in trailer bill language. If approved, the proposed trailer bill language would allow the department to renew the waiver with specified changes. The budget includes $9.8 million ($4.9 million General Fund and $4.9 million federal funds) for costs related to implementation of the proposed waiver renewal.

Background. According to DHCS, the Nursing Facility/Acute Hospital Transition and Diversion (NF/AH) waiver is an alternative to costly institutional care and affords frail and vulnerable Medi-Cal members the opportunity to remain in a home- or community-based setting or to transition out of an institution into a home- or community-based setting. Federal law requires Medicaid waivers to maintain budget neutrality, which means the cost of services provided by the waiver program must be no more than the services provided to a peer group in an institutional placement. To maintain cost neutrality, individuals on the NF/AH waiver are assigned at the point of enrollment an annual institutional cost limit based on assessed level of care. NF/AH waiver participants have care plans and a menu of services from which they can select and self-direct as long as the cost of these services are within their annual individual cost limit. Nurse case managers have been managing the care plans and the annual individual cost limit and require participants who are at the cost limit to adjust the care plan, even if there is no change in the health status.

The NF/AH model of care provides a medical and social service delivery system using a person-centered planning approach that provides and coordinates all needed LTSS. Services are provided to adults who would otherwise reside in nursing facilities. The NF/AH waiver allows eligible individuals to remain independent and in their homes for as long as possible. The NF/AH waiver was scheduled to expire December 31, 2016. However, DHCS reports it obtained an extension of the current waiver until June 29, 2017.

Proposed NF/AH Waiver Renewal. After consulting with stakeholders, DHCS has submitted a proposal to extend the NF/AH waiver and proposes trailer bill language to codify the provisions contained in the proposed extension. These provisions would:

1) Authorize DHCS, when renewing the NF/AH Waiver, to take the following actions:
    a. Contract with one or more case management contractors qualified to provide care management and waiver services.
    b. Propose that the waiver demonstrates cost neutrality in the aggregate rather than based on individual cost limits. Waiver participants will still be subject to individual cost limits set to their established level of care but would have the ability to exceed institutional cost limits on a case-by-case basis determined by medical necessity.
    c. Expand the number of waiver slots by 5,000 beginning January 1, 2017. These slots would phase in over the course of the waiver term. Expansion of the existing cap, currently 3,964 slots, on the number of waiver participants will allow DHCS to reduce the existing community wait list, currently 1,800 members.
    d. Require care management contractors to enroll 60 percent of all total enrollments from institutional settings to assist members to return to home- and community-based settings.

e. Establish a managed fee-for-service model utilizing a per member per month rate developed with actuarial methods, to prevent further deterioration of existing provider networks and attract new provider organizations to contract with DHCS to provide waiver services.
f. Identify performance outcomes to evaluate quality of services provided by a care management contractor.
g. Develop criteria to evaluate the fiscal solvency of a care management contractor.
h. If the care management contractor is in danger of becoming fiscally insolvent, authorize DHCS to 1) immediately terminate the contract or 2) require the contractor to submit a compliance plan addressing fiscal solvency concerns.
i. Require a care management contractor to immediately notify DHCS in writing of any fact or facts that are likely to result in its inability to meet its financial obligations. The contractor must also submit an improvement plan outlining the steps that will be taken to improve the subsequent years' financial performance.
j. Allow renewal of a care management contract.
k. Require a point of contact, if at any event, either DHCS or the contractor needs to makes changes to the care management contract.
l. DHCS can terminate or decide not to renew a care management contract for any of the following reasons: 1) DHCS determines that the contractor does not meet the requirements for participation in the Medi-Cal or NF/AH waiver program; 2) A waiver participant's health is jeopardized by continuing the contract; or 3) Appropriated funds entered into the care management contract are unavailable. In addition, the care management contractor can terminate the contract for the following reasons: 1) Failure to reach mutual agreements on managed fee-for-service rates or unwillingness to accept the managed fee-for-service rates determined by DHCS; or 2) If the contractor can demonstrate to DHCS that it cannot remain fiscally solvent through the term of the contract due to a change in contractual obligations created by a state or federal change in the Medi-Cal or NF/AH waiver program.

2) Authorize DHCS to implement this section by means of all-county letters, provider bulletins, policy letters or other means to further execute policy direction.
3) Exempt contracts under this section from Department of General Services review and approval.
4) Require DHCS to implement this section only to the extent it can demonstrate fiscal neutrality on the overall health care costs spent by DHCS for waiver participants, as specified and only to the extent federal financial participation is available.
5) DHCS will submit the NF/AH waiver renewal for approval by the federal Centers for Medicare and Medicaid Services prior to implementing these provisions.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the provisions of the NF/AH Waiver Renewal.

Issue 11: Home- and Community-Based Services & Long-Term Care - Proposals For Investment

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

AIDS Waiver Reimbursement Parity With Other HCBS Programs. The HIV Alliance requests $8.1 million ($4.1 million General Fund, $4.1 million federal funds) to increase reimbursement rates in the AIDS Waiver to better align with reimbursement rates received by other home- and community-based service waiver programs. The AIDS Waiver Program is one of eight home- and community-based services waiver programs targeting vulnerable populations in California and provides comprehensive case management and direct, in-home services to people living with HIV or AIDS as an alternative to nursing facility care or hospitalization.

Home Upkeep Allowance and Transitional Needs Fund. Disability Rights California and other organizations request up to $121.9 million ($61 million General Fund and $61 million federal funds) to increase the dollar amount for the Home Upkeep Allowance, which allows Medi-Cal beneficiaries in a nursing facility placement with a share-of-cost to maintain a home in the community. These organizations also propose to create a Transitional Needs Fund to allow share-of-cost Medi-Cal beneficiaries who have lost their homes to save income for six months to secure housing. Costs associated with the Transitional Needs Fund are unknown, but potentially significant.

Skilled Nursing Facility Nursing Hours Per Patient Day. SEIU California requests $70.3 million ($35.1 million General Fund and $35.1 million federal funds) in 2017-2018, $160.3 million ($80.1 million General Fund and $80.1 million federal funds) in 2018-19, and $282.4 million ($141.2 million General Fund and $141.2 million federal funds) annually thereafter. If approved, these resources would fund Medi-Cal local assistance payments to skilled nursing facilities to support a phased increase in the minimum direct care nursing hours per patient day (nhppd) from the current 3.2 nhppd to 4.1 nhppd.

Intermediate Care Facilities-Developmental Disabilities (ICF-DDs) Rate Reforms. The Developmental Services Network requests $28.9 million ($14.5 million General Fund and $14.5 million federal funds) to lift the freeze on reimbursement rates enacted in 2008 and rebase those rates to the unfrozen rates for 2016-17, develop a new rate methodology based on the Centers for Medicare and Medicaid Services skilled nursing facility market basket, implement a Quality Assurance Supplemental Payment program effective August 1, 2018, and establish a new rate for facilities with four beds.

Medically Tailored Meals Program. The Food is Medicine Coalitaion requests $2 million General Fund for three years to make a cost-effective, medically tailored, home delivered meal intervention available to approximately 2,500 Medi-Cal beneficiaries with certain complex and traditionally high-cost health conditions and determine how such an intervention could lead to better outcomes and lower health care costs for recipients and the state Medi-Cal program.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold these proposals for investment 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 12: SF Community Living Services Benefit Transition to Assisted Living Waiver

Budget Issue and Trailer Bill Language Proposal. DHCS proposes trailer bill language to transition individuals receiving home and community-based services in the San Francisco Community Living Support Benefit (SF CLSB) waiver into the Assisted Living Waiver (ALW). The budget includes savings of $746,340 ($373,170 General Fund and $373,170 federal funds), which is the net of additional costs for providing services to new ALW beneficiaries offset by savings from transitioning individuals from skilled nursing facilities into a community placement under the ALW.

SF Community Living Services Benefit Transition Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	$373,170
0890 – Federal Trust Fund	$-	$373,170
Total Funding Request:	**$-**	**$746,340**

Background. The SF CLSB waiver, administered by the city and county of San Francisco on behalf of DHCS, assists eligible individuals to move into available community settings and exercise increased control and independence over their lives. The waiver provides or coordinates services at community-based housing sites that enable beneficiaries to remain in the least restrictive, most home-like environment while receiving health-related services, including personal care and psychosocial services. Medi-Cal beneficiaries eligible to participate in the program must be:

1) 21 years of age and older.
2) A resident of San Francisco who would otherwise be homeless, living in shelters, or institutionalized.
3) Would be determined eligible for skilled nursing facility level of care.

The SF CLSB waiver is scheduled to expire on June 30, 2017. San Francisco has decided not to renew the waiver.

DHCS proposes to sunset the SF CLSB waiver effective July 1, 2017, and transition its 22 participants into the Medi-Cal Assisted Living Waiver (ALW). The ALW offers services in an assisted living or publicly subsidized housing setting to Medi-Cal beneficiaries who would likely otherwise receive care in a skilled nursing facility. Qualification for a skilled nursing level of care is determined by a care coordination agency utilizing an assessment tool to assess potential participants. According to DHCS, the goals of the ALW are to:

1) Facilitate a safe and timely transition of Medi-Cal beneficiaries from a nursing facility to a community home-like setting in a residential care facility, an adult residential care facility, or public subsidized housing, utilizing ALW services.
2) Offer eligible seniors and persons with disabilities, who reside in the community, but are at risk of being institutionalized, the option of utilizing ALW services to develop a program that will safely meet his or her care needs wlyhile continuing to reside in a residential care facililty, adult residential care facility, or public subsidized housing.

In addition to the trailer bill language to manage the transition, DHCS proposes to expand the ALW, which is currently operating in 14 counties, to serve the city and county of San Francisco. The ALW

expires February 28, 2019. According to DHCS, the services provided through the SF CLSB waiver are comparable and available under the ALW.

The department also expects the transition will result in 22 additional ALW enrollments from institutional providers within the city and county of San Francisco, in particular, from the highest cost skilled nursing facility in the state, Laguna Honda. DHCS expects these new transitions to community settings to result in General Fund savings based on reduced expenditures for institutional care. The budget includes savings of $746,340 ($373,170 General Fund and $373,170 federal funds), which is the net of additional costs for providing services to new ALW beneficiaries offset by savings from transitioning individuals from skilled nursing facilities into a community placement under the ALW.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. Please describe the planned transition process for individuals currently receiving services under the SF CLSB waiver. How will this process be communicated to beneficiaries?

3. Please describe how the department intends to maintain continuity of care for beneficiaries transitioning from the SF CLSB to the ALW. Are there providers that serve SF CLSB participants that may not participate in the ALW?

Issue 13: Alternative Birthing Center Reimbursement

Budget Issue and Trailer Bill Language Proposal. DHCS proposes trailer bill language to allow reimbursement for deliveries in alternative birthing centers (ABCs) based on the equivalent, lowest acuity diagnosis-related group (DRG) reimbursement provided to general acute care hospitals. The budget includes $43,500 ($21,755 General Fund and $21,765 federal funds) for increased costs associated with higher reimbursement rates to ABCs upon approval of the proposed trailer bill language. The trailer bill language also makes technical changes to remove outdated reporting requirements and other statutory references.

Alternative Birthing Center Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	$21,755
0890 – Federal Trust Fund	$-	$21,765
Total Funding Request:	**$-**	**$43,500**

Background. An ABC is a clinic that is not part of a hospital and provides comprehensive perinatal services and delivery care to pregnant women who remain in the facility for less than 24 hours. On average, there are approximately 200 births within an ABC each year. Along with providing pregnant mothers an alternative to traditional low-risk hospital births, ABCs provide cost-effective birthing services and help to reduce high overall medical costs as compared to low-risk hospital births.

Existing state law requires DHCS to reimburse ABCs for facility-related delivery costs at a statewide, all-inclusive rate per delivery that cannot exceed 80 percent of the average Medi-Cal reimbursement to general acute care hospitals, as identified in the California Medical Assistance Commission (CMAC) annual legislative report. However, the contract between CMAC and DHCS has been dissolved and rate-setting responsibilities transferred to DHCS. The department currently utilizes a payment methodology that is based on DRGs, which pay similarly across hospitals for similar care for equivalent diagnoses.

DHCS proposes trailer bill language to implement an ABC reimbursement methodology based on the Medi-Cal DRG payment system, which replaced the CMAC system, and to align existing law to reflect an all-inclusive delivery rate-setting methodology. The proposed rate would be based on the DRG level-1 based general acute care hospital rate and would impose the following requirements: 1) ABC reimbursements may not exceed provider charges made to the general public; 2) federal approvals must be obtained before implementing the revised methodology; and 3) the application of the ten percent provider payment reduction, pursuant to AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, would continue.

Additionally, DHCS proposes to: 1) remove certain provider and departmental reporting requirements that are not currently being administered and are no longer necessary; 2) add cross-references identifying other provider licensing and oversight provisions, as applicable; and 3) remove the annual legislative reporting requirements in regards to the ABC provider type assessing cost-effectiveness and quality of care. The budget includes $43,500 ($21,755 General Fund and $27,765 federal funds) for increased reimbursements to ABCs upon approval of the department's proposed trailer bill language.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 14: Ground Emergency Medical Transportation Supplemental Pmt. Program Audits

Budget Issue. DHCS requests three positions (conversion of limited-term to permanent) and expenditure authority of $393,000 ($197,000 federal funds and $196,000 reimbursements) annually. If approved, these resources would allow the department to continue auditing workload for its supplemental reimbursement program for ground emergency medical transportation (GEMT) providers.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0890 – Federal Trust Fund	$-	$197,000
0995 – Reimbursements	$-	$196,000
Total Funding Request:	**$-**	**$393,000**
Total Positions Requested:	**3.0**	

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 678 (Pan), Chapter 397, Statutes of 2011, authorizes state and local government entities to use CPEs to claim federal matching funds for the difference between the Medi-Cal reimbursement rate and the allowable cost for providing GEMT services. Public entities certify and submit CPEs for GEMT services and reimburse DHCS for the non-federal share of costs to administer the program. DHCS must audit cost reports submitted to claim CPE prior to submission to CMS for federal matching funds.

According to DHCS, approximately 100 local fire districts currently participate in the GEMT supplemental payment program. Participation has increased each year and is projected to be 120 in 2017-18. The department reports a backlog of approximately 428 cost reports caused by a delay in federal approval of audit requirements and expects an additional 120 cost reports requiring audit annually.

Limited-Term Resources Approved in 2014. The 2014 Budget Act approved seven positions, four permanent and three limited-term, for auditing workload related to implementation of the GEMT supplemental payment program. Three Health Program Auditor III positions will expire on June 30, 2017. DHCS proposes to convert these three positions from limited-term to permanent. These positions were approved as limited-term to clear an initial backlog of cost reports based on a retroactive implementation date for supplemental payments to 2010. According to DHCS, CMS auditing requirements have added to the complexity and resulting workload for each audit and, consequently, requests conversion of these limited-term positions to permanent to complete audits of provider cost reports timely.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. How does the department intend to clear its auditing backlog with the same level of resources?

Issue 15: AB 959 Clinic Supplemental Reimbursement Audits

Budget Issue. DHCS requests a two-year extension of expenditure authority of $1.4 million ($697,000 federal funds and $697,000 reimbursements). If approved, these resources would allow the department to implement supplemental Medi-Cal payments to state veterans homes and public clinics pursuant to AB 959 (Frommer), Chapter 162, Statutes of 2006.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0890 – Federal Trust Fund	$-	$697,000
0995 – Reimbursements	$-	$697,000
Total Funding Request:	**$-**	**$1,394,000**
Total Positions Requested:	**0.0**	

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 Jaw 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.

DHCS proposes 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 are equivalent to the ten positions in the previously approved request, except with two Health Program Auditor III positions replaced with one Attorney and one Legal Analyst. The department expects cost report auditing, appeal, and litigation workload once CMS approves the new cost report template.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. Why has the implementation of this supplemental reimbursement program been delayed for more than 10 years?

3. What is the expected timeframe for CMS approval of the cost reports? When will the supplemental reimbursement program become operative?

4. How did the department fund the non-federal share of the previously approved positions if no cost reports, and therefore no clinic reimbursements, were received?

Issue 16: Third Party Liability Recovery – Fifty Percent Rule and Contracting Authority

Budget Issue and Trailer Bill Language Proposals. DHCS proposes trailer bill language to change the statutory amount it may recover from personal injury awards for services provided to Medi-Cal beneficiaries as a result of the injury. If approved, the budget includes $12.2 million General Fund savings to account for the increased recoveries the department expects to receive. DHCS also proposes trailer bill language to clarify and update its contracting requirements for third party liability recoveries consistent with other provisions of state contracting law.

Fifty Percent Rule Proposal Savings Estimate		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	($12,160,000)
Total Funding Request:	**$-**	**($12,160,000)**

Background. Federal and state law require DHCS to recover Medi-Cal costs from liable third parties, so that Medi-Cal is the payer of last resort. DHCS manages personal injury (PI) recovery cases in-house and uses a contractor to perform workers' compensation recovery activities. In 2015-16, the PI program recovered $60.4 million and the workers compensation program recovered $2.5 million.

Personal Injury Recoveries and the Fifty Percent Rule. DHCS' PI program reviews Medi-Cal expenditures paid for treating a member's injury and files a lien with the liable third party. The PI program may settle its lien directly with the liable third party or assert the lien against any settlement, judgment, or award resulting from a member's claim or action. However, state law requires DHCS to take no more than half of a settlement after all attorney's fees and legal costs are paid, a requirement known as the "Fifty Percent Rule." Federal Medicaid law, regulations, and guidance require the federal government's share of financing for injury-related services in a third party liability action to be fully reimbursed prior to the beneficiary receiving funds. Prior to the federal Affordable Care Act (ACA), most Medi-Cal beneficiaries had a federal matching percentage of 50 percent. When a lien was reduced under the Fifty Percent Rule for a beneficiary with a 50 percent federal match, DHCS reimbursed the federal government up to 100 percent of the amount recovered, with no funds remaining for state General Fund reimbursement. After the ACA expansion, the newly eligible group of beneficiaries has a federal matching percentage of 95 percent (100 percent prior to January 2017). For these members, DHCS reimburses CMS up to 200 percent of the amount recovered from the settlement, resulting in a loss to the state's General Fund.

DHCS proposes trailer bill language to do the following:

1) Clarify the formula that defines the state's portion of litigation costs – State law allows for a reduction of the Medi-Cal PI lien so each party pays a proportionate share of litigation costs based on the amount they receive when an attorney facilitates the settlement. According to DHCS, state law and various case law creates situations where DHCS must reduce its lien by amounts greater than the actual litigation costs incurred by the member. The department's proposed language requires each party to pay a proportionate share of actual litigation costs based on the proportion of the settlement received.

2) Clarify right to recover when there are multiple settlements – According to DHCS, existing law does not explicitly address the department's right to recover the costs of treating a member's injury when there are multiple settlements, limiting the recovery to the amount derived from applying the lowest of three statutory reductions defined in statute. The department's proposed language:
   a. Clarifies the recovery is based on the aggregated amount of all settlements once the entire action has been resolved, not just a single settlement.
   b. Renames five references to the amount to be collected from "reasonable value of benefits so provided" to "amount of the director's lien as defined in subsection (d) of Section 14124.70".
   c. Requires the Medi-Cal member or DHCS, whoever initiates a claim with a carrier for a member's injury, to notify the other party, so both parties are protected in their rights to recover injury-related losses.
3) Revise Fifty Percent Rule - DHCS proposes to limit its recovery to no more than the settlement after deducting reasonable attorney's fees and litigation costs. According to DHCS, this approach conforms to federal law, stops General Fund losses, guarantees plaintiffs' attorneys receive their expected fees, and avoids making the member liable for attorney's fees or litigation costs.

The budget includes $12.2 million General Fund savings to account for increased recoveries the department expects to receive based on its proposed revision to the Fifty Percent Rule. This savings estimate assumes the state will no longer be required to pay approximately $4 million to the federal government for its share of ACA-related recoveries and will receive approximately $8.2 million from non-ACA-related recoveries that had previously been awarded to the beneficiary. The savings estimate does not account for changes to the number of beneficiaries filing personal injury claims if the beneficiary is no longer able to receive compensation.

The budget also includes no savings for the other two provisions of its proposal to clarify the formula to define the state's portion of litigation costs and to clarify the department's right to recover when there are multiple settlements.

Third Party Liability Contracting. In 1981, the state began a pilot program allowing contracting and outsourcing of some Medi-Cal third party liability recoveries. DHCS was required to enter into contracts with private entities to obtain missing information that was held by private companies on a contingency basis. Recent workers' compensation data provided by the Department of Industrial Relations eliminates the need to outsource discovery of missing information for workers' compensation claims. However, because many PI actions remain solely in private sector databases that are unreported to the state, the department reports it needs a contractor to gain information about these unreported PI cases. State law requires these contracts to be awarded based on a no cost, percentage of recovery formula not to exceed 25 percent of the gross recovery amount.

DHCS proposes trailer bill language to do the following:
1) Eliminate mandates for contracts for workers' compensation.
2) Eliminate mandates for regional contracts for northern and southern California. According to DHCS, both contracts have been awarded to the same contractor over five bidding cycles.
3) Provide a finite end to contracts consistent with state contracting policy.

4) Technical, clarifying amendments to statute to remove obsolete pilot-related provisions and align with current practice.
5) Allow DHCS to offer non-exclusive or non-competitive contracts to multiple contractors.
6) Repeals sections providing delegated authority of the DHCS Director to contractors for recovery. According to DHCS, contractor authority will be defined within future contracts to mitigate the risk of a contractor working inconsistent with state policy, ensure the state complies with federal law, and reduce susceptibility to lawsuits.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of these proposals.

2. What additional recoveries does the department expect from the trailer bill language provisions clarifying the formula for the state's portion of litigation costs and clarifying the department's right to recover when there are multiple settlements?

3. If Medi-Cal beneficiaries will receive no compensation from filing a personal injury claim, why does the department expect such claims will continue to be filed?

Issue 17: Federally Qualified Health Ctrs. – Delayed Implementation of Payment Changes

Budget Issue and Trailer Bill Language Proposal. DHCS proposes budget actions and trailer bill language to delay implementation of two planned changes to reimbursements for federally qualified health centers (FQHCs).

According to its *2017-18 Governor's Budget Highlights*, DHCS plans to delay implementation until no sooner than July 1, 2018, a demonstration project to test an alternative payment methodology (APM) for FQHCs pursuant to SB 147 (Hernandez), Chapter 760, Statutes of 2015. Because SB 147 authorized implementation of the APM no sooner than July 1, 2016, the department does not require legislative approval for this delay.

DHCS also proposes trailer bill language to delay implementation of AB 1863 (Wood), Chapter 610, Statutes of 2016, which allows FQHCs to bill Medi-Cal for services provided by marriage and family therapists (MFTs) as a separate visit beginning July 1, 2017. If the department's trailer bill language proposal is approved, AB 1863 implementation would be delayed until July 1, 2018.

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.

SB 147 Establishes an Alternative Payment Methodology Pilot for FQHCs. SB 147 authorizes an alternative payment methodology demonstration project designed to provide flexibility for clinics' delivery of health care services to Medi-Cal beneficiaries. The alternative methodology would pay clinics a monthly capitation rate for beneficiaries, which would allow clinics to receive payment for a beneficiary's care that is unrelated to the number of visits he or she makes to the clinic. This payment structure would be implemented no sooner than July 1, 2016, and would allow clinics to provide multiple provider services to beneficiaries on a single day.

AB 1863 Allows Separate Billing for MFTs. AB 1863 includes, beginning July 1, 2017, 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.

Prioritization of Department Workload. In its *2017-18 Governor's Budget Highlights*, DHCS reports that it must prioritize certain initiatives and delay others. In particular, the department plans to prioritize implementation of various resource-intensive federal regulations, such as the Medicaid managed care, Medicaid mental health parity, and home- and community-based services regulations. As a result, the department intends to delay several initiatives including the APM demonstration and MFT billing implementation for FQHCs, which would begin no sooner than July 1, 2018.

Proposed Amendment to Trailer Bill Language. The California Association of Marriage and Family Therapists (CAMFT) proposes to amend the department's trailer bill language to require implementation of FQHC billing for MFTs "no later than July 1, 2018". This language would allow the department to delay implementation for no more than one year from the original implementation date of July 1, 2017.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please describe the rationale for delaying implementation of the APM and billing for MFTs at clinics.

2. When does the department intend to implement these required reimbursement changes?

Issue 18: Family Health Estimate Overview

Budget Issue. The November 2016 Family Health Local Assistance Estimate includes $251 million ($175.2 million General Fund, $10.5 million federal funds, and $65.2 million special funds and reimbursements) for expenditures in 2016-17, and $266.9 million ($218.1 million General Fund, $4.5 million federal funds, and $44.3 million special funds and reimbursements) for expenditures in 2017-18.

Family Health Local Assistance Funding Summary			
Fiscal Year:	**2016-17**	**2017-18**	**BY to CY**
California Children's Services (CCS)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$67,805,000	$73,877,000	$6,072,000
Federal Funds	$6,061,000	$-	($6,061,000)
Special Funds/Reimbursements	$4,723,000	$5,453,000	$730,000
County Funds [non-add]	[$78,685,000]	[$79,444,000]	[$759,000]
Total CCS Expenditures	**$78,589,000**	**$79,330,000**	**$741,000**
Child Health and Disability Prevention (CHDP)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$32,000	$1,000	($31,000)
Total CHDP Expenditures	**$32,000**	**$1,000**	**($31,000)**
Genetically Handicapped Persons Program (GHPP)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$106,186,000	$144,206,000	$38,020,000
Special Funds and Reimbursements	$36,425,000	$16,425,000	($20,000,000)
Total GHPP Expenditures	**$142,611,000**	**$160,631,000**	**$18,020,000**
Every Woman Counts Program (EWC)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$1,190,000	$-	($1,190,000)
Federal Funds	$4,509,000	$4,509,000	$-
Special Funds and Reimbursements	$24,083,000	$22,427,000	($1,656,000)
Total EWC Expenditures	**$29,782,000**	**$26,936,000**	**($2,846,000)**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$175,213,000	$218,084,000	$42,871,000
Federal Funds	$10,570,000	$4,509,000	($6,061,000)
Special Funds and Reimbursements	$65,231,000	$44,305,000	($20,926,000)
County Funds [non-add]	[$78,685,000]	[$79,444,000]	[$759,000]
Total Family Health Expenditures	**$251,014,000**	**$266,898,000**	**$15,884,000**

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 174,178 in 2016-17, an increase of 60 or 0.03 percent, compared to the 2016 Budget Act. The budget estimates Medi-Cal CCS caseload of 177,396 in 2017-18, an increase of 3,218 or 1.8 percent, compared to the revised 2016-17 estimate.
  Caseload Estimate (State-Only): The budget estimates state-only CCS caseload of 12,803 in 2016-17, an increase of 701 or 5.8 percent, compared to the 2016 Budget Act. The budget estimates state-only CCS caseload of 12,557 in 2017-18, a decrease of 246 or 1.9 percent, compared to the revised 2016-17 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 509 in 2016-17, a decrease of 1,284 or 71.6 percent, compared to the 2016 Budget Act. The budget estimates state-only CHDP caseload of zero in 2017-18, a decrease of 509 or 100 percent, compared to the revised 2016-17 estimate. According to DHCS, these significant caseload reductions are primarily due to the 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. (See *Issue 21: Elimination of State-Only Child Health and Disability Prevention Program*)
- **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: The budget estimates state-only GHPP caseload of 931 in 2016-17, an increase of 44 or 5 percent, compared to the 2016 Budget Act. The budget estimates state-only GHPP caseload of 936 in 2017-18, an increase of 5 or 0.5 percent, compared to the revised 2016-17 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. In prior Family Health Estimates, program benefits and administrative costs were budgeted on an accrual basis, while other programs in the Family

Health Estimate are budgeted on a cash basis. Beginning in 2017-18, the EWC program will transition from an accrual basis to budgeting on a cash basis. (See *Issue 22: Every Woman Counts Accrual to Cash Budgeting*)

Caseload Estimate: The budget estimates EWC caseload of 161,000 in 2016-17, unchanged compared to the 2016 Budget Act. The budget estimates EWC caseload of 25,000 in 2017-18, a decrease of 136,000 or 84.5 percent, compared to the revised 2016-17 estimate. The significant decrease in 2017-18 caseload is due to the proposed transition from an accrual basis to budgeting on a cash basis.

Delay of CCS 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 three COHS counties beginning July 1, 2017. However, the department's *2017-18 Governor's Budget Highlights* indicates it intends to delay implementation of the Whole Child Model until July 1, 2018. This would result in shifting of the currently budgeted costs into 2018-19, with a one-time savings in 2017-18 of $45.1 million ($21.1 million General Fund and $23.9 million federal funds).

Subcommittee Staff Comment and Recommendation—Hold Open.

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 19: Elimination of State-Only Child Health and Disability Prevention Program

Trailer Bill Language Proposal. DHCS proposes to repeal the statutory provisions granting eligibility for the state-only Child Health and Disability Prevention (CHDP) program. If approved, this language would eliminate access to CDHP's health screening and immunization services for children not enrolled in Medi-Cal.

Background. The state-only CHDP program, established in 1973, provides complete child health assessments and immunizations to children under 21 years of age enrolled in Medi-Cal, and non-Medi-Cal children under 19 years of age whose family income is at or below 200 percent of the federal poverty level (FPL). Children from families with incomes at or below 200 percent of the FPL can pre-enroll in fee-for-service Medi-Cal under the presumptive eligibility for children provisions of the Medicaid program. This pre-enrollment takes place electronically at CHDP provider offices at the time children receive health assessments. This process is known as the CHDP Gateway to Medi-Cal.

The CHDP program is responsible for the screening component of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit of the Medi-Cal program. The health assessments, immunizations, and laboratory screening procedures provided for eligible children not enrolled in full-scope Medi-Cal are funded with 100 percent General Fund.

Child Health and Disability Prevention Program (State-Only) – *Funding and Caseload Estimate*			
Fund Source	**2016-17**	**2016-17**	**2017-18**
	2016 Budget	***Revised***	***Proposed***
0001 – General Fund	$115,000	$32,000	$1,000
Estimated Caseload (State-Only Screens):	**1,794**	**509**	**0**

Full-Scope Medi-Cal for Children Regardless of Immigration Status. SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015, expands eligibility for full-scope Medi-Cal to all income-eligible children under age 19, regardless of immigration status. Undocumented children were previously eligible for restricted-scope Medi-Cal coverage, which includes emergency and pregnancy related services only. Services provided under restricted-scope Medi-Cal receive a 50 percent federal match, while the additional non-emergency services provided under the full-scope expansion are funded entirely by state General Fund. DHCS estimates there are 250,000 undocumented children under age 19 covered under the expansion of eligibility and, according to latest department data, 182,531 have enrolled as of March 2017.

According to DHCS, pursuant to the provisions of SB 75 all children who previously were only eligible for limited-scope services are now eligible for full-scope Medi-Cal, including the EPSDT benefit. Because EPSDT provides screening services to full-scope Medi-Cal beneficiaries that are currently provided to limited-scope beneficiaries under the state-only CHDP program, DHCS believes the program is no longer necessary. The department reports that it has received no claims for state-only CHDP since November 2016 and, as noted above, the CHDP local assistance estimate assumes no state-only screens will be performed in 2017-18.

Immigration Enforcement Concerns from Beneficiaries. Various stakeholders have reported an increase in inquiries from parents of undocumented children considering disenrollment from Medi-Cal, citing concerns about immigration enforcement actions by the new federal administration. The department does not capture information on the reasons for disenrollment, but has observed a slowdown in enrollment in recent months. These stakeholders have raised concerns about elimination of the state-only CHDP program's screening services at a time when significant uncertainty regarding federal immigration is driving anxiety about enrollment in public health and human services programs.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item open pending further information about caseload assumptions for this program in the May Revision.

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

1. Please provide a brief overview of this proposal.

Issue 20: Every Woman Counts Accrual to Cash Budgeting

Trailer Bill Language Proposal. DHCS proposes trailer bill language to change the Every Woman Counts (EWC) program budget from an accrual to a cash basis beginning in 2017-18 and reduce the frequency of program reporting requirements from quarterly to biannually.

Background. The EWC program provides free breast and cervical cancer screening and diagnostic services to uninsured and underinsured individuals who reside in California, with income at or below 200 percent of the federal poverty level. Breast cancer screening is available for individuals age 40 and older and individuals of any age who are symptomatic. Cervical cancer screening is covered for individuals age 21 and older. EWC covered benefits and categories of service include office visits, screening, diagnostic mammograms, and diagnostic breast procedures, such as ultrasound, fine needle and core biopsy, pap test and HPV co-testing, colposcopy and other cervical cancer diagnostic procedures and case management.

Medi-Cal has been on a cash basis for budgeting and accounting since 2004-05. On a cash basis, expenditures are accounted for based on the fiscal year in which payments are made, regardless of when the services are provided. On an accrual basis, expenditures are accounted for based on the fiscal year in which the services are rendered, regardless of when the payments are made. The EWC program, since transferring from the California Department of Public Health in 2012, has continued to be budgeted on an accrual basis despite the prevalence of cash basis budgeting for other DHCS programs. The proposed trailer bill language would convert the EWC program budget from an accrual to a cash basis beginning in 2017-18. In addition, the 2010 Budget Act requires quarterly reporting to the Legislature on caseload, estimated expenditures, and related program monitoring data and activities of the EWC program. The proposed trailer bill language would instead require biannual reporting of this information. According to DHCS, this timeframe would allow for incorporation of additional claims information to make caseload and expenditure projections.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

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, May 4, 2017
Upon adjournment of Joint Subcommittee Hearing
State Capitol - Room 4203

PART A

Consultant: Scott Ogus

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.

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

Issue 1: Overview

Emergency Medical Services Authority - *Three-Year Funding Summary*			
Fund Source	**2015-16**	**2016-17**	**2017-18**
	Actual	***Revised***	***Proposed***
0001 – General Fund	$8,482,000	$8,753,000	$8,793,000
0194 – EMS Training Prog. Approval Fund	$208,000	$205,000	$207,000
0312 – EMS Personnel Fund	$2,408,000	$2,106,000	$2,647,000
0890 – Federal Trust Fund	$5,944,000	$6,089,000	$6,216,000
0995 – Reimbursements	$16,894,000	$17,413,000	$17,421,000
3137 – EMT Certifcation Fund	$1,592,000	$1,498,000	$1,503,000
Total Department Funding:	**$35,528,000**	**$36,064,000**	**$36,787,000**
Total Authorized Positions:	**73.4**	**66.9**	**68.9**

Emergency Medical Services Authority - *Comparison to 2016 Budget Act*			
Fund Source	**2016-17**	**2016-17**	**2016-17**
	Appropriation	***Revised***	***Difference***
0001 – General Fund	$8,725,000	$8,753,000	$28,000
0194 – EMS Training Prog. Approval Fund	$200,000	$205,000	$5,000
0312 – EMS Personnel Fund	$2,258,000	$2,106,000	($152,000)
0890 – Federal Trust Fund	$6,035,000	$6,089,000	$54,000
0995 – Reimbursements	$17,355,000	$17,413,000	$58,000
3137 – EMT Certifcation Fund	$1,574,000	$1,498,000	($76,000)
Total Department Funding:	**$36,147,000**	**$36,064,000**	**($83,000)**
Total Authorized Positions:	**66.9**	**66.9**	**-**

Emergency Medical Services Authority - *Comparison 2016-17 (Rev) to 2017-18*			
Fund Source	**2016-17**	**2017-18**	**2017-18**
	Revised	***Proposed***	***Difference***
0001 – General Fund	$8,753,000	$8,793,000	$40,000
0194 – EMS Training Prog. Approval Fund	$205,000	$207,000	$2,000
0312 – EMS Personnel Fund	$2,106,000	$2,647,000	$541,000
0890 – Federal Trust Fund	$6,089,000	$6,216,000	$127,000
0995 – Reimbursements	$17,413,000	$17,421,000	$8,000
3137 – EMT Certifcation Fund	$1,498,000	$1,503,000	$5,000
Total Department Funding:	**$36,064,000**	**$36,787,000**	**$723,000**
Total Authorized Positions:	**66.9**	**68.9**	**2.0**

Background. Prior to 1980, California did not have a central state agency responsible for ensuring the development and coordination of emergency medical services (EMS) and programs statewide. After several years of efforts by EMS stakeholders to establish a state lead agency and centralized resource to oversee emergency and disaster medical services, the Emergency Medical Services System and Prehospital Emergency Care Personnel Act was passed, creating the Emergency Medical Services Authority (EMSA) in the California Health and Human Services Agency. EMSA's mission is to provide quality patient care by administering an effective statewide system of coordinated emergency medical care, injury preventions, and disaster medical response that integrates public health, public safety, and healthcare. EMSA is organized into three program divisions: the Disaster Medical Services Division, the Emergency Medical Services Personnel Division, and the Emergency Medical Services Systems Division.

Disaster Medical Services Division. The Disaster Medical Services Division coordinates California's medical response to major disasters by carrying out EMSA's mandate to provide medical resources to local governments in support of their disaster response efforts. The division coordinates with the Governor's Office of Emergency Services, the Office of Homeland Security, the California National Guard, the Department of Public Health, and other local, state, and federal agencies, private sector hospitals, ambulance companies, and medical supply vendors, to promote and improve disaster preparedness and emergency medical response in California.

EMS Personnel Division. The EMS Personnel Division is responsible for the certification, licensing, and discipline of all active paramedics throughout the state. The division develops and implements regulations that set training standards and the scope of practice for various levels of personnel; sets standards for and approves training programs in pediatric first aid, CPR, and preventive health practices for child day care providers and school bus drivers; and is developing standards for emergency medical dispatcher training, pre-arrival emergency care instructions, and the epinephrine auto-injector training program.

EMS Systems Division. The Systems Division is in charge of developing and implementing EMS systems throughout California, including supporting local Health Information Exchange projects that will allow the state to collect more meaningful data so emergency medical services providers can deliver better patient care. The division oversees system development and implementation by the local EMS agencies, the statewide trauma system, and emergency medical dispatcher and communication standards. It establishes regulations and guidelines for local agencies, reviews and approves local plans to ensure they meet minimum state standards, coordinates injury and illness prevention activities with the Department of Public Health and the Office of Traffic Safety, manages the state's EMS data and quality improvement processes, conducts Ambulance Exclusive Operating Area evaluations, and oversees the operation of California's Poison Control System and EMS for Children programs.

Subcommittee Staff Comment. This is an informational item.

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

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

Issue 2: E-Commerce Online Paramedic Licensing Module (eGov)

Budget Issue. EMSA requests expenditure authority from the Emergency Medical Services Personnel Fund of $211,000 in 2017-18 and $71,000 annually thereafter. If approved, these resources would allow EMSA to purchase proprietary software to implement an online paramedic licensing application system.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0312 – EMS Personnel Fund	$-	$211,000
Total Funding Request:	**$-**	**$211,000**

Background. AB 2917 (Torrico), Chapter 274, Statutes of 2008, requires EMSA to establish and maintain a centralized system for monitoring and tracing emergency medical technician (EMT) certification status and paramedic licensure status to be used by certifying entities. In response, EMSA established, My License Office (MLO), a statewide public electronic registry system, which was originally intended to be implemented in two phases: 1) implementation of a centralized EMT electronic registry system to manage paramedic licensure, EMT certification, and paramedic enforcement information that included a web-based, public registry look-up component; and 2) a real-time, self-service online paramedic licensing electronic government (eGov) module option for new, renewing, and reinstating paramedic license applicants.

Due to technical problems related to delays in virtual server procurement and acquisition of a payment processor, the scope of the project was reduced to exclude the implementation of the eGov licensure module. The California Department of Technology created virtual servers to support the MLO system and EMSA purchased credit card payment equipment to process payments received in-person and by mail. However, the real-time, self-service online licensing function was never implemented.

EMSA requests expenditure authority from the Emergency Medical Services Personnel Fund of $211,000 in 2017-18 and $71,000 annually thereafter to purchase proprietary software to implement the online paramedic licensing eGov module originally intended during development of the MLO system. According to EMSA, the MLO eGov module will be located in a cloud-based network environment hosted, administered, and maintained by the current MLO vendor, System Automation. The module will support legible, accurate, and complete data entry by paramedic licensing applicants, reducing the need for staff to support licensing workload. EMSA reports staff time spent processing renewals will be reduced to six minutes, as time previously required to review and upload renewal applicant information and fee payments will be eliminated. According to EMSA, staff will be redirected to address other program services currently underserved within the unit such as increasing the number of random audits of continuing education reported by paramedics during the licensing renewal application review process to ensure compliance with existing paramedic licensing regulations.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 3: EMT-P Discipline Case Workload

Budget Issue. EMSA requests two positions and expenditure authority from the Emergency Medical Services Personnel Fund of $314,000 in 2017-18 and 2018-19. If approved, these resources would allow EMSA to manage an increase in disciplinary legal caseload related to its oversight of paramedic licensing.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0312 – EMS Personnel Fund	$-	$314,000
Total Funding Request:	**$-**	**$314,000**
Total Positions Requested:	**2.0**	

Background. Under its regulatory authority over paramedic licensing, EMSA may deny, revoke, suspend, or place on probation a paramedic's license if there is evidence of a threat to public health and safety. EMSA's legal counsel is responsible for disciplinary actions under this authority. Currently, EMSA's legal unit consists of one full-time attorney, two retired annuitant attorneys, one retired annuitant staff services analyst, and one student assistant. The full-time attorney provides all legal services to EMSA, which includes: legal advice to the director, review of contracts, legal support for all EMSA divisions, review of local EMS agency solicitations and ambulance exclusive operating areas, public records act request review, subpoena and litigation response, employee discipline, and paramedic enforcement case supervision. The two retired annuitant attorneys prepare paramedic enforcement cases, negotiate settlements, and represent EMSA at administrative hearings at various locations throughout the State. The remaining staff provide administrative support to all three attorneys.

EMSA reports it has experienced an increase in litigation related to local EMS plan appeals and local EMS agency Exclusive Operating Area solicitation reviews. According to EMSA, appeals and reviews of this kind had previously occurred rarely, but have increased in response to adverse findings in EMSA's review processes. As a result of the increase in other litigation responsibilities, EMSA's full-time attorney is unable to devote sufficient time to review and monitor paramedic liensing enforcement cases. This workload is currently being supported exclusively by the retired annuitant attorneys. Because retired annuitants have limited hours per year available to work, these attorneys are insufficient to meet the increased paramedic licensing enforcement caseload, resulting in delayed litigation.

EMSA requests one Attorney I and one Staff Services Analyst, and expenditure authority from the Emergency Medical Services Personnel Fund of $314,000 in 2017-18 and 2018-19 to manage the increased workload related to paramedic licensing enforcement.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Public Health Emergency Preparedness

Budget Issue and Trailer Bill Language Proposal. DPH requests 88.3 positions (76.8 conversion from limited-term and 11.5 new positions) and expenditure authority of $11.8 million federal funds annually. If approved, these resources would allow DPH to continue its public health emergency preparedness activities pursuant to requirements in state and federal law. Accompanying the request is proposed trailer bill language to make technical and clarifying changes to provisions of state law governing the program.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0890 – Federal Trust Fund	$-	$11,752,000
Total Funding Request:	**$-**	**$11,752,000**
Total Positions Requested:	**88.3**	

Background. DPH responds to numerous public health events on a daily basis. Recent disasters requiring a significant departmental response include the California wildfires of 2003, 2007, 2008 and 2012; Hurricane Katrina in 2005; floods in 2006; extreme heat events in 2006, 2007, 2008, 2013, and 2016; H1N1 in 2009; the tsunami and radiation threat from the Fukushima earthquake in 2011; the 2011 Southern California power outage; the Napa Earthquake; Ebola Virus Disease; Drought, H1N1 Outbreak of 2014; the Valley & Butte Fires in 2015; the June 2016 Heat Event; and the 2016 Zika Virus Outbreak.

With the events of September 11, 2001, and subsequent anthrax attacks, DPH's public health emergency preparedness responsibilities increased significantly to include activities related to countering potential bioterrorism, chemical, nuclear, or radiologic threats. Federal funds to build and maintain capabilities to address these threats are provided to states through the Public Health Emergency Preparedness (PHEP) and Hospital Preparedness Program (HPP) Cooperative Agreements.

Public Health Emergency Preparedness (PHEP). The PHEP Cooperative Agreement, issued by the Centers for Disease Control and Prevention (CDC), funds state and local health departments to enhance the California public health system's preparedness and response to public health emergencies. DPH allocates 70 percent of this grant to fund local health jurisdictions' (LHJs) preparedness activities and funds state operations with the remaining 30 percent. The PHEP grant is delineated by 15 Public Health Preparedness Capabilities with supporting Functions, Resource Elements and Performance Measures that state health departments must meet. These Public Health Preparedness Capabilities are as follows:

1. Community Preparedness
2. Community Recovery
3. Emergency Operations Coordination
4. Emergency Public Information and Warning
5. Fatality Management
6. Information Sharing
7. Mass Care
8. Medical Countermeasure Dispensing

9. Medical Materiel Management and Distribution
10. Medical Surge
11. Non-Pharmaceutical Interventions
12. Public Health Laboratory Testing
13. Public Health Surveillance and Epidemiologic Investigations
14. Responder Safety and Health
15. Volunteer Management

Hospital Preparedness Program (HPP). The HPP Cooperative Agreement provides federal funding to prepare hospitals, clinics and other health care facilities and emergency medical services systems to respond to disasters. The HPP grant has eight Health Care Preparedness Capabilities with supporting Functions, Resource Elements and Performance Measures that states are required to meet. The Healthcare Preparedness Capabilities are as follows:

1. Healthcare System Preparedness
2. Healthcare System Recovery
3. Emergency Operations Coordination
4. Fatality Management
5. Information Sharing
6. Medical Surge
7. Responder Safety and Health
8. Volunteer Management

Continuation of PHEP and HPP Funded Emergency Preparedness Programs. In 2003, DPH received limited-term positions and resources to build capacity for public health preparedness using PHEP and HPP federal grant funding. There are 76.8 positions remaining from the original request, which have been reauthorized several times since 2003 and expire on July 1, 2017. DPH proposes to convert these positions from limited-term to permanent as the department expects federal grant funding for emergency preparedness programs to continue. In addition, as the post September 11, 2001, emergency preparedness activities have continued, the field of trained and experienced individuals has grown, increasing the ability of DPH to hire state staff with relevant experience in these activities instead of contractors. As a result, DPH is able to convert former contract positions to state positions, which results in cost savings. As qualified civil service classifications are capable of performing the workload, the conversions are also required under state law. The conversion results in an additional resource request of 11.5 permanent positions. The 88.3 positions are located in the following DPH divisions: Emergency Preparedness Office, Center for Infectious Diseases, Center for Environmental Health, Center for Chronic Disease Prevention and Health Promotion, Office of Public Affairs, Office of Compliance, Information Technology Services Division, and the Administration Division.

Trailer Bill Language Proposal. Accompanying the requested extension of resources, DPH proposes trailer bill language to make the following technical and clarifying changes to the provisions of state law governing expenditures of public health emergency preparedness federal funding:

1. Change references for the use of funds from "bioterrorism" to "public health emergency" to be consistent with current uses allowable under federal grants.
2. Clarify initial quarterly payment of grant funds would be made to LHJs upon DPH approval of the application for funding and subsequent payments would be made either quarterly or as

reimbursements upon submission of documentation. According to DPH, this is consistent with current practice.

3. Allow DPH to accept certification from a designee, authorized by the chair of the board of supervisors or mayor, regarding non-supplantation requirements. According to DPH, current law requires the chair of the board or mayor to sign certifications personally.
4. Remove the requirement for LHJs to place federal funds into an interest bearing trust fund account, if exempted from this requirement by federal funding guidance. According to DPH, certain counties have found it difficult and expensive to comply with the trust fund requirement, which is no longer consistent with federal guidance.
5. Require LHJs to remit earned interest in excess of $500 annually to DPH in accordance with federal regulations.
6. Adjust the baseline allocation for emergency preparedness, including pandemic influenza preparedness, in accordance with current appropriations.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 2: Newborn Screening Program (SB 1095)

Budget Issue. DPH requests one position and expenditure authority from the Genetic Disease Testing Fund of $2.69 million ($769,000 state operations and $1.92 million local assistance) in 2017-18 and $137,000 state operations annually thereafter. If approved, these resources would allow the Genetic Disease Screening Program (GDSP) to implement additional newborn screening requirements for genetic diseases required pursuant to SB 1095 (Pan), Chapter 363, Statutes of 2016.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0203 – Genetic Disease Testing Fund		
State Operations:	$-	$769,000
Local Assistance:	$-	$1,928,000
Total Funding Request:	**$-**	**$2,689,000**
Total Positions Requested:	**1.0**	

Background. GDSP administers a statewide genetic disorder screening program for pregnant women and newborn babies that is fully supported by fees. When the Newborn Screening (NBS) program within GDSP began in 1980, each newborn was screened for only three disorders. Today, more than 500,000 newborns are screened for 80 disorders annually, resulting in more than 700 diagnoses. According to DPH, California leads the nation in the number of disorders screened and provides the most comprehensive program in terms of quality control, follow-up services, genetic counseling, confirmatory testing, and diagnostic services.

SB 1095 requires the NBS program to expand statewide screening of newborns to include screening for any disease that is detectable in blood samples within two years of the disease being adopted by the federal Recommended Uniform Screening Panel (RUSP). There are two disorders currently on the RUSP that are not on the NBS program panel. Mucopolysaccharidosis type I (MPS-I) and Pompe disease were added to the RUSP in 2016 and 2015, respectively, and will be added to the panel for newborn screening by August 30, 2018.

DPH also plans to couple its primary screening methods with a second-tier, linked test that can improve diagnostic specificity without reducing sensitivity and uses the same blood specimen that was sampled for the original test. The secondary screen measures additional metabolites that either strongly support the presumption of a true positive case or demonstrate the patient does not have the disorder. According to DPH, significant published research supports the public health and cost-saving benefits of adoption of a second-tier testing method to rule out false positive results.

Resources for Implementation of New Screening Protocols Results in Fee Increase. Based on an assessment of laboratory and processing costs, an increase of approximately $10.00 to the current NBS program fee of $130.25 will be required to implement the new testing protocols and provide ongoing funding. Funding from the fee increase will support expenditures associated with processing blood specimens; performing the actual blood screen; testing chemicals, equipment and supplies used to assay results; and arranging for follow-up services for positive cases. Follow-up services may include case

management, diagnostic work-up, confirmatory processing, provider and family education, or informative result mailers.

DPH requests one position and expenditure authority from the fee-supported Genetic Disease Testing Fund of $2.69 million. If approved, $2.25 million would fund one-time costs to develop testing protocols to incorporate MPS-I and Pompe into the NBS program screening panel by August 30, 2018. $139,000 would fund one Research Scientist II to support testing activities. In addition, DPH is requesting a one-time increase of $300,000 in state operations expenditure authority and a transfer of $330,000 in expenditure authority from local assistance to state operations for the purchase of mass spectrometry equipment and support for second-tier testing. The department plans to purchase the equipment in early 2017-18 to begin performing second-tier testing by early 2018.

According to DPH, implementation of second-tier testing would save the NBS program approximately $380,000 per year in local assistance costs related to follow-up services provided in response to a false positive result, beginning in 2018-19.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 3: Genetic Disease Screening Program

Budget Issue. The November 2016 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of $132.3 million ($26.5 million state operations and $105.8 million local assistance) in 2016-17, and $136.6 million ($26.8 million state operations and $109.9 million local assistance) in 2017-18.

Genetic Disease Screening Program (GDSP) Funding Summary			
	2016-17	**2017-18**	**BY to CY**
Fund Source	***Revised***	***Proposed***	***Change***
0203 – Genetic Disease Testing Fund			
State Operations:	$26,540,000	$26,767,000	$227,000
Local Assistance:	$105,771,000	$109,857,000	$4,086,000
Total GDSP Expenditures	**$132,311,000**	**$136,624,000**	**$4,313,000**

Background. According to DPH, the Genetic Disease Screening Program (GDSP) performs the following tasks to support its mission:

- Screens newborns and pregnant women for genetic and congenital disorders in a cost-effective and clinically effective manner. The screening programs provide testing, follow-up and early diagnosis of disorders to prevent adverse outcomes or minimize clinical effects.
- Ensures quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance.
- Fosters informed participation in its programs in an ethical manner through a combination of patient, professional, and public education, and accurate and up-to-date information and counseling.
- Provides ongoing critical review, testing, and evaluation of existing programs to ensure program objectives and goals are being met.
- Develops programs to adopt new methods and implement new services that further enhance the effectiveness and efficiency of current and future prevention programs.
- Promotes use of high-quality consumer education materials on genetic disorders, screening for birth defects and genetic services.

GDSP operates two primary screening programs: the Newborn Screening program and the Prenatal Screening program. Caseload and expenditures for these programs are reflected in the GDSP Estimate along with operational support costs for the programs.

Newborn Screening (NBS) Program. Newborn screening, recognized nationally as an essential preventive health measure, began in California in 1966 with the testing of infants for phenylketonuria (PKU). In 1980, the program was expanded to include galactosemia, primary congenital hypothyroidism, and included a more comprehensive follow-up system. In 1990, screening for sickle cell disease was added to the screening program, which allows for identification of related non-sickling hemoglobin disorders, including beta-thalassemia major, and Hb E/beta thalassemia. In 1999, the program implemented screening for hemoglobin H and hemoglobin H - Constant Spring disease. In 2005 the screening panel was expanded to include additional metabolic disorders and congenital adrenal

hyperplasia (CAH), and in 2007, the screening panel was expanded to include cystic fibrosis (CF) and biotinidase deficiency (BD). In 2010, Severe Combined Immunodeficiency (SCID) was added to the screening panel.

According to DPH, disorders screened for by the program have varying degrees of severity and, if identified early, many can be treated before they cause serious health problems. Between 1980 and 2009, 14,989,863 babies were screened resulting in early identification of the following disorders:

Disorder	Cases
Phenylketonuria (PKU)	1,026
Primary Congenital Hypothyroidism	5802
Galactosemia	191
Sickle Cell Disease and other clinically significant Hemoglobinopathies	2,500
Hemoglobin H Disease	529
Biotinidase Deficiency (BD)	16
Cystic Fibrosis (CF)	242
Congenital Adrenal Hyperplasia (CAH)	114
Metabolic/Fatty Acid Oxidation Disorders	559
TOTAL	**10,979**

The NBS program currently screens infants in California for 80 separate disorders. Pursuant to SB 1095 (Pan), Chapter 363, Statutes of 2016, two additional disorders, Mucopolysaccharidosis type I (MPS-I) and Pompe disease, will be added to the screening panel by August 30, 2018. In addition, as conditions are added to the federal Recommended Uniform Screening Panel (RUSP), they will be added to the NBS program screening panel within two years. The fee for screening in the NBS program is $130.25.

Caseload Estimate: The budget estimates NBS program caseload of 494,862 in 2016-17, a decrease of 2,221 or 0.4 percent, compared to the 2016 Budget Act. The budget estimates NBS program caseload of 497,973 in 2017-18, an increase of 3,111 or 0.6 percent, compared to the revised 2016-17 estimate. These estimates are based on state projections of an increase in the number of live births. DPH assumes 97.4 percent of births will participate in the NBS program annually.

Prenatal Screening (PNS) Program. The Prenatal Screening (PNS) program provides prenatal screening services and follow-up diagnostic services, where indicated, to all pregnant women in California to detect birth defects during pregnancy. The program offers three types of screening tests to pregnant women in order to identify individuals who are at increased risk for carrying a fetus with a specific birth defect:

- Sequential Integrated Screening – This screen combines first and second blood test results with nuchal translucency (NT) ultrasound results, which measures the back of a fetus' neck. This measurement helps screen for Down syndrome (trisomy 21).
- Serum Integrated Screening – This screen combines a first trimester blood test screening result with a second trimester blood test screening result.
- Quad Marker Screening - One blood specimen drawn at 15 weeks - 20 weeks of pregnancy (second trimester test).

The PNS program provides pregnant women with a risk assessment for open neural tube defects (NTD), Down syndrome (trisomy 21), trisomy 18 and Smith-Lemli-Opitz Syndrome (SLOS) through one or two blood tests. The screening test indicates risk, but does not diagnose fetal birth defects.

For women with screening results indicating a high risk for a birth defect, the program provides free follow-up diagnostic services at state-approved Prenatal Diagnosis Centers (PDCs). Services offered at these centers include genetic counseling, ultrasound, and amniocentesis. Participation in the screening testing and follow-up services is voluntary and the fee for testing through the PNS program is $221.60.

Caseload Estimate: The budget estimates PNS program caseload of 360,288 in 2016-17, a decrease of 840 or 0.2 percent, compared to the 2016 Budget Act. The budget estimates PNS program caseload of 362,553 in 2017-18, an increase of 2,265 or 0.6 percent, compared to the revised 2016-17 estimate. These estimates are based on state projections of an increase in the number of live births. DPH assumes 70.9 percent of births will participate in the PNS program annually.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the caseload and expenditure changes for the Newborn Screening Program.

2. Please provide a brief overview of the caseload and expenditure changes for the Prenatal Screening Program.

Issue 4: Women, Infants, and Children (WIC) Program

Budget Issue. The November 2016 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of $1.3 billion ($1.1 billion federal funds and $223.4 million WIC manufacturer rebate funds) in 2016-17 and $1.3 billion ($1.1 billion federal funds and $216.4 million WIC manufacturer rebate funds) in 2017-18. The federal fund amounts include state operations costs of $61.4 million in 2016-17 and $63.2 million in 2017-18.

Genetic Disease Screening Program (GDSP) Funding Summary			
	2016-17	**2017-18**	**BY to CY**
Fund Source	***Revised***	***Proposed***	***Change***
0890 – Federal Trust Fund			
State Operations:	$61,429,000	$63,209,000	$1,780,000
Local Assistance:	$1,035,439,000	$1,057,618,000	$22,179,000
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$223,377,000	$216,412,000	($6,965,000)
Total WIC Expenditures	**$1,320,245,000**	**$1,337,239,000**	**$16,994,000**

Background. The WIC program provides nutrition services and food assistance for pregnant, breastfeeding, and non-breastfeeding women, infants, and children up to their fifth birthday at or below 185 percent of the federal poverty level. WIC program services include nutrition education, breastfeeding support, assistance with finding health care and other community services, and vouchers for specific nutritious foods that are redeemable at WIC-authorized retail food outlets throughout the state. The WIC program receives federal funds from the United States Department of Agriculture (USDA) under the federal Child Nutrition Act of 1966. Specific uses of WIC Program funds are governed by federal laws and regulations, and DPH must report funds and expenditures monthly.

The WIC program's food expenditures are funded by a combination of federal grants and rebates from manufacturers of infant formula. Federal WIC regulations require that state WIC programs have sole supplier rebate contracts in place with infant formula manufacturers for milk-based and soy-based infant formula. As infant formula is provided to WIC recipients, the program receives a rebate from the manufacturer which is used to fund additional food expenditures. In addition to food expenditures, the program receives federal funds from the Nutrition Services and Administration (NSA) grant, which are used to contract with local agencies for direct services provided to WIC families including intake, eligibility determination, benefit issuance, nutrition education, breastfeeding support, and referrals to health and social services. The NSA grant also funds state operations for administering the WIC program.

Food expenditures are divided into five participant categories, each with special nutrition needs that influence food costs:

- **Pregnant women** are eligible for the WIC program at any point in their pregnancy, and receive supplemental foods high in protein, calcium, iron, vitamin A, and vitamin C to support optimal fetal development.

- **Breastfeeding women** are eligible for benefits up to their infant's first birthday, and receive an enhanced supplemental food package with foods high in protein, calcium, iron, vitamin A, and vitamin C to support caloric needs during breastfeeding.
- **Non-breastfeeding women** are eligible for benefits up to six months after the birth of their infants, and receive a supplemental food package to help in rebuilding nutrient stores, especially iron and calcium, and achieving a healthy weight after delivery.
- **Infants** are eligible until one year of age. The WIC Program promotes breastfeeding as the optimal infant feeding choice due to its many health, nutritional, economical, and emotional benefits to mother and baby. Infants may also receive supplemental foods that are rich in protein, calcium, iron, vitamin A, and vitamin C during this critical period of development.
- **Children** are eligible from age one to up to age five, and receive supplemental foods rich in protein, calcium, iron, vitamin A, and vitamin C. These nutrients have been shown to be lacking in the diets of children who qualify for WIC benefits and are needed to meet nutritional needs during critical periods of development. The food package also provides foods lower in saturated fat to reduce the risk of childhood obesity.

According to the WIC program Estimate, food expenditures by participant category are as follows:

EXPENDITURE COMPARISON (all funds)							
Expenditure Category	2016 Budget Act	SFY 2016-17			SFY 2017-18		
		November Estimate	Change from 2016 Budget Act		November Estimate	Change from 2016 Budget Act	
Pregnant	75,577,000	70,450,000	(5,127,000)	-6.78%	69,259,000	(6,318,000)	-8.36%
Breastfeeding	64,788,000	61,893,000	(2,895,000)	-4.47%	62,542,000	(2,246,000)	-3.47%
Non-Breastfeeding	33,085,000	31,846,000	(1,239,000)	-3.74%	31,545,000	(1,540,000)	-4.65%
Infants	356,215,000	362,555,000	6,340,000	1.78%	361,352,000	5,137,000	1.44%
Children	419,389,000	389,216,000	(30,173,000)	-7.19%	406,033,000	(13,356,000)	-3.18%
Yogurt	10,787,000	10,787,000	-	0.00%	10,787,000	-	0.00%
Cash Value Voucher Increase	3,300,000	3,300,000	-	0.00%	3,300,000	-	0.00%
Reserve	28,894,000	27,902,000	(992,000)	-3.43%	28,345,000	(549,000)	-1.90%
Total Food Expenditures	**992,035,000**	**957,949,000**	**(34,086,000)**	**-3.44%**	**973,163,000**	**(18,872,000)**	**-1.90%**
Food Expenditures Paid from Rebate Funds	*217,085,000*	*223,377,000*	*6,292,000*	*2.90%*	*216,412,000*	*(673,000)*	*-0.31%*
Food Expenditures Paid from Federal Funds	*774,950,000*	*734,572,000*	*(40,378,000)*	*-5.21%*	*756,751,000*	*(18,199,000)*	*-2.35%*
Other Local Assistance Expenditures (Federal NSA)	300,867,000	300,867,000	-	0.00%	300,867,000	-	0.00%
Total Federal Local Assistance Expenditures (Food + NSA)	**1,075,817,000**	**1,035,439,000**	**(40,378,000)**	**-3.75%**	**1,057,618,000**	**(18,199,000)**	**-1.69%**
State Operations (Federal NSA)	61,429,000	61,429,000	-	0.00%	63,209,000	1,780,000	2.90%

The budget assumes 1,170,997 WIC participants in 2016-17, a decrease of 29,708 or 2.5 percent from the assumptions in the 2016 Budget Act. The budget assumes 1,164,043, a decrease of 6,954 or 0.6 percent from the revised 2016-17 caseload estimate.

Food Expenditures Estimate. The budget includes $957.9 million in 2016-17 for WIC program food expenditures, a decrease of $34.1 million or 3.4 percent, compared to the 2016 Budget Act. According to DPH, this decrease is due to lower than projected participation levels. Of these expenditures, federally funded food expenditures are $734.6 million, a decrease of $40.4 million from the 2016 Budget Act, and WIC Manufacturer Rebate Fund food costs are $223.4 million, an increase of $6.3 million from the 2016 Budget Act. According to DPH, rebate funded food costs are increasing by 2.9 percent due to a manufacturer wholesale price increase for infant formula.

The budget includes $973.2 million in 2017-18 for WIC program food expenditures, an increase of $15.2 million or 1.6 percent from the revised 2016-17 food expenditures estimate. According to DPH, these increased costs are due to a 2.9 percent rate of inflation for food. Of these expenditures, federally funded food costs are $756.8 million, an increase of $22.2 million from the revised 2016-17 food expenditure estimate, and WIC Manufacturer Rebate Fund food costs are projected to be $216.4 million, a decrease of $7 million from the revised 2016-17 food expenditure estimate.

Nutrition Services and Administration (NSA) Estimate. The budget includes $300.9 million for other local assistance expenditures for the NSA budget in 2016-17 and 2017-18, which is unchanged from the level assumed in the 2016 Budget Act. The budget also includes $61.4 million for state operations expenditures in 2016-17, also unchanged from the level assumed in the 2016 Budget Act. The budget includes $63.2 million for state operations expenditures in 2017-18, an increase of $1.8 million or 2.9 percent compared to the revised 2016-17 estimate. According to DPH, the increase in 2017-18 is attributed to the $1.8 million increase in expenditures for the eWIC Electronic Benefit Transfer (EBT) and Management Information System (MIS) Project.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the caseload and expenditure changes for the WIC program.

2. Please describe the WIC program's outreach efforts to ensure maximum participation in the program and full use of available federal funds.

3. Please describe how federal WIC allocations are affected by state WIC programs' utilization of federal funds. Is the state at risk of reduction in federal funding allocations due to low participation?

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

SUBCOMMITTEE NO. 3 Agenda

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

May 4, 2017
Upon Adjournment of Budget and Fiscal Joint Hearings
with Subcommittees No. 2, 3, and 4
Room 4203, State Capitol
Part B

Consultant: Theresa Pena

ISSUES RECOMMENDED FOR VOTE-ONLY

ISSUES FOR DISCUSSION

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.

ISSUES RECOMMENDED FOR VOTE ONLY

4185 CALIFORNIA SENIOR LEGISLATURE

Issue 1: Budget Change Proposal: 2016 Budget Act General Fund Reappropriation

The California Senior Legislature (CSL) requests a reappropriation of any unexpended General Fund appropriated in the 2016 Budget Act to be available for expenditure until the end of fiscal year 2017-18 in order to support state operations while the CSL pursues an ongoing revenue source. The amount projected to roll over is $175,000. The CSL is funded through voluntary contributions received with state income tax returns, but in recent years has been removed from the tax check-off list for not meeting the minimum requirement to stay on the list. The Legislature included a one-time $500,000 General Fund appropriation in the Budget Act of 2016 to keep the CSL operative.

Staff Comment and Recommendation. Approve. This subcommittee heard and discussed this item during its March 2, 2017, hearing. No concerns have been raised. However, given the instability of the tax check-off VCF as a funding source over the last several years and the many competing demands for General Fund resources, staff recommends that the CSL remain proactive in finding other funding sources.

0530 HEALTH AND HUMAN SERVICES AGENCY, OFFICE OF SYSTEMS INTEGRATION
5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: Budget Change Proposal: Horizontal Integration Office: Transfer to Office of Systems Integration (OSI)

The Administration requests to move the Horizontal Integration (HI) Office and its three existing staff and associated funding with the Department of Social Services (DSS) to OSI. This is a cost-neutral proposal. The HI Office has interactions with various departments and programs under the purview of the Health and Human Services Agency (Agency). The Office of the Agency Information Officer (AIO), which is currently housed in OSI under Agency, already has the responsibility of looking across issues under the entirety of Agency, which aligns closely to HI's mission.

Staff Comment and Recommendation. Approve. This subcommittee heard and discussed this item during its April 20, 2017 hearing. No concerns have been raised.

5160 DEPARTMENT OF REHABILITATION

Issue 1: Budget Change Proposal: California Innovations Program: Federal Work-Based Learning Grant for Students with Disabilities

The Administration is requesting one permanent full-time position to provide program oversight and perform contracting and data management activities required to administer the California Innovations Program - Federal Work-Based Learning Grant. The $8.5 million federal grant has a five-year grant period and there is no state match requirement. The Department of Rehabilitation (DOR) will use existing federal fund authority for the expenditures. The California Innovations Program is meant to increase self-sufficiency for students with disabilities through planned education and work-based learning.

Staff Comment and Recommendation. Approve. This subcommittee heard and discussed this item during its March 16, 2017 hearing. No concerns have been raised.

Issue 2: Budget Change Proposal: Information Security Compliance

The Administration is requesting two permanent full-time positions and $281,000 in General Fund to ensure adequate staffing in DOR's Information Security Office (ISO), compliance with the information security regulations prescribed in the State Administrative Manual (SAM) 5300, and to maintain the overall safety and security of DOR data. DOR's case management system contains confidential and sensitive information, including social security numbers, on over 100,000 active consumers, as well as information in over 500,000 records that include both open and closed cases. The two requested positions would maintain the safety and security of this personal and private information and save the state from costly data breaches.

Staff Comment and Recommendation. Approve. This subcommittee heard and discussed this item during its March 16, 2017 hearing. No concerns have been raised.

Issue 3: Budget Change Proposal: Supported Employment Program: Increase Job Coaching Rates

The Administration requests $500,000 General Fund in 2017-18 and ongoing to match the increased supported employment (SE) provider hourly rate identified in the Department of Developmental Services' (DDS) June 2016 New Provider Rate memo, as required by AB1 X2 (Thurmond) Chapter 3, Statutes of 2016. The additional funding will help DOR sustain the job coaching rate at $36.57 per hour, consistent with the DDS rate, without reducing other services to individuals with disabilities. DDS SE job coaching hourly rates, intake, placement, and retention services are statutorily defined. DOR has historically set a rate structure consistent with DDS to avoid disparity among the job coaching service providers.

Staff Comment and Recommendation. Approve. This subcommittee heard and discussed this item during its March 16, 2017 hearing. No concerns have been raised.

5175 DEPARTMENT OF CHILD SUPPORT SERVICES

Issue 1: Trailer Bill Language: Extend Suspension of Improved Performance Incentives

The Administration proposes to extend the suspension of Improved Performance Incentives for the Department of Child Support Services (DCSS) through 2017-18. The department notes that they are currently evaluating how this program should be restructured to better direct incentives towards specific reforms or innovations that could improve collections, the reliability of child support payments owed by non-custodial parties, and increase the pool of eligible Local Child Support Agencies (LCSAs).

Staff Comment and Recommendation. Approve proposed trailer bill language as placeholder. This subcommittee heard and discussed this item during its March 30, 2017 hearing. No concerns have been raised.

Issue 2: Trailer Bill Language: Repeal Health Insurance Incentives Program

The Administration proposes to repeal the Health Insurance Incentives Program. The Health Insurance Incentives Program requires that DCSS provide payments to the LCSA of $50 per case for obtaining third-party health coverage or insurance of Medi-Cal beneficiaries, to the extent that funds are appropriated in the budget act. However, this program was only operative for one year and these payments have been suspended since 2003-04. This incentive was originally suspended due to a decline in General Fund revenues and subsequently suspended due to ongoing budget constraints. The department notes that this suspension was extended from 2015-16 through 2016-17, in order for DCSS to reevaluate the incentive program and determine its relevance. DCSS states that federal and state laws already require the enforcement of medical support.

Staff Comment and Recommendation. Approve proposed trailer bill language as placeholder. This subcommittee heard and discussed this item during its March 30, 2017 hearing. No concerns have been raised.

5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: Budget Change Proposal: Full Year Costs for Child Welfare Services Near Fatality Case Reviews

The Administration requests $483,000 ($242,000 General Fund) in the budget year and $449,000 ($225,000 General Fund) ongoing for four positions to address workload associated with new federal Child Abuse Prevention Treatment Act (CAPTA) requirements to review and disclose information relating to child near fatalities, and AB 1625 (Committee on Budget), Chapter 320, Statutes of 2016. The department notes that this legislation doubles the annual number of near fatality cases reported to DSS, and requires additional staff time to review each incident. Currently, DSS has six staff performing this work for fatalities.

Staff Comment and Recommendation. Approve. This subcommittee heard and discussed this item during its March 30, 2017 hearing. No concerns have been raised.

ISSUES FOR DISCUSSION

4700 COMMUNITY SERVICES AND DEVELOPMENT

Issue 1: Overview

The Department of Community Services and Development (CSD) partners with a statewide network of private, non-profit and public community-based organizations commonly referred to as community Action Agencies or Local Service Providers dedicated to helping low-income families and individuals achieve and maintain self-sufficiency, manage their home energy needs, and reside in housing free from the dangers of lead hazards. The Governor's budget proposes total spending of $252.7 million (no General Fund) for CSD for 2017-18. Below is a summary of the Governor's proposed funding for 2016-17 and 2017-18:

Funding for Dept. of Community Services and Development - 4700	
Funding Source	**FFY 2016**
Low Income Home Energy Assistance Program	$176.8
Community Services Block Grant	$63.0
Dept. of Energy Weatherization Assistance Program	$5.8
Greenhouse Gas Reduction Fund [1/]	$20.0

Funding for Dept. of Community Services and Development - 4700	
Funding Source	**FFY 2017** [2/]
Low Income Home Energy Assistance Program	$151.8
Community Services Block Grant	$35.8
Dept. of Energy Weatherization Assistance Program	$5.8
Greenhouse Gas Reduction Fund [3/]	-

Dollars in Millions

Footnote 1: $20M in LIWP Funding for the 2016/17 State Fiscal Year

Footnote 2: 2017 Funding is on Continuing Resolution. Funding received to date.

Footnote 3: GGRF reflects funding for the 2017/18 State Fiscal Year

CSD's programs include:

- Community Services Block Grant (HHS- CSBG). CSBG is an annual federal grant that provides or supports a variety of local services to alleviate the causes and conditions of poverty with the goal of helping people achieve self-sufficiency. Examples of CSBG supported services and activities include local programs to address employment, education, asset building, housing and shelter, nutrition and emergency services.

- Low-Income Home Energy Assistance Program (HHS -LIHEAP). LIHEAP is an annual federal grant that provides financial assistance to offset the costs of heating/cooling residential dwellings, for energy-related emergencies, and weatherization services to improve the energy-efficiency of homes.

- U.S. Department of Energy Weatherization Assistance Program (DOE-WAP). WAP is an annual federal grant that provides weatherization services to eligible low-income individuals to improve the energy-efficiency of low-income homes and safeguard the health and safety of occupants.

- Lead-Based Paint Hazard Control Program (HUD-Lead). LEAD is a competitive federal grant that provides for the remediation of lead-based paint in low-income homes with young children.

- Low-Income Weatherization Program (LIWP). LIWP is funded by state cap-and-trade auction proceeds to provide energy efficiency and renewable energy services such as solar photovoltaic systems. These services are provided to low-income single-family and multi-family dwellings within disadvantaged communities to help reduce greenhouse gas emissions and save energy.

- Drought Emergency Assistance Program (DEAP). DEAP is funded by state general funds and provides supportive services and emergency assistance for low-income workers in agriculture and ancillary industries who have suffered job losses related to the state's drought. DEAP supports a broad range of supportive services in over 24 highly drought impacted counties, including housing assistance, food, transportation, and employment services.

Federal Budget Update. The proposed federal budget calls for eliminating two U.S. Department of Health and Human Services' grant programs, the LIHEAP and the CSBG, and also calls for eliminating the DOE-WAP. There is still much uncertainty about whether Congress will adopt this budget.

Staff Comment and Recommendation. This item is informational only and no action is required.

Questions.

1. Please provide an overview of the department, programs, and current funding levels.

2. Please briefly discuss the proposed elimination of several federal grants.

Issue 2: Oversight: Low-Income Weatherization Program (LIWP) Procurement

Background. Phase I of LIWP procurement was developed in 2014, when CSD received what was anticipated to be a one-time appropriation of $75 million cap-and-trade funds. After receiving an additional cap-and-trade appropriation in 2015-16, CSD recognized the need to open up LIWP's single-family energy efficiency component to new potential service providers through a competitive procurement (Phase II). In addition, based on input from some stakeholders and potential providers, and experience gained from the initial implementation of LIWP, CSD pursued a stand-alone program model, designed to improve program administration, promote the leveraging of existing resources, and provide more cost-effective greenhouse gas reductions.

CSD retained an independent consulting firm that specializes in state procurements to help design and administer the LIWP Regional Administrator Request for Proposals (RFP). CSD actively sought public input in developing program design, guidelines and subsequent RFP for Phase II of LIWP. Beginning in Spring of 2016, CSD convened a series of stakeholder meetings and workshops to solicit public contributions to the program design and procurement process and criteria for LIWP. In November 2016, CSD issued the LIWP RFP to award approximately $57 million of 2015-16 cap-and-trade funds towards LIWP's single-family program component. The RFP sought to identify up to five regional administrators to cover disadvantaged communities across California. These regional administrators will oversee and implement all aspects of the single-family component of LIWP in their respective regions. CSD received proposals from nine prospective non-profit and local governmental regional administrators in response to the RFP. Of these nine, four proposals were submitted by existing LIWP service providers, and five were submitted by new entities. Four non-profit regional administrators received notices of intent to award; of the four, two are existing CSD local service providers and two are non-profits with no prior experience as LIWP providers. The providers selected under the LIWP RFP are specified in the table below:

Region	Proposed Awardee	Existing LIWP Provider?
Region 1 (Northern California)	Community Resource Project, Inc.	Yes
Region 2 (Bay Area)	Build It Green	No
Region 3 (Central Valley)	Community Action Partnership of Orange County	Yes
Region 4 (Los Angeles)	Build It Green	No
Region 5 (Southern California)	La Cooperativa Campesina de California	No

Stakeholder concerns. The California Weatherization Providers Network (Network), made up of energy service providers who have previously delivered services through LIWP, has significant concerns with the Phase II procurement process:

- Geographic Negligence. The Network is concerned that as a result of removing geographic preference, an award was made to a Southern California organization to serve the Central Valley. The Network cites the long-standing service reputation of the other competitors and the innate trust and familiarity with the local community that is necessary to facilitate effective service-delivery, which it states would be more difficult for a provider external to the region:

- Process. The Network states that the process was overly competitive, with the selection of one regional administrator per region (five total). The Network also cites that the process toward the procurement and ultimate award selection was not transparent, did not adequately involve stakeholders and incorporate input when offered, and did not include notice to and collaboration with the Legislature. They state that a justification for a deviation from Phase I to the new method for procurement under Phase II is lacking.

The Network asks for the subcommittee's consideration of the following requests to be made of CSD:

1. Extension of the current Phase I LIWP contracts for at least six months (or until there is no gap in service delivery due to a requested revised implementation of Phase II).

2. A rescoring of Phase II LIWP applications with, at minimum, preference for applicants geographically located in the region they propose to serve.

3. Delay of any future appropriation to CSD until agreement for a new bid process, if one is needed, that will result in strong industry protocols, a priority for local contracting, efficient and productive performance standards, and that will meet the energy savings needs of the greatest number of qualified consumers. The Network requests trailer bill language to ensure that any new funding to CSD is designed with appropriate parameters and that Supplemental Report Language is developed, instructing CSD to provide regular check-ins and reports to the Legislature on their program effectiveness.

Panel. The subcommittee has requested that a representative of the Network, in addition to CSD, the Department of Finance, and the Legislative Analyst's Office, provide comment on this issue.

Staff Comment and Recommendation. Hold open. In response to stakeholder concerns, staff recommends that the Legislature adopt trailer bill language to ensure that in any future procurement processes, CSD prioritizes existing ties to local communities for both regional administrators and providers, and other appropriate parameters to ensure a more transparent and inclusive process. Staff also recommends Supplemental Reporting Language be adopted that requires, at minimum, quarterly updates in the form of meetings or documentation to the Legislature and stakeholders on the status of the current, and any future, procurement processes, to begin July 2017.

Questions.

1. Please explain the procurement process shift from Phase I to Phase II. What prompted this change, and how were stakeholders involved in the process?

2. How does the department respond to stakeholder concerns about the process and geographic negligence?

3. What is the current status of Phase II contracts?

Issue 3: Budget Change Proposal: Low-Income Weatherization Program (LIWP)

Governor's Proposal. The Administration requests reappropriation of any unexpected balances of 2014-15 local assistance appropriations received from the Greenhouse Gas Reduction Fund (GGRF) to be available for encumbrance until the end of 2017-18, and available for liquidation until the end of 2018-19. The proposal includes budget bill language (BBL).

Background. Implementation of the California Global Warming Solutions Act of 2006 (Nuñez and Pavley), Chapter 488, Statutes of 2006, includes measures to achieve real and quantifiable cost-effective reductions of greenhouse gas (GHG) emissions. The Air Resources Board (ARB) has developed a market-based cap-and-trade program as a key element of its GHG reduction strategy, where there is a system of tradable permits to emit GHGs, and the market allows exchange of these allowances. A portion of the allowances are sold at auction, with the proceeds deposited in the GGRF which has been established for the purpose of funding measures that allow California to achieve its GHG reduction goals.

All of CSD's 2014-15 $70.3 million local assistance appropriation of GGRF monies has been awarded to vendors. However, there have been various issues such as the requirement that providers work exclusively in disadvantaged communities or the ability to identify appropriate housing stock in certain areas that make the liquidation of all of the funds by the end of 2016-17 difficult or impossible. If the reappropriation authority is not granted, CSD anticipates reverting a total of $11 million in GGRF.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

5180 DEPARTMENT OF SOCIAL SERVICES – COMMUNITY CARE LICENSING (CCL)

Issue 1: Oversight – Key Indicator Tool (KIT) Report Findings

Background. CCL conducts pre- and post-licensing inspections for new facilities and unannounced visits to licensed facilities under a statutorily-required timeframe. Prior to 2003, these routine inspection visits were required annually for almost all facilities. In 2003, budget cuts resulted in significantly reduced funding for CCL, and reduced the frequency of these inspections. In 2015, the frequency of inspections was increased from at least once every five years, to at least once every three years or more frequently depending on facility type. These reforms go into effect incrementally through 2018-19, and as of January 2017, DSS has begun implementing the required increased visit protocol. However, these requirements are still less frequent than required in most states.

In 2010, after much of the budget cuts had taken place, CCL fell behind in meeting visitation frequency requirements. In an effort to increase the number of routine inspections CCL could perform each year, DSS proposed moving from the comprehensive inspections required by state law to the use of a key indicator tool (KIT). The KIT was proposed to be a standardized, shortened protocol for measuring compliance with a small number of rules, such as inspection review categories and facility administration and records review, which is then used to predict the likelihood of compliance with other rules. Some facilities, such as facilities on probation, those pending administration action, or those under a noncompliance plan, would have been ineligible for a key indicator inspection and would receive an unannounced comprehensive health and safety compliance inspection. Under the proposal, if the KIT inspection revealed concerns, a comprehensive visit would also have been triggered.

Several stakeholders supported the department's proposal on the basis that increased frequency of licensing visits would enhance the safety and quality of community care facilities. However, other stakeholders opposed the proposal because they did not believe there was sufficient evidence to support the validity of the indicators and feared that truncated visits would be less effective than comprehensive visits. The Legislature declined at the time to make any changes to state law to officially authorize the use of KITs (with the possibility of triggering a comprehensive inspection) as a replacement for state law that required comprehensive inspections.

Since that time, the department moved ahead with piloting the design and implementation of the KIT for inspections of its licensed programs. CCL also contracted with the California State University, Sacramento, Institute of Social Research (CSUS, ISR) to provide an analysis and recommendations regarding the development, refinement, and validation of the KIT. The department has provided Legislative staff with some of the related reports, in addition to a summary of findings. The department notes that it considers this work by CSUS, ISR to be complete.

The findings in the reports provided by the department are focused on various iterations and refinement of the KIT (i.e., KITs 1, 2 and 3). To some extent, the reports validated that the third iteration of the KIT, which CSUS, ISR was more involved in developing, was the most effective in identifying the need for further inspections for half of the facility types. However, these findings do not answer the critical question of whether the use of the KIT(s) is ultimately saving time and allowing for more inspections to take place without augmenting resources or sacrificing the effectiveness of licensing oversight, which was one of the primary reasons that the KIT was first proposed by the department.

In recent discussions, the department indicated that all three iterations of the KIT are now being used in place of many comprehensive inspections that are otherwise required by existing state law.

Staff Comment and Recommendation. Hold open. It is not clear whether there is sufficient research to indicate that the KIT saves time and money without sacrificing the quality of CCL's oversight of licensed facilities. Even if such research does exist and the resulting policy direction that the department has taken may be appropriate, the department is not proposing statutory or budgetary changes to align its current practice with state law. Staff recommends that the department provide further explanation regarding its continued use of the KIT. Staff also recommends the adoption of Supplementary Reporting Language that at a minimum would require the department to meet with legislative staff and stakeholders to discuss the research reports and current status of the use of the KIT no later than July 31, 2017, and that the department distribute a document or summary report to the Legislature that addresses what their long-term plan is regarding the KIT and comprehensive inspections, and justification for it, including how this may affect future budget requests, no later than September 30, 2017.

Questions.

1. Please discuss the genesis and purpose of the KIT.

2. Is the KIT more efficient than the prior use of comprehensive inspections? If so, how? Is this varied by facility type at all?

3. What are the pros and cons of continuing to use the KIT, as opposed to returning to comprehensive inspections?

4. Does the budget for CCL, including current requests before this subcommittee, account for the use of the KIT?

Issue 2: Trailer Bill Language: Delay Licensing Requirements for Private Alternative Boarding Schools and Outdoor Programs

Governor's Proposal. The Administration proposes to modify implementation of SB 524 (Lara), Chapter 864, Statutes of 2016, by making funding for its requirements contingent upon appropriation in the budget act. Additionally, it would specify the operative dates of the respective statutes to take effect 18 months after the appropriation of funds.

Background. In response to the absence of state oversight for facilities and outdoor programs that advertise services and care for troubled teens, SB 524 established "private alternative boarding schools" and "private alternative outdoor programs" as two new types of licensed community care facilities under the purview of DSS beginning January 1, 2018, and January 1, 2019, respectively. Without an appropriation of funds, however, DSS is unable to implement the provisions of SB 524. The proposed trailer bill language would delay the requirements of SB 524 until sufficient resources are provided for DSS to implement.

Staff Comment and Recommendation. Hold open. DSS has stated that they are proposing to delay this statute not because of any administrative issues in ramping up to the original implementation dates, but rather due to costs associated with SB 524. Yet, the Department of Finance (DOF) has been asked about the cost of the activities to enact SB 524, and they have not provided an answer as to what the assumed savings to delaying this proposal are. Staff recommends that DOF share with the subcommittee members what this would cost.

Questions.

1. Please provide an overview of the proposal.

2. What changed between the signing of the bill last year to the decision to not provide funding for the provisions of this bill?

3. What are the savings associated with this TBL? If the cost/savings are unknown, why would the Administration proposed to delay funding?

Issue 3: Trailer Bill Language: Continue Fingerprinting Licensing Fee Exemption

Governor's Proposal. The Administration proposes to continue for an additional two years the suspension of existing law that prohibits DSS and the Department of Justice (DOJ) from charging a fee to process a criminal history check of individuals who are licensed to operate child and adult facilities, provide care in a facility, or reside at that facility. Enactment of this TBL will continue the practice of allowing DSS to charge fees for this service.

Background. Individuals who are licensed to operate child and adult facilities, provide care to facility clients, or reside at a facility, undergo a comprehensive background check. DSS requires a fingerprint-based background check from both the DOJ and the Federal Bureau of Investigations (FBI) for these individuals. DOJ bills DSS $17 for the FBI and $18 for the Live Scan service per person ($35 total). The background check for an individual associated with children's facilities that serve six or fewer children also includes an additional check for $15.

Since 2003-04, TBL has been enacted on an annual basis to suspend existing statute that prohibits DSS from charging the fingerprint licensing fee. To the extent that the prohibition to charge a fee is not suspended, the fee collection for this service ends and the state would be required to fund this activity with General Fund dollars.

Staff Comment and Recommendation. Hold open. These statutory provisions have been routinely delayed due to the costs associated with their enactment. No issues have been raised to subcommittee staff at this time.

Questions.

1. Please provide an overview of the proposal.

Issue 4: Spring Finance Letter: Home Care Services Program

Governor's Proposal. The Administration requests to convert 9.5 limited-term positions to permanent, an additional 4.5 positions, and increased expenditure authority of $2 million General Fund ($1.8 million General Fund ongoing) to continue implementation and administration of the Home Care Services Program pursuant to AB 1217 (Lowenthal), Chapter 790, Statutes of 2013. DSS states that these additional resources are needed to address ongoing workload and are supported by a biennial fee increase for Home Care Organizations and Home Care Aides. The requested positions are as follows:

- 0.5 Staff Services Manager I
- 7.0 Staff Services Analyst (General)
- 5.5 Associate Governmental Program Analyst
- 1.0 Attorney

The Administration is also seeking one-time increased expenditure authority of $100,000 for an interactive voice response telephone system to address current and ongoing workload.

Background. The Home Care Services Program regulates home care organizations and manages a registry of home care aides. The department states that current resources are insufficient to meet the demand of the program to register home care aides, conduct biennial inspections of home care organizations, and provide due process and technical assistance. Original assumptions for the Home Care Services Program estimated applications for approximately 1,000 organizations and 35,000 aides annually. After just one year, DSS had received over 90,000 aide applications and over 1,400 organization applications. The department also notes that as the state's population continues to age, the demand for this program will only increase.

Additionally, in the first year of the program, the Home Care Services Bureau received over 97,000 phone calls averaging 400 calls per day. This workload was also unanticipated and resulted in staff having less time to process applications and background clearances, which resulted in delays. DSS is requesting one-time expenditure authority of $100,000 to support an interactive voice response platform that will allow callers to access self-help information before speaking to a department representative.

The Home Care Services Consumer Protection Act requires that the program be entirely fee supported. The department states that the additional and ongoing resource needs will be supported by a fee increase for organizations and aides. Biennial fees for home care organizations will need to be increased by $638 for home care services companies and $25 for individuals beginning January 1, 2018.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

2. Please elaborate on how this proposal would work, since fee increases are necessary to pay for the positions. Does the General Fund provide a loan that these fee increases would pay back?

3. Would trailer bill language be needed to increase the fees?

4. How were the fee increases calculated, and are stakeholders aware that this fee increase is coming? What are the potential effects of the fee increase on stakeholders?

Issue 5: CalWORKs Participation Update

Background. CalWORKs child care seeks to help a family transition smoothly from the immediate, short-term child care needed as the parent starts work or work-related activities, to stable, long-term child care. CalWORKs Stage 1 is administered by the county welfare departments; Stages 2 and 3 are administered by Alternative Payment Program (APP) agencies under contract with CDE. The three stages of CalWORKs child care are defined as follows:

- Stage 1 begins with a family's entry into the CalWORKs program. Clients leave Stage 1 after six months or when their situation is "stable," and when there is a slot available in Stage 2 or 3.

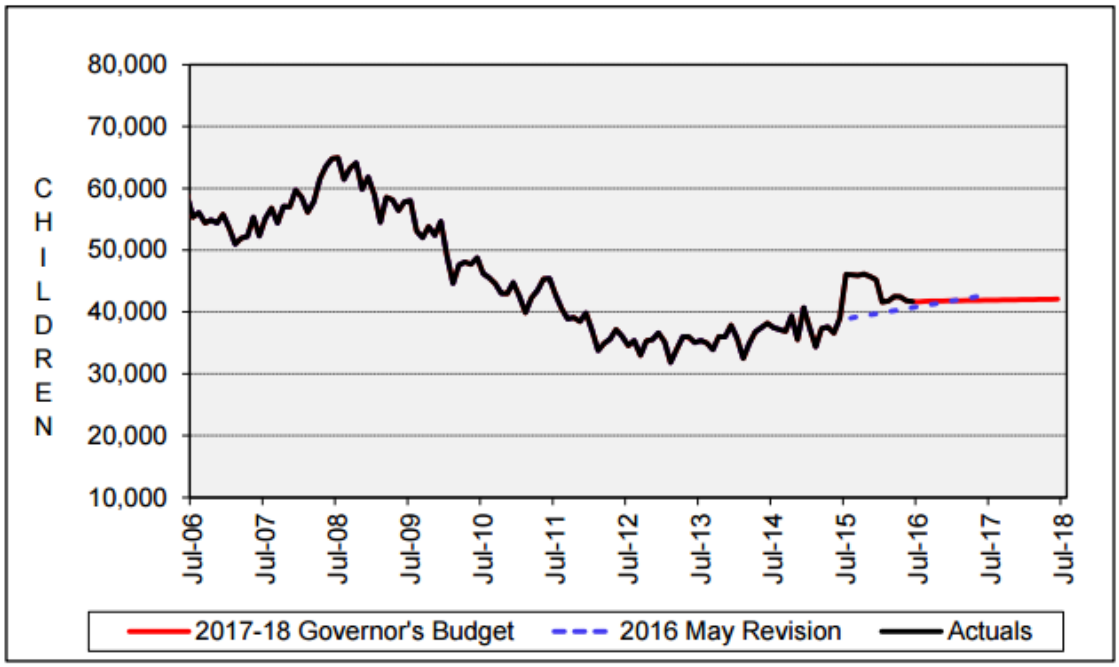
- Stage 2 begins after six months or after a recipient's work or work activity has stabilized, or when the family is transitioning off of aid. Clients may continue to receive child care in Stage 2 up to two years after they are no longer eligible for aid.

- Stage 3 begins when a funded space is available and when the client has acquired the 24 months of child care after transitioning off of aid (for former CalWORKs recipients).

Historically, caseload projections have generally been funded for Stages 1, 2, and 3 in their entirety – although Stage 3 is not technically an entitlement or caseload-driven program.

CalWORKs Stage 1 Participation. In past years, the Legislature has expressed concern about low utilization rates for CalWORKs child care, particularly Stage 1. Child care in Stage 1 is provided both to families working and those who are participating in Welfare-to-Work (WTW) activities. Participation in these programs decreased significantly during the recession as program policies shifted, and since this time enrollment has slowly increased, but is not back to pre-recession levels. In the first half of 2015-16, the utilization rate for Stage 1 and 2 child care of families with children participating in Welfare-to-Work activities is approximately 34 percent, compared to 30 percent in 2014-15 (this is not adjusted for families in which one parent is in WTW activities and the other parent is available to provide care for children.) For context, the County Welfare Director Association completed a survey, published in June 2016, that looked at the number of families eligible for Stage 1 and 2 child care. Based on responses, they estimate the utilization rate in CalWORKs Stage 1 and 2 and all other CDE-subsidized child care is approximately 45 percent. This survey also indicates that about 29 percent of children are in some other informal care arrangement. The most common reason families choose not to utilize Stage 1 and 2 child care, according to the survey, are a preference to do things on their own, followed by concerns over burdensome paperwork and low reimbursement rates.

CalWORKs Stage 1 Trend*



Source: Department of Social Services
*Note: The spike in 2015 reflects a shift in data collection rather than an actual increase in caseload.

In response to ongoing concerns, DSS has been working to increase understanding of CalWORKS Stage 1 caseload and the processes of counties as they qualify families for Stage 1 child care and transition eligible families to Stage 2 child care. DSS has updated their data system as of July 1, 2015, to collect information on the actual number of children receiving care, whereas the prior system collected payment information quarterly, with limited ability of the department to track care provided accurately across the year.

DSS is also analyzing data in greater depth and has learned that in CalWORKs Stage 1, 84 percent of children are older than age two, meaning they are eligible for a variety of other state and federal child care and education programs. DSS staff also embarked on series of site visits to 14 counties to observe processes and practices in providing CalWORKs child care. Over the past year, DSS has participated in a working group with CDE and child care stakeholders to examine some of the potential issues with families accessing child care. This work informed a DSS All County Notice that will be released in the coming days addressing best practices around access, enrollment, funding, and transferring of care.

Staff Comment and Recommendation. Informational only.

Questions.

1. What information did DSS gather from site visits with counties?

2. What data is DSS collecting that will allow for a more complete assessment of participation in Stage 1 CalWORKs?

Issue 6: Miscellaneous Proposals for Investment

The subcommittee has received the following miscellaneous advocate requests:

- Funding to prevent unintended pregnancies among foster youth

Budget Issue. The John Burton Advocates for Youth and others request $2.88 million General Fund in 2017-18, and $2.58 million General Fund ongoing, to prevent unintended pregnancies among foster youth by ensuring foster youth participate in state-mandated comprehensive sexual health education in California public schools, requiring social workers to document that they have informed foster youth of their reproductive rights, and requiring that training for social workers, caregivers, and judges include how to address reproductive health with foster youth.

Background. More than half of California foster youth have been pregnant at least once by age 19, which is approximately 2.5 times higher than that of youth not in foster care. In early 2016, DSS convened a group of experts to develop a statewide plan to address unplanned pregnancy in foster care. In October of 2016, DSS issued a document entitled "California's Plan for the Prevention of Unintended Pregnancy for Youth and Non-Minor Dependents."

Staff Comment and Recommendation. Hold open.

- Assist Welfare-to-Work participants with the cost of diapers by making them an ancillary expense or supportive service

Budget Issue. Assemblywoman Gonzalez Fletcher requests that diapers be an ancillary expense or supportive service in the CalWORKs program.

Background. As a result of Supplementary Reporting Language included in the 2016-17 budget, DSS convened a workgroup in the fall of 2016 on diaper assistance, and released a report in February 2017 entitled "Options for the Provision of Diaper Assistance to Low-Income Families. The report includes preliminary implementation details and a rough cost estimate.

Staff Comment and Recommendation. Hold open.

- Additional funding for CalWORKs Indian Health Clinics

Budget Issue. The California Rural Indian Health Board requests $1.1-$1.5 million General Fund for Indian Health Clinics. 36 clinics across California, split the current $1.9 million General Fund, which pays for less than one full-time drug and alcohol counselor in most regions. The requested augmentation would fund at least one full-time employee per clinic.

Background. The CalWORKs Indian Health Clinic (IHC) program was created to help Native American CalWORKs recipients remove barriers to sustainable employment such as mental health and substance abuse issues. The IHC program is still funded at the same level as it was in 2002.

Staff Comment and Recommendation. Hold open.

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

SUBCOMMITTEE NO. 3 Agenda

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

May 4, 2017
Upon Adjournment of Budget and Fiscal Joint Hearings
with Subcommittees No. 2, 3, and 4
Room 4203, State Capitol
Part B

Consultant: Theresa Pena

OUTCOMES

ISSUES RECOMMENDED FOR VOTE-ONLY

Item	Department	Action
4185	**California Senior Legislature**	
Issue 1	BCP: 2016 Budget Act General Fund Reappropriation	Approve (3-0)
0530	**Health and Human Services Agency, Office of Systems Integration**	
5180	**Department of Social Services**	
Issue 1	BCP: Horizontal Integration Office: Transfer to OSI	Approve (3-0)
5160	**Department of Rehabilitation**	
Issue 1	BCP: California Innovations Program: Federal Work-Based Learning Grant for Students with Disabilities	Approve (3-0)
Issue 2	BCP: Information Security Compliance	Approve (3-0)
Issue 3	BCP: Supported Employment Program: Increase Job Coaching Rates	Approve (3-0)
5175	**Department of Child Support Services**	
Issue 1	TBL: Extend Suspension of Improved Performance Incentives	Approve (3-0)
Issue 2	TBL: Repeal Health Insurance Incentives Program	Approve (3-0)
5180	**Department of Social Services**	
Issue 1	BCP: Full Year Costs for Child Welfare Services Near Fatality Case Reviews	Approve (3-0)

ISSUES FOR DISCUSSION

Item	Department	Action
4700	**Department of Community Services and Development**	
Issue 1	Overview	Informational
Issue 2	Oversight: Low-Income Weatherization Program Procurement	Hold Open
Issue 3	Budget Change Proposal: Low-Income Weatherization Program Reappropriation	Hold Open
5180	**Department of Social Services – Community Care Licensing**	
Issue 1	Oversight: Key Indicator Tool Report Findings	Hold Open
Issue 2	Trailer Bill Language: Delay Licensing Requirements for Private Alternative Boarding Schools and Outdoor Programs	Hold Open
Issue 3	Trailer Bill Language: Continue Fingerprinting Licensing Fee Exemption	Hold Open
Issue 4	Spring Finance Letter: Home Care Services Program	Hold Open
5180	**Department of Social Services**	
Issue 5	CalWORKs Child Care Stage 1	Informational
5180	**Department of Social Services**	
Issue 6	Miscellaneous Proposals for Investment	Hold Open

Senate Budget and Fiscal Review—Holly Mitchell, Chair

JOINT HEARING Agenda

Senate Budget Subcommittee No. 2 on Resources, Environmental Protection, Energy and Transportation, No. 3 on Health and Human Services, and No. 4 on State Administration and General Government

Wieckowski, Pan and Roth, Chairs

Thursday, May 4, 2017
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultants: Renita Polk, Joe Stephenshaw, Scott Ogus and Mark Ibele

Cannabis Regulatory Implementation

PROPOSED FOR DISCUSSION AND VOTE

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.

ITEMS PROPOSED FOR DISCUSSION AND VOTE

0860 STATE BOARD OF EQUALIZATION (BOE)
1111 DEPARTMENT OF CONSUMER AFFAIRS (DCA) – BUREAU OF MARIJUANA CONTROL
4265 DEPARTMENT OF PUBLIC HEALTH (DPH)
8570 CALIFORNIA DEPARTMENT OF FOOD AND AGRICULTURE (CDFA)

Issue 1: Implementation of Cannabis Regulation (BCPs)

Budget. The Governor's budget includes a total of $51.4 million (Marijuana Control Fund) and 190 positions for cannabis implementation across four departments in the 2017-18 fiscal year. The budget also includes a General Fund loan to the Marijuana Control Fund for $62.7 million.

- The Governor's budget includes $5.4 million for BOE in 2017-18 to administer the new excise taxes. Specifically, the proposal includes:
    - In 2016-17: 1.9 positions and $1.1 million
    - In 2017-18: 22 positions and $5.4 million
    - In 2018-19: 21.3 positions and $2.7 million
    - In 2019-20: 17.4 positions and $2.1 million
    - In 2020-21 and ongoing: 16.9 positions and $2 million
- **Comments on BOE Proposal.** Subsequent to the submission of the budget proposal, BOE and the Department of Finance have worked to reconcile the resources required with existing BOE staffing. Consequently, the request will be adjusted to reflect this downward adjustment in required positions, as well as required resource. Notwithstanding this additional change, the BOE proposal is reasonable based on the revisions, and may be slightly understaffed given the significant undertaking with respect to a new universe of tax payers. BOE must, in its activities, pay particular attention to the statewide nature of the policy and ensure that outreach efforts, tax administration and collection of the tax are uniform across board member districts.
- The Governor's budget contains a total of $22.5 million for DCA in 2017-18. Specifically, the proposal includes:
    - In 2017-18: 82 positions and $12 million for licensing and enforcement; 38 positions and $5.4 million to address workload increase in DCA's Division of Investigation (DOI) and administrative staff to support the bureau; and $5.1 million for the

implementation of an information technology (IT) solution that would provide licensing and enforcement functions.

- In 2018-19: 68 positions and $21 million for licensing and enforcement; $6.2 million to address workload increase in DOI and administrative staff to support the bureau; and $3.6 million in 2018-19 and ongoing for IT implementation.

- In 2019-20: 17 positions and $21.8 million in 2019-20 and ongoing for implementation of the bureau's licensing and enforcement activities; and $5 million in 2019-20 and ongoing to address the anticipated increase in investigative workload for the DOI and administrative staff to support the bureau.

- **Comments on DCA proposal.** The licensing and enforcement request includes funding for a total of 205 positions (120 positions in 2017-18), the establishment of five field offices, testing laboratory services, equipment, vehicles, and new facilities. This request also includes ongoing funding for positions established in 2016-17. It is likely that the Legislature's decisions about aligning the Medical Cannabis Regulation and Safety Act (MCRSA) and the Adult Use of Marijuana Act (AUMA) will affect resource needs and the requests above will need to be adjusted. In addition, there is significant uncertainty regarding resource needs, and regulatory decisions will likely affect these needs.

- The Governor's budget proposes a total of $1 million for DPH in 2017-18. Specifically, the proposal includes:

  - In 2017-18: $1.4 million for an IT application for licensing medical cannabis manufacturers. The proposal also includes the redirection of three positions and $410,000 for licensing medical cannabis testing laboratories to the Bureau of Marijuana Control.

  - In 2018-19: $494,000 to complete the IT project.

  - In 2019-20 and ongoing: $238,000 for maintenance and operation of the IT application.

- **Comments on DPH proposal.** While DPH plans to implement its IT application for licensing of medical cannabis manufacturers by the statutory deadline of January 1, 2018, the application must be able to interact with other state entities' IT applications related to the regulation of cannabis products. The Legislature should continue to monitor the department's progress establishing this interoperability. In addition, although responsibility for licensing medical cannabis testing laboratories was transferred to the Bureau of Marijuana Control, this proposal requests to transfer to the bureau only three of the eleven positions approved in the 2016 Budget Act to support this workload. According to DPH, its ongoing licensing workload for medical cannabis manufacturers is more extensive than originally expected and the remaining positions will instead be redirected for this purpose. Because regulation of medical cannabis manufacturers is a new workload for DPH, a measure of flexibility with allocation of staff resources is

reasonable. However, the Legislature should monitor whether the bureau has received the appropriate level of resources to implement and sustain its new testing laboratory licensing program.

- The Governor's budget proposes a total of $22.4 million for CDFA in 2017-18. Specifically, the proposals include:

    - In 2017-18: $16.9 million and 13 positions for implementation of the Track and Trace IT project; 3.5 positions to enforce measurement standards; three year limited-term funding of $5.5 million and 34.3 positions for licensing and enforcement activities.

    - In 2018-19: $10.5 million for the Track and Trace IT project; an additional four positions to enforce measurement standards.

- **Comments on CDFA proposal.** In addition to licensing and regulating cannabis cultivation, CDFA's implementation of the Track and Trace system is an essential part of the regulatory structure as a whole. The system will track cannabis and cannabis products throughout the supply chain and will serve as a primary mechanism to ensure compliance as products move throughout the supply chain. As such, the Legislature should continue to closely monitor the department's progress in implementing this system.

Background. The statutorily authorized use of medical cannabis was approved in California in 1996 when voters approved Proposition 215, the Compassionate Use Act (CUA). The CUA provides certain Californians the right to obtain and use cannabis for medical purposes, as recommended by a physician; and, prohibits criminal prosecution or sanction against physicians who make medical cannabis recommendations.[1] In 2003, Senate Bill 420 (Vasconcellos), Chapter 875, Statutes of 2003, established the Medical Cannabis Program under the California Department of Public Health, and created a medical cannabis identification card and registry database to verify qualified patients and primary caregivers.

Since 2003, advocates, patients, and local governments recognized some deficiencies in the oversight of medical cannabis and called for additional safety regulations. In June 2015, Governor Brown signed the MCRSA, comprised of Assembly Bill 243 (Wood), Chapter 688, Statutes of 2015; Assembly Bill 266 (Bonta), Chapter 689, Statutes of 2015; and Senate Bill 643 (McGuire), Chapter 719, Statutes of 2015. Together, these bills established the oversight and regulatory framework for the cultivation, manufacture, transportation, storage, and distribution of medical cannabis in California. SB 837 (Committee on Budget and Fiscal Review), Chapter 32, Statutes of 2016, was a trailer bill that furthered the intent of the MCRSA legislation.

With California having the largest economy in the U.S., many advocates called for the legalization of recreational use of cannabis, predicting an increase of hundreds of millions of dollars in state revenue. In November 2016 voters approved Proposition 64, the AUMA. AUMA legalized nonmedical, adult use of cannabis in California. Similarly to MCRSA, the act creates a

[1] Health and Safety Code §11362.5

regulatory framework for the cultivation, manufacture, transportation, storage and distribution of cannabis for nonmedical use. Below is a table listing the responsibilities of licensing and other state entities under AUMA and MCRSA.

Cannabis Regulation
Responsibilities by Department

Department	Tasks Assigned by MCRSA	Tasks Assigned by AUMA
Department of Consumer Affairs	License dispensaries, distributors, testing laboratories, and transporters.	License dispensaries, distributors, and microbusinesses.
Department of Fish and Wildlife	Expand its pilot project to address the environmental impacts of cannabis cultivation.	Expand pilot project to a statewide level and make project permanent.
State Water Resources Control Board	Authorized to address waste discharge resulting from cannabis cultivation.	Authorized to address waste discharge resulting from cannabis cultivation.
Department of Food and Agriculture	License indoor and outdoor cultivation sites. Ensure water diversion and discharge from cultivation does not affect instream flows for fish spawning, migration, or rearing. Establish a medical cannabis cultivation program, with specified criteria. Establish program that identifies a permitted medical cannabis plant by a unique identifier. Develop a separate "track-and-trace" system to report movement of commercial products through distribution.	License indoor and outdoor cultivation sites. Ensure water diversion and discharge from cultivation does not affect instream flows for fish spawning, migration, or rearing. Establish a cannabis cultivation program. Implement a unique identification program for retail cannabis and cannabis products. Expand "track-and-trace" system to include the same level of information for nonmedical products.
Department of Public Health	License cannabis manufacturers. Develop regulations for producing and labeling of cannabis products.	License cannabis manufacturers and testing sites.
Department of Pesticide Regulation	Develop cultivation regulations for pesticide use.	Develop cultivation regulations for pesticide use.

Legislative Analyst's Office (LAO). The LAO makes the following recommendations to the Legislature when looking at these proposals.

- Make policy decisions on aligning medical and nonmedical cannabis regulation before making decisions on funding and positions. Doing so could better enable the Legislature to provide funding and staffing levels consistent with the ultimate regulatory structure.

- Limit funding provided for out years. Specifically:

    - Approve IT funding requests for 2017-18 but reject proposed funding in out years.

    - Approve a portion of funding requested by DCA in 2017-18 on a two year limited term basis, making 20 percent of its licensing and support staff funding limited term. This would be consistent with the share of its enforcement staff that DCA proposes to fund on a limited-term basis.

    - Reject requests for future increases in DCA's licensing and enforcement requests. It is too early to tell what the ongoing resource needs will be.

- Once the Legislature determines its preferred level of funding for 2017-18, tailor the General Fund loan to meet those needs.

- Enact legislation to require the Administration to submit a report each year on the implementation of MCRSA and AUMA, summarizing department activities and outcomes.

- Adopt language to require departments implementing new cannabis-related IT projects to provide legislative staff with quarterly briefings on the status of these projects.

Issues to Consider. Under MCRSA, **t**he Bureau of Marijuana Control, along with other licensing entities, would be responsible for 17 different types of medical cannabis business licenses, including: cultivators, nurseries, processors, testing labs, dispensaries, and distributors. With the passage of AUMA, licensing authorities have been charged with issuing 19 other license types for recreational use. Licensing authorities must begin issuing licenses by January 1, 2018, and will need to have regulations in place prior to issuing licenses. The bureau, CDFA, and DPH issued draft regulations on April 28, 2017, and will be holding public hearings to discuss the proposed regulations in May and June. However, these regulations only relate to medicinal cannabis. Even though some of the regulatory framework for medical cannabis can be applied to nonmedical cannabis, there are significant differences that require a different regulatory approach. As such, the Administration's proposed trailer bill attempts to reconcile the majority of these differences to create a unified regulatory structure. Even with the reconciliation of the regulatory structures, January 1 is an ambitious timeline for departments to finalize regulations and set up IT systems to administer such a large and complex program.

In addition, merging these two frameworks into one may alleviate confusion, and allow more efficient regulation by state agencies. However, there may be merit in keeping distinct lines of delineation between medical and adult use businesses. As the sale and distribution of cannabis is

illegal under federal law, federal prosecutors may choose to take action against cannabis operations, thus affecting the cannabis industry in California. There is some belief that, if this were to happen, federal enforcement may target adult use businesses. If there is no distinction between these two structures, then the medical cannabis industry may be affected as well.

Given the issues mentioned above, and the lack of recent precedent for establishing an oversight and regulatory scheme of this magnitude,[2] the subcommittees may wish to consider the following:

- As licensing entities must begin issuing licenses on January 1, 2018, will they be accepting applications for licenses before that date? If so, are the licensing entities currently equipped to handle intake of those applications?

- The bureau, CDFA, and CDPH are all charged with various licensing duties and may have different IT systems to handle licenses. How are these departments collaborating to ensure that their systems work with the others?

- What is the plan for hiring staff, specifically at CDFA and the bureau, where a large number of positions have been requested?

- What is the plan for accepting cash payments? Have extra security measures, specifically for the BOE and bureau, been considered?

- What will happen if state agencies are unable to meet the January 1, 2018 deadline?

- While it is important to provide adequate resources for the development and implementation of a cannabis regulatory and enforcement structure, there is a large amount of uncertainty in how this system will work. The subcommittees may wish to require the department to come back in future years and provide information on implementation and outcomes, as suggested by the LAO, to help determine future funding levels.

- The subcommittees may also wish to consider how to ensure departments can hire for positions that will be ongoing in nature – but will have limited-term funding. The goal being to ensure that there is adequate oversight and resources.

Staff Recommendation. Hold open.

[2] The last bureau to be created under DCA was the Professional Fiduciaries Bureau, established in 2007, which only licenses approximately 600 individuals.

Issue 2: Cannabis Regulation Trailer Bill Language (TBL)

In April 2017, the Administration released a draft of the cannabis regulation trailer bill language (TBL).

Background. The Administration proposes to unite components of the regulatory structures for medicinal and nonmedicinal cannabis, while preserving the integrity and separation of the two industries by maintaining the two as separate categories of license types with the same regulatory requirements for each.

There are many similarities in the regulatory structures under MCRSA and AUMA; however, there are also differences. Some of these differences are significant policy distinctions, such as MCRSA's requirement that distributors must be independent within the supply chain. While other differences are not as significant and may have been the result of timing, such as the Legislature passing the MCRSA TBL, SB 837 (Committee on Budget and Fiscal Review), Chapter 32, Statutes of 2016, after the drafting of AUMA had been completed. For example, the Department of Consumer Affairs is responsible for licensing testing laboratories for medical cannabis, while the Department of Public Health is responsible for licensing testing laboratories for recreational use. More specifics on the laws governing the implementation of legal cannabis use are below.

Licensing and fees. Licensing authorities must establish a scale of application, licensing, and renewal fees. The licensing and renewal fees are calculated to cover the costs of regulatory activities, and are set on a scaled basis depending on the size of the business. All fees are deposited into an account specific to that licensing authority, which will be established within the Cannabis Control Fund. There are a total of 17 different types of licenses for medical cannabis businesses, while AUMA lists 19 different license types.

Local control. Cities and counties may regulate all cannabis businesses and require them to obtain local licenses. Cities and counties may ban cannabis-related businesses, but not cannabis transportation through their jurisdictions. Under AUMA, recreational cannabis businesses are not required to have a local license, but must abide by local ordinances in order to obtain a state license. Local authorities must send notice to the Bureau of Marijuana Control, or relevant licensing authority, when they revoke a cannabis license.

Penalties and Violations. State law authorizes a civil penalty of up to twice the amount of the license fee for each violation relating to the use of medical cannabis, and a civil penalty of up to three times the amount of the license fee for violations relating to commercial cannabis. The department, state, local authority, or court may also order the destruction of the cannabis associated with the violation. Statute establishes different locations for where the penalties will be deposited, depending on whether the Attorney General, district attorney or county counsel, or a city attorney or city prosecutor brings forth the action.

Taxes. AUMA instituted a new state tax on the cultivation of cannabis that enters the commercial market, as well as a new state retail excise tax. Both of these taxes would affect both medical and nonmedical cannabis. AUMA eliminated sales tax on medical cannabis, but

recreational cannabis would be subject to existing state and local sales tax. Revenues from these new taxes would be deposited into a new special fund, the California Cannabis Tax Fund. The fund would first be used to reimburse state agencies for cannabis related regulatory costs, and remaining funds would be distributed as follows:

- $10 million annually until 2028-29 to evaluate effects of recreational cannabis use.
- $3 million annually until 2022-23 to develop methods to determine whether an individual is driving impaired.
- $10 million in 2018-19, with a $10 million increase annually until 2022-23, and $50 million annually afterward, for a grant program to provide services to communities most affected by past drug policies.
- $2 million annually to study hazards and values of medicinal cannabis.
- After the above allocations, remaining funds would be apportioned, as such: 60 percent for youth programs, 20 percent to mediate environmental damage from cannabis cultivation, and 20 percent for programs to reduce impaired driving and a grant program to reduce negative public health impacts.

Below is a summary of the solutions offered by the Administration's proposed TBL to address key differences between AUMA and MCRSA.

Dual state and local licensing. Under MCRSA, a local permit, license, or other authorization is a prerequisite for obtaining a state license. Under this law, the applicant is responsible for providing proof of compliance with these local requirements to state licensing authorities. Under Proposition 64, adult-use cannabis businesses must be in compliance with any local ordinance or regulation in order to obtain a license, but the burden is on the state licensing authorities to determine whether or not businesses are in fact in compliance.

- Proposed solution: With 58 counties and 482 cities, it is unrealistic to expect the licensing entities to verify that each applicant is in compliance with any local law or regulation. The proposed solution does the following:

    - Since, the state licensing authorities cannot require applicants to show proof of a local permit, new language will require the bureau to work with local jurisdictions to collect all the ordinances that govern cannabis in the state, including those that have bans. Also, local jurisdictions shall be responsible for providing the contact for their jurisdiction, so that state licensing entities know who to call when questions arise about an applicant.

    - Authorizes an applicant to voluntarily submit a copy of the permit, license, or local authorization to the state licensing entities for jurisdictions that have taken action to regulate cannabis and have completed a programmatic environmental impact report (EIR) in order to issue local permits.

    - In instances where a local jurisdiction allows cannabis business to operate, but does not issue permits, then the applicant will be responsible for submitting the

EIR for certification to the state licensing entity. This will be similar to how a land developer has to work on their own EIR before a project moves forward.

- As an incentive for locals to take on more of the environmental compliance work, a narrow CEQA streamlining is proposed for local jurisdictions that moves forward to regulate. The proposed solution maintains local autonomy of zoning and planning decisions while providing state regulators with local compliance information in a timely manner.

Vertical integration. MCRSA places restrictions on the number and type of licenses cannabis business may acquire. There are 17 license classifications and six licensure categories (cultivation, manufacturing, testing, dispensary, distributor, and transporter). Under MRCSA, licensees can hold up to two separate license categories, with the exception of testing and distribution. The restrictions seek to limit the ability of one entity to control multiple steps in the cultivation, distribution, and retail chain. AUMA does not include prohibitions against holding multiple licenses. The only exception is that a testing licensee cannot hold a license or ownership interest in any other category.

- Proposed solution: The Administration proposes to maintain AUMA's vertically integrated licensing structure for both adult use and medicinal cannabis licensees. Overly restrictive vertical integration stifles new business models and does not enhance public and consumer safety. AUMA has restrictions to protect against the over concentration of licenses in areas as well as monopolies. It also requires that testing licensees to be independent of all licensees in other categories.

Distribution. Under MCRSA, all medicinal cannabis and medicinal cannabis products are required to go through a third-party distributor. The distributor is responsible for arranging testing of the flower or cannabis product prior to it going to market. A distributor can hold a transportation license, but is precluded from holding any other license type. Under AUMA, a distribution license regulates only transportation activities and allows a distributor to hold any other license except for a testing license. Both third-party and in-house distributors owned by licensed cultivators, manufacturers, and retailers are allowed. The responsibility for testing cannabis or cannabis product falls on the licensee taking the product to market.

- Proposed solution: The Administration proposes to maintain the AUMA's open distribution model. Allowing for a business to hold multiple licenses including a distribution license will make it easier for businesses to enter the market, encourage innovation, and strengthen compliance with state law. To ensure the integrity of the testing is maintained, all distributors must arrange for an independent licensed testing laboratory to select a random sample, transport it to a laboratory, and test the product.

Ownership. The definition of an applicant varies in MCRSA and AUMA, depending on the level of ownership. MCRSA defines applicant as any person having decision making authority or an ownership or financial interest. Under MCRSA, all applicants and those having a five percent interest or more in a publicly-traded company are required to pass a background check. AUMA

only requires a background check for licensees having at least a 20 percent ownership and having direct management authority.

- Proposed solution: The Administration proposes two separate definitions for applicant and owner. For ease of administration, only one designee will be required as the applicant. Owners must pass a background check under both systems. The Administration proposes to adopt the AUMA definition of owner of having at least 20 percent ownership, or any person with the power to impact management decisions. In addition, with the exception of publicly traded companies, licensees must disclose the identity of all investors to the licensing authorities.

Cultivation limits. MCRSA includes a limit on the scale of cultivation and the number of medium size (Type 3) licenses that can be issued. Most cultivation licenses authorize a maximum of one acre of cultivation. The Type 10A multiple-cultivation license allows a maximum of four acres of cultivation, although the four acre limit sunsets on January 1, 2026. AUMA added a new cultivation license type not included in MCRSA, the Type 5, which allows large size cultivation of over one acre or greater than 22,000 square feet indoors. This license type cannot be issued until January 1, 2023. AUMA does not limit the number of medium size (Type 3) licenses that can be issued.

- Proposed solution: In furtherance of the intent of Proposition 64 to prevent illegal production and avoid illegal diversion to other states, the Administration proposes to limit the number of Type 3 licenses consistent with MCRSA.

Microbusinesses. AUMA establishes a new license type called microbusiness which was not included in the MCRSA. A microbusiness is authorized to engage in activities in four market segments: cultivation, manufacturing using non-volatile solvents, distribution, and retail. Unlike other license types, a microbusiness would only require a license from the Bureau.

- Proposed solution: In order to protect the public health and safety and compliance with state environmental laws, the Department of Food and Agriculture and the Department of Public Health must also review microbusiness licensees. The Administration proposes a process whereby licensing authorities shall establish a process to ensure that a microbusiness applicant and licensee can demonstrate compliance with all the requirements under the law for the activity or activities they conduct.

Environmental protections. Senate Bill 837 (Committee on Budget and Fiscal Review), Chapter 32, Statutes of 2016, was legislation that clarified the roles of the appropriate state environmental entities, all of which must coordinate with CDFA before a cultivation license is issued. For example, SB 837 requires that all CDFA licenses include a pending application, registration, or other water right documentation that has been filed with the State Water Resources Control Board. SB 837 clarifies that the State Water Board has enforcement authority if water is diverted or illegally used for cannabis cultivation.

- Proposed solution: Due to the timing of the passage of the above legislation, the drafters of the AUMA were unable to conform to the changes made in SB 837. The

Administration proposes to amend the AUMA to include the same environmental protection requirements as MCRSA.

Appeals panel. AUMA establishes a Marijuana Control Appeals Panel, consisting of three members appointed by the Governor and subject to confirmation by the Senate. Any applicant or licensee can appeal to the panel to review a penalty, a license issuance, denial, or other adverse action by any of the licensing authorities. This panel was not contemplated in MCRSA.

- Proposed solution: The Administration proposes to extend the review of the panel to all licensing decisions relating to cannabis. The panel will streamline the appeals process and bring needed expertise and due process to the review of any licensing decision. The language allows a party to appeal a panel decision directly to the Court of Appeals, which is similar to how the Alcoholic Beverage Control Appeals Board works.

Appellation. Appellation of origin is a legally-defined and protected geographic indication usually used for wine and certain food. Appellation of origin is typically determined by the federal government. Because the federal government will not establish appellations, MCRSA authorizes CDFA to establish appellations of origin for cannabis. The AUMA also addresses appellation of origin, but instead requires the bureau to establish standards by January 1, 2018.

- Proposed solution: In order to provide sufficient time and expertise to establish and set standards for appellations of origin, the initiative should be amended to transfer the responsibility to establish appellation of origin from the bureau to CDFA and extend the deadline to accomplish this to January 1, 2020.

State issued medicinal ID cards. SB 420 established a voluntary registry identification card system, maintained by Department of Health Services, for patients that have a recommendation from their doctor to use medicinal cannabis. The card was intended to provide some protection to the cardholder from arrest and prosecution for possession, transportation, and cultivation of marijuana for medicinal purposes. Approximately 80 percent of cannabis patients do not currently use medical cannabis identification cards, but instead use their physician recommendation to purchase medical cannabis. The identification card in its current form cannot be used to confirm the identity of any individual as it contains no identifying information other than a photo and the name of the county from which it was obtained. The photo and county name is also the only information maintained by the state.

- Proposed solution: The Administration proposes to delete the requirement for state issued medicinal ID cards and provides the county with the authority to issue local cards.

LAO. The LAO, in general, agrees with the concept of aligning MCRSA and AUMA. However, the LAO states that the Legislature will want to closely evaluate the specifics of the choices made by the Administration to ensure that it has provided clear rationales for these changes and that they are consistent with legislative priorities for the regulation of cannabis. The Legislature will also want to consider whether proposed changes to AUMA might require voter approval, as well as keep in mind that cannabis remains illegal under federal law. More specifics on the LAO

assessment can be found in the handout entitled "The 2017-18 Budget: Overview of Governor's Cannabis-Related Trailer Bill Legislation," available on the LAO's website.

Staff Recommendation. Hold open.

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, May 11, 2017
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Scott Ogus

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.

VOTE ONLY

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

Issue 1: E-Commerce Online Paramedic Licensing Module (eGov)

Budget Issue. EMSA requests expenditure authority from the Emergency Medical Services Personnel Fund of $211,000 in 2017-18, and $71,000 annually thereafter. If approved, these resources would allow EMSA to purchase proprietary software to implement an online paramedic licensing application system.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0312 – EMS Personnel Fund	$-	$211,000
Total Funding Request:	**$-**	**$211,000**

This issue was heard during the subcommittee's May 4th hearing.

Subcommittee Staff Comment and Recommendation—Approve. Implementation of the eGov module for online paramedic licensing was part of the original planning for EMSA's centralized licensing system mandated by AB 2917 (Torrico), Chapter 274, Statutes of 2008. Approval of this request, funded by special fund revenue from EMT licensing fees, will allow EMSA to reduce licensing workload and improve the licensing process for applicants.

Issue 2: EMT-P Discipline Case Workload

Budget Issue. EMSA requests two positions and expenditure authority from the Emergency Medical Services Personnel Fund of $314,000 in 2017-18 and 2018-19. If approved, these resources would allow EMSA to manage an increase in disciplinary legal caseload related to its oversight of paramedic licensing.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0312 – EMS Personnel Fund	$-	$314,000
Total Funding Request:	**$-**	**$314,000**
Total Positions Requested:	**2.0**	

This issue was heard during the subcommittee's May 4th hearing.

Subcommittee Staff Comment and Recommendation—Approve. EMSA's unexpected increase in legal workload related to local plan appeals warrants additional resources on a temporary basis to manage neglected paramedic licensing disciplinary workload. Approval of this request, funded by special fund revenue from EMT licensing fees for two years, will allow EMSA to manage its paramedic

disciplinary workload in the short-term and reassess its needs if other legal workload declines in the future.

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: Health Care Workforce Recruitment Legislation (AB 2024 and AB 2048)

Budget Issue. OSHPD requests expenditure authority from the California Health Data and Planning Fund of $400,000 in 2017-18, $250,000 in 2018-19 and 2019-20, and $70,000 in 2020-21 through 2023-24. If approved, these resources would allow OSHPD to implement health care workforce requirements pursuant to AB 2024 (Wood), Chapter 496, Statutes of 2016, and AB 2048 (Gray), Chapter 454, Statutes of 2016.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0143 – CA Health Data & Planning Fund	$-	$400,000
Total Funding Request:	**$-**	**$400,000**
Total Positions Requested:	**0.0**	

This issue was heard during the subcommittee's April 27th hearing.

Subcommittee Staff Comment and Recommendation—Approve. AB 2024 requires OSHPD to collect data from critical access hospitals to report on physician and surgeon recruitment. The requested resources are reasonable to implement the data collection protocols and prepare the required report. AB 2048 requires OSHPD to add 2,500 FQHC sites to its state loan repayment certified eligible sites list. The expected increase in technical assistance requests warrants additional resources to manage this increased workload. Approval of this request, funded by special fund revenue from health facility fees, will allow OSHPD to implement these legislative requirements.

Issue 2: Elective Percutaneous Coronary Interventions Reporting

Budget Issue. OSHPD requests two positions (conversion of limited-term to permanent) and expenditure authority from the California Health Data and Planning Fund of $358,000 annually. If approved, these resources would allow OSHPD to continue to collect data and analyze clinical outcomes for the Elective Percutaneous Coronary Interventions (PCI) program authorized by SB 906 (Correa), Chapter 368, Statutes of 2014.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0143 – CA Health Data & Planning Fund	$-	$358,000
Total Funding Request:	**$-**	**$358,000**
Total Positions Requested:	**2.0**	

This issue was heard during the subcommittee's April 27th hearing.

Subcommittee Staff Comment and Recommendation—Approve. SB 906 requires annual reporting on outcomes for elective PCI performed in hospitals without on-site surgical backup. Reauthorization of the previously approved positions and resources for this purpose is appropriate given the ongoing mandate of the legislation. Approval of this request, funded by special fund revenue from health facility fees, will allow OSHPD to continue planning and preparation for delivery of its outcomes reporting.

Issue 3: Relocation Rent Adjustment

Budget Issue. OSHPD requests expenditure authority from special funds of $1.2 million annually. If approved, these resources would support rent increases associated with OSHPD's planned relocation of its Sacramento headquarters and Los Angeles location due to expiring lease agreements.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0121 – Hospital Building Fund	**$-**	$733,000
0143 – CA Health Data & Planning Fund	**$-**	$402,000
0518 – Health Facility Construction Loan Insurance Fund	**$-**	$72,000
0829 – Health Professions Education Fund	**$-**	($11,000)
3085 – Mental Health Services Fund	$-	$4,000
Total Funding Request:	**$-**	**$1,200,000**

This issue was heard during the subcommittee's April 27th hearing.

Subcommittee Staff Comment and Recommendation—Approve. The expiration of OSHPD's existing lease agreements led to the need to find alternative office locations for its staff in Sacramento and Los Angeles. OSHPD is working with the Department of General Services to negotiate favorable lease terms in a tightening commercial real estate market. Approval of this request, funded by various special funds, will allow OSHPD to manage these necessary office relocations.

4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 1: Help Center Case Backlog and Workload

Budget Issue. DMHC requests 11 positions and expenditure authority from the Managed Care Fund of $3.4 million in 2017-18, $3.3 million in 2018-19 and 2019-20, and $2.7 million annually thereafter. If approved, these resources would allow DMHC's Help Center to address increased workload and subsequent backlog attributed to full implementation of the Affordable Care Act and conforming legislation.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0933 – Managed Care Fund	$-	$3,422,000
Total Funding Request:	**$-**	**$3,422,000**
Total Positions Requested:	**11.0**	

This issue was heard during the subcommittee's March 23rd hearing.

Subcommittee Staff Comment and Recommendation—Approve. DMHC's Help Center has experienced a substantial increase in consumer call and complaint volume related to the large volume of new consumers enrolled in managed care since implementation of the Affordable Care Act. Approval of this request, funded by special fund revenue from health plan regulatory fees, will allow DMHC to manage this new workload.

Issue 2: Information Technology Resource Request

Budget Issue. DMHC requests two positions and expenditure authority from the Managed Care Fund of $746,000 in 2017-18, $722,000 in 2018-19 and 2019-20, and $289,000 annually thereafter. If approved, these resources would allow DMHC to address information security needs and transition to an efficient information technology (IT) systems architecture and forward looking roadmap to meet business intelligence requirements.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0933 – Managed Care Fund	$-	$746,000
Total Funding Request:	**$-**	**$746,000**
Total Positions Requested:	**2.0**	

This issue was heard during the subcommittee's March 23rd hearing.

Subcommittee Staff Comment and Recommendation—Approve. DMHC's legacy applications face security and interoperability issues that may interfere with its health plan oversight and regulatory program responsibilities. DMHC intends to address these issues with the positions and resources contained in this request. In addition, DMHC will improve its IT operations by migrating its applications, servers, and workstations to the Office of Technology's Cloud, pursuant to the state's "Cloud First" technology policy. Approval of this request, funded by special fund revenue from health plan regulatory fees, will allow DMHC to manage these IT upgrades and transitions.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Use of CalWORKs Eligibility to Determine Medi-Cal Eligibility

Trailer Bill Language Proposal. DHCS proposes trailer bill language to provide statutory authority to seek federal approval to use determination of eligibility for the California Work Opportunity and Responsibility to Kids (CalWORKs) program as a determination of eligibility for the Medi-Cal program.

This issue was heard during the subcommittee's March 23rd hearing.

Subcommittee Staff Comment and Recommendation—Approve. This proposal is consistent with current practice in Medi-Cal, which has allowed CalWORKs beneficiaries to be determined eligible for

Medi-Cal since 1999. DHCS is proposing this language to provide statutory authority for its current practice at the request of the federal Centers for Medicare and Medicaid Services. Approval of this proposal, which has no fiscal impact, will allow DHCS to comply with the federal request and provide explicit statutory authority for its current practice.

Issue 2: County Administration COLA Trailer Bill Language Proposal

County Administration COLA Trailer Bill Language. ABX4 12 (Evans), Chapter 12, Statutes of 2009, prohibits automatic cost-of-living adjustments (COLAs) to state departments and agencies. However, Welfare and Institutions Code Section 14154(c)(1) states legislative intent that counties receive adequate funding, including an annual COLA, for the eligibility work performed on behalf of the Medi-Cal program. Since 2009, the Legislature has approved trailer bill language annually to state legislative intent to not appropriate funds for a COLA for county's eligibility workload in that year. DHCS proposes trailer bill language to add 2017-18 to the list of fiscal years beginning in 2008-09 during which it is the intent of the Legislature not to appropriate funds for a county COLA.

This issue was heard during the subcommittee's March 23rd hearing.

Subcommittee Staff Comment and Recommendation—Approve. This proposal is consistent with the Legislature's previous annual actions since 2009 to add the upcoming fiscal year to the years in which it does not intend to appropriate funds for a county eligibility COLA. Approval of this proposal, which has no fiscal impact, will continue this past practice.

Issue 3: Substance Use Disorder Licensing Workload

Budget Issue. DHCS requests 20 permanent positions (conversion of six limited-term positions and 14 new positions) and expenditure authority of $2.5 million ($290,000 Narcotic Treatment Program Licensing Trust Fund, $1.7 million Residential and Outpatient Program Licensing Fund, and $531,000 reimbursements). If approved, these resources would support increased licensing, monitoring, and complaint investigation workload as a result of expansion of services under the federal Affordable Care Act (ACA) and the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0243 – Narcotic Treatment Program Licensing Trust Fund	$-	$290,000
3113 – Residential and Outpatient Program Licensing Fund	$-	$1,726,000
0995 – Reimbursements	$-	$531,000
0890 – Federal Trust Fund [non-add]	$-	[$1,046,000]
Total Funding Request:	**$-**	**$2,547,000**

This issue was heard during the subcommittee's March 30th hearing.

Subcommittee Staff Comment and Recommendation—Approve. Implementation of the federal ACA and the DMC-ODS Waiver has resulted in additional workload for DHCS, particularly licensing and monitoring of new narcotic treatment programs and investigations of consumer complaints.

Approval of this request, funded by a combination of special fund revenue from program licensing fees and reimbursements, will allow DHCS to manage this increased workload. In addition, according to DHCS, it does not expect to request an increase in program licensing fees to fund this request.

Issue 4: Alternative Birthing Center Reimbursement

Budget Issue and Trailer Bill Language Proposal. DHCS proposes trailer bill language to allow reimbursement for deliveries in alternative birthing centers (ABCs) based on the equivalent, lowest acuity diagnosis-related group (DRG) reimbursement provided to general acute care hospitals. The budget includes $43,500 ($21,755 General Fund and $21,765 federal funds) for increased costs associated with higher reimbursement rates to ABCs upon approval of the proposed trailer bill language. The trailer bill language also makes technical changes to remove outdated reporting requirements and other statutory references.

Alternative Birthing Center Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	$21,755
0890 – Federal Trust Fund	$-	$21,765
Total Funding Request:	**$-**	**$43,500**

This issue was heard during the subcommittee's April 27th hearing.

Subcommittee Staff Comment and Recommendation—Approve. Reimbursement rates for ABCs are based on determinations made by a a commission that no longer exists. This proposal aligns ABC reimbursement with the lowest acuity DRG reimbursement provided to general acute care hospitals. Approval of this trailer bill language proposal, which results in minor increases in General Fund and federal fund expenditures, will update ABC reimbursement to align with the current hospital birth reimbursement methodology.

Issue 5: Ground Emergency Medical Transportation Supplemental Pmt. Program Audits

Budget Issue. DHCS requests three positions (conversion of limited-term to permanent) and expenditure authority of $393,000 ($197,000 federal funds and $196,000 reimbursements) annually. If approved, these resources would allow the department to continue auditing workload for its supplemental reimbursement program for ground emergency medical transportation (GEMT) providers.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0890 – Federal Trust Fund	$-	$197,000
0995 – Reimbursements	$-	$196,000
Total Funding Request:	**$-**	**$393,000**
Total Positions Requested:	**3.0**	

This issue was heard during the subcommittee's April 27th hearing.

Subcommittee Staff Comment and Recommendation—Approve. The GEMT supplemental reimbursement program provides an enhanced rate to GEMT providers using certified public expenditures to draw down additional federal matching funds. Approval of this request, which is funded by federal funds and reimbursements from local public entities, will allow DHCS to continue auditing and other activities associated with the operation of this program.

Issue 6: AB 959 Clinic Supplemental Reimbursement Audits

Budget Issue. DHCS requests a two-year extension of expenditure authority of $1.4 million ($697,000 federal funds and $697,000 reimbursements). If approved, these resources would allow the department to implement supplemental Medi-Cal payments to state veterans homes and public clinics pursuant to AB 959 (Frommer), Chapter 162, Statutes of 2006.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0890 – Federal Trust Fund	$-	$697,000
0995 – Reimbursements	$-	$697,000
Total Funding Request:	**$-**	**$1,394,000**
Total Positions Requested:	**0.0**	

This issue was heard during the subcommittee's April 27th hearing.

Subcommittee Staff Comment and Recommendation—Approve. AB 959 allows state veteran's homes and public clinics to receive supplemental reimbursements using certified public expenditures to draw down additional federal matching funds. Approval of this request, which is funded by federal funds and reimbursements from state veterans homes and public clinics, will allow DHCS to implement the required auditing and other activities associated with the operation of this program.

Issue 7: Elimination of State-Only Child Health and Disability Prevention Program

Trailer Bill Language Proposal. DHCS proposes to repeal the statutory provisions granting eligibility for the state-only Child Health and Disability Prevention (CHDP) program. If approved, this language would eliminate access to CHDP's health screening and immunization services for children not enrolled in Medi-Cal.

Child Health and Disability Prevention Program (State-Only) – *Funding and Caseload Estimate*			
Fund Source	**2016-17**	**2016-17**	**2017-18**
	2016 Budget	***Revised***	***Proposed***
0001 – General Fund	$115,000	$32,000	$1,000
Estimated Caseload (State-Only Screens):	**1,794**	**509**	**0**

This issue was heard during the subcommittee's April 27th hearing.

Subcommittee Staff Comment and Recommendation—Reject Proposed Trailer Bill Language. While DHCS reports it has received no claims for state-only CHDP since November 2016, uncertainty regarding changes in federal policy on immigration enforcement and health care suggest caution in eliminating the availability of this program prematurely. It is recommended to reject the proposed trailer bill language to eliminate eligibility for the state-only program, while maintaining the program's caseload estimate. Rejection of the proposed trailer bill language has no fiscal impact.

Issue 8: Third Party Liability Contracting Authority

Trailer Bill Language Proposal. DHCS proposes trailer bill language to clarify and update its contracting requirements for third party liability recoveries consistent with other provisions of state contracting law.

This issue was heard during the subcommittee's April 27th hearing.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language Including Administration's Proposal and Clarifying Amendments. Medi-Cal is seeking to align statutory requirements for third party liability recovery contracting with current practice. Stakeholders proposed additional clarifying language to limit the contracting authority to the department's personal injury and workers' compensation recovery programs. According to the Administration, this amendment is consistent with the intent of its proposal. Adoption of the Administration's proposed trailer bill language, with the clarifying amendments, will align statutory requirements with other state contracting requirements and eliminate unnecessary contracting mandates.

Issue 9: Every Woman Counts Accrual to Cash Budgeting

Trailer Bill Language Proposal. DHCS proposes trailer bill language to change the Every Woman Counts (EWC) program budget from an accrual to a cash basis beginning in 2017-18 and reduce the frequency of program reporting requirements from quarterly to biannually.

This issue was heard during the subcommittee's April 27th hearing.

Subcommittee Staff Comment and Recommendation—Approve. EWC is one of the few remaining DHCS programs budgeted on an accrual basis, rather than a cash basis. This proposal results in one-time General Fund savings of approximately $1.2 million due to shifting of budgeting for EWC services provided in 2017-18 to future years when claims are received. Approval of this request will allow DHCS to consistently budget its programs and results in one-time General Fund savings.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Childhood Lead Poisoning Prevention Program IT Project Planning

Budget Issue. DPH requests one position and expenditure authority from the Childhood Lead Poisoning Prevention (CLPP) Fund of $480,000 in 2017-18 and $158,000 annually thereafter. If

approved, these resources would allow the CLPP program to conduct required Project Approval Lifecycle analyses to upgrade its electronic blood lead testing information system.

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

This issue was heard during the subcommittee's March 9th hearing.

Subcommittee Staff Comment and Recommendation—Approve. The CLPP program's existing electronic information system for laboratory blood testing is reaching the limits of its ability to meet the needs of the program. Approval of this request, funded by special fund revenue from fees on manufacturers of lead-containing products, will allow DPH to continue project planning to develop a replacement system.

Issue 2: Youth Tobacco Enforcement Staffing

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

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

This issue was heard during the subcommittee's March 9th hearing.

Subcommittee Staff Comment and Recommendation—Approve. DPH enforces federal restrictions on the sale and marketing of tobacco products to children pursuant to a contract with the FDA. Approval of this request, funded by federal reimbursements, will allow DPH to continue its tobacco retailer inspections as part of its federal enforcement activities.

Issue 3: Preventing Healthcare-Associated Infections in Facilities

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

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

This issue was heard during the subcommittee's March 9th hearing.

Subcommittee Staff Comment and Recommendation—Approve. The HAI program collects, analyzes, interprets and publishes HAI data from 392 California hospitals to help prevent the incidence of HAIs in patients. Approval of this request, funded by special fund revenue from health facility licensing fees, will allow the program to work closely with hospitals to improve prevention of HAIs, hire a Medical Director, and improve public outreach.

Issue 4: L&C: Performance Measurement and Quality Improvement

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

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

This issue was heard during the subcommittee's March 9th hearing.

Subcommittee Staff Comment and Recommendation—Approve. IDQIA funding is meant for internal quality improvement activities in the Licensing and Certification Program. This request intends to use these funds to improve IT procurement, develop external dashboards and data displays, improve automation, evaluate outcomes, develop and retain staff, and redesign IT systems. Approval of this request, funded by special fund revenue from fines on health facilities, will allow DPH to implement these quality improvement projects.

Issue 5: Improved Access to Vital Statistics Data

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

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

This issue was heard during the subcommittee's March 9th hearing.

Subcommittee Staff Comment and Recommendation—Approve. The CA-VSQ system, which provides access to medical and demographic data collected by DPH, is twenty years old and has several important functional limitations. Approval of this request, funded by special fund revenue from record search and document fees, will allow DPH to hire a vendor to develop and implement a new, more functional and flexible system for public access to vital statistics data.

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

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

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

This issue was heard during the subcommittee's March 9th hearing.

Subcommittee Staff Comment and Recommendation—Approve. The recent HRSA site visit found the Ryan White program had not implemented required Standards of Care or a Clinical Quality Management Program and was not in compliance with state requirements on prompt payment of invoices. Approval of this request, funded by federal Ryan White grant funds and special fund revenue

from ADAP-related drug manufacturer rebates, will allow the Ryan White program to address these issues identified by HRSA.

Issue 7: Demographic Data – Asian-American, Native Hawaiian, Pacific Islander (AB 1726)

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

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

This issue was heard during the subcommittee's March 9th hearing.

Subcommittee Staff Comment and Recommendation—Approve. AB 1726 requires, on or after July 1, 2022, DPH to collect and publish separate data for specified Asian-American, Native Hawaiian, and other Pacific Islander subgroups. Approval of this request, funded by special fund revenue from record search and document fees, will allow DPH to implement these data collection and publication requirements.

Issue 8: Certified Copies of Vital Records: Electronic Application (AB 2636)

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

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

This issue was heard during the subcommittee's March 9th hearing.

Subcommittee Staff Comment and Recommendation—Approve. AB 2636 authorizes state and local government officials to accept electronic acknowledgment of requests for certified copies of vital records. Approval of this request, funded by special fund revenue from record search and document fees, will allow DPH to implement the requirements of AB 2636.

Issue 9: Public Health Emergency Preparedness

Budget Issue and Trailer Bill Language Proposal. DPH requests 88.3 positions (76.8 conversion from limited-term and 11.5 new positions) and expenditure authority of $11.8 million federal funds annually. If approved, these resources would allow DPH to continue its public health emergency preparedness activities pursuant to requirements in state and federal law. Accompanying the request is proposed trailer bill language to make technical and clarifying changes to provisions of state law governing the program.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0890 – Federal Trust Fund	$-	$11,752,000
Total Funding Request:	**$-**	**$11,752,000**
Total Positions Requested:	**88.3**	

This issue was heard during the subcommittee's May 4th hearing.

Subcommittee Staff Comment and Recommendation—Approve. Cooperative agreements with the federal Centers for Disease Control and Prevention (CDC) provide federal funding for a variety of state and local health system emergency preparedness activities to counter potential bioterrorism, chemical, nuclear, or radiologic threats. Approval of this request, funded by federal funds, and the accompanying trailer bill proposal will allow DPH to continue its public health emergency preparedness activities pursuant to the CDC agreements and make technical and clarifying changes to provisions of state law to update code references, align financial requirements to current practice, and adjust baseline allocations to reflect current budgeting.

Issue 10: Newborn Screening Program (SB 1095)

Budget Issue. DPH requests one position and expenditure authority from the Genetic Disease Testing Fund of $2.69 million ($769,000 state operations and $1.92 million local assistance) in 2017-18, and $137,000 state operations annually thereafter. If approved, these resources would allow the Genetic Disease Screening Program (GDSP) to implement additional newborn screening requirements for genetic diseases required pursuant to SB 1095 (Pan), Chapter 363, Statutes of 2016.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0203 – Genetic Disease Testing Fund		
State Operations:	$-	$769,000
Local Assistance:	$-	$1,928,000
Total Funding Request:	**$-**	**$2,689,000**
Total Positions Requested:	**1.0**	

This issue was heard during the subcommittee's May 4th hearing.

Subcommittee Staff Comment and Recommendation—Approve. SB 1095 requires GDSP to implement screening for any disease detectable in blood samples within two years of being adopted by the federal Recommended Uniform Screening Panel. Approval of this request, funded by special fund revenue from genetic testing fees, will allow GDSP to implement the new testing protocols for the first two diseases, mucopolysaccharidosis type I and Pompe disease, and to implement secondary testing protocols to help reduce false positive results.

ISSUES FOR DISCUSSION

0977 CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY
4260 DEPARTMENT OF HEALTH CARE SERVICES
4265 DEPARTMENT OF PUBLIC HEALTH
5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: Proposals for Investment

Stakeholder Proposals for Investment. Various stakeholders have proposed the following investments for inclusion in the budget:

0977 California Health Facilities Financing Authority

Extension of Expenditure Authority for Investment in Mental Health Wellness Grants. The California Behavioral Health Directors Association (CBHDA) requests extension of expenditure authority for grants provided under the Investment in Mental Wellness Act of 2013. The 2013 Budget Act included $144.8 million General Fund to increase capacity for mobile crisis support, crisis intervention, crisis stabilization services, crisis residential treatment, and specified personnel resources. The funds were made available for encumbrance or expenditure until June 30, 2016. CBHDA requests

budget bill language to instead make these grant funds available for encumbrance or expenditure until December 31, 2021.

Healthcare Expansion Loan Program (HELP II) Funding for Clinic Operations. The Treasurer requests budget authority of $20 million from the fund balance supporting the HELP II program for a grant program for operations costs of non-profit small or rural health centers in critical service areas at risk of losing federal funding. Because HELP II funding is required to be allocated to the expansion of facilities, trailer bill language is required to allow allocation of the HELP II fund balance for operations.

4260 Department of Health Care Services

Revised Proposition 56 Allocation Proposal. The California Medical Association (CMA) and the California Dental Association (CDA) have revised their proposed allocation of Proposition 56 tobacco tax revenue, heard in the subcommittee's April 27th hearing. CMA and CDA, along with Planned Parenthood, request approximately $1 billion Proposition 56 tobacco tax revenue for the following augmentations: 1) $50 million for provider rate increases for family planning (Family PACT), 2) $639.2 million for incentive payments to physicians based on access to care for Medi-Cal beneficiaries, 3) $274 million for incentive payments to dentists based on access to care for Denti-Cal beneficiaries, and 4) $39.3 million for stakeholder proposals previously included in the 1115 Waiver, but not approved.

Erroneous Payment Correction Recoupments from Medi-Cal Providers. CMA proposes trailer bill language regarding recoupment of erroneous payments to Medi-Cal providers that would: 1) limit the recoupment period to 365 days after the date of payment, 2) limit payment offsets to recoup erroneous payments to no more than twenty percent of the payment, and 3) require notice to providers of the amount owed and other relevant information. This proposal would likely result in an unknown, but potentially significant increase in General Fund expenditures in Medi-Cal as erroneous payment correction recoupments are delayed into future fiscal years.

Aged and Disabled Program Eligibility. The Western Center on Law and Poverty and 32 other organizations request approximately $30 million General Fund to raise the income eligibility for Medi-Cal's Aged and Disabled program to 138 percent of the federal poverty level. This proposal would bring the Aged and Disabled program into alignment with other income-based Medi-Cal eligibility programs.

Robert F. Kennedy Farm Workers Health Plan Stop-Loss Payments. The Robert F. Kennedy Farm Workers Health Plan requests trailer bill language to extend until January 1, 2026, the funding requirements contained in SB 145 (Pan), Chapter 712, Statutes of 2015. SB 145 requires DHCS to annually reimburse the plan up to $3 million per year for claim payments that exceed $70,000 made by the plan on behalf of an eligible employee or dependent for a single episode of care on or after September 1, 2016. If approved, this request would extend these reimbursements for five years. According to representatives of the Robert F. Kennedy Farm Workers Health Plan, this extension would allow the plan to build sufficient reserves to no longer require stop-loss funding from the state.

Santa Rosa Community Health Centers Grant. The Santa Rosa Community Health Centers request $6.4 million General Fund over two years for a grant supporting service expansion at the Dutton Health Center clinic. The clinic intends to begin providing primary care, mental health, and oral health services to individuals with disabilities in Sonoma County beginning December 2017. These funds are intended

to provide short-term funding for the increased costs of providing services to this high acuity population while it works with DHCS to establish a clinic reimbursement rate consistent with its increased costs.

4265 Department of Public Health

Mosquito Surveillance. The Mosquito and Vector Control Association of California request $2 million General Fund to create the California Mosquito Surveillance and Research Program Account, to be administered by DPH, to fund California-based surveillance and research on mosquitoes. This request includes $1.5 million to fund the California Vectorborne Disease Surveillance System, known as CalSurv.

Sickle Cell Treatment Centers. Several organizations request $80 million one-time General Fund for Sickle Cell Treatment Centers. If approved, these centers would provide resources and training to health care providers and those affected by Sickle Cell Disease, as well as aid in the formulation of best practice guidelines for reliable care.

5180 Department of Social Services

Deaf Access Program Augmentation. The California Coalition of Agencies Serving the Deaf and Hard of Hearing requests $3 million General Fund for the Deaf Access Program (DAP) in the Department of Social Services (DSS). The DAP provides deaf and hard of hearing individuals with the communication services they need to access state and local programs to which they are entitled. The Office of Deaf Access, housed in DSS, administers this program. Currently, the DAP is funded at $5.2 million and serves approximately 158,000 people.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold these items open pending updates to the state's General Fund condition at the May Revision.

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, May 11, 2017
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Scott Ogus

OUTCOMES

ISSUES RECOMMENDED FOR VOTE-ONLY

Item	Department	Action
4120 EMERGENCY MEDICAL SERVICES AUTHORITY		
Issue 1: E-Commerce Online Paramedic Licensing Module (eGov)		Approve (3-0)
Issue 2: EMT-P Discipline Case Workload		Approve (3-0)
4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT		
Issue 1: Health Care Workforce Recruitment Legislation (AB 2024 and AB 2048)		Approve (3-0)
Issue 2: Elective Percutaneous Coronary Interventions Reporting		Approve (3-0)
Issue 3: Relocation Rent Adjustment		Approve (3-0)
4150 DEPARTMENT OF MANAGED HEALTH CARE		
Issue 1: Help Center Case Backlog and Workload		Approve (3-0)
Issue 2: Information Technology Resource Request		Approve (3-0)
4260 DEPARTMENT OF HEALTH CARE SERVICES		
Issue 1: Use of CalWORKs Eligibility to Determine Medi-Cal Eligibility		Approve (3-0)
Issue 2: County Administration COLA Trailer Bill Language Proposal		Approve (3-0)
Issue 3: Substance Use Disorder Licensing Workload		Approve (3-0)
Issue 4: Alternative Birthing Center Reimbursement		Approve (3-0)
Issue 5: Ground Emergency Medical Transportation Supplemental Pmt. Program Audits		Approve (3-0)

Issue 6: AB 959 Clinic Supplemental Reimbursement Audits — Approve (3-0)
Issue 7: Elimination of State-Only Child Health and Disability Prevention Program — Reject (2-1)
Issue 8: Third Party Liability Contracting Authority — Adopt Modified TBL (3-0)
Issue 9: Every Woman Counts Accrual to Cash Budgeting — Approve (3-0)

4265 DEPARTMENT OF PUBLIC HEALTH
Issue 1: Childhood Lead Poisoning Prevention Program IT Project Planning — Approve (3-0)
Issue 2: Youth Tobacco Enforcement Staffing — Approve (3-0)
Issue 3: Preventing Healthcare-Associated Infections in Facilities — Approve (3-0)
Issue 4: L&C: Performance Measurement and Quality Improvement — Approve (3-0)
Issue 5: Improved Access to Vital Statistics Data — Approve (3-0)
Issue 6: Ryan White Program Compliance with Standards, Quality, and Timeliness — Approve (3-0)
Issue 7: Demographic Data – Asian-American, Native Hawaiian, Pac Islander (AB 1726) — Approve (3-0)
Issue 8: Certified Copies of Vital Records: Electronic Application (AB 2636) — Approve (3-0)
Issue 9: Public Health Emergency Preparedness — Approve (3-0)
Issue 10: Newborn Screening Program (SB 1095) — Approve (3-0)

ISSUES RECOMMENDED FOR DISCUSSION

0977 CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY
4260 DEPARTMENT OF HEALTH CARE SERVICES
4265 DEPARTMENT OF PUBLIC HEALTH
5180 DEPARTMENT OF SOCIAL SERVICES
Issue 1: Proposals for Investment — Held Open

Senate Budget and Fiscal Review—Richard Pan, M.D, Chair
SUBCOMMITTEE NO. 3 **Agenda**

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

Wednesday, May 17, 2017
10 a.m. or upon adjournment of session
State Capitol - Room 4203

Part A

Consultant: Peggy Collins

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.

VOTE ONLY ISSUE

ISSUE 1: Information Security and Privacy Support-Budget Change Proposal (BCP)

Proposal: The budget proposes $398,000 ($317,000 General Fund) and three positions to monitor, train, advise, and support required security activities at headquarters, the developmental centers, and the regional centers for compliance with state and federal information security and privacy laws. Specifically, the department requests to hire three systems software specialists. Two specialists will assist and support developmental centers and regional center security efforts, and conduct activities in compliance with the State Administrative Manual, the State Information Management Manual, and federal requirements. The third specialist will be dedicated full-time to threat monitoring and risk reduction, and provide expertise to staff in utilizing complex security monitoring tools, including vulnerability scanning, centralized logging, anti-virus monitoring, patch management and firewall configuration management, and security audit log monitoring.

Staff Comments and Recommendation – Approve as budgeted: This issue was discussed on March 16th and no issues have been raised.

ISSUES TO BE DISCUSSED

ISSUE 2: Developmental Center – May Revision Adjustments

Background: The department directly provides services to persons with developmental disabilities in three developmental centers and one state-leased and operated community facility (Canyon Springs). Sonoma Developmental Center is scheduled to close by the end of 2018; and Fairview and Porterville developmental centers (not including the Secure Treatment Program (STP) at Porterville) are schedule to close by the end of 2021. The May Revision proposes total funds for current year support of the developmental centers and Canyon Springs of $540 million ($376 million General Fund), an increase of $10.1 million over the January budget. For the budget year, the May Revision proposes $466 million ($348 million General Fund), an increase of $16.2 million over the January budget.

The following chart shows population estimates for June 30th in the current year and fiscal year and compares expenditures across each fiscal year based on January and May estimates.

Developmental Centers 2016-17 and 2017-18 Comparison Chart (Dollars in Thousands)						
	2016-17 January	2016-17 May	Change	2017-18 January	2017-18 May	Change
Population (ending pop 6/30)	760	793	33	490	495	5
Proposed Expenditures	$529,869 ($368,523 GF)	$539,948 ($376,132 GF)	$10,079 ($7,609 GF)	$449,796 ($329,985 GF)	$465,983 ($348,179 GF)	$16,187 ($18,194 GF)

Current Year Adjustments: The May Revision proposes an increase of $10.1 million ($7.6 million General Fund) for the new memorandum of understanding (MOU) with various bargaining units. Funding for this is reflected in Item 9800.

Budget Year Adjustments: The May Revision proposes a net increase of $16.2 million ($18.2 million General Fund) to reflect the following adjustments:

- $10.5 million increase ($7.8 million General Fund) for the new MOU with various bargaining units. Funding for this is reflected in Item 9800.

- $5.7 million ($3.0 million General Fund) increase for population-driven adjustments. Specifically, the beginning year population in developmental centers is now estimated to be 793 – 33 residents more than anticipated in the January budget. This results in the need to keep open one additional intermediate care facility (ICF) unit and 50.5 positions, and associated operating expenses and equipment (OE&E), for nine months.

- $7.4 million ($5.7 million General Fund) for corrections to the new zero-based budgeting approach that the department adopted for the January budget. Through the May Revision development process, the department identified a total of 85.8 program support positions across headquarters, three developmental centers, and the Canyon Springs facility, that are currently filled but not included in the January budget.

- A net reduction of $1 million (net decrease of $0.2 million General Fund) for various technical adjustments and a proportional redistribution of $3.4 million from the general treatment area to the secure treatment program at Porterville Developmental Center, based on the number of staff working at each.

- For the Community State Staff Program (CSSP), transfer of $8.3 million in reimbursement authority and the administrative transfer of participating state employees, from the developmental center budget to headquarters. CSSP enables qualified developmental center staff familiar with the needs of developmental center residents to continue supporting them in the community by working for regional center-contracted vendors. There are currently approximately 108 state employees participating in this program. Four positions were transferred from the developmental centers to headquarters in the 2016 budget act in order to centralize contract administration, accounting functions, and program oversight. This action will transfer the remaining program components to headquarters as the program will be ongoing following the closure of the developmental centers.

- $1.9 million General Fund and 14.5 positions to operate two statewide mobile acute crisis unit teams as a part of the Governor's overall "safety net" proposal. This will be discussed later in the agenda.

Questions for DDS:

- Briefly present the May Revision proposal for developmental centers.

- What factors led to the department not meeting its target for placements into the community in the current year? What actions has the department taken, or will take, to address this issue? Does the department anticipate it will still meet its closure date targets for the developmental centers?

- Please describe how the first year implementation of the new zero-based budgeting approach on a developmental center-specific basis resulted in the budgeting errors that are proposed for correction in the May Revision.

Staff Comments and Recommendation - Approve May Revision, as adjusted by other subcommittee actions.

ISSUE 3: Regional Centers – May Revision - Current Year

Proposal: For the current year, the Governor's May Revision proposes an updated regional center budget of $6.1 billion ($3.6 billion General Fund), a net decrease of $12.3 million ($22.5 million General Fund increase) from the Governor's January budget. The May Revision decrease reflects a projected $16.4 million reduction ($21 million General Fund increase) in the purchase of services (POS), and an increase of $0.7 million ($1.5 million General Fund decrease) in regional center operations. The incremental fund source adjustments reflect an estimated decrease in expenditures eligible for reimbursements and the loss of behavioral health treatment (BHT) – fee-for-service (FFS) reimbursement from the Department of Health Care Services (DHCS), which caused an increase in General Fund expenditures (discussed later in the agenda). The following tables reflect the updated current and budget year projected costs by fund sources and caseload changes. There is a net increase of 152 consumers in the updated 2016-17 caseload, comprised of 72 Early Start consumers and 80 active consumers, for a total estimated population of 303,599 in the current year.

2016-17 Costs and Fund Sources *(Values in thousands)*			
Governor's Budget		Updated 2016-17	Request
Total Costs	**$6,064,913**	**$6,052,632**	**-$12,281**
Operations	730,529	731,302	773
Purchase of Services	5,313,272	5,300,218	-13,054
Early Start -Other Agency Costs	19,109	19,109	0
Early Start Family Resource Services	2,003	2,003	0
Fund Sources	**$6,064,913**	**$6,052,632**	**-$12,281**
General Fund (GF)	3,558,448	3,580,955	22,507
GF Match	*2,193,091*	*2,189,400*	*(3,691)*
GF Other	*1,365,357*	*1,391,555*	*26,198*
Reimbursements	2,433,943	2,415,269	-18,674
Program Development Fund	2,537	2,537	0
Developmental Disabilities Services Account	150	150	0
Mental Health Services Fund	740	740	0
Federal Funds	53,707	52,981	-726
BHT -FFS Reimbursement from DHCS	15,388	0	-15,388

Source: Regional Center Local Assistance Estimate, 2017 May Revision, Department of Developmental Services

Current Year Adjustments: The May Revision reflects a net increase of $3.4 million ($3.0 million General Fund decrease) from the January budget and proposes the following adjustments:

- $31.7 million decrease ($19.3 million General Fund decrease) due to updated actual expenditures multiplied by the growth rate of each POS budget category related to the minimum wage increase on January 1, 2016.

- $29.8 million increase ($14.2 million General Fund increase) reflecting a decrease in BHT transition savings (discussed later in this agenda).

- $5.2 million decrease ($3 million General Fund decrease) due to actual expenditures coming in lower that projected for the Alternative Residential Model (ARM) four-bed rate adjustment.

- $10.5 million net increase ($6.2 million General Fund increase) reflecting updated expenditure estimates for wage and administrative cost increases for regional centers and community providers made pursuant to AB X2 1 (Thurmond), Chapter 3, Statutes of 2016.

- Developmental Center Closure -Net zero $0 difference ($4.9 million General Fund increase). Total expenditures remain unchanged, but General Fund increased due to a shift in funding from reimbursements to General Fund resulting from less expenditures eligible for reimbursement.

Questions for DDS:

- Please briefly present the May Revision proposal for the Regional Center Current Year budget.

Staff Comments and Recommendation – Approve May Revision, as adjusted by other subcommittee actions.

ISSUE 4: Regional Centers –May Revision – Budget Year

The 2017 May Revision proposes $6.4 billion ($3.8 billion General Fund); a net decrease of $35.7 million ($42.7 million General Fund decrease) from the January budget. The net decrease reflects a $39.7 million decrease ($36.8 million General Fund decrease) in POS and a $3.7 million increase ($5.9 million General Fund decrease) in regional center operations. The 2017-18 budget reflects a $335.5 million increase ($215.3 million General Fund) over updated 2016-17 expenditures. There is a net increase of 554 consumers over the January budget, comprised of 481 Early Start consumers and 73 Active consumers, for a total estimated population of 317,837 in the budget year.

Costs and Fund Sources *(Values in thousands)*			
Governor's Budget		**2017-18**	**Request**
Total Costs	**$6,423,741**	**$6,388,088**	**-$35,653**
Operations	753,784	757,488	3,704
Purchase of Services	5,648,845	5,609,488	-39,357
Early Start -Other Agency Costs	19,109	19,109	0
Early Start Family Resource Services	2,003	2,003	0
Fund Sources	**$6,423,741**	**$6,388,088**	**-$35,653**
General Fund (GF)	3,838,894	3,796,228	-42,666
GF Match	*2,274,753*	*2,287,123*	*12,370*

GF Other	*1,564,141*	*1,509,105*	*-55,036*
Reimbursements	2,511,945	2,535,175	23,230
Program Development Fund	2,537	2,537	0
Developmental Disabilities Services Account	150	150	0
Mental Health Services Fund	740	740	0
Federal Funds	54,087	53,258	-829
BHT -FFS Reimbursement from DHCS	15,388	0	-15,388

Source: Department of Developmental Services, May Revision Estimate

Budget Year Adjustments: The May Revision reflects a net decrease of $35.7 million ($42.7 million General Fund decrease) from the January budget and proposes the following adjustments:

- $1.3 million ($1.0 million General Fund) in 2017-18 (Operations) to fund 0.5 psychologists per regional center to assess children with an Autism Spectrum Disorder (ASD) diagnosis and provide medical referrals for BHT services (discussed later in this agenda).

- $33.6 million decrease ($20.6 million General Fund decrease) in 2017-18 reflecting updated actual expenditures multiplied by the growth rate of each POS budget category related to the minimum wage increase effective January 1, 2016.

- $29.8 million increase ($14.2 million General Fund increase) reflecting a decrease in BHT transition savings (discussed later in this agenda).

- $3.3 million General Fund reduction based on the BHT transition schedule for consumers without an autism spectrum disorder (ASD) diagnosis, starting January 1, 2018 (discussed later in this agenda).

- $1.8 million net increase ($1.1 million General Fund) reflecting updated expenditure estimates for wage and administrative cost increases for regional centers and community providers made pursuant to AB X2 1 (Thurmond), Chapter 3, Statutes of 2016.

- $5.6 million General Fund, one-time, to develop components of the safety net plan (discussed later in this agenda).

- Developmental Center Closure -Net zero $0 difference ($6.5 million General Fund increase). Total expenditures remain unchanged, but General Fund increased due to a shift in funding from reimbursements to GF resulting from less expenditures eligible for reimbursement.

Questions for DDS:

- Please briefly present the May Revision proposal for the Regional Center Current Year budget.

Staff Comments and Recommendation – Approve May Revision, as adjusted by other subcommittee actions.

ISSUE 5: Behavioral Health Treatment (BHT) Services – May Revision Proposal and Adjustments

The May Revision proposes multiple changes related to the provision of BHT services to children served by regional centers. These are outlined below and chart on page 22.

Behavioral Health Treatment (BHT) Services for Children without a Diagnosis of Autism Spectrum Disorder. The department proposes $14.8 million General Fund in 2016-17 and $16.5 million General Fund in 2017-18 to cover the loss of federal financial participation (FFP) for BHT services provided to children without an autism diagnosis.

In January 2016, the Department of Health Care Services (DHCS) obtained approval from the Centers for Medicare & Medicaid Services (CMS) to include BHT as a Medi-Cal benefit for children with a diagnosis of autism spectrum disorder (ASD). Between February and October 2016, children with an ASD diagnosis transitioned to DHCS for BHT services. Children without an ASD diagnosis did not transition, and it was expected their BHT services would remain eligible for FFP under the federal 1915(i) State Plan Amendment (SPA) or the Home and Community-Based Services (HCBS) Waiver. However, CMS determined Medi-Cal must cover medically necessary BHT services for all children, regardless of their diagnoses. Beginning October 1, 2016, FFP is not available under either the 1915(i) SPA or HCBS Waiver for BHT services provided to children without an ASD diagnosis.

As a result of this CMS determination, the department proposes to coordinate with DHCS to transition to Medi-Cal Managed Care in 2017-18, an estimated 1,720 children whose BHT services will be determined as medically necessary by Medi-Cal Managed Care plans. In contrast, the General Fund will fund the costs of BHT services provided to an estimated 4,000 children whose individual program plans indicate a need for these services but are estimated to not meet the Medi-Cal medical necessity criteria.

In addition to the children without an ASD diagnosis enrolled in Medi-Cal Managed Care plans, the department estimates that 280 children are in fee-for-service Medi-Cal. These children will continue to receive services through the regional centers, and DCHS will fully reimburse the department for the related expenditures.

Backfill for Unrealized Reimbursements for Children who Transitioned to DHCS and Received BHT Services on a Fee-for-Services Basis. The department requests $7.1 million General Fund in 2016-17 to backfill unrealized reimbursements for children who transitioned to DHCS and those who received BHT services on a fee-for-service basis.

In 2016, approximately 12,000 regional center consumers under the age of 21 with an ASD diagnosis transitioned to DHCS and Medi-Cal Managed Care for BHT services. An additional 1,683 fee-for-service consumers transitioned to DHCS, but continued to receive BHT services through the regional centers with the expectation that DHCS would reimburse the department for the expenditures.

However, DHCS has been unable to reimburse the department for approximately $7.1 million in BHT expenditures because a recommendation from a physician or psychologist is required for those services to be eligible for FFP under Medi-Cal. This provision was not previously required for the department to claim FFP for BHT services under the 1915i SPA or HCS Waiver. Therefore, funding is required to

support additional regional center workload.

Psychological Evaluations for BHT Fee-for-Service Consumers. The department requests $1.3 million ($1.0 million General Fund) in 2017-18 to fund 0.5 psychologists per regional center to assess children with an ASD diagnosis and provide medical referrals for BHT services so these services will be eligible for FFP under Medi-Cal, thus enabling DHCS to reimburse the department for expenditures.

Reimbursements for BHT Services Provided to Fee-for-Service Consumers. In 2017-18, the department proposes $7.4 million in reimbursement authority from DHCS to cover the costs of BHT services provided to children on a fee-for-service basis. This includes expenditures for approximately 1,700 children with an ASD diagnosis, as well as 280 children who do not have an ASD diagnosis but for which BHT services are medically necessary.

Question for DDS:

- Please present your proposal.

- Generally, how has this process been going for families?

Staff Comments and Recommendation – Approve May Revision.

ISSUE 6: Headquarters Research Unit – Open Issue

Background. At its March 16th hearing, the subcommittee heard testimony from the department regarding its newly-established Fiscal and Program Research Section, funded in the 2016-17 budget act with $923,000 ($630,000 General Fund) for seven new permanent positions and the redirection of one position, for a total of eight positions. The department testified how they are setting short and long-term goals for this section.

Budget trailer bill language adopted in AB 1606 (Committee on the Budget), Chapter 26, Statutes of 2106, require that these resources be used, in part, to "*annually assess disparities data reported by regional centers, caseload ratio requirements by regional centers, and performance dashboard data collected pursuant to Section 4572 of the Welfare and Institutions Code, as it becomes available.*"

Legislative Analyst's Office (LAO). The LAO recommends the Legislature set more specific research goals to encourage data-driven decision-making.

Staff Comments and Recommendation – Adopt placeholder trailer bill language: The Fiscal and Program Research Section is relatively new and still staffing up. While the Legislature has set some priorities relative to the work of this section, it is also important that the section have the agility to respond to emerging issues. The subcommittee may wish to consider adoption of the following placeholder supplemental report language:

The department shall annually report during the budget subcommittee budget hearing process on the status of previously undertaken and/or ongoing research projects; their research priorities in the

upcoming fiscal year; and how the research is applied in informing departmental decision-making and service provision.

ISSUE 7: Disparities – Open Issue

Background: $11 million (General Fund) was provided in AB 2X 1 (Thurmond), Chapter 3, Statutes of 2016, to address this issue. On March 14, 2017, the issue of funding disparities in the regional center system was discussed at length by the Senate Committee on Human Services; and again at the March 16th hearing of this subcommittee.

Disparities Funding. In October, 2016, the department approved proposed activities for all 21 regional centers, totaling $10.7 million. According to the department, in reviewing regional centers' proposals, they took into account statewide needs and available resources, as well as information gathered during the department's statewide stakeholder meetings. In addition, proposals were analyzed for compliance with applicable statute and regulations, and the department's guidelines.

Grants to regional centers ranged from $24,000 to $1.3 million and funded projects include the translation of printed materials, hiring of specialized regional center staff, interpreter services and equipment, training for regional center staff and providers, outreach activities, and incentives to increase multilingual provider services.

Stakeholders have proposed various actions related to this issue, including, but not limited to:

- Provide grant funding to community-based organizations, other than regional centers, who reflect those groups disadvantaged by funding disparities.
- Require proposals to be publicly posted prior to, and following, approval.
- Fund statewide strategies, such as cultural sensitivity training to all regional center management and case workers.
- Utilize an independent evaluator to assess the effectiveness of funded activities.
- Remove the cap on the provision of respite services and reinstate the provision of recreation and services that have historically been highly utilized by ethnically diverse families.
- Remove barriers to the timely delivery of Early Start Program services.

Respite and Recreation Services. In the face of a serious economic downturn and acute budget shortfalls, the Budget Act of 2009 suspended the provision of social recreational and camping services through the regional center system and limited the use of respite services to 90 hours of in-home respite over a three month period and 21 days of out-of-home respite in a fiscal year. At the time, these limitations were anticipated to be temporary, pending implementation of the "Individual Choice Budget" option, established by AB X4 9 (Evans), Chapter 9, Statutes of 2009. However, that option has never been implemented.

At the March 16th hearing of this subcommittee, Disability Rights CA (DRC) and the Association of Regional Center Agencies (ARCA) proposed the reinstatement of recreational and camping services and removing the cap on respite services, as a significant way to address disparities. According to the ARCA, individuals requesting these services generally reside with their families, and those with ethnically diverse backgrounds are far more likely to live with their families into adulthood. ARCA

argues that restoring these services will assist families in continuing to live together and reduce the disparities in POS expenditures.

In response to a request for technical assistance, the department estimates that, with an effective date of January 1, 2018, and accounting for a ramp up effect over two fiscal years, the budget year costs for the restoration of social recreation programs would be $6.2 million ($4.1 million General Fund); $30.2 million ($19.6 million General Fund) in 2018-19. The full year impact when ramp-up is complete would be $37.8 million ($24.6 million General Fund).

The department's estimated costs for removing the cap on respite services is $10.3 million ($5.6 million General Fund) in the budget year, assuming a January 1, 2018 implementation date; $21.6 million ($11.7 million General Fund) in 2018-19.

Early Start Program. The Early Start Program provides families with children aged 0-3 who have a developmental delay or disability, or an established condition with a high probability of resulting in a delay, with appropriate early intervention and family support services.

AB X4 9 also required that early start families use private insurance or health care service plan for medical services other than evaluation and assessment, requiring families to produce a written letter of denial of coverage and a regional center to determine further appeal would be unsuccessful before the regional center can fund services. In practice, families have been challenged by the sometimes complex process of pursuing an appeal to their insurance provider, whether the frequency and manner in which a service is approved by their insurer meets the needs of the child or family, and whether a sufficient network of providers exists.

Under an exception process, regional centers may provide funding while coverage is being sought, pending a decision on an appeal, or until coverage begins. Additionally, the individual family service plan (IFSP), required for each regional center consumer and/or family, specifies the nature, frequency and duration of each needed service and should result in the regional center's ability to fund or augment any service where the benefit provided by the insurer does not meet the stated need in the IFSP. However, regional centers interpret and apply this exception differently. Given the central role of early intervention and support in the Early Start Program, these delays can be significant and potentially life-altering to impacted children and families. The appeal process with insurers and with regional centers are often time-consuming and complex; sometime families must pursue both concurrently. For families already under stress, or families facing language or cultural barriers, these barriers may be insurmountable.

DRC proposes trailer bill language to clarify that regional centers should consider if the insurance benefits are available and appropriate as part of the IFSP.

Question for DDS:

- Provide an update on the status of the projects funded through the disparities funding and discuss how you plan to evaluate the impact of these efforts.

Staff Comments and Recommendation: Although concerns about the disparities in service delivery in the developmental disabilities system are not new, historically, little concerted effort has been made to address the problem. The stated commitment of the new director is encouraging; however, the

subcommittee may wish to take additional steps to reduce disparities in the regional center system by taking the following actions:

1. **Adopt placeholder trailer bill language** to require the department to post the following on its website each year:

- *By September 1st, a proposed grant structure including:*
    - *How community-based organizations reflecting groups disadvantaged by funding disparities will be invited to participate.*
    - *How statewide strategies were considered.*
    - *How the department will ensure grant funds are not used for activities that regional centers are otherwise require by statute or regulation to conduct.*
    - *How funded activities will be evaluated.*

- *By October 1st, the final request for proposals or other mechanism through which grant proposals are solicited.*

- *By January 1st, a list of grant recipients, funding level per grant, and a description of the funded project.*

- *By May 1st of any year in which the information is available, evaluation results.*

2. **Adopt conceptual placeholder trailer bill language** to clarify that regional centers should consider if insurance benefits are available and appropriate as part of the IFSP process.

3. **Augment the POS budget by $5.6 million GF ($10.3 million total funds) and adopt placeholder trailer bill language** to remove the cap on respite services.

ISSUE 8: Home and Community-Based Services Waiver Policy Directives – Trailer Bill Language – Open Issue

Background: The Administration has proposed trailer bill language that will allow the department to issue policy directives in advance of emergency regulations in order to align state and federal regulations prior to the implementation deadline of the federal final rule related to the Home and Community-Based (HCBS) Waiver.

California receives approximately $1.8 billion in federal funding annually for approximately 130,000 persons with developmental disabilities through the federal HCBS programs and 1915(i) State Plan option. These programs provide Medicaid funding for eligible individuals to receive services and supports in home and community-based settings, rather than in an institution. In order to continue to receive these funds, states must comply with new waiver conditions, called the "final rule", by March 2019. The final rule requires a person-centered planning process, greater choice in life decisions and daily living, and requires services and supports be provided in settings that maximize independence and community integration. The federal final rule was published in early 2014 and states are required to submit their transition plan describing how they will bring programs into compliance with the regulations by March 2019. The state submitted its revised transition plan to the federal Centers for Medicare and Medicaid Services (CMS) in November of 2016.

Staff Comments and Recommendation – Reject proposed trailer bill language. This issue was discussed on March 16th**.** On May 9th, the department was informed by the CMS that the transition period for states to demonstrate compliance with the HCBS criteria has been extended until March 1, 2022. With this three-year extension, granting the department the authority to issue policy directives in advance of emergency regulations is premature. However, the subcommittee may wish to encourage the department to begin the regular regulatory process with due haste so there is sufficient time for a full public process prior to their adoption.

ISSUE 9: Paid Internships – Trailer Bill Language – Open Issue

Background. WIC 4648.55 (a) prohibits regional centers from purchasing specified services, including employment-related services, for a consumer aged 18 to 22, if the consumer is eligible for special education and has not received a diploma or certification of completion, unless the individual program plan (IPP) planning team determines the consumer's needs cannot be met by the educational system or an exemption is granted.

AB X2 1 (Committee on Budget), Chapter 3, Statutes of 2016, provided $29 million ($20 million General Fund) for the department to establish a competitive integrated employment (CIE) program.

The Administration has proposed trailer bill language to exempt 18 to 22 year olds from the provisions of WIC 4648.55 (a) if the consumer is still receiving educational services and participating in a paid internship. The Administration argues the proposed trailer bill language is necessary to allow individuals who, pursuant to their IPP, express a desire to and could benefit from an internship program.

Stakeholders have suggested that the language be expanded to also exempt a consumer who has completed a paid internship and is ready to transfer to paid employment with supports.

Staff Comments and Recommendation – Adopt placeholder modified trailer bill language: This issue was discussed on March 16th.

(1) For participation in a paid internship or competitive integrated employment that is an outcome of a paid internship pursuant to subdivision (a) of section 4870 if the IPP planning team determines that the consumer could benefit from participation in a paid internship. Participation in a paid internship or competitive integrated employment that is an outcome of a paid internship does not preclude an individual from continuing to receive public education services to the extent those services are determined to continue to meet the individual's needs.

ISSUE 10: Reporting of Employment Outcomes by Regional Centers – Trailer Bill Language – Open Issue

Background: The department has proposed language to require regional centers, through the performance contract process, to measure progress and report outcomes in implementing the "employment first" policy. According to the department, the outcomes and measures contained in performance contracts have remained relatively unchanged since 2001. They further report that three years ago, the department began "encouraging" regional centers to include employment outcomes as part of their local measures, however, five regional centers have not done so.

California Disability Services Association (DSA) requests language to require more specific data collection and reporting outcomes over time, specifically related to the number of individuals with reported earnings and average earnings. SB 433 (Mendoza) would authorize data sharing between the Department of Developmental Services and Employment Development Department in order to assess and implement statewide employment goals for individuals with developmental disabilities. The bill has been approved by the Senate and is awaiting committee assignment in the Assembly. Disability Rights CA proposes more detailed reporting focused on outcomes.

Staff Comments and Recommendation – Adopt placeholder trailer bill language: When this issue was discussed on March 16th**,** questions were raised as to whether the department needed statutory authority to include performance contract objectives necessary to ensure regional centers are in compliance with state law and regulations. The subcommittee may wish to modify the Administration's proposed language, as follows, to clarify this point.

(a) The state shall enter into five-year contracts with regional centers, subject to the annual appropriation of funds by the Legislature.

(b) The contracts shall include a provision requiring each regional center to render services in accordance with applicable provision of state laws and regulations.

(c) (1) The contracts shall include annual performance objectives that the department determines are necessary to ensure each regional center is complying with subsection (b), including but not limited to, ~~shall do both of~~ the following:

ISSUE 11: Unanticipated Rate Adjustments and Health and Safety Waiver Requests – Stakeholder Proposal

Background: The department has two processes to increase a community provider's rate outside of the usual rate-setting mechanisms. These are the health and safety waiver process, designed to be used on a consumer-by-consumer basis; and the unanticipated rate adjustment process, intended for use by day programs and in-home respite programs.

At its March 16th hearing, the subcommittee heard testimony that these processes can be burdensome, not always suited to the situation in which a provider requires a rate adjustment, and can lack the agility for timely decision-making.

Staff Comments and Recommendation – Adopt placeholder trailer bill language: The subcommittee may wish to adopt the following placeholder trailer bill language to accomplish the following:

The department shall convene a working group consisting of regional centers and providers to consider a simplified process for providers seeking rate adjustments due to the health and safety of one or more consumers served by a provider; necessary to prevent movement of a consumer into a more restrictive and/or more costly program; or necessary to prevent the loss of services being provided and for which no appropriate alternative service is available; or other criteria agreed upon by the working group. The department shall report on the workgroup process and product during the 2018 budget subcommittee process.

ISSUE 12: Community Placement Plan (CPP) Funding – Trailer Bill Language – Open Issue

Background. The Administration proposes to amend existing statute to allow regular CPP funds to be used to develop and fund resources in the community for individuals transitioning from other institutional settings or who are already living in the community.

WIC Section 4418.25 requires the department to establish policies and procedures for the development of an annual community placement plan by regional centers. The CPP is designed to enhance the capacity of the community service delivery system and to reduce the reliance on the use of developmental centers other restrictive living environments by providing funding to the regional centers for the development of a variety of resources. These resources include residential development, initial placement costs, transportation, day program services, and mental health and crisis services.

The CPP provides dedicated funding for comprehensive assessments of developmental center residents, for identified costs of moving individuals from DCs to the community, and for deflection of individuals from developmental center admission. The plans include budget requests for regional center operations, assessments, resource development, and ongoing placement costs.

As the developmental centers move toward closure, the need to develop new specialized resources for these populations will decline. However, as institutional and out-of-state service options become unavailable, there will be an increasing demand for community-based services and supports to meet the needs of consumers already in the community, including those with complex and challenging needs. The proposed language will authorize the use of CPP funds to develop resources for individuals transitioning from institutional settings or are already living in the community.

Staff Comments and Recommendation – Adopt placeholder modified trailer bill language: This issue was discussed on March 16th**.** The Administration proposes to modify existing statute, Welfare and Institutions Code (WIC) 4418.25, that was designed to primarily facilitate the movement of persons from a developmental center to the community. As the developmental centers are scheduled to close within the next few years, amending this section may not be the appropriate route for establishing the process by which ongoing CPP funds are used to address gaps in community resources.

Alternatively, Article 2 of the WIC (Sections 4675, et al), describes another process by which the department, in consultation with other system stakeholders, plan and develop new and expanded community resources.

The subcommittee may wish to adopt conceptual placeholder trailer bill language, and direct staff to work with the Administration to develop language that more appropriately reflects the goals of addressing community system gaps and emerging needs, including those that relate to reducing reliance on restrictive settings and serving persons with complex and challenging needs.

ISSUE 13: Headquarters-Community Housing Development Oversight- BCP – Open Issue

Proposal: The budget proposes $597,000 ($554,000 General Fund) for four permanent positions to

oversee the development of permanent community housing by the regional centers. Specifically, the department requests:

- One career executive assignment (CEA) position to review and make recommendations regarding housing development and funding policies and guidelines, as well as provide overall planning, leadership, and guidance from concept through post development.

- One staff services manager I who will assist the CEA and existing Community Development and Housing Section management with the coordination and implementation of housing review activities.

- Two associate governmental program analysts who will conduct housing review and compliance activities, including reviewing and updating tracking tools.

Staff Comments and Recommendation – Approve as budgeted and adopt placeholder supplemental report language: This issue was heard on March 16. For many years, the department has used community placement plan funding to develop new housing options in the community. These efforts accelerated as closure plans for developmental centers were adopted, and are proposed to continue through the previously discussed CPP proposal. The subcommittee may wish to consider adopting the following supplemental report language to require the department to submit more detailed information regarding housing development and funding policies and guidelines and how unmet needs and community priorities will be addressed and how the development of housing will be monitored. Additionally, the subcommittee may wish to require on-going annual reporting to measure the impact of these housing development initiatives on the overall availability of housing options to meet the varied needs of regional center consumers.

By September 1, 2018, the department shall report to the Senate and Assembly committees on human services and the appropriate legislative budget subcommittees on the following:

- *Housing development and funding policies and guidelines.*
- *How the department and regional centers will assess community unmet needs and local priorities.*
- *How the department will monitor housing development.*

Annually, by April 1, the department shall report to the Senate and Assembly committees on human services and the appropriate legislative budget subcommittees on the following:

- *Type and number of housing projects approved, in progress, open, occupancy, by regional center.*
- *Total number of new beds by facility type, by regional center.*
- *The degree to which housing development gains have been offset by program closures, by facility type, by regional center.*

ISSUE 14: Safety Net Development – May Revision Proposal – Trailer Bill Language.

Proposal: The May Revision proposes an augmentation of $21.2 million ($7.5 million in new one-time General Fund; $13.7 million other) for the following initiatives related to the development of a system "safety net" for persons in crisis or otherwise difficult to serve.

Background: In 2013, the secretary of the California Health and Human Services Agency established a task force on the future of developmental centers which included a broad cross-section of members representing consumers, family members, regional centers, consumer advocates, community service providers, organized labor and the Legislature. The work of the task force culminated in the "Plan for the Future of Developmental Centers in California," available at: http://www.chhs.ca.gov/DSTaskForce/PlanfortheFutureofDevelopmentalCenters.pdf.

Included in the task force report were the following six recommendations:

1. *More community style homes/facilities should be developed to serve individuals with enduring and complex medical needs using existing models of care.*

2. *For individuals with challenging behaviors and support needs, the State should operate at least two acute crisis facilities, and small transitional facilities. The State should develop a new "Senate Bill 962" like model (medical) that would provide a higher level of behavioral services. Funding should be made available so that regional centers can expand mobile crisis response teams, crisis hotlines, day programs and short-term crisis homes, new-model behavioral homes, and supported living services for those transitioning to their own homes.*

3. *For individuals who have been involved in the criminal justice system, the State should continue to operate the Porterville DC-Secure Treatment Program (STP) and the transitional program at Canyon Springs Community Facility. Alternatives to the Porterville DC-STP should also be explored.*

4. *The development of a workable health resource center model should be explored, to address the complex health needs of DC residents who transition to community homes.*

5. *The State should enter into public/private partnerships to provide integrated community services on existing State lands, where appropriate. Also, consideration should be given to repurposing existing buildings on DC property for developing service models identified in Recommendations 1 through 4.*

6. *Another task force should be convened to address how to make the community system stronger.*

In 2014, the secretary formed the Developmental Services Task Force, including members of the previous task force and five additional members with expertise specific to community-based services. Among other things, this task force made recommendations related to a system "safety net", defined by the task force as:

> *Timely access to essential services and supports necessary for persons with developmental disabilities to maintain health and safety and to address medical, psychiatric, behavioral, residential, staffing, equipment, or other needs, when other services and supports fail, are interrupted, are not available, or additional*

services and supports are necessary for an urgent or medical need. May or may not require a change in placement.

Specific recommendations from the task force included:

1. *Creation of a funding source similar to the Community Placement Plan (CPP) to start up new services for individuals currently being served in the community and develop safety net services.*

2. *Development of crisis services throughout the state, including more mobile crisis teams for timely intervention and more attention to medication management.*

3. *Increased options for developmental center staff staff to support consumers in the community.*

In response to SB 82 (Committee on Budget and Fiscal Review), Chapter 23, Statutes of 2015, which required the department to submit a plan or plans to close one or more developmental center(s) to the Legislature by October 1, 2015, the department submitted a plan to close Sonoma by December 31, 2018. On April 1, 2016, the department submitted to the Legislature a plan for the closure of the Fairview Developmental Center and the Porterville Developmental Center – General Treatment Area by the end of December 2021.

The Budget Act of 2017-18 included trailer bill language to require the department to report back on its safety net strategy:

Welfare and Institutions Code Section 4474.15(a):

The State Department of Developmental Services shall include an update to the Legislature in the 2017–18 May Revision regarding how the department will provide access to crisis services after the closure of a developmental center and how the state will maintain its role in providing residential services to those whom private sector vendors cannot or will not serve. As part of this plan, the department shall assess the option of expanding the community state staff program authorized in Section 4474.2 to allow the department's employees to serve as regional crisis management teams that provide assessment, consultation, and resolution for persons with developmental disabilities in crisis in the community.

In January and February 2017, the department organized and facilitated three safety net stakeholder meetings in Napa, Fresno and Costa Mesa. Participants in these meetings included representatives from the developmental services system, and included experts from universities, practitioners in the fields of psychiatry and behavioral health, and other interested state agencies.

On May 11th, as part of the May Revision, the Administration proposed to fund the following initiatives related to the development of the safety net. However, the department's Plan for Crisis and Other Safety Net Services in the California Developmental Services System, otherwise known as the "safety net plan," was not publicly released until May 13th. The following chart describes each proposed component and the fund source. Outside of this chart, no fiscal detail has been provided for the proposed components of the safety net plan.

Safety Net Plan Concept	May Revise Request	Existing Funds	Funding	2017-18 Estimated Cost
Establish two state-operated mobile acute crisis teams.	$1.9 million		General Fund	$1.9 million
Develop intensive wrap-around services for persons with co-occurring developmental disabilities and mental health needs.		$3.0 million	RC POS	$3.0 million
Plan for the relocation and expansion of the current state-operated acute crisis services, known as STAR homes. • **Renovate two existing homes on Fairview Developmental Center's Mark Lane.** • **Develop 2 four- or five-bed homes in Fiscal Year (FY) 2017-18 and 1 four- or five-bed home in FY 2018-19 in Northern California to relocate Sonoma STAR services and expand crisis capacity in Northern California.**	$2.6 million	$1.3 million $0.4 million	Harbor Village Account General Fund and CPP Start-Up	$1.3 million $3.0 million
Increase options to serve individuals with the most challenging service needs. • **Develop 4 vendor-operated four-bed homes in FY 2017-18 to provide step-down services for dual diagnosed individuals transitioning from IMDs or other restrictive settings.** • **Develop 2 vendor-operated four-bed homes in FY 2017-18 and 1 four-bed home in FY 2018-19 to provide step-down services for the Porterville Secure Treatment Program (STP).** • **Develop intensive wrap-around services for transitioning out of STP.**	$3.0 million	$6.0 million $3.0 million	CPP Start-Up CPP Start-Up General Fund	$6.0 million $3.0 million $3.0 million
Total	$7.5 million	$13.7 million		$21.2 million

Source: Department of Developmental Services

Generally, the plan provides multiple strategies to address the needs of persons who may be hard to serve in traditional models or who are in crisis. These strategies add to the development of enhanced behavioral supports homes (EBSH) and community crisis homes, approved in the 2014 budget act; and the ongoing funding of transitional homes, crisis support services and health services funded through the regular POS budget and enhanced through CPP funding.

Several of the initiatives proposed to be funded through the May Revision request have been described by the department, as follows.

- **State-operated mobile acute crisis teams.** The department proposes to establish northern and southern mobile crisis teams, to be co-located with existing STAR services (crisis units) at Sonoma and Fairview developmental centers. The teams would provide community assessment, crisis services/mental health treatment for stabilization, and provide services and supports to help maintain individuals in their existing residence. These teams will be available 24-hours a day, seven days a week. With 10 days of deployment of a state mobile crisis team, an interdisciplinary team meeting will be scheduled to assess services supports. If needed, the mobile acute crisis team support may continue as identified through the IPP, until ongoing services support alternatives are identified. Mobile crisis teams are expected to be operational in August 2017. DDS will be providing the existing STAR training to additional developmental center staff to ensure trained staff are available for STAR and mobile acute crisis services. Staffing will be re-evaluated after one year of operation. Starting in 2018-19, the department will bill regional centers for these services. For each mobile unit, the department proposes .5 psychologist; .75 social worker, and five psychiatric technicians and one supervising senior psychologist position located at headquarters. The department notes that they will contract for additional services as needed and that staffing is subject to change as program design is finalized.

- **Intensive wrap-around services for persons with co-occurring developmental disabilities and mental health needs.** These services will allow individuals to successfully transition out of placement in highly restrictive settings such as Institutions for Mental Disease (IMDs) and acute crisis services, into appropriate community settings. Availability of these services will also help prevent admissions into these highly restrictive settings. DDS proposes to convene key regional centers to develop this service option for individuals currently being served in, or at risk of admission to, an IMD setting. Vendored services will be provided under the service code established to support transitions from CCHs, with individualized rate setting. Services are expected to be operational in October 2017.

- **Development of four vendor-operated four-bed homes in 2017-18 to provide step-down services for dual diagnosed individuals now served in IMDs or other emergency facilities.** These homes will be located throughout the state to serve as "step-down" options from IMDs, STAR units at the developmental centers, and other highly restrictive settings. The homes will provide time-limited residential services, as defined in the IPP and include intensive psychiatric supports and intensive services and treatment to address the developmental needs and prepare individuals for transition to a less restrictive setting, in combination with the concept of intensive transitional and preventative support services. These homes will be licensed as CCHs, with intensive mental health components. Homes may use delayed egress devices. The department does not expect these homes will require a secure perimeter. Homes are projected to be available by March 2019.

Similar descriptions have not been provided to staff for the following proposed safety net initiatives.

- Refurbishing two existing homes on Fairview Developmental Center's Mark Lane, through an amendment of the existing ground lease. Once complete, one home will be used to relocate the current five-bed Southern STAR (Stabilization, Training, Assistance and Reintegration) services, and the other home will allow an expansion for up to five individuals.

- Development of two four- or five-bed homes in 2017-18 and one four- or five-bed home in 2018-19 in Northern California to relocate Sonoma DC STAR services and expand the crisis capacity by eight to 10 beds.

- Development of two vendor-operated four-bed homes in FY 2017-18 and one four-bed home in 2018-19 in the Porterville area to provide step-down services for the Porterville Secure Treatment Program (STP).

- Development of intensive wrap-around services for individuals transitioning out of the Porterville STP, through a contract with a private organization.

Proposed Trailer Bill Language. The May Revision proposes trailer bill language to authorize an amendment to the existing ground lease for property at Fairview Developmental Center, known as Harbor Village, to renovate and maintain the two Southern STAR homes. They further identify the CPP trailer bill language proposed in the January budget and discussed earlier in the agenda, as a part of the "safety net" package. Committee staff would add to the list of proposed trailer bill associated with the "safety net" package the Administration's proposed trailer bill to extend the exemption from federal funding eligibility to EBSHs and CCHs that utilize delayed egress/secured perimeters, discussed by this subcommittee at its March 16th hearing.

Legislative Analyst's Office. The LAO issued preliminary comments prior to the release of the department's safety net plan report. Overall, the LAO agrees with the important purpose of this proposal, believe that it begins to address longstanding concerns and complements existing community efforts, and includes a "resourceful" funding model. However, the LAO finds that the proposal lacks some supporting detail, such as the extent of demand of safety net services; implementation details, such as staffing, facility locations and characteristics, and opening dates; how services will be chosen for or by consumers and whether services will be culturally sensitive; how the department will evaluate the proposal's effectiveness and how it will determine future need. Finally, the LAO notes that the Legislature has little time to evaluate this proposal, despite the significant need to begin timely development of safety net services in light of the pending closures of the developmental centers.

The LAO recommends the adoption of supplemental report language to direct DDS to submit a long-term funding plan for crisis and other safety net services in conjunction with the submittal of the 2018-19 Governor's budget.

Questions for DDS:

- Please present your proposal.

- Why weren't these proposals made in January or April, affording both the Legislature and the public more time to review?

- How were the funding levels determined?

- At this point, you've proposed very little trailer bill language. Do you envision that more will be necessary before these facilities open? If so, in what areas?

- Do you envision that the same rights and protections provided to persons in developmental

centers now will be extended to persons living in these safety net facilities?

- Do you envision that the STAR units at the developmental centers will remain open until the proposed crisis facilities are available in the community?

- Once the STAR facilities are closed, where will the mobile crisis teams be housed?

- How will providers and families access mobile crisis team?

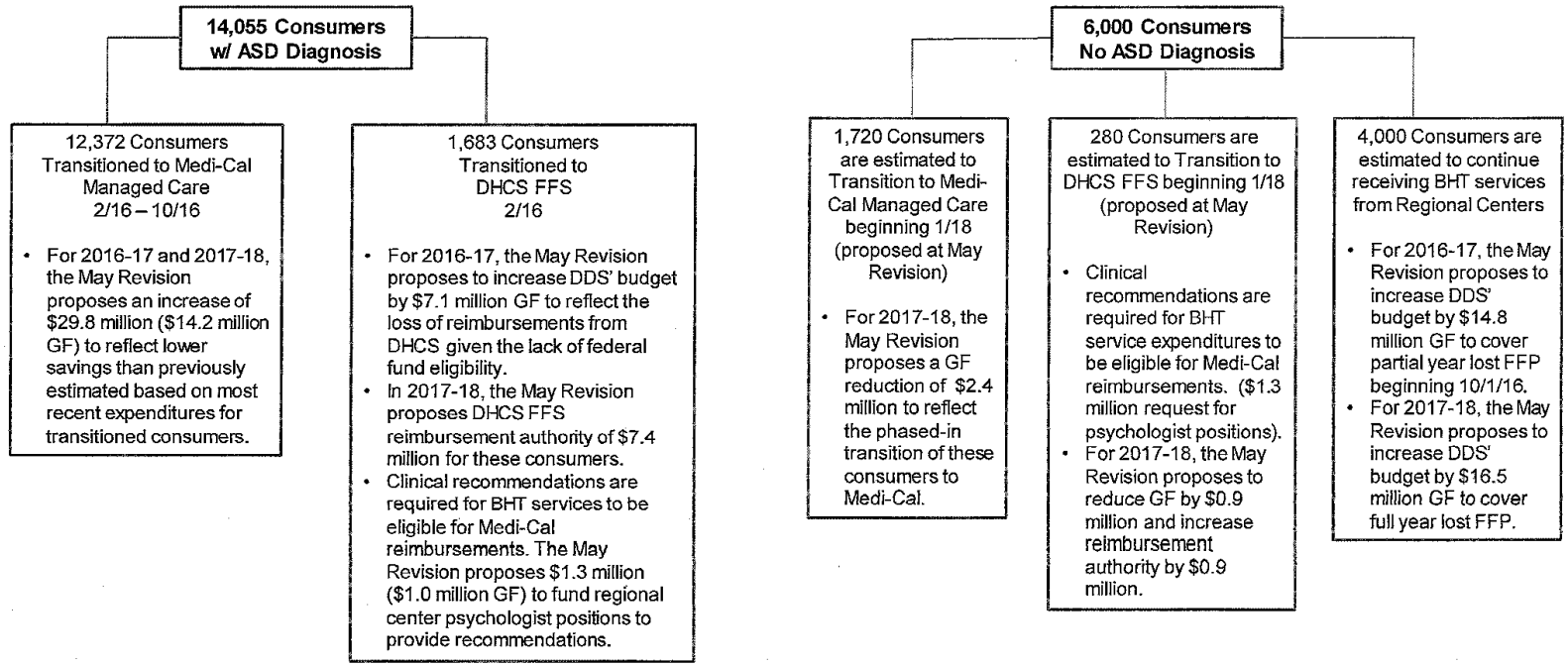
- Will crisis teams to enable to make "real time" decisions that are responsive to the crisis at hand?

Staff Comment and Recommendation: Reduce May Revision by $1 million (General Fund) in order to move the discussion (funding and three pieces of tbl) forward to budget conference committee. The department should be commended for their efforts to address safety net needs in light of the pending closure of the developmental centers, and to meet the needs of persons already living in the community. However, the issues are complex, the plan lacks detail, and staff and the public have had insufficient time to review the plan. Staff finds merit in the LAO recommendation to require the department to report back to the Legislature in January 2018. However, by that time significant decisions about the issues LAO raises will have been made.

An alternative approach might be to require the department to submit a more detailed implementation and spending plan that includes detailed program and process design descriptions, to the Joint Legislative Budget Committee, and policy and budget subcommittees prior to the expenditure of funds.

The best approach may require further discussion between the Administration and legislative staff, and afford stakeholders more time to comment on the proposal. Therefore, staff recommends that the committee approve a reduced augmentation to send this issue to the budget conference committee.

2017-18 May Revision
Department of Developmental Services
Consumers Receiving BHT Services



Wednesday, May 17, 2017

SBFR Subcommittee No. 3 - Part A Agenda

Department of Developmental Services

OUTCOMES

ISSUE 1: Information Security and Privacy Support-Budget Change Proposal (BCP) – p.2

Approve as budgeted.

VOTE: 3-0

ISSUE 2: Developmental Center – May Revision Adjustments – p.2

Approve May Revision, as adjusted by other subcommittee actions.

VOTE: 3-0

ISSUE 3: Regional Centers – May Revision - Current Year – p.4

Approve May Revision, as adjusted by other subcommittee actions.

VOTE: 3-0

ISSUE 4: Regional Centers –May Revision – Budget Year - p. 5

Approve May Revision, as adjusted by other subcommittee actions.

VOTE: 3-0

ISSUE 5: Behavioral Health Treatment (BHT) Services – May Revision Proposal and Adjustments - p. 7

Approve May Revision.

VOTE: 3-0

ISSUE 6: Headquarters Research Unit – Open Issue – p. 8

Adopt placeholder trailer bill language as described in the agenda.

VOTE: 3-0

ISSUE 7: Disparities – Open Issue - p. 9

(1) Adopt placeholder trailer bill language to require the department to post information on its website each year, as described in the agenda;
(2) Adopt conceptual placeholder trailer bill language to clarify that regional centers should consider if insurance benefits are available and appropriate as part of the IFSP process;
(3) Augment the POS budget by $5.6 million General Fund ($10.3 million total funds) and adopt placeholder trailer bill language to remove the cap on respite services.

VOTE: 3-0

ISSUE 8: Home and Community-Based Services Waiver Policy Directives – Trailer Bill Language – Open Issue – p. 11

- Reject proposed trailer bill language.

VOTE: 3-0

ISSUE 9: Paid Internships – Trailer Bill Language – Open Issue – p.12

Adopt placeholder trailer bill language as described in the agenda.

VOTE: 3-0

ISSUE 10: Reporting of Employment Outcomes by Regional Centers – Trailer Bill Language – Open Issue – p. 12

Adopt placeholder trailer bill language as described in the agenda.

VOTE: 3-0

ISSUE 11: Unanticipated Rate Adjustments and Health and Safety Waiver Requests – Stakeholder Proposal – p. 13

Adopt placeholder trailer bill language as described in the agenda.

VOTE: 3-0

ISSUE 12: Community Placement Plan (CPP) Funding – Trailer Bill Language – Open Issue – p. 14

Adopt modified placeholder trailer bill language as described in the agenda.

VOTE: 3-0

ISSUE 13: Headquarters-Community Housing Development Oversight- BCP – Open Issue – p. 14

Approve as budgeted and adopt placeholder supplemental report language as described in the agenda.

VOTE: 2 - 1 (Stone)

ISSUE 14: Safety Net Development – May Revision Proposal – Trailer Bill Language – p. 15

Reduce the May Revision by $1 million (General Fund) in order to move the discussion (funding and 3 pieces of TBL) forward to budget conference committee.

Vote: 3-0

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

SUBCOMMITTEE NO. 3 Agenda

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

May 17, 2017
10 a.m., or Upon Call of the Chair
Room 4203, State Capitol

PART B

Consultant: Theresa Pena

ISSUES RECOMMENDED FOR VOTE ONLY

ISSUES FOR DISCUSSION

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.

ISSUES RECOMMENDED FOR VOTE ONLY

4700 DEPARTMENT OF COMMUNITY SERVICES AND DEVELOPMENT (CSD)

Issue 1: BCP: Low-Income Weatherization Program (LIWP) Reappropriation (Governor's Budget)

Governor's Budget. The Administration requests reappropriation of any unexpected balances of 2014-15 local assistance appropriations received from the Greenhouse Gas Reduction Fund (GGRF) to be available for encumbrance until the end of 2017-18, and available for liquidation until the end of 2018-19. The proposal includes budget bill language (BBL). If the reappropriation authority is not granted, CSD anticipates reverting a total of $11 million in GGRF.

Staff Recommendation. Approve as requested. This subcommittee heard and discussed this item during its May 4, 2017 hearing.

Issue 2: LIWP Procurement

Background. Phase I of LIWP procurement was developed in 2014, when CSD received what was anticipated to be a one-time appropriation of $75 million cap-and-trade funds. After receiving an additional cap-and-trade appropriation in 2015-16, CSD opened up LIWP's single-family energy efficiency component to new potential service providers through a competitive procurement (Phase II), and pursued a stand-alone program model. CSD retained an independent consulting firm that specializes in state procurements to help design and administer the LIWP Regional Administrator Request for Proposals (RFP). CSD actively sought public input in developing program design, guidelines and subsequent RFP for Phase II of LIWP. The RFP identified five regional administrators to cover disadvantaged communities across California. The California Weatherization Providers Network, made up of energy service providers who have previously delivered services through LIWP, has concerns with the Phase II procurement process, including the fact that an award was made to a Southern California organization to serve the Central Valley, that the process was overly competitive and not transparent enough, and that a justification for a deviation from Phase I to the new method for procurement under Phase II is lacking.

Staff Comment and Recommendation. In response to stakeholder concerns, staff recommends that the Legislature adopt placeholder trailer bill language to ensure that in any future procurement processes, CSD prioritizes existing ties to local communities for both regional administrators and providers, and other appropriate parameters to ensure a more transparent and inclusive process. Staff also recommends placeholder supplemental reporting language be adopted that requires, at minimum, quarterly updates in the form of meetings or documentation to the Legislature and stakeholders on the status of the current, and any future, procurement processes, to begin July 2017. This subcommittee heard and discussed this item during its May 4, 2017 hearing.

Issue 3: Program Number Change (Issue 403-MR)

May Revision. The Administration requests that items 4700-001-0890 and 4700-101-0890 be amended to change the FI$Cal program number assigned to Energy Programs from 4180 to 4181. These technical changes will allow the department to track budgeting and accounting detail at the subprogram and subtask level in the FI$Cal System.

Staff Recommendation. Approve as requested. No concerns have been raised.

5175 DEPARTMENT OF CHILD SUPPORT SERVICES (DCSS)

Issue 1: May Revision Estimate (Issue 402-MR)

May Revision. The Administration requests a shift between Child Support Services and the Child Support Recovery Fund of $2,154,000 due to an overall increase in Federal recovery collections, with a corresponding increase the collections level in the federal Collections Recovery fund and decrease the Federal Trust Fund draw down by the same amount. There is also a current year adjustment of $1,118,000 million for the same reason.

Staff Recommendation. Approve as requested. No concerns have been raised.

0530 HEALTH AND HUMAN SERVICES AGENCY/OFFICE OF SYSTEMS INTEGRATION (OSI)
5180 DEPARTMENT OF SOCIAL SERVICES (DSS)

Issue 1: BCP: Child Welfare Digital Services Adjustment (Governor's Budget)

Governor's Budget. The Administration requests a total of 57 positions and reclassification of 10 positions and an overall increase of $51.0 million ($25.5 million General Fund) for 2017-18 to continue activities related to delivering the CWS-NS solution and to reflect the project's recent adoption of the agile approach. This request operates within the established overall total cost for the CWS-NS project. DSS and OSI point out that the project has identified emerging resource gaps in several key areas, and the requested positions are meant to address these gaps and mitigate the risk and schedule delays that would ensue if this BCP were not approved. DSS and OSI are also looking to build the state's technical capacity in the long run so that the project can reduce dependency on vendors, develop a pool of qualified state resources, allow the state to be more flexible in the enhancements of future services, and eventually lower the operational costs.

Staff Recommendation. Approve as requested. This subcommittee heard and discussed this item during its April 20, 2017 hearing. No concerns have been raised.

Issue 2: BCP: CMIPS II – Implementation of Paid Sick Leave for IHSS Providers (Governor's Budget)

Governor's Budget. OSI requests a one-time increase of $4.8 million in spending authority to implement paid sick leave for IHSS and Waiver Personal Care Services providers, beginning July 1, 2018. The Department of Social Services requests a corresponding one-time increase of $4.8 million General Fund in local assistance authority to increase contract service costs with OSI. SB 3 (Leno), Chapter 4, Statutes of 2016 entitles IHSS providers to paid sick days. Implementation of this functionality is scheduled to be deployed in a phased approach, beginning July 2018. The BCP notes that half of the $4.8 million is for application changes, business interface process changes, training of county staff, and provider help desk resources. The CMIPS II application changes will implement functionality to calculate, accrue, and track sick leave hours required to support variable yearly sick leave caps and accrual rates at both the state and county levels. The remaining half of the $4.8 million is to provide four statewide mass mailings informing recipients and providers about the SB 3 changes to the IHSS program.

Staff Recommendation. Approve as requested. This subcommittee heard and discussed this item during its April 20, 2017 hearing. No concerns have been raised.

Issue 3: BCP: CMIPS II – Vendor Contract Transitional Activities (Governor's Budget)

Governor's Budget. OSI requests a one-time increase of $8.9 million in spending authority to support potential prime vendor contract transition activities related to CMIPS II. DSS requests a corresponding one-time increase of $8.9 million General Fund local assistance authority and corresponding budget bill provisional language. The existing prime vendor contract ends March 31, 2018. OSI is conducting a competitive procurement to award a new prime vendor contract for maintenance and operations services in August 2017. If a contract is awarded to a new prime vendor, there will be an eight-month transition period during which the incumbent prime vendor, which is currently Hewlett-Packard, winds down operations and the new prime vendor ramps up activities. Budget bill language (BBL) will be necessary to implement this BCP if approved. The BBL would be triggered if there is a funding need for transition activities for a new vendor.

Staff Recommendation. Approve as requested. This subcommittee heard and discussed this item during its April 20, 2017 hearing. No concerns have been raised.

5180 DEPARTMENT OF SOCIAL SERVICES – CALWORKS

Issue 1: TANF Block Grant Funds Transfer to California Student Aid Commission (Issue 405-MR)

May Revision. The Administration requests an increase of $211,587,000 in federal funds to reflect an increase in the amount of federal TANF block grant funds available to offset General Fund costs of $17,533,000 the Department of Developmental Services and $194,034,000 in the Cal Grant program administered by the California Student Aid Commission. An increase in unspent TANF funds from prior years, decrease in the CalWORKs caseload projection, and other TANF and TANF maintenance-of-effort funding adjustments result in excess TANF funds.

Staff Recommendation. Approve as requested.

Issue 2: Homeless Assistance Program (Issue 406-MR)

May Revision. The Administration requests an increase of $5,038,000 General Fund and an increase of $15,910,000 in Federal Funds to reflect recent caseload data indicating increased participation in the CalWORKs Homeless Assistance Program.

Staff Recommendation. Approve as requested. No concerns have been raised.

Issue 3: Reappropriation of Funding for the Housing Support Program (Issue 413-MR)

May Revision. The Administration requests to extend the availability of funds appropriated in the 2016 Budget Act for the Housing Support Program for an additional year, until June 30, 2018. The 2016 Budget Act included $46,675,000 General Fund for the program. Five counties were newly awarded grants in 2016-17 and require additional time to fully expend their allocations.

Staff Recommendation. Approve as requested. No concerns have been raised.

Issue 4: TBL: Expand Use of Local Family Support Account (Governor's Budget)

Governor's Budget. The Administration proposes to allow funds in a county's family support subaccount to be used to fund a portion of the CalWORKs Single Allocation in lieu of using General Fund. The department notes that thirteen counties realized additional indigent health care savings in 2014-15 ($265.9 million) compared to initial estimate. This proposal would be a one-time cost shift to allow the extra savings to be redirected towards the CalWORKs Single Allocation.

Staff Recommendation. Approve trailer bill language as placeholder. No concerns have been raised.

5180 DEPARTMENT OF SOCIAL SERVICES – CALFRESH

Issue 1: CalFood Program (Issue 418-MR)

May Revision. The Administration requests a one-time increase of $2 million General Fund to allow the CalFood Program to purchase and distribute food to needy families.

Staff Recommendation. Approve as requested. This proposal overlaps with a request from advocates.

5180 DEPARTMENT OF SOCIAL SERVICES – CHILD WELFARE SERVICES

Issue 1: Reappropriation of Funding for Various Child Welfare Services Items (Issue 414-MR)

May Revision. The Administration requests to extend the availability of funds appropriated in the 2016 Budget Act until June 30, 2018, for counties to perform various child welfare services administrative activities. The primary programs affected are Commercially Sexually Exploited Children and Foster Parent Recruitment, Retention and Support.

Staff Recommendation. Approve as requested. No concerns have been raised.

Issue 2: TBL: Approved Relative Caregiver (ARC) Program (Governor's Budget)

Governor's Budget. The Administration proposes to modify the ARC program consistent with implementation of the CCR. AB 1603 (Committee on the Budget) Chapter 25, Statutes of 2016, effective January 1, 2017, allows all relatives who are approved under the Resource Family Approval process in the CCR to receive an amount equal to the resource family basic rate, regardless of federal eligibility. The department notes that this TBL will result in a cost of approximately $21.4 million General Fund for 2016-17, and $25.2 million for 2017-18.

Staff Comment and Recommendation. Approve trailer bill language as placeholder. This proposal overlaps with a request from advocates and May Revision item.

5180 DEPARTMENT OF SOCIAL SERVICES – IN-HOME SUPPORTIVE SERVICES (IHSS)

Issue 1: IHSS Travel Time and Medical Accompaniment Wait Time Decrease (Issue 409-MR)

May Revision. The Administration requests a decrease of $84,842,000 General Fund and a decrease in reimbursements of $189,761,000 to reflect a reduction in the projected number of providers claiming travel time and medical accompaniment wait time associated with the federal Fair Labor Standards Act.

Staff Recommendation. Approve as requested.

5180 DEPARTMENT OF SOCIAL SERVICES – COMMUNITY CARE LICENSING

Issue 1: BCP: Continuance of CCL Staffing Resources (Governor's Budget)

Governor's Budget. The Administration requests increased expenditure authority of $3.3 million in the Technical Assistance Fund (TAF) to address various program and service delivery issues related to complaint investigations, the Centralized Application Unit, RCFE Reform, and Group Home Oversight, within the Community Care Licensing Division. All licensing fees are deposited into the TAF and are utilized to offset general fund expenditures of licensing functions. The Adult and Senior Care and Children's Residential Programs' civil penalties collected are deposited into the TAF and used only for technical assistance, training, and education of licensees and for emergency resident relocation and care when a license is revoked or temporarily suspended. TAF guidelines specify that the fund should only be used for administrative and other activities to support the licensing program. There is no negative impact to any other programs or departments, as only CCL may utilize these funds.

Staff Recommendation. Approve as requested. No concerns have been raised. This subcommittee heard and discussed this item during its March 2, 2017 hearing.

Issue 2: TBL: Delay Licensing Requirements for Private Alternative Boarding Schools and Outdoor Programs (Governor's Budget)

Governor's Budget. The Administration proposes to modify implementation of SB 524 (Lara), Chapter 864, Statutes of 2016, by making funding for its requirements contingent upon appropriation in the budget act. Additionally, it would specify the operative dates of the respective statutes to take effect 18 months after the appropriation of funds. SB 524 established "private alternative boarding schools" and "private alternative outdoor programs" as two new types of licensed community care facilities under the purview of DSS in response to the absence of state oversight for facilities and outdoor programs that advertise services and care for troubled teens.

Staff Comment and Recommendation. Reject and implement SB 524 pursuant to current law. DOF has stated that they are proposing to delay this statute not because of any administrative issues in ramping up to the original implementation dates, but rather due to costs associated with SB 524; yet the Administration has refused to let the subcommittee know how much this proposal will save them. This subcommittee heard and discussed this item during its May 4, 2017 hearing.

Issue 3: TBL: Continue Fingerprinting Licensing Fee Exemption (Governor's Budget)

Governor's Budget. The Administration proposes to continue for an additional two years the suspension of existing law that prohibits DSS and the Department of Justice (DOJ) from charging a fee to process a criminal history check of individuals who are licensed to operate child and adult facilities, provide care in a facility, or reside at that facility. Enactment of this TBL will continue the practice of allowing DSS to charge fees for this service. Since 2003-04, TBL has been enacted on an annual basis to suspend existing statute that prohibits DSS from charging the fingerprint licensing fee. To the extent that the prohibition to charge a fee is not suspended, the fee collection for this service ends and the state would be required to fund this activity with General Fund dollars.

Staff Comment and Recommendation. Approve as requested. These statutory provisions have been routinely delayed due to the costs associated with their enactment. No issues have been raised to subcommittee staff at this time. This subcommittee heard and discussed this item during its May 4, 2017 hearing.

Issue 4: SFL: Home Care Services Program (Governor's Budget)

Governor's Budget. The Administration requests to convert 9.5 limited-term positions to permanent, an additional 4.5 positions, and increased expenditure authority of $2 million General Fund ($1.8 million General Fund ongoing) to continue implementation and administration of the Home Care Services Program pursuant to AB 1217 (Lowenthal), Chapter 790, Statutes of 2013. DSS states that these additional resources are needed to address ongoing workload and are supported by a biennial fee increase for Home Care Organizations and Home Care Aides. The Administration is also seeking one-time increased expenditure authority of $100,000 for an interactive voice response telephone system to address current and ongoing workload.

The Home Care Services Consumer Protection Act requires that the program be entirely fee supported. The department states that the additional and ongoing resource needs will be supported by a fee increase for organizations and aides. Biennial fees for home care organizations will need to be increased by $638 for home care services companies and $25 for individuals beginning January 1, 2018.

Staff Recommendation. Approve as requested. No concerns have been raised. This subcommittee heard and discussed this item during its May 4, 2017 hearing.

Issue 5: KIT Report Findings

Background. In 2010, after many budget cuts, CCL fell behind in meeting visitation frequency requirements. In an effort to increase the number of routine inspections CCL could perform each year, DSS proposed moving from the comprehensive inspections required by state law to the use of a key indicator tool (KIT). The KIT was proposed to be a standardized, shortened protocol for measuring compliance with a small number of rules, which is then used to predict the likelihood of compliance with other rules. Under the proposal, if the KIT inspection revealed concerns, a comprehensive visit would also have been triggered. CCL contracted with the California State University, Sacramento, Institute of Social Research (CSUS, ISR) to provide an analysis and recommendations regarding the development, refinement, and validation of the KIT. The department has provided legislative staff with some of the related reports, in addition to a summary of findings. However, these findings do not answer the critical question of whether the use of the KIT is ultimately saving time and allowing for more inspections to take place without augmenting resources or sacrificing the effectiveness of licensing oversight, which was one of the primary reasons that the KIT was first proposed by the department.

Staff Comment and Recommendation. Staff recommends the adoption of placeholder supplementary reporting language that would require the department to meet with legislative staff and stakeholders to discuss the research reports and current status of the use of the KIT no later than July 31, 2017, and that the department distribute a document or summary to the Legislature that addresses how they intend to evaluate how the KIT is working in comparison to comprehensive inspections, what their long-term plan is regarding the KIT and comprehensive inspections and justification for it, including how this may

affect future budget requests, no later than September 30, 2017. This subcommittee heard and discussed this item during its May 4, 2017 hearing.

5180 MISCELLANEOUS DEPARTMENTS – ADVOCATE PROPOSALS

Issue 1: Child Care for Foster Children

Budget Issue. Los Angeles County, the County Welfare Directors Association, and others request $31 million to increase access to child care and enable a larger pool of families to become foster parents. This proposal includes three pieces: (1) Any resource family needing child care for children ages 0 through 3, would receive an immediate, time-limited voucher to pay for child care for up to six months following a child's placement at a cost of $22 million. (2) Funding of $5 million to support child care navigators through the county resource and referral agencies who work with the resource family to facilitate the use of the emergency voucher to ensure a foster child's immediate access to child care and continue to work with the family to facilitate placement. (3) Inclusion of $4 million to provide appropriate trauma-informed training for child care providers, with a trainer to cover every county.

Staff Comment and Recommendation. Approve trailer bill as placeholder. This subcommittee heard and discussed this issue during its March 30, 2017 hearing.

Issue 2: Funding for Medical Review of Psychotropic Medication Authorizations for Foster Youth

Budget Issue. National Center for Youth Law requests $80,025 General Fund (75% Federal Match for $320,100 Total Funds) to provide a centralized medical review service (through contracted services) of requests for authorizations of psychotropic medications for foster youth. The position would be housed within the Department of Social Services.

Staff Comment and Recommendation. Approve trailer bill as placeholder. This subcommittee heard and discussed this issue during its March 30, 2017 hearing.

Issue 3: Additional Foster Care Public Health Nurses (PHNs)

Budget Issue. SEIU requests $3.8 million General Fund (75% Federal Match for $15.4 million Total Funds) to hire an additional 96 PHNs to provide for the necessary oversight on foster youth on psychotropic medications.

Staff Comment and Recommendation. Approve as requested. This subcommittee heard and discussed this issue during its March 30, 2017 hearing.

Issue 4: Enact pilot to aid CalFresh families impacted by unsafe drinking water

Budget Issue. California Food Policy Advocates requests $5 million in the 2017-18 budget for a three-county supplemental nutrition benefit pilot to bring relief to CalFresh families impacted by unsafe drinking water.

Staff Comment and Recommendation. Approve trailer bill as placeholder. This subcommittee heard and discussed this issue during its April 20, 2017 hearing

Issue 5: Protect ABAWDs from expiring federal waiver

Budget Issue. Under SNAP regulations, a state can qualify for a 12-month statewide ABAWD waiver if it is determined that the unemployment level is below a certain amount. However, the current ABAWD waiver is set to expire in 2018, and certain counties and regions within California will lose waiver eligibility due to their declining unemployment rates. Those counties will then be required to implement the ABAWD time limit, putting likely hundreds of thousands of individuals at risk for not receiving CalFresh benefits.

Staff Comment and Recommendation. Approve trailer bill as placeholder that authorizes self-initiated volunteer work to be performed in order to qualify for the ABAWDs exemption and exempts people who are dealing with homelessness from the time limits, to the maximum extent permitted by federal law. Further, approve Supplemental Reporting Language to require the department to update the Legislature on its development of statistical reports relative to the CalFresh program. These reports shall be developed by the department in consultation with a workgroup composed of advocates for beneficiaries and county representatives. This subcommittee heard and discussed this issue during its April 20, 2017 hearing.

Issue 6: Additional funding for CalFood

Budget Issue. The California Association of Food Banks requests funding CalFood (formerly the State Emergency Food Assistance Program, or SEFAP) at $17.5 million General Fund in the 2017-18 budget. The May Revision includes one-time funding of $2 million General Fund for CalFood in 2017-18.

Staff Comment and Recommendation. Approve $6 million General Fund ongoing in addition to the May Revision funding for CalFood. This subcommittee heard and discussed this issue during its March 2, 2017 hearing.

Issue 7: Senior Nutrition Program

Budget Issue. The California Association of Area Agencies on Aging and other advocates requests $12.5 million General Fund to augment existing senior nutrition programs. Area Agencies on Aging operate these programs, including Congregate Mealsites and Home-delivered Meals (known as Meals on Wheels).

Staff Comment and Recommendation. Approve $4 million General Fund ongoing for the Senior Nutrition Program. This subcommittee heard and discussed this issue during its March 2, 2017 hearing.

ISSUES FOR DISCUSSION

Public testimony will be taken at the end for all items listed in this section.

5180 DEPARTMENT OF SOCIAL SERVICES – MISCELLANEOUS

Issue 1: May Revision Caseload Adjustments (Issues 401-MR and 402-MR)

May Revision. The May Revision proposes a net increase of $946,241,000 (increases of $1,273,224,000 reimbursements, $250,000 Special Olympics Fund, and $1,000 Child Health and Safety Fund, partially offset by a decrease of $138,455,000 General Fund, $188,398,000 Federal Trust Fund, $375,000 State Children's Trust Fund, and $6,000 Emergency Food Assistance Program) primarily resulting from updated caseload estimates since the Governor's Budget. Realigned programs are displayed for the purpose of federal fund adjustments and other technical adjustments. Caseload and workload changes since the Governor's budget are displayed in the following table:

Program	Item	Change from Governor's Budget
California Work Opportunity and Responsibility to Kids (CalWORKs)	5180-101-0001 5180-101-0890 Reimbursements	-$44,299,000 -$163,449,000 -$40,000
Kinship Guardianship Assistance Payment	5180-101-0001	-$4,170,000
Supplemental Security Income/State Supplementary Payment (SSI/SSP)	5180-111-0001	-$37,266,000
In-Home Supportive Services (IHSS)	5180-111-0001 Reimbursements	-$26,461,000 $1,259,776,000
Other Assistance Payments	5180-101-0001 5180-101-0122 5180-101-0890 5180-101-8106	-$283,000 -$6,000 $3,566,000 $250,000
County Administration and Automation Projects	5180-141-0001 5180-141-0890 Reimbursements	-$27,823,000 -$34,466,000 $20,668,000
Community Care Licensing	5180-151-0001 5180-151-0890	-$347,000 -$65,000
Special Programs	5180-151-0001	-$201,000
Realigned Programs		
Adoption Assistance Program	5180-101-0890	$2,325,000
Foster Care	5180-101-0001 5180-101-0890	$676,000 -$2,529,000

Program	Item	Change from Governor's Budget
	5180-141-0001 5180-141-0890	$2,000 -$435,000
Child Welfare Services (CWS)	5180-151-0001 5180-151-0279 5180-151-0803 5180-151-0890 Reimbursements	$1,999,000 $1,000 -$375,000 $15,630,000 $8,000
Title IV-E Waiver	5180-153-0001 5180-153-0890	-$282,000 -$9,090,000
Adult Protective Services	5180-151-0890 Reimbursements	$115,000 -$7,188,000

The updated 2017-18 caseload estimates for the largest programs are summarized below:

Program[1]	**January estimate**	**May Revision**
CalWORKs	464,782	454,736
SSI/SSP	1,284,131	1,275,638
IHSS	516,935	517,115

LAO Comments. In response to the May Revision, the LAO makes the following comments:

- SSI/SSP caseload assumptions appear reasonable, but lower than expected. The May Revision estimates are slightly below what was estimated in January.

- Administration's CalWORKs caseload estimates are likely overstated. While the LAO agrees that the rate of decline will likely slow in 2017-18 and is subject to some uncertainty, they believe the rate of decline will be more significant than assumed in the May Revision.

- IHSS estimates, including increases in caseload, hours per case, and cost per hour relative to January, appear reasonable, and are based off of the most recent actuals available.

Questions.

1. DSS: Please provide an overview of the May Revision estimates for major programs.

2. LAO: Are the estimates reasonable? Can you discuss your take on the CalWORKs caseload in more detail?

Staff Comment and Recommendation. Approve May Revision caseload estimate changes, subject to additional conforming changes made by other legislative actions.

[1] Total average caseload, by program

5180 DEPARTMENT OF SOCIAL SERVICES – IMMIGRATIONS BRANCH

Issue 1: Immigration Services (Issue 410-MR)

Budget Proposal. The Administration requests that Immigration Services funding be increased by $15 million General Fund, for a total of $30 million General Fund, to further expand the availability of legal services for people seeking naturalization services or assistance in securing other legal immigration status.

Staff Comment and Recommendation. Hold open. Trailer bill language is forthcoming, and this proposal overlaps with the One California request.

Issue 2: Proposal for Investment: One California

Budget Proposal. The One California coalition, Due Process Coalition, and various immigrant rights and civil rights organizations, joined by the Latino Legislative Caucus and the Asian Pacific Islander Legislative Caucus on various pieces, make the following requests: 1) That there be $30 million General Fund for affirmative immigration remedies and naturalization services including education, outreach, and application assistance be ongoing instead of one-time (this portion acknowledges the $15 million ongoing existing funding); 2) $31 million General Fund ongoing for removal defense services, including $1 million General Fund one time to aid deported veterans with post-conviction relief and return; and 3) $545,000 General Fund one-time to support expanded legal training and resources. The request totals $61,545,000 million.

Staff Comment and Recommendation. Hold open. Trailer bill language is forthcoming, and this proposal overlaps with the Administration's May Revision proposal.

Issue 3: Proposal for Investment: Special Immigrant Juvenile Status (SIJS)

Budget Proposal. When placed with a guardian or non-offending parent, abused, abandoned, or neglected immigrant children have the opportunity to seek Special Immigrant Juvenile Status (SIJS), which protects them from deportation and puts them on a path to receiving a green card. The Immigrant Defenders Law Center and others request several clarifications to the California Code of Civil Procedure, as some state judges remain confused about their role in the SIJS process. The requested changes are 1) to limit the scope of SJIS findings to be used in SIJS petitions only to ensure that judges are aware that the offending parent will not suffer any repercussions; 2) to make clear that when a child is independently represented by counsel, the guardian ad litem (GAL) does not also need legal representation; and 3) provides a mechanism to allow for counsel for the minor child in SIJS cases to serve the dual role of attorney and GAL absent a conflict of interest.

Staff Comment and Recommendation. Hold open. Last year, the Legislature made clarifications in statute regarding this issue in budget trailer bills to ensure that immigrant children can have access to the courts and SIJS findings so they can petition the federal government for SIJS relief.

5180 DEPARTMENT OF SOCIAL SERVICES – STATE HEARINGS DIVISION

Issue 1: BBL: Appeals Case Management System (Issue 415-MR)

Governor's Budget. The Administration requests that items 5180-141-0001 and 5180-141-0890 be amended to include provisional language to both allow for the transfer of funds between these items and 5180-001-0001 and 5180-001-0890 to continue funding for the Appeals Case Management System project staff that are set to expire on December 31, 2017, and to allow the project to increase expenditure authority to the extent that project vendor contract negotiations result in additional up-front costs, subject to Department of Finance and California Department of Technology approval. Total project costs remain unchanged from Special Project Report No.1, and the proposed Budget Bill Language will allow the project to accelerate funding estimated for future fiscal years based on the final vendor agreement.

Staff Recommendation. Approve as requested. No concerns have been raised.

5180 DEPARTMENT OF SOCIAL SERVICES – CHILD WELFARE SERVICES

Issue 1: Continuum of Care Reform: Social Worker Hourly Rate (Issue 411-MR)

May Revision. The Administration requests that Item 5180-151-0001 be increased by $5,504,000, Item 5180-151-0890 by increased by $2,690,000 and Item 5180-153-0001 be increased by $4,054,000 to reflect the actual county social worker rates for the Child and Family Team and Second Level Administrative Review components of the Continuum of Care Reform (CCR).

Staff Comment and Recommendation. Approve as requested. No concerns have been raised.

Issue 2: Infant Supplement and Dual Agency Rate Parity (Issue 412-MR)

May Revision. The Administration requests an increase of $1,610,000 General Fund to provide foster youth placed with relative caregivers the same infant supplement and dual agency rate for special needs as federally eligible foster youth. This provides parity for all foster youth, regardless of federal eligibility, consistent with CCR efforts. Trailer bill language is necessary to implement this program.

Staff Comment and Recommendation. Approve trailer bill as placeholder. This subcommittee heard and discussed this issue during its March 30, 2017 hearing.

5180 DEPARTMENT OF SOCIAL SERVICES – CALWORKS

Issue 1: CalWORKs Single Allocation

May Revision. The CalWORKs Single Allocation reflects the cost to administer the CalWORKs program and provide employment services and Stage One Child Care to individuals in the CalWORKs Welfare to Work program, and Cal-Learn Intensive Case Management. Funding for each category within the Single Allocation is based on different methodologies that adjust funding from prior years based on caseload projections and assumed costs per case. In the Governor's Budget, the Single Allocation was proposed to be cut by $200 million in 2017-18. The May Revision proposes to cut an additional $45 million from the Single Allocation in 2017-18, bringing the total cut up to $245 million on top of a $160 million Single Allocation cut in the current year.

Advocate Concerns. The County Welfare Directors Association and others have previously brought up concerns that the methodology behind the Single Allocation is problematic. When the program sees dramatic swings in caseload, it makes it difficult for counties to ramp up quickly in years when caseload and funding increases, as well as when they have to make rapid cuts when caseload and funding drops. With the latest proposed cuts, counties will likely be forced to enact immediate service reductions, eliminate positions, and lay off existing staff.

Staff Comment and Recommendation. Hold open for further discussion.

Questions.

1. DSS: Please provide an overview of the proposal.

2. DSS: Please comment on advocate concerns referenced in this agenda. Are you working with advocates to address these concerns?

Issue 2: Statewide Fingerprinting Imaging System (SFIS) Contract Renewal

Budget Issue. State law requires applicants and recipients of CalWORKs benefits to provide fingerprint images as a condition of eligibility, using the Statewide Fingerprinting Imaging System (SFIS). The contract for SFIS expires on August 31, 2017. The contract for SFIS is valued at $12.1 million General Fund.

Background. Currently, CalWORKs applicants are required to extensively prove their identity and other information regarding eligibility in multiple ways, including:

- Providing a Social Security Number (SSN) and various documents to prove identity, such as a driver's license or state ID card, a photo ID from a government agency (such as a school), a passport, or immigration documentation.

- Providing additional documentation to verify various eligibility factors such as income (recent pay stubs or tax records), unearned income (such as SSI benefits, child support or worker's compensation), relationships (birth certificates), residency (rental agreements or current bills), property and other resources (vehicle registration, bank statements), and immunization records for children under the age of six.

- Identity verification using the information provided in the previous two bullets are checked against multiple databases, including: 1) the federal databases of the Social Security Administration (SSA) and the United States Citizenship and Immigration Services (USCIS); 2) the Medi-Cal Eligibility Data System (MEDS), which consolidates information on individuals who have applied or are receiving public benefits; 3) the Income Eligibility Verification System (IEVS) Applicant System, which checks for data against Employment Development Department and Franchise Tax Board data in addition to the SSA and USCIS; 4) the Statewide Client Index (SCI), which generates a unique identifier for each public assistance case; 4) the Statewide Automated Welfare System (SAWS).

- In addition to verifying identity, counties use many of these same documents to perform a "file clearance" to ensure that none of the people on the application are already active in a case to avoid opening duplicate cases and/or identifying potentially fraudulent activity.

In addition to these means of verifying identity and avoiding cases of duplicate aid, CalWORKs applicants are also required to provide fingerprint images. However, this practice has not proven to be an efficient use of resources. An early 2000s State Auditor report found that, after reviewing cases of almost 2 million public benefit recipients, the total number of cases of verified fraud identified by SFIS were as low as 45.

AB 6 (Fuentes), Chapter 501, Statutes of 2011, was successful in eliminating the fingerprinting requirement for CalFresh, but not CalWORKs. In the years since this bill passed, the department has not raised fraud as an issue in the CalFresh program. CalFresh uses a process similar to that of CalWORKs, with the exception of fingerprinting.

Staff Recommendation. Hold open.

Questions.

1. LAO: Please provide a brief history of fingerprinting in the CalWORKs program and summarize the results of the audit.

2. LAO: Please discuss the current system of verifying identity in the CalWORKs program.

5180 DEPARTMENT OF SOCIAL SERVICES – IN-HOME SUPPORTIVE SERVICES (IHSS)

Issue 1: Elimination of Coordinated Care Initiative (Issue 407-MR)

Background. The Coordinated Care Initiative (CCI) was created in 2012 as an effort to reduce state costs and improve health care delivery by coordinating services through a single health plan. The Governor's budged estimated that the CCI will no longer be cost-effective and does not meet the statutory savings requirements. Current law allows the Administration to discontinue the CCI if this is found to be the case. The Governor's proposal for unwinding of the CCI included ending the IHSS Maintenance-of-Effort (MOE) and returning to the prior state-county sharing ratio, and shifting collective bargaining responsibility back to demonstration counties. The Administration estimated that eliminating the IHSS County MOE provided approximately $600 million General Fund savings in 2017-18, and a corresponding shift of these costs to counties due to the return to the cost-sharing ratio for the program. Counties were concerned that 1991 Realignment funds, which fund the counties' share of IHSS, would not be enough to cover these costs, and this would only be exacerbated in out years.

May Revision. The May Revision reflects an updated estimate of $592.2 million General Fund savings, and the Administration has put forth a new proposal which stemmed from discussions with stakeholders during the spring. The proposal includes the following provisions:

- General Fund Assistance for counties of $400 million in 2017-18, $330 million in 2018-19, $200 million in 2019-20, and $150 million in 2020-21 and ongoing.

- Redirection of all Vehicle License Fee (VLF) growth for three years from the Health, County Medical Services Program (CMSP), and Mental Health Subaccounts to provide additional resources for IHSS. In years four and five, 50 percent of the VLF growth will be redirected.

- A new MOE structure rather than a share-of-cost structure as proposed in the Governor's Budget. A new base for county costs of IHSS in 2017-18 will be created for this purpose, and will include both services and, notably, administration costs. The portion of the MOE obligation met by administrative costs is capped. In year one, the inflation factor will be zero; in the second year, five percent, and in future years, will be on a sliding scale based on 1991 Realignment revenue performance.

- Counties experiencing financial hardship due to the increased costs of IHSS may apply to the Department of Finance for a low-interest loan to help cover these costs.

- Returns collective bargaining to counties and maintains the 35 percent county share of negotiated increases and proposes that the state participation cap always be $1.10 above the hourly minimum wage set in SB 3 (Leno), Chapter 4, Statutes of 2016, for large employers. The cap would rise with inflation once the minimum wage reaches $15 per hour. For counties at or exceeding the current state cap of $12.10, the state would agree to participate at its 65 percent share of costs up to a 10 percent increase in wages and benefits over three years.

- Beginning July 1, 2017, if a county does not conclude bargaining with its IHSS workers within nine months, the union may appeal to the Public Employment Relations Board.

Below is a table provided by the LAO summarizing the main components of the proposal:

Main Features of the Proposal

	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23 And On
General Fund support to partially offset increased county IHSS costs	$400 million	$330 million	$200 million	$150 million	$150 million	$150 million
Realignment revenue growth to partially offset increased county IHSS costs[a]	All sales tax and VLF growth	All sales tax and VLF growth	All sales tax and VLF growth	All sales tax growth and half of VLF growth	All sales tax growth and half of VLF growth	All sales tax growth
Adjustment factor to maintenance of effort[b]	0%	5%	0, 3.5, or 7%	0, 3.5, or 7%	0, 3.5, or 7%	0, 3.5, or 7%
DOF estimate of county IHSS costs not covered by state General Fund or realignment revenues	$141 million	$129 million	$230 million	$251 million	No projection	No projection

[a] A small portion of VLF growth would still be provided to the Child Poverty and Family Supplemental Support Subaccount in 1991 realignment.

[b] Starting in 2019-20, the adjustment factor will depend on the rate of growth in realignment revenues. If realignment revenues are negative, the adjustment factor will be zero. If the realignment revenues are less than 2 percent, the adjustment factor will be 3.5 percent. If the realignment revenues exceed 2 percent, the adjustment factor will be 7 percent. DOF forecasts the adjustment factor will be 7 percent in 2019-20 and 2020-21.

IHSS = In-Home Supportive Services; VLF = vehicle license fee; and DOF = Department of Finance.

Below is a table provided by the Department of Finance showing a breakdown of the various realignment subaccounts:

2017 May Revision

County IHSS Mitigation

($ millions)

	2017-18	2018-19	2019-20	2020-21
Increased County IHSS Costs[1/]	$592.2	$681.3	$812.3	$952.6
Offsets:				
Realignment Growth Funds[2/]				
Available Sales Tax Growth	-$18.2	-$128.6	-$235.9	-$339.9
Redirect Mental Health VLF Growth	-$36.0	-$66.8	-$96.7	-$110.5
Redirect Health/CMSP VLF Growth	-$20.4	-$37.8	-$54.7	-$62.5
Redirect AB 85 VLF Savings	-$12.6	-$23.4	-$33.9	-$38.7
State General Fund[3/]	-$364.0	-$296.1	-$161.3	-$150.0
Total Offsets	-$451.2	-$552.7	-$582.5	-$701.6
Net Increase in County Costs	$141.0	$128.6	$229.8	$251.0
Total GF Impact	-$400.0	-$330.0	-$200.0	-$150.0

[1/] Resets county IHSS base costs in 2017-18 using historical state/county cost-sharing ratios. 5-percent growth factor applied in 2018-19 and 7-percent growth factor applied annually thereafter.

[2/] Reflects year growth is allocated and paid to counties instead of accrual year.

[3/] Amounts adjusted to reflect accrual of AB 85 growth in year prior to county allocation.

LAO Comments. The LAO makes the following comments and recommendations:

- Other 1991 Realignment programs using the Health, Mental Health, and Child Poverty subaccounts would not receive any growth funding until 2020-21. Counties may have to provide local general fund to support costs in these programs or make program reductions until growth funding is partially or fully restored.

- Counties would not receive caseload growth costs incurred in 2016-17. The May Revision shifts revenues that traditionally would have been paid for costs incurred in 2016-17 to cover IHSS costs that will be incurred in 2017-18. As a result, counties will have to cover costs incurred in 2016-17 that realignment revenues would have paid.

- Overall, the proposal achieves some county priorities, including the reduction of 2017-18 IHSS costs to counties; the MOE and tiered adjustment factors make increases to counties' IHSS costs relatively predictable; and the adjustment factors tied to the growth in the realignment funding; and the Administration's proposal to adjust the wage cap based on changes in statewide minimum wage recognizes the impact of this state policy decision on counties' IHSS costs.

- However, the proposal is extremely complex and many details of the proposal are unsettled. The 1991 realignment fiscal structure is already complex, and this adds an additional layer of complexity. Offering this solution in the May Revision gives the Legislature almost no time to review such a complex – and still incomplete – proposal that could have significant long-term impacts to both state and county finances.

- The LAO recommends adopting a simpler, shorter-term solution such as providing some General Fund relief for the counties in the next few years, while allowing time for the Legislature to fully consider a solution for the long-term.

Staff Comment and Recommendation. Hold open. Staff is concerned that that there is a lack of detailed information concerning the forthcoming trailer bill language and encourages the Administration to provide any detail it can before the full Senate Budget and Fiscal Review Committee hearing.

Questions.

1. DSS: Please discuss the May Revision proposal, and all individual components of it.

2. DSS: Please discuss any anticipated impacts on programs that typically use the growth funds from the realignment subaccounts used in this proposal.

3. DSS: Please discuss stakeholder involvement in the process of developing this proposal, as well as any reactions you have heard from stakeholders.

4. LAO: Please provide any comments, concerns, or recommendations you may have regarding this proposal.

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

SUBCOMMITTEE NO. 3 Agenda

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

May 17, 2017
10 a.m., or Upon Call of the Chair
Room 4203, State Capitol

PART B

Consultant: Theresa Pena

OUTCOMES

ISSUES RECOMMENDED FOR VOTE ONLY

Item	Department	Action
4700	**Department of Community Services and Development**	
Issue 1	BCP: LIWP Reappropriation (Governor's Budget)	Approve (3-0)
Issue 2	LIWP Procurement	Approve (2-1)
Issue 3	Program Number Change (Issue 403-MR)	Approve (3-0)
5175	**Department of Child Support Services**	
Issue 1	May Revision Estimate (Issue 402-MR)	Approve (3-0)
0530	**Health and Human Services Agency/Office of Systems Integration**	
5180	**Department of Social Services**	
Issue 1	BCP: Child Welfare Digital Services Adjustment (Governor's Budget)	Approve (3-0)
Issue 2	BCP: CMIPS II – Implementation of Paid Sick Leave for IHSS Providers (Governor's Budget)	Approve (3-0)
Issue 3	BCP: CMIPS II – Vendor Contract Transitional Activities (Governor's Budget)	Approve (3-0)
5180	**Department of Social Services – CalWORKs**	
Issue 1	TANF Block Grant Funds Transfer to California Student Aid Commission (Issue 405-MR)	Approve (3-0)
Issue 2	Homeless Assistance Program (Issue 406-MR)	Approve (2-1)

Issue 3	Reappropriation of Funding for the Housing Support Program (Issue 413-MR)	Approve (3-0)
Issue 4	TBL: Expand Use of Local Family Support Account (Governor's Budget)	Approve (3-0)
5180	**Department of Social Services – CalFresh**	
Issue 1	CalFood Program (Issue 418-MR)	Approve (3-0)
5180	**Department of Social Services – Child Welfare Services**	
Issue 1	Reappropriation of Funding for Various Child Welfare Services Items (Issue 414-MR)	Approve (3-0)
Issue 2	TBL: Approved Relative Caregiver (ARC) Program (Governor's Budget)	Approve (3-0)
5180	**Department of Social Services – IHSS**	
Issue 1	IHSS Travel Time and Medical Accompaniment Wait Time Decrease (Issue 409-MR)	Approve (3-0)
5180	**Department of Social Services – Community Care Licensing**	
Issue 1	BCP: Continuance of CCL Staffing Resources (Governor's Budget)	Approve (3-0)
Issue 2	TBL: Delay Licensing Requirements for Private Alternative Boarding Schools and Outdoor Programs (Governor's Budget)	Reject (2-1)
Issue 3	TBL: Continue Fingerprinting Licensing Fee Exemption (Governor's Budget)	Approve (3-0)
Issue 4	SFL: Home Care Services Program	Approve (2-1)
Issue 5	KIT Report Findings	Approve (3-0)
Misc.	**Miscellaneous Departments – Proposals for Investment**	
Issue 1	Child Care for Foster Children	Approve (3-0)
Issue 2	Funding for Medical Review of Psychotropic Medication Authorizations for Foster Youth	Approve (3-0)
Issue 3	Additional Foster Care Public Health Nurses	Approve (2-1)
Issue 4	Enact pilot to aid CalFresh families impacted by unsafe drinking water	Approve (2-1)
Issue 5	Protect ABAWDS from expiring waiver	Approve (2-1)
Issue 6	Additional funding for CalFood	Approve (3-0)
Issue 7	Senior Nutrition Program	Approve (3-0)

ISSUES FOR DISCUSSION

5180	**Department of Social Services – Miscellaneous**	
Issue 1	May Revision Caseload Adjustments (Issues 401-MR, 402-MR, 403-MR and 404-MR)	Approve (2-1)
5180	**Department of Social Services – Immigration Branch**	
Issue 1	Immigration Services (Issue 410-MR)	Hold open
Issue 2	Proposals for Investment: One California	Hold open
Issue 3	Proposals for Investment: Special Immigrant Juvenile Status (SIJS)	Hold open

5180	**Department of Social Services – State Hearings Division**	
Issue 1	Budget Bill Language: Appeals Case Management System (Issue 415-MR)	Approve (3-0)
5180	**Department of Social Services – Child Welfare Services**	
Issue 1	Continuum of Care Reform: Social Worker Hourly Rate (Issue 411-MR)	Approve (3-0)
Issue 2	Infant Supplement and Dual Agency Rate Parity (Issue 412-MR)	Approve (3-0)
5180	**Department of Social Services – CalWORKs**	
Issue 1	CalWORKs Single Allocation	Hold open
Issue 2	State Fingerprinting Imaging System (SFIS)	Hold open
5180	**Department of Social Services – IHSS**	
Issue 1	Elimination of Coordinated Care Initiative (Issue 407-MR)	Hold open

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, May 18, 2017
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Scott Ogus

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.

VOTE ONLY

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Medi-Cal Eligibility Data Systems (MEDS) Modernization

DOF Issue#: 0530-011-BCP-2017-GB
4260-019-BCP-2017-GB

Budget Issue. The Office of Systems Integration (OSI) and Department of Health Care Services (DHCS) request $6.6 million ($727,000 General Fund and $5.9 million federal funds) to extend support of 16.0 positions and other resources approved in the 2016 Budget Act for two additional years. If approved, these resources would continue the agency-wide planning effort to replace the Medi-Cal Eligibility Data System (MEDS). These staffing and other resources would support completion of activities required by the Department of Technology's Project Approval Lifecycle (PAL) Stage Gate requirements.

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

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

This issue was heard during the subcommittee's March 9th hearing.

Subcommittee Staff Comment and Recommendation—Approve. MEDS serves as the "system of record" to determine eligibility for many of the state's health and human services programs, including Medi-Cal, CalWORKs, CalFresh, and In-Home Supportive Services. Because MEDS suffers from functional limitations due to its programming language (COBOL) and age, a multi-year, multi-agency process has been underway to modernize MEDS to address system issues, meet current and future operational needs, and fulfill requirements of state and federal guidance. Approval of these requests, funded by General Fund and federal funds managed by OSI, will allow OSI and DHCS to effectively upgrade this vital eligibility system for the state's health and human services programs.

0977 CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY

Issue 1: Extension of Expenditure Authority for Investment in Mental Health Wellness Grants

DOF Issue#: None – Legislative Proposal

Extension of Expenditure Authority for Investment in Mental Health Wellness Grants. The California Behavioral Health Directors Association (CBHDA) requests extension of expenditure authority for grants provided under the Investment in Mental Wellness Act of 2013. The 2013 Budget Act included $144.8 million General Fund to increase capacity for mobile crisis support, crisis intervention, crisis stabilization services, crisis residential treatment, and specified personnel resources. The funds were made available for encumbrance or expenditure until June 30, 2016. CBHDA requests budget bill language to instead make these grant funds available for encumbrance or expenditure until December 31, 2021.

This issue was heard during the subcommittee's May 11th hearing.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Budget Bill Language to extend expenditure authority for Investment in Mental Health Wellness Grants until December 31, 2021. The community-based mental health crisis capacity building projects funded by these grants are in various stages of completion. By extending the budgetary expenditure authority for these projects, grantees may apply to CHFFA to extend the terms of existing grants if the circumstances warrant, and complete the capacity building projects under development.

Issue 2: Healthcare Expansion Loan Program Funding for Small or Rural Health Centers

DOF Issue#: None – Legislative Proposal

Healthcare Expansion Loan Program (HELP II) Funding for Clinic Operations. The Treasurer requests budget authority of $20 million from the fund balance supporting the HELP II program for a grant program for operations costs of non-profit small or rural health centers in critical service areas, or at risk of losing federal funding. Because HELP II funding is required to be allocated to the expansion of facilities, trailer bill language is required to allow allocation of the HELP II fund balance for operations.

This issue was heard during the subcommittee's May 11th hearing.

Subcommitee Staff Comment and Recommendation—It is recommended the subcommittee take the following actions:

1. **Approve** budget authority of $20 million from the California Health Facilities Financing Authority Fund for a grant program for operations costs of non-profit small or rural health centers in critical service areas, or at risk of losing federal funding.

2. **Adopt Placeholder Trailer Bill Language** to authorize funds from the California Health Facilities Financing Authority Fund to be used for this purpose.

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: Reversion of Health Care Workforce Funding

DOF Issue#: 4140-100-BCP-2017-GB

Budget Issue. The Administration requests reversion of $33.3 million General Fund in 2016-17. These funds are the first year of a three-year, $100 million General Fund allocation approved in the 2016 Budget Act for augmentation of health care workforce initiatives at OSHPD. If the reversion is approved, the Administration would reallocate this funding to other budgetary expenditures and the previously approved health care workforce initiative augmentations would be permanently eliminated.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	($33,334,000)	$-
Total Funding Request:	**($33,334,000)**	**$-**

This issue was heard during the subcommittee's April 27th hearing.

Subcommittee Staff Comment and Recommendation—It is recommended the subcommittee take the following actions:

1. **Approve** the Administration's proposed reversion of $33.3 million in 2016-17.

2. **Adopt Placeholder Budget Bill Language and General Fund Expenditure Authority** to augment OSHPD's primary care workforce programs by $6 million annually for the next three fiscal years, as follows:
   a. **$5.7 million** to fund primary care residency slots for existing teaching health centers under the Song-Brown Program.
   b. **$333,000** for the State Loan Repayment Program.

4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 1: Prohibition of Surprise Balance Billing (AB 72)

DOF Issue#: 4150-004-BCP-2017-GB

Budget Issue. The Department of Managed Health Care (DMHC) requests 16 positions, limited-term resources (equivalent to 3.75 staff) and expenditure authority from the Managed Care Fund of $3.6 million in 2017-18, $3.2 million in 2018-19, $3 million in 2019-20, and $2.3 million annually thereafter. If approved, these resources would allow DMHC to regulate the elimination of "surprise balance billing" pursuant to the requirements of AB 72 (Bonta), Chapter 492, Statutes of 2016.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0933 – Managed Care Fund	$-	$3,588,000
Total Funding Request:	**$-**	**$3,588,000**
Total Positions Requested:	**16.0**	

This issue was heard during the subcommittee's March 23rd hearing.

Subcommittee Staff Comment and Recommendation— It is recommended the subcommittee take the following actions:

1. **Approve Budget Request.** AB 72 imposes several requirements on DMHC including developing procedures related to the independent dispute resolution process (IDRP) and development of average contracted rates. In addition, DMHC expects increased provider complaints and utilization of the new IDRP, which will require staff resources. Approval of this request, funded by special fund revenue from health plan regulatory fees, will allow DMHC to implement AB 72 requirements.

2. **Adopt Placeholder Supplemental Reporting Language** for DMHC to provide information regarding the extent of alignment between contracted providers and contracted facilities in managed care plan networks.

Issue 2: Medi-Cal Interagency Agreement Reduction

DOF Issue#: 4150-004-BCP-2017-GB
TBL# 615 (DMHC Components)

Budget Issue and Trailer Bill Language Proposal. DMHC is requesting a reduction of 18.5 positions and a reduction in expenditure authority of $5.3 million ($3.4 million Managed Care Fund and $1.9 million reimbursements) in 2017-18 and $4.3 million ($2.9 million Managed Care Fund and $1.4 million reimbursements) annually thereafter. If approved, these reductions and the related trailer bill language proposal would reflect the termination of existing interagency agreements between DMHC and the Department of Health Care Services (DHCS).

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0933 – Managed Care Fund	$-	($3,398,000)
0995 – Reimbursements	$-	($1,870,000)
Total Funding Request:	**$-**	**($5,268,000)**
Total Positions Requested:	**(18.5)**	

This issue was heard during the subcommittee's March 23rd hearing.

Subcommittee Staff Comment and Recommendation—Approve. According to DHCS and DMHC, the increased monitoring of Medi-Cal managed care plans required by the new rulemaking is more stringent than the surveys, reviews and other regulatory oversight provided by DMHC under the interagency agreements. DHCS reports this workload will be completed by staff in its Managed Care Operations, Managed Care Quality and Management, Capitated Rates, Dental Services, and Audits and Investigations Divisions. Approval of this request and the accompanying trailer bill language, which reduces special fund expenditures funded by health plan regulatory fees and federal reimbursements, will eliminate duplication of regulatory activities between the two departments. (Note: The proposed trailer bill language recommended for approval is part of the draft language proposing continuation of the Coordinated Care Initiative, which will be considered separately in the subcommittee's agenda.)

Issue 3: Consumer Participation Program Extension

DOF Issue#: None – Legislative Proposal

Consumer Participation Program. SB 1092 (Sher), Chapter 792, Statutes of 2002, created the Consumer Participation Program (CPP) and authorized the director of DMHC to "award reasonable advocacy and witness fees to any person or organization that demonstrates that the person or organization represents the interests of consumers and has made a substantial contribution on behalf of consumers to the adoption of any regulation or to an order or decision made by the director if the order or decision has the potential to impact a significant number of enrollees." The CPP has provided funding to organizations to represent consumer interests in a variety of DMHC proceedings. The statute allows DMHC to award a total of $350,000 each fiscal year. In 2016-17, Consumers Union, the Western Center on Law and Poverty, and Health Access California received awards for a combined total of approximately $50,000. The statutory authority for the CPP is scheduled to sunset on January 1, 2018. The program's sunset date has been extended twice in trailer bill language, in 2007 and 2011.

This issue was heard during the subcommittee's March 23rd hearing.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language to eliminate the sunset date for the Consumer Participation Program. This program, funded by special fund revenue from health plan regulatory fees, helps managed care consumers have a voice in regulatory decisions impacting their health care coverage and has been extended by the Legislature twice. Continuation of this program carries no fiscal impact, as DMHC has not reduced its budget to account for the scheduled sunset of the program.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: County Administration Budgeting Methodology Staffing Extension

DOF Issue#: 4260-016-BCP-2017-GB

Budget Issue. DHCS requests expenditure authority of $1.5 million ($731,000 General Fund and $730,000 federal funds) in 2017-18 and 2018-19, and $244,000 ($122,000 General Fund and $122,000 federal funds) in 2019-20. If approved, these resources would allow the department to continue development of a new budgeting methodology for county administrative costs that reflects the impact of the Affordable Care Act, pursuant to the requirements of SB 28 (Hernandez), Chapter 442, Statutes of 2013.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	$731,000
0890 – Federal Trust Fund	$-	$730,000
Total Funding Request:	**$-**	**$1,461,000**
Total Positions Requested:	**0.0**	

This issue was heard during the subcommittee's March 23rd hearing.

Subcommittee Staff Comment and Recommendation—Approve. SB 28 requires development of a new budgeting methodology for county administrative costs for the Medi-Cal program. Given the significant increase in county workload since implementation of the Affordable Care Act, this methodology will assist the state and counties to provide an appropriate level of funding for this work. Approval of this proposal, funded by General Fund and federal funds, will allow DHCS to continue development of the required methodology.

Issue 2: New Qualified Immigrant Affordability and Benefit Program Elimination

DOF Issue#: TBL# 604

May Revision Issue and Trailer Bill Language. The May Revision eliminates implementation of the transition of New Qualified Immigrants (NQIs) into the New Qualified Immigrant Affordability and Benefit Program. According to the Administration, due to operational and programmatic uncertainties, the Medi-Cal program will stop efforts to implement the program. The Administration intends to seek federal designation of the existing, state-funded NQI health care coverage program as minimum essential coverage (MEC). The Governor's January budget included savings of $120.8 million ($48 million General Fund and $72.8 million federal funds) for this purpose. The May Revision removes these savings consistent with the updated elimination proposal.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	$48,035,000
0890 – Federal Trust Fund	$-	$72,775,000
Total Funding Request:	**$-**	**$120,810,000**

This issue, as reflected in the Governor's January budget, was heard during the subcommittee's March 23rd hearing.

Subcommittee Staff Comment and Recommendation—It is recommended the subcommittee take the following actions:

1. **Approve** the Administration's May Revision proposal to eliminate the NQI Affordability and Benefit Program.

2. **Adopt Placeholder Trailer Bill Language** to: 1) amend the authorizing statute for the NQI Affordability and Benefit Program, consistent with the Administration's proposed elimination of the program; and 2) provide statutory authority for DHCS to seek MEC designation for the existing, state-funded NQI health care coverage program.

Issue 3: Elimination of Major Risk Medical Insurance Fund Proposal

DOF Issue#: 4260-403-ECP-2017-MR
4260-410-BBA-2017-MR
TBL# 614

May Revision Issue and Trailer Bill Language Proposal. DHCS proposes budget actions and trailer bill language to abolish the Major Risk Medical Insurance Fund, transfer its fund balance to a new Health Care Services Plans Fines and Penalties Fund, redirect existing health plan administrative fines and penalties transfers to the new fund, and allow the fund to support expenditures in the Major Risk Medical Insurance Program and to offset General Fund spending in the Medi-Cal program. The May Revision reduces administrative expenditures from the new fund by $834,000 as follows:

- Item 4260-001-3311 decreased by $818,000
- Item 4260-017-3311 decreased by $16,000 and the item eliminated

The May Revision also reduces the General Fund local assistance spending in Medi-Cal offset by the new fund as follows:

- Item 4260-101-0001 increased by $19,067,000
- Item 4260-101-3311 decreased by $19,067,000

According to the Administration, these adjustments reflect updated expenditure levels for the Major Risk Medical Insurance Program, which DHCS proposes to support with resources from the new fund.

This issue, as reflected in the Governor's January budget, was heard during the subcommittee's March 23rd hearing.

Subcommittee Staff Comment and Recommendation—Approve and Adopt Modified Placeholder Trailer Bill Language that amends the Administration's proposed language to clarify that resources in the proposed new Health Care Services Plans Fines and Penalties Fund fully support necessary administrative and health care expenditures in the Major Risk Medical Insurance Program prior to offsetting General Fund expenditures in the Medi-Cal program.

Issue 4: Delayed Implementation of Previously Chaptered Legislation

DOF Issue#: TBL# 617
TBL# 618
TBL# 619

Trailer Bill Language Proposals. DHCS proposes trailer bill language to delay required implementation of three programs pursuant to previously chaptered legislation:

Delay Billing for Marriage and Family Therapists in Federally Qualified Health Centers - DHCS proposes trailer bill language to delay implementation of AB 1863 (Wood), Chapter 610, Statutes of 2016, which allows FQHCs to bill Medi-Cal for services provided by marriage and family therapists (MFTs) as a separate visit beginning July 1, 2017. If the department's trailer bill language proposal is approved, AB 1863 implementation would be delayed until July 1, 2018.

This issue was heard during the subcommittee's April 27th hearing.

Assisted Outpatient Treatment Evaluation Report (Laura's Law) Delay - DHCS proposes trailer bill language to allow for a one year delay of its annual reporting requirements under the Assisted Outpatient Treatment (AOT) Program, also known as Laura's Law. The proposal would delay the report due July 1, 2017, until July 1, 2018.

This issue was heard during the subcommittee's March 30th hearing.

Out-of-County Foster Care Presumptive Transfer Regulations Delay - DHCS proposes trailer bill language to extend its deadline, pursuant to AB 1299 (Ridley-Thomas), Chapter 603, Statutes of 2016, to adopt out-of-county foster care presumptive transfer regulations from July 1, 2019, to July 1, 2020.

This issue was heard during the subcommittee's March 30th hearing.

Subcommittee Staff Comment and Recommendation—Reject. It is recommended to reject all three trailer bill proposals to delay these statutory requirements. Legislators and staff spend substantial time and resources analyzing and considering the fiscal impacts of proposed legislation. In addition, the Administration provides the Governor with detailed programmatic and fiscal analyses of all proposals approved by the Legislature for his consideration. On the basis of approved legislation, various stakeholders and California residents may change business practices or funding arrangements in anticipation of implementation. The Administration's request to discuss whether these important policy changes are a worthwhile use of state resources was more appropriate during the legislative process prior to their approval. Furthermore, the Administration's rationale that these legislative requirements must be delayed due to other, more important priorities is not compelling.

Issue 5: Specialty Mental Health Services – Performance Outcomes System

DOF Issue#: 4260-407-ECP-2017-MR

May Revision Issue. The May Revision includes $14.9 million ($6.2 million General Fund and $8.8 million federal funds) in 2017-18 for costs to reimburse mental health plans for the costs of capturing and reporting functional assessment data as part of the Performance Outcomes System (POS) for EPSDT mental health services. These figures represent a reduction of $10.2 million ($5.1 million General Fund and $5.1 million federal funds) in 2016-17 and an increase of $1.3 million (a decrease of $629,000 General Fund and an increase of $1.9 million federal funds) compared to the Governor's January budget to reflect updated costs and implementation of the functional assessment tool beginning in 2017-18.

According to DHCS, the Pediatric Symptom Checklist (PSC 35) and the Child and Adolescents Needs and Strengths (CANS) have been selected as the functional assessment tools best suited to measure child and youth functional outcomes. DHCS estimates 3,925 clinical staff will need to be trained on these tools in the first year and 794 annually thereafter.

Program Funding Request Summary – May Revision Update		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	$6,190,000
0890 – Federal Trust Fund	$-	$8,762,000
Total Funding Request:	**$-**	**$14,952,000**

This issue, as reflected in the Governor's January budget, was heard during the subcommittee's March 30th hearing.

Subcommittee Staff Comment and Recommendation—Approve. DHCS is required to develop a Performance Outcomes System for EPSDT mental health services to improve outcomes at the individual and system levels and to inform fiscal decision-making related to the purchase of services. Approval of this request, funded with General Fund and federal funds, will allow collection of functional assessment data and development of the IT resources to implement the system.

Issue 6: Medi-Cal 2020 Waiver Contract Resources

DOF Issue#: 4260-010-BCP-2017-GB

Budget Issue. DHCS requests expenditure authority of $2 million ($980,000 federal funds and $980,000 reimbursements) in 2017-18 through 2020-21 and $460,000 ($230,000 federal funds and $230,000 reimbursements) in 2021-22. If approved, these resources would fund contracts to facilitate learning collaboratives, provide technical assistance, and conduct an independent evaluation for components of the state's Section 1115 Medicaid Waiver, known as Medi-Cal 2020.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0890 – Federal Trust Fund	$-	$980,000
0995 – Reimbursements	$-	$980,000
Total Funding Request:	**$-**	**$1,960,000**
Total Positions Requested:	**0.0**	

This issue was heard during the subcommittee's April 27th hearing.

Subcommittee Staff Comment and Recommendation—Approve. According to the Special Terms and Conditions of the state's Medi-Cal 2020 Waiver, DHCS must facilitate learning collaboratives for entities participating in the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) and Whole Person Care (WPC) pilot programs. DHCS must also conduct an independent evalution of the Dental Transformaton Initiative. Approval of this request, funded with federal funds and reimbursements from participating local entities, will allow DHCS to facilitate the required learning collaboratives and conduct the required independent evaluation pursuant to its agreement with the federal government.

Issue 7: Coordinated Care Initiative – Continuation of Cal MediConnect and MLTSS

DOF Issue#: 4260-010-ECP-2017-GB
4260-405-ECP-2017-MR
TBL# 615

May Revision Issue and Trailer Bill Language Proposal. The May Revision continues the Department of Finance certification that the Coordinated Care Initiative does not result in General Fund savings and the program will be eliminated effective January 1, 2018, pursuant to SB 94 (Committee on Budget and Fiscal Review), Chapter 37, Statutes of 2013. However, the Administration proposed trailer bill language to continue the duals demonstration project, continue the mandatory enrollment of individuals in managed care for long-term services and supports (MLTSS), except In-Home Supportive Services (IHSS), but eliminate the maintenance-of-effort (MOE) and Statewide Authority for IHSS. The budget included $626.2 million of General Fund savings in 2017-18 in the Department of Social Services' (DSS) budget from the elimination of the MOE. However, the May Revision includes General Fund and other support to mitigate county impacts of the MOE elimination. The May Revision includes $8 million of General Fund savings in the DHCS budget from continuation of the demonstration, a reduction of approximately $12 million from the estimate in the Governor's January budget.

In addition to the continuation of the Coordinated Care Initiative programs, the proposed trailer bill language repeals four interagency agreements with the Department of Managed Health Care (DMHC) the department reports are unnecessary due to its new oversight and monitoring responsibilities pursuant to new federal regulations governing Medi-Cal managed care plans.

This issue, as reflected in the Governor's January budget, was heard during the subcommittee's April 27th hearing.

Subcommittee Staff Comment and Recommendation—Approve and Adopt Placeholder Trailer Bill Language approving the Administration's proposed extension of the duals demonstration project

and continuation of mandatory enrollment of individuals in managed care for MLTSS. The May Revision proposal to mitigate county impacts of the elimination of the MOE was heard during the subcommittee's May 17th hearing.

Issue 8: Federal Medi-Cal Managed Care Regulations

DOF Issue#: 4260-018-BCP-2017-GB

Budget Issue. DHCS requests 15 positions and expenditure authority of $8.9 million ($4.5 million General Fund and $4.5 million federal funds) in 2017-18 through 2020-21 and $2.6 million ($1.3 million General Fund and $1.3 million federal funds) in 2021-22. If approved, these positions and resources would support compliance with new federal rules governing Medi-Cal managed care plans, dental managed care plans, county mental health plans, and Drug Medi-Cal organized delivery system waiver providers.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	$4,460,000
0890 – Federal Trust Fund	$-	$4,460,000
Total Funding Request:	**$-**	**$8,920,000**
Total Positions Requested:	**15.0**	

This issue was heard during the subcommittee's April 27th hearing.

Subcommittee Staff Comment and Recommendation—Approve. The new federal Medicaid regulations impose significant new requirements on oversight, monitoring, data collection, and consumer assistance activities of Medi-Cal managed care plans. Approval of this request, funded by General Fund and federal funds, will allow DHCS to comply with these new federal requirements.

Issue 9: Medi-Cal Managed Care Ombudsman Staffing

DOF Issue#: 4260-013-BCP-2017-GB

Budget Issue. DHCS requests 15 positions (nine converted from limited-term and six new, permanent positions) and expenditure authority of $1.8 million ($895,000 General Fund and $894,000 federal funds). If approved, these resources would allow the department to continue managing increased call volume and consumer assistance activities in the Office of Ombudsman.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	$895,000
0890 – Federal Trust Fund	$-	$894,000
Total Funding Request:	**$-**	**$1,789,000**
Total Positions Requested:	**15.0**	

This issue was heard during the subcommittee's April 27th hearing.

Subcommittee Staff Comment and Recommendation—It is recommended to approve the following actions regarding this proposal:

1. **Approve Budget Request.** The increased call and complaint volume at the Office of Ombudsman has persisted beyond the implementation of new coverage transitions, suggesting the office's workload will require continuation of its limited-term resources. Approval of this request, funded by General Fund and federal funds, will allow DHCS to manage this increased call and complaint workload.

2. **Adopt Placeholder Trailer Bill Language** to require reporting on calls received by the Ombudsman, including:
   a. Number and type of contacts received.
   b. Wait time for callers or average speed to answer.
   c. Number of calls abandoned.
   d. Result of contacts, including destination of referred calls and time to resolution of complaint or grievance.

   The collected data shall include demographic, coverage and complaint-related information, in coordination with the Office of Patient Advocate. The data shall be posted on the department's website and reported and included with other stakeholder reports at least quarterly and at least once a year shall include recommedations for training protocols for staff, including cultural and linguistic competency; an assessment of trends; and protocols for call or complaint referrals.

Issue 10: Third Party Liability Recovery – Fifty Percent Rule

DOF Issue#: TBL# 610

Budget Issue and Trailer Bill Language Proposal. DHCS proposes trailer bill language to change the statutory amount it may recover from personal injury awards for services provided to Medi-Cal beneficiaries as a result of the injury. If approved, the budget includes $12.2 million General Fund savings to account for the increased recoveries the department expects to receive.

Fifty Percent Rule Proposal Savings Estimate		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	($12,160,000)
Total Funding Request:	**$-**	**($12,160,000)**

This issue was heard during the subcommittee's April 27th hearing.

Subcommittee Staff Comment and Recommendation—Approve the Administration's Medi-Cal Savings Estimate and Adopt Modified Trailer Bill Language with the Administration's proposals regarding Medi-Cal's share of litigation costs and ability to recover in the case of multiple settlements, but deleting the proposed change to the fifty percent rule. Stakeholders have attempted to arrive at a

compromise with the Adminstration that protects Medi-Cal plaintiffs and the Medi-Cal program, but have been unable to reach agreement. The subcommittee recommends DHCS continue discussions with the Legislature and stakeholders regarding the underlying third party liability and federal repayment issues and pursue a solution through the normal legislative policy process.

Issue 11: Nursing Facility/Acute Hospital Waiver Implementation

DOF Issue#: TBL# 607

Waiver Renewal and Trailer Bill Language Proposal. DHCS proposes to renew its Nursing Facility/Acute Hospital (NF/AH) Transition and Diversion Waiver agreement with the federal government. The department proposes to codify the provisions of its proposed waiver renewal in trailer bill language. If approved, the proposed trailer bill language would allow the department to renew the waiver with specified changes. The May Revision includes $8.9 million ($4.5 million General Fund and $4.5 million federal funds) for costs related to implementation of the proposed waiver renewal.

This issue was heard during the subcommittee's April 27th hearing.

Subcommittee Staff Comment and Recommendation—Approve. The NF/AH Waiver renewal has been submitted to the federal government for approval, after an extensive stakeholder process incorporating several proposed improvements to the program. According to DHCS, the NF/AH Waiver is an alternative to costly institutional care and affords frail and vulnerable Medi-Cal members the opportunity to remain in a home- or community-based setting or to transition out of an institution into a home- or community-based setting. Approval of this trailer bill proposal will authorize DHCS to implement the proposed NF/AH Waiver renewal.

Issue 12: SF Community Living Services Benefit Transition to Assisted Living Waiver

DOF Issue#: TBL# 609

Budget Issue and Trailer Bill Language Proposal. DHCS proposes trailer bill language to transition individuals receiving home and community-based services in the San Francisco Community Living Support Benefit (SF CLSB) Waiver into the Assisted Living Waiver (ALW). The budget includes savings of $746,340 ($373,170 General Fund and $373,170 federal funds), which is the net of additional costs for providing services to new ALW beneficiaries offset by savings from transitioning individuals from skilled nursing facilities into a community placement under the ALW.

SF Community Living Services Benefit Transition Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	($373,170)
0890 – Federal Trust Fund	$-	($373,170)
Total Funding Request:	**$-**	**($746,340)**

This issue was heard during the subcommittee's April 27th hearing.

Subcommittee Staff Comment and Recommendation—Approve. San Francisco has decided not to renew the SF CLSB Waiver. Expansion of the ALW to the city and county of San Francisco is an effective way to continue services for the 22 affected individuals, as well as provide additional resources for transitioning individuals from skilled nursing into a home- or community-based setting. Approval of this trailer bill language proposal will authorize DHCS to close the SF CLSB and expand the ALW to San Francisco.

Issue 13: Robert F. Kennedy Farm Workers Health Plan Stop-Loss Payments

DOF Issue#: None – Legislative Proposal

Robert F. Kennedy Farm Workers Health Plan Stop-Loss Payments. The Robert F. Kennedy Farm Workers Health Plan requests trailer bill language to extend until January 1, 2026, the funding requirements contained in SB 145 (Pan), Chapter 712, Statutes of 2015. SB 145 requires DHCS to annually reimburse the plan up to $3,000,000 per year until January 1, 2021 for claim payments that exceed $70,000 made by the plan on behalf of an eligible employee or dependent for a single episode of care on or after September 1, 2016. If approved, this request would extend these reimbursements for five years. According to representatives of the Robert F. Kennedy Farm Workers Health Plan, this extension will allow the plan to build sufficient reserves to no longer require stop-loss funding from the state.

Subcommitee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language to extend the reimbursements authorized by SB 145 an additional five years to January 1, 2026. This extension will allow the Robert F. Kennedy Farm Workers Health Plan to build sufficient reserves so that it will no longer be dependent on state funding.

Issue 14: Medically Tailored Meals Pilot Program

DOF Issue#: None – Legislative Proposal

Medically Tailored Meals Program. The Food is Medicine Coalition requests $2 million General Fund for three years to make a cost-effective, medically tailored, home delivered meal intervention available to approximately 2,500 Medi-Cal beneficiaries with certain complex and traditionally high-cost health conditions and determine how such an intervention could lead to better outcomes and lower health care costs for recipients and the state Medi-Cal program.

This issue was heard during the subcommittee's April 27th hearing.

Subcommitee Staff Comment and Recommendation—Augment the DHCS budget and Adopt Placeholder Trailer Bill Language to allocate $2 million General Fund annually for three years to implement a medically tailored meals pilot program to serve Medi-Cal beneficiaries with complex and high-cost health conditions and direct DHCS to seek any available federal funding for this purpose.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: L&C: Los Angeles County Contract

DOF Issue#: 4265-008-BCP-2017-GB

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

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

This issue was heard during the subcommittee's March 9th hearing.

Subcommittee Staff Comment and Recommendation—Approve. The state's licensing and certification contract with Los Angeles County did not account for general salary increases later approved by the county's Board of Supervisors. Approval of these resources, funded by special fund revenue from health facility licensing fees, will allow DPH to account for these additional costs and allow Los Angeles County to continue its licensing and certification activities pursuant to the contract.

Issue 2: Long-Term Care Ombudsman Funding

DOF Issue#: None – Legislative Proposal

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

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

Subcommitee Staff Comment and Recommendation—Augment Funding for the Long-Term Care Ombudsman Program with $1 million in ongoing funds from the State Health Facilities Citation Account. There is substantial evidence that the monitoring, assistance, and other services provided by this program improves the health, safety and quality of life for residents of long-term care facilities.

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

DOF Issue#: 4265-016-BCP-2017-GB
4265-404-BCP-2017-MR

Budget Issue and May Revision Adjustment. DPH requests 57 positions and expenditure authority of $226.1 million annually from the State Dental Program Account, Tobacco Law Enforcement Account, and Tobacco Prevention and Control Programs Account of the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) Fund. These resources would also offset $3.4 million of General Fund expenditures in the department's Oral Health Program. If approved, these resources would fund oral health, tobacco law enforcement, and tobacco prevention programs as required by voter approval of Proposition 56. The amount of these resources reflects revisions requested by DPH to the distribution of funding between state operations and local assistance, as well as updates to the allocation of revenue to the department from Proposition 56 revenues.

Program Funding Request Summary (2017-18)		
Fund Source	**January Budget**[1]	**May Revision**[1]
0001 – General Fund	($774,000) – SO ($2,880,000) – LA	($550,000) – SO ($2,880,000) – LA
TOTAL Fund 0001 – General Fund	**($3,654,000)**	**($3,430,000)**
3307 – State Dental Program Account (Prop. 56 Fund)	$1,875,000 – SO $35,625,000 - LA	$15,000,000 – SO $22,500,000 – LA
TOTAL Fund 3307 – State Dental Program Account	**$37,500,000**	**$37,500,000**
3308 – Tobacco Law Enforcement Account (Prop. 56 Fund)	$2,875,000 – SO $4,625,000 – LA	$5,800,000 – SO $1,700,000 – LA
TOTAL Fund 3308 – Tobacco Law Enf. Account	**$7,500,000**	**$7,500,000**
3309 – Tobacco Prevention and Control Programs Account (Prop. 56 Fund)	$8,923,000 – SO $169,532,000 - LA	$84,082,000 – SO $97,041,000 - LA
TOTAL Fund 3309 – Tobacco Prev/Cont Pgm Account	**$178,455,000**	**$181,123,000**
Total Funding Request:	**$219,801,000**	**$222,693,000**
Total Positions Requested:	**57.0**	
[1] ***SO = State Operations; LA = Local Assistance***		

This issue, as reflected in the Governor's January budget, was heard during the subcommittee's March 9th hearing.

Subcommittee Staff Comment and Recommendation—Approve. Proposition 56 authorizes specific allocations of tobacco tax revenue to DPH for the Oral Health Program, for tobacco retailer enforcement, and tobacco prevention activities. Approval of this proposal will allow DPH to implement these requirements of the initiative.

Issue 4: Center for Health Care Quality Estimate – May Revision

May Revision Update. The May Revision estimate for the Center for Health Care Quality includes $266.5 million ($3.7 million General Fund, $95.9 million federal funds, and $166.9 million special funds and reimbursements) in 2016-17, an increase of $3.3 million ($507,000 federal funds and $2.7 million special funds and reimbursements) compared to the Governor's January budget, and $263.9 million ($3.7 million General Fund, $97.6 million federal funds, and $162.7 million special funds and reimbursements) in 2017-18, an increase of $1.2 million ($274,000 federal funds and $943,000 special funds and reimbursements) compared to the Governor's January budget.

Center for Health Care Quality Funding 2016-17 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0001 – General Fund (transfer to fund 3098)	$3,700,000	$3,700,000
0890 – Federal Trust Fund	$95,386,000	$95,893,000
0942 – Internal Departmental Quality Improvement Acct	$2,304,000	$2,304,000
0942 – State Health Facilities Citation Penalty Acct	$2,144,000	$2,144,000
0942 – Federal Health Facilities Citation Penalty Acct	$973,000	$973,000
0995 – Reimbursements	$16,444,000	$16,572,000
3098 – Licensing and Certification Program Fund	$142,287,000	$144,943,000
Total CHCQ Funding – All Funds	**$263,238,000**	**$266,529,000**

Center for Health Care Quality Funding 2017-18 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0001 – General Fund (transfer to fund 3098)	$3,700,000	$3,700,000
0890 – Federal Trust Fund	$97,296,000	$97,570,000
0942 – Internal Departmental Quality Improvement Acct	$2,389,000	$2,389,000
0942 – State Health Facilities Citation Penalty Acct	$2,144,000	$2,144,000
0942 – Federal Health Facilities Citation Penalty Acct	$973,000	$973,000
0995 – Reimbursements	$9,672,000	$9,706,000
3098 – Licensing and Certification Program Fund	$146,536,000	$147,445,000
Total CHCQ Funding – All Funds	**$262,710,000**	**$263,927,000**

The Licensing and Certification Division of CHCQ was heard during the subcommittee's March 9th hearing.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve the CHCQ estimate. The subcommittee will continue to monitor the center's oversight of health facilities, particularly the management of complaints of abuse and neglect, and may revisit the issue in future hearings, if necessary.

Issue 5: Genetic Disease Screening Program – May Revision Update

DOF Issue#: 4265-009-ECP-2017-GB
4265-402-ECP-2017-MR

May Revision Issue The May 2017 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of $130.3 million ($26.8 million state operations and $103.5 million local assistance) in 2016-17, and $131.6 million ($26.9 million state operations and $104.7 million local assistance) in 2017-18. These figures represent a decrease of $2.1 million (an increase of $256,000 state operations and a decrease of $2.3 million local assistance) in 2016-17 and $5 million (an increase of $87,000 state operations and a decrease of $5.1 million local assistance) in 2017-18, compared to the Governor's January budget. According to DPH, these reductions are primarily due to reduced demographic projections of live births by the Department of Finance's Demographic Research Unit.

Genetic Disease Screening Program Funding 2016-17 May Revision Comparison to January			
	2016-17	**2016-17**	**Jan-May**
Fund Source	***January Budget***	***May Revision***	***Change***
0203 – Genetic Disease Testing Fund			
State Operations:	$26,540,000	$26,796,000	$256,000
Local Assistance:	$105,771,000	$103,463,000	($2,308,000)
Total GDSP Expenditures	**$132,311,000**	**$130,259,000**	**($2,052,000)**

Genetic Disease Screening Program Funding 2017-18 May Revision Comparison to January			
	2017-18	**2017-18**	**Jan-May**
Fund Source	***January Budget***	***May Revision***	***Change***
0203 – Genetic Disease Testing Fund			
State Operations:	$26,767,000	$26,854,000	$87,000
Local Assistance:	$109,857,000	$104,732,000	($5,125,000)
Total GDSP Expenditures	**$136,624,000**	**$131,586,000**	**($5,038,000)**

Newborn Screening Program (NBS) Caseload Estimate: The May Revision estimates NBS program caseload of 483,363 in 2016-17, a decrease of 11,449 or 2.3 percent, compared to the Governor's January budget. The May Revision estimates NBS program caseload of 486,207 in 2017-18, a decrease of 11,766 or 2.4 percent, compared to the Governor's January budget, and an increase of 2,844 or 0.6 percent compared to the revised 2016-17 estimate. These updated estimates are based on state projections of an increase in the number of live births. DPH assumes up to 99 percent of births will participate in the NBS program annually.

Prenatal Screening (PNS) Caseload Estimate: The May Revisoin estimates PNS program caseload of 351,711 in 2016-17, a decrease of 8,577 or 2.4 percent, compared to the Governor's January budget. The May Revision estimates PNS program caseload of 348,437 in 2017-18, a decrease of 14,116 or 3.9 percent, compared to the Governor's January budget, and a decrease of 3,274 or 0.9 percent, compared to the revised 2016-17 estimate. These updated estimates are based on state projections of an increase in the number of live births. DPH assumes 71.9 percent of births will participate in the PNS program annually.

May Revision Finance Letter Adjustments. Consistent with the local assistance expenditure updates to GDSP at May Revision, DPH requests the following adjustment:

- 4265-111-0203 be decreased by $5,125,000

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve the May Revision updates to the GDSP estimate.

Issue 6: Women, Infants, and Children (WIC) Program – May Revision Update

DOF Issue#: 4265-007-ECP-2017-GB
4265-403-ECP-2017-MR

May Revision Issue. The May 2017 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of $1.2 billion ($1 billion federal funds and $221.7 million WIC manufacturer rebate funds) in 2016-17, a reduction of $93.7 million ($92.1 million federal funds and $1.7 million WIC manufacturer rebate funds) compared to the Governor's January budget. The May 2017 WIC Program Estimate includes $1.2 billion ($1 billion federal funds and $236.7 million WIC manufacturer rebate funds) in 2017-18, a reduction of $98.6 million (a decrease of $118.9 million federal funds and an increase of $20.3 million WIC manufacturer rebate funds) compared to the Governor's January budget, and an increase of $12.1 million (a decrease of $2.9 million federal funds and an increase of $15 million WIC manufacturer rebate funds) compared to the revised 2016-17 estimate. The federal fund amounts include state operations costs of $62.1 million in 2016-17 and $63.5 million in 2017-18.

WIC Funding Summary 2016-17 May Revisoin Comparison to January Budget			
	2016-17	**2016-17**	**Jan-May**
Fund Source	***January Budget***	***May Revision***	***Change***
0890 – Federal Trust Fund			
State Operations:	$61,429,000	$62,082,000	$653,000
Local Assistance:	$1,035,439,000	$942,725,000	($92,714,000)
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$223,377,000	$221,725,000	($1,652,000)
Total WIC Expenditures	**$1,320,245,000**	**$1,226,532,000**	**($93,713,000)**

WIC Funding Summary 2017-18 May Revisoin Comparison to January Budget			
	2017-18	**2017-18**	**Jan-May**
Fund Source	***January Budget***	***May Revision***	***Change***
0890 – Federal Trust Fund			
State Operations:	$63,209,000	$63,463,000	$254,000
Local Assistance:	$1,057,618,000	$938,424,000	($119,194,000)
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$216,412,000	$236,711,000	$20,299,000
Total WIC Expenditures	**$1,337,239,000**	**$1,238,598,000**	**($98,641,000)**

The May Revision assumes 1,139,305 WIC participants in 2016-17, a decrease of 31,692 or 2.7 percent compared to the Governor's January budget. The May Revision assumes 1,130,793 WIC participants in 2017-18, a decrease of 33,250 or 2.9 percent compared to the Governor's January budget, and a decrease of 8,512 or 0.7 compared to the revised 2016-17 caseload estimate.

Food Expenditures Estimate. The May Revision includes $863.6 million 2016-17 for WIC program food expenditures, a decrease of $94.4 million or 9.9 percent, compared to the Governor's January budget. The May Revision includes $874.3 million in 2017-18 for WIC program food expenditures, a decrease of $98.9 million or 10.2 percent compared to the Governor's January budget, and an increase of $10.7 million or 1.2 percent compared to the revised 2016-17 food expenditures estimate. According to DPH, the decreases in both years are due to lower than projected participation levels and a significantly lower inflation rate.

Nutrition Services and Administration (NSA) Estimate. The May Revision includes $300.9 million for other local assistance expenditures for the NSA budget in 2016-17 and 2017-18, which is unchanged from the level assumed in the Governor's January budget.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve the May Revision updates to the WIC Program estimate.

4260 DEPARTMENT OF HEALTH CARE SERVICES
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Mental Health Services Act Fiscal Reversion

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

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

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

3. *Innovation:* Up to 5 percent of MHSA funds received for CSS and PEI may be used for innovative programs that develop, test and implement promising practices that have not yet demonstrated their effectiveness.

MHSA also required counties to spend a portion of their revenues on two additional components to build the infrastructure to support mental health programs. Since 2008-09, counties have the option of using a portion of their CSS funding in these areas or to build up a prudent reserve:

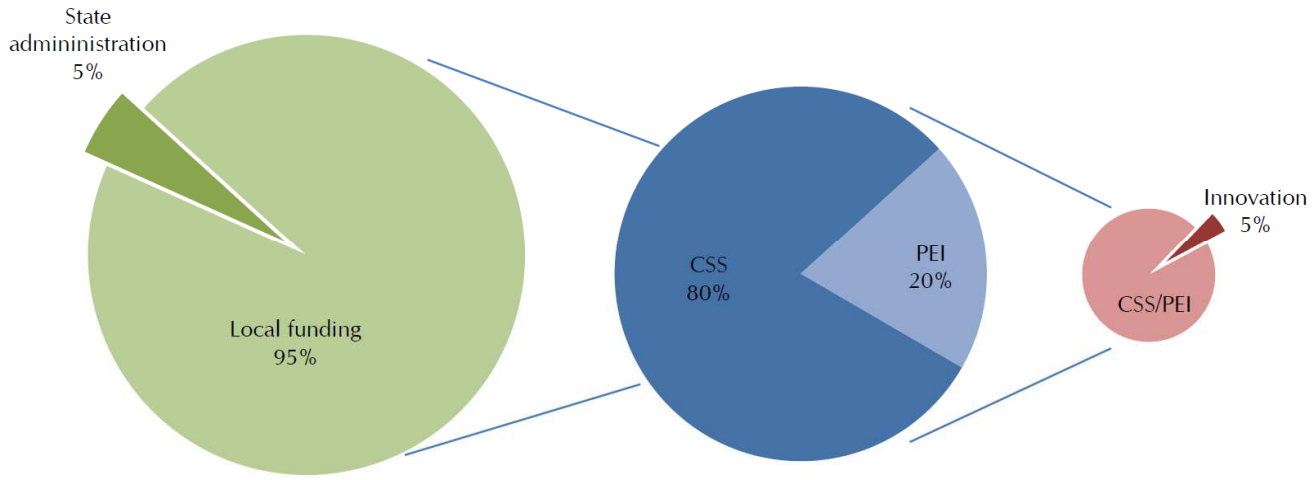
4. *Workforce Education and Training:* This component aims to train more people to remedy the shortage of qualified individuals who provide services to address severe mental illness. Counties may use funds to promote employment of mental health clients and their family members in the mental health system and increase the cultural competency of staff and workforce development programs.

5. *Capital Facilities and Technological Needs:* This component finances necessary capital and infrastructure to support implementation of other MHSA programs. It includes funding to improve or replace technology systems and other capital projects.

MHSA funds are allocated to counties through a formula that weighs each county's need for mental health services, the size of its population most likely to apply for services, and the prevalence of mental illness in the county. Adjustments are made for the cost of living and other available funding resources. The formula also provides a minimum allocation to rural counties for the CSS and PEI components.

State Administration Funds. MHSA authorizes the use of up to five percent of annual revenues for state administration and specifies that these funds are to be used by state agencies to "implement all duties pursuant to the [MHSA] programs." This includes ensuring adequate research and evaluation regarding the effectiveness and outcomes of MHSA services and programs.

Apportionment of Mental Health Services Act Funds.



Source: Little Hoover Commission Report #225: *Promises to Keep: A Decade of the Mental Health Services Act* (Jan. 2015)

Reversion Requirements for Unspent County Funds. MHSA requires the reversion of unspent county funds to the state. According to Welfare and Institutions Code section 5892 (h), "any funds allocated to a county which have not been spent for their authorized purpose within three years shall revert to the state to be deposited into the fund and available for other counties in future years". However, DHCS has not reverted unspent county funds since 2008.

Concerns About Reversion Policies. Mental health advocates have expressed concerns that counties are retaining MHSA funds that could be reverted and reallocated to the provision of additional mental health services. However, counties have reported various challenges with accurate reporting of funds subject to reversion, including limitations on reporting forms from DHCS, inadequate identification of funds owed, and unclear policies for reversion.

This issue was heard during the subcommittee's March 30th hearing.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language enacting the following provisions to the extent they are not considered an amendment to the Mental Health Services Act:

1. Hold counties harmless for reversion prior to 2017-18
2. Extend reversion period from three to five years for small counties
3. Require DHCS, with stakeholder input, to develop procedures and guidance for counties to provide clarity regarding the amounts of MHSA funds subject to reversion.
4. Allow Counties to Revise Annual Revenue and Expenditure Reports
5. Establish an MHSA Reversion Fund

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Contract Administration

DOF Issue#: 4560-003-BCP-2017-GB

Budget Issue. MHSOAC requests one position and expenditure authority from the Mental Health Services Fund of $157,000 annually. If approved, these resources would support MHSOAC's ability to implement new and expanded contracting obligations authorized by the 2016 Budget Act.

Program Funding Request Summary (Budgeting Methodology BCP)		
Fund Source	**2016-17**	**2017-18**
3085 – Mental Health Services Fund	$-	$157,000
Total Funding Request:	**$-**	**$157,000**
Total Positions Requested:	**1.0**	

This issue was heard in the subcommittee's March 30th hearing.

Subcommittee Staff Comment and Recommendation—Approve. MHSOAC has new and existing contract responsibilities related to stakeholder advocacy and implementation of children's crisis services authorized in the 2016 Budget Act. Approval of this request, funded by Mental Health Services Act income tax revenue, will allow MHSOAC to support administration of these contracts.

Issue 2: Prevention and Early Intervention Plan Reviews

DOF Issue#: 4560-002-BCP-2017-GB

Budget Issue. MHSOAC requests two positions and expenditure authority from the Mental Health Services Fund of $309,000 annually. If approved, these resources would allow MHSOAC to implement regulations for Prevention and Early Intervention (PEI) and Innovation programs pursuant to AB 82 (Committee on Budget), Chapter 23, Statutes of 2013.

Program Funding Request Summary (Budgeting Methodology BCP)		
Fund Source	**2016-17**	**2017-18**
3085 – Mental Health Services Fund	$-	$309,000
Total Funding Request:	**$-**	**$309,000**
Total Positions Requested:	**2.0**	

This issue was heard in the subcommittee's March 30th hearing.

Subcommittee Staff Comment and Recommendation—Approve. AB 82 imposed new requirements on MHSOAC including the provision of technical assistance to county mental health programs for prevention and early intervention programs. Approval of this request, funded by Mental Health Services Act income tax revenue, will allow MHSOAC to provide the necessary technical assistance.

5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: Overtime Exemptions Proposal

DOF Issue#: None – Legislative Proposal

Budget Issue. The IHSS Coalition requests $16.5 million General Fund for 1) DSS to expand IHSS exemption criteria; 2) That consumers and providers receive notification about the criteria and process to request and exemption; and 3) That DSS establish an appeals process.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language for a total of approximately $1.65 million that 1) codifies existing exemptions for live-in family care providers and extraordinary circumstances; 2) adds that an exemption be granted for providers on an individual basis when there is failure to grant an exemption if the recipient is at serious risk of institutionalization; 3) provides notices and hearing for IHSS consumers where a denial of a provider exemption would result in a loss of services; and 4) adds a one-time notice mailing and exemption request form to all providers who may be eligible for exemptions; and 5) adds an annual reassessment evaluation for potential eligibility for exemptions . This subcommittee heard and discussed this issue during its March 2, 2017 hearing.

Issue 2: Statewide Fingerprinting Imaging System

Subcommittee Staff Comment and Recommendation—The Subcommittee heard and discussed various issues related to CalWORKs in both its April 20, 2017 and May 17, 2017 hearings, including:

- The State Fingerprinting Imaging System (SFIS), which is up for contract renewal this year, is inefficient as multiple audits have demonstrated, and there are other, extensive identity verification and duplicate aid avoidance measures that now protect applicant information and program integrity in CalWORKs. If SFIS were eliminated, it would save approximately $8 million in the first year and $12 million thereafter.
- The Online CalWORKs Appraisal Tool (OCAT) system, which is used to assess the needs of CalWORKs clients in order to more effectively aid them and help them to overcome barriers, is still a standalone system that requires county staff to do duplicate data entry and the lack of integration within SAWS impedes outcome tracking. OCAT needs to be integrated into the larger SAWS system in order for OCAT data to be utilized effectively. The Administration did not include funding for these purposes.
- Various advocates have requested that Department of Social Services be required to work on the establishment of a new outcomes and accountability review system to foster continuous quality improvement in the program, as the only official measure of success currently is the federal Work Participation Rate, which is a narrow measure that has significant limitations.

Staff recommends eliminating the use of SFIS, for a total savings of $8 million, and redirecting a portion of these monies towards goals that aim to strengthen the CalWORKs program as laid out below:

- $3.7 million to fund the integration of OCAT into SAWS (proposal heard in subcommittee April 20, 2017)
- Placeholder trailer bill to establish a new outcomes and accountability system, including a process for developing this system that relies on client and stakeholder participation.

ISSUES FOR DISCUSSION

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: May Revision – Technical Adjustment for Administration (Issues 403-MR and 404-MR)

DOF Issue#: 4140-403-BBA-2017-MR
4140-404-BBA-2017-MR

May Revision Issue. OSHPD requests net-zero, technical adjustments to budget items, schedules and reimbursements to facilitiate the accounting and budgeting of administrative expenditures. These changes would remove distributed administrative expenditures, reimbursements and positions from existing schedules and instead reflect them in a newly created Program 3860-Administration.

The requested amounts and positions to be scheduled under the new program are as follows:

- $7,800,000 in Item 4140-001-0121
- $8,285,000, -$151,000 Reimbursements, and 96.4 positions in Item 4140-001-0143
- $57,000 in Item 4140-001-0181
- $31,000 in Item 4140-001-3064
- $16,000 in Item 4140-001-3068
- $298,000 in Item 4140-001-3085
- $126,000 in Item 4140-017-0143

Subcommittee Staff Comment and Recommendation—Approve. These are net-zero technical adjustments to the accounting and budgeting of administrative expenditures.

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

1. Please provide a brief overview of this proposal.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Medi-Cal Local Assistance Estimate – May Revision Update

DOF Issue#: 4260-001-ECP-2017-GB (November Estimate – Caseload Adjustments)
4260-003-ECP-2017-GB (November Estimate – Hospital Quality Assurance Fee)
4260-004-ECP-2017-GB (November Estimate – ACA Optional Expansion)
4260-007-ECP-2017-GB (November Estimate – SB 75 Full-Scope Expansion)
4260-008-ECP-2017-GB (November Estimate – Drug Medi-Cal ODS Waiver)
4260-009-ECP-2017-GB (November Estimate – Managed Care Enrollment Tax)
4260-012-ECP-2017-GB (November Estimate – Provisional Adjustment)
4260-013-ECP-2017-GB (November Estimate – Provisional Adjustment)
4260-014-ECP-2017-GB (November Estimate – Provisional Adjustment)
4260-401-ECP-2017-MR (May Revision Estimate Update – Caseload Adjustments)

May Revision Issue. The May 2017 Medi-Cal Local Assistance Estimate includes $89.2 billion ($18.9 billion General Fund, $57.7 billion federal funds, and $12.6 billion special funds and reimbursements) for expenditures in 2016-17, and $105.6 billion ($18.6 billion General Fund, $68.3 billion federal funds, and $18.8 billion special funds and reimbursements) for expenditures in 2017-18. These figures represent a decrease in estimated General Fund expenditures in the Medi-Cal program of $619.8 million in 2016-17 and $536.4 million in 2017-18 compared to the Governor's January budget

Caseload. In 2016-17, the May Revision assumes annual Medi-Cal caseload of 13.6 million, a decrease of 3.4 percent compared to assumptions in the Governor's January budget. In 2017-18, the budget assumes annual Medi-Cal caseload of 13.7 million, a decrease of 4.2 percent compared to assumptions in the Governor's January budget and a 1.8 percent increase compared to the revised caseload estimate for 2016-17. According to the Administration, the decrease in estimated caseload is primarily due to lower projected enrollment in the Optional Expansion of Medi-Cal than estimated in the Governor's January budget.

May Revision Local Assistance Adjustments. The Administration requests the following adjustments to reflect caseload and miscellaneous adjustments:

- Item 4260-101-0001 be decreased by $409,075,000 and reimbursements be increased by $2,349,760,000
- Item 4260-101-0232 be decreased by $675,000
- Item 4260-101-0233 be increased by $3,418,000
- Item 4260-101-0236 be decreased by $473,000
- Item 4260-101-0890 be decreased by $1,207,001,000
- Item 4260-101-3156 be added in the amount of $99,407,000
- Item 4260-101-3168 be increased by $852,000
- Item 4260-102-0001 be increased by $23,406,000
- Item 4260-102-0890 be increased by $23,406,000
- Item 4260-104-0001 be increased by $127,000
- Item 4260-105-0001 be increased by $18,250,000
- Item 4260-106-0890 be increased by $355,000

- Item 4260-113-0001 be decreased by $199,408,000
- Item 4260-113-0890 be decreased by $666,322,000
- Item 4260-117-0001 be increased by $25,000
- Item 4260-117-0890 be decreased by $172,000

Medi-Cal Local Assistance Funding Summary 2016-17 Comparison to January Budget			
Fiscal Year:	**2016-17**	**2016-17**	**Jan-May**
Benefits			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$18,580,262,000	$17,972,052,000	($608,210,000)
Federal Funds	$63,114,015,000	$54,229,749,000	($8,884,266,000)
Special Funds/Reimbursements	$13,681,542,000	$12,562,986,000	($1,118,556,000)
Total Expenditures	**$95,375,819,000**	**$84,764,787,000**	**($10,611,032,000)**
County Administration			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$859,237,000	$852,711,000	($6,526,000)
Federal Funds	$3,397,740,000	$3,207,957,000	($189,783,000)
Special Funds and Reimbursements	$11,956,000	$13,032,000	$1,076,000
Total Expenditures	**$4,268,933,000**	**$4,073,700,000**	**($195,233,000)**
Fiscal Intermediary			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$120,524,000	$115,477,000	($5,047,000)
Federal Funds	$296,767,000	$287,849,000	($8,918,000)
Special Funds and Reimbursements	$-	$-	$-
Total Expenditures	**$417,291,000**	**$403,326,000**	**($13,965,000)**
TOTAL MEDI-CAL EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$19,560,023,000	$18,940,240,000	($619,783,000)
Federal Funds	$66,808,522,000	$57,725,555,000	($9,082,967,000)
Special Funds and Reimbursements	$13,693,498,000	$12,576,018,000	($1,117,480,000)
Total Expenditures	**$100,062,043,000**	**$89,241,813,000**	**($10,820,230,000)**

Medi-Cal Local Assistance Funding Summary 2017-18 Comparison to January Budget			
Fiscal Year:	**2017-18**	**2017-18**	**Jan-May**
Benefits			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$18,118,289,000	$17,478,590,000	($639,699,000)
Federal Funds	$62,976,866,000	$64,392,933,000	$1,416,067,000
Special Funds/Reimbursements	$16,693,070,000	$18,757,921,000	$2,064,851,000
Total Expenditures	**$97,788,225,000**	**$100,629,444,000**	**$2,841,219,000**
County Administration			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$858,771,000	$960,561,000	$101,790,000
Federal Funds	$3,502,083,000	$3,601,595,000	$99,512,000
Special Funds and Reimbursements	$11,819,000	$12,191,000	$372,000
Total Expenditures	**$4,372,673,000**	**$4,574,347,000**	**$201,674,000**
Fiscal Intermediary			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$152,982,000	$154,539,000	$1,557,000
Federal Funds	$271,148,000	$268,691,000	($2,457,000)
Special Funds and Reimbursements	$-	$-	$-
Total Expenditures	**$424,130,000**	**$423,230,000**	**($900,000)**
TOTAL MEDI-CAL EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$19,130,042,000	$18,593,690,000	($536,352,000)
Federal Funds	$66,750,097,000	$68,263,219,000	$1,513,122,000
Special Funds and Reimbursements	$16,704,889,000	$18,770,112,000	$2,065,223,000
Total Expenditures	**$102,585,028,000**	**$105,627,021,000**	**$3,041,993,000**

Significant General Fund Changes. The May 2017 Medi-Cal Local Assistance Estimate includes the following significant General Fund changes:

Medi-Cal Unanticipated Costs: 2016-17 Deficiency — The May Revision estimates the Medi-Cal 2016-17 General Fund deficiency has decreased by $619.8 million compared to the Governor's January budget, from $1.8 billion to approximately $1.2 billion. According to the Administration, the reduction is primarily attributable to savings from drug rebates in Medi-Cal managed care, retroactive managed care rate adjustments, and slower caseload growth than previously estimated.

Erroneous Enrollment of Medicare Part A Beneficiaries in Optional Expansion. The May Revision includes a one-time repayment of $227.1 million General Fund to the federal government for enhanced federal matching funds for individuals erroneously enrolled in the Optional Expansion of Medi-Cal. These individuals were also enrolled in Medicare Part A, which is considered minimum essential coverage. Individuals with minimum essential coverage are ineligible for the Optional Expansion. The department reports it must repay the federal government for the difference between the 100 percent match paid for the Optional Expansion and the 50 percent match for which these individuals were otherwise eligible. In addition, the department will recoup from managed care plans the difference between the Optional Expansion managed care capitation rate and the Dual/Partial Eligible managed care capitation rate. This recoupment is expected to be $364.8 million total funds.

Coordinated Care Initiative (CCI) Duals Demonstration Pilot — The May Revision continues the Administration's estimate that CCI will no longer be cost-effective and discontinues many components of CCI in 2017-18. Based on lessons learned, the May Revision continues the Administration's proposed: (1) extension of the Cal MediConnect program, (2) mandatory enrollment of dual eligibles, and (3) long-term services and supports integration into managed care, except IHSS. The May Revision estimates General Fund savings of approximately $8 million based on the proposed continuation of the Cal MediConnect duals demonstration pilot, a decrease of approximately $12 million compared to the Governor's January budget. According to the Administration, the reduced savings is attributable to a decrease in the number of beneficiaries choosing to participate in the pilot.

Elimination of Newly Qualified Immigrants (NQI) Affordability and Benefit Program — The May Revision includes an increase of $48 million General Fund to reflect elimination of the NQI Benefits and Affordability Program. According to the Administration, due to operational and programmatic uncertainties, the Medi-Cal program will stop efforts to implement the program. The Administration intends to seek federal designation of the existing, state-funded NQI health care coverage program as minimum essential coverage.

Palliative Care — The May Revision includes net General Fund costs of $1.3 million in 2017-18 for the implementation of the Palliative Care Services program no later than January 1, 2018. This program will serve adult Medi-Cal beneficiaries and provide one-time grants to health care plans of up to $50,000 for provider network development, data analysis, and other palliative care program development costs. Conditions eligible for palliative care include cancer, congestive heart failure, chronic obstructive pulmonary disease, or liver disease for patients with no more than a one-year life expectancy.

Performance Outcomes System — The May Revision includes a total of $15 million ($6.2 million General Fund and $8.8 million federal funds) for the implementation of functional assessment tools for populations receiving specialty mental health services through county mental health plans. These figures represent an increase of $1.3 million ($629,000 General Fund and $628,000 federal funds) compared to the Governor's January budget. These assessment tools will gather data from both a clinician's and caregiver's perspective and will be used to track outcomes for Medi-Cal mental health services provided to children up to age 21. According to the Administration, the revised funding reflects training, staff, and information technology costs associated with implementation of the newly selected functional assessment tools.

Medi-Cal Local Assistance Issues Previously Heard in Subcommittee Hearings. The following previously heard local assistance issues, as reflected in the Governor's January budget, were also previously heard by the subcommittee:

March 23, 2017 Hearing

- *Issue 2: November 2016 Medi-Cal Estimate – Overview*
- *Issue 4: County Administration Estimate and Budget Proposals*
- *Issue 6: Undocumented Children Full-Scope Expansion (SB 75)*
- *Issue 8: Title XXI Federal Match Reduction*
- *Issue 9: Denti-Cal*

March 30, 2017 Hearing

- *Issue 5: Drug Medi-Cal Estimate – Overview*
- *Issue 6: Drug Medi-Cal – Organized Delivery System Waiver*

April 27, 2017 Hearing

- *Issue 1: Medi-Cal 2020 Waiver Implementation Update*
- *Issue 3: Affordable Care Act – Optional Expansion of Medi-Cal*

In addition, several other issues are discussed separately in the subcommittee's hearing agenda.

Subcommittee Staff Comment and Recommendation—It is recommended the subcommittee take the following actions:

1. **Reject** the proposed allocation of $1.3 billion Proposition 56 revenue in Medi-Cal Estimate Policy Changes 11, 55, 64, 70, 96, 97, 99, 102, 104, 135, 167, 168, 171, and 208.

2. **Approve** the balance of the technical adjustments to the Medi-Cal Local Assistance Estimate, with any changes necessary to conform to other actions that have been, or will be, taken.

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

1. Please provide a brief overview of the significant caseload and expenditure changes in the May 2017 Medi-Cal Estimate.

Issue 2: Family Health Estimate – May Revision Update

DOF Issue#: 4260-002-ECP-2017-GB
4260-402-ECP-2017-MR

May Revision Issue. The May 2017 Family Health Local Assistance Estimate includes $237.7 million ($161.2 million General Fund, $10.5 million federal funds, and $66 million special funds and reimbursements) for expenditures in 2016-17, and $262.2 million ($213.4 million General Fund, $4.5 million federal funds, and $44.3 million special funds and reimbursements) for expenditures in 2017-18. These figures represent a decrease in estimated General Fund expenditures in Family Health programs of $14 million in 2016-17 and $4.7 million in 2017-18 compared to the Governor's January budget.

These reductions are primarily attributed to blood factor drug rebates and reductions in utilization of high cost drugs, particularly the cystic fibrosis drug Orkambi, by beneficiaries in the state-only Genetically Handicapped Persons Program. These reductions are partially offset by increased costs for recently approved high cost drugs provided to beneficiaries in the state-only California Childrens' Services program.

Family Health Local Assistance Funding Summary 2016-17 Comparison to January Budget			
Fiscal Year:	**2016-17**	**2016-17**	**Jan-May**
California Children's Services (CCS)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$67,805,000	$68,375,000	$570,000
Federal Funds	$6,061,000	$6,025,000	($36,000)
Special Funds/Reimbursements	$4,723,000	$5,453,000	$730,000
County Funds [non-add]	[$78,685,000]	[$79,448,000]	[$763,000]
Total CCS Expenditures	**$78,589,000**	**$79,853,000**	**$1,264,000**
Child Health and Disability Prevention (CHDP)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$32,000	$33,000	$1,000
Total CHDP Expenditures	**$32,000**	**$33,000**	**$1,000**
Genetically Handicapped Persons Program (GHPP)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$106,186,000	$91,976,000	($14,210,000)
Special Funds and Reimbursements	$36,425,000	$36,427,000	$2,000
Total GHPP Expenditures	**$142,611,000**	**$128,403,000**	**($14,208,000)**
Every Woman Counts Program (EWC)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$1,190,000	$857,000	($333,000)
Federal Funds	$4,509,000	$4,509,000	$-
Special Funds and Reimbursements	$24,083,000	$24,083,000	$-
Total EWC Expenditures	**$29,782,000**	**$29,449,000**	**($333,000)**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$175,213,000	$161,241,000	($13,972,000)
Federal Funds	$10,570,000	$10,534,000	($36,000)
Special Funds and Reimbursements	$65,231,000	$65,963,000	$732,000
County Funds [non-add]	[$78,685,000]	[$79,448,000]	[$763,000]
Total Family Health Expenditures	**$251,014,000**	**$237,738,000**	**($13,276,000)**

Family Health Local Assistance Funding Summary 2017-18 Comparison to January Budget			
Fiscal Year:	**2017-18**	**2017-18**	**Jan-May**
California Children's Services (CCS)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$73,877,000	$80,170,000	$6,293,000
Federal Funds	$-	$-	$-
Special Funds/Reimbursements	$5,453,000	$5,453,000	$-
County Funds [non-add]	[$79,444,000]	[$81,527,000]	[$2,083,000]
Total CCS Expenditures	**$79,330,000**	**$85,623,000**	**$6,293,000**
Child Health and Disability Prevention (CHDP)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$1,000	$1,000	$-
Total CHDP Expenditures	**$1,000**	**$1,000**	**$-**
Genetically Handicapped Persons Program (GHPP)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$144,206,000	$133,138,000	($11,068,000)
Special Funds and Reimbursements	$16,425,000	$16,427,000	$2,000
Total GHPP Expenditures	**$160,631,000**	**$149,565,000**	**($11,066,000)**
Every Woman Counts Program (EWC)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$-	$87,000	$87,000
Federal Funds	$4,509,000	$4,509,000	$-
Special Funds and Reimbursements	$22,427,000	$22,427,000	$-
Total EWC Expenditures	**$26,936,000**	**$27,023,000**	**$87,000**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$218,084,000	$213,396,000	($4,688,000)
Federal Funds	$4,509,000	$4,509,000	$-
Special Funds and Reimbursements	$44,305,000	$44,307,000	$2,000
County Funds [non-add]	[$79,444,000]	[$81,623,000]	[$2,083,000]
Total Family Health Expenditures	**$266,898,000**	**$262,212,000**	**($4,686,000)**

The May Revision caseload estimates for Family Health programs are as follows:

- **California Children's Services (CCS) Caseload Estimate**
  Medi-Cal: The May Revision estimates Medi-Cal CCS caseload of 172,634 in 2016-17, a decrease of 1,544 or 0.9 percent, compared to the Governor's January budget. The May Revision estimates Medi-Cal CCS caseload of 176,087 in 2017-18, a decrease of 1,309 or 0.7 percent, compared to the Governor's January budget, and a decrease of 3,453 or 2.0 percent, compared to the revised 2016-17 estimate.
  State-Only: The May Revision estimates state-only CCS caseload of 15,925 in 2016-17, an increase of 3,122 or 24.4 percent, compared to the Governor's January budget. The May Revision estimates state-only CCS caseload of 16,069 in 2017-18, an increase of 3,512 or 28 percent, compared to the Governor's January budget, and an increase of 144 or 0.9 percent, compared to the revised 2016-17 estimate. According to DHCS, the significant increase in caseload compared to the Governor's January budget is attributable to higher actual enrollment than previously estimated.
- **Child Health and Disability Prevention (CHDP) Caseload Estimate**
  The May Revision estimates state-only CHDP caseload of 475 in 2016-17, a decrease of 34 or 6.7 percent, compared to the Governor's January budget. The May Revision estimates state-only CHDP caseload of zero in 2017-18, unchanged compared to the Governor's January budget, and a decrease of 475 or 100 percent, compared to the revised 2016-17 estimate. According to DHCS, these significant caseload reductions are primarily due to the 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) Caseload Estimate**
  The May Revision estimates state-only GHPP caseload of 942 in 2016-17, an increase of 11 or 1.2 percent, compared to the Governor's January budget. The May Revision estimates state-only GHPP caseload of 951 in 2017-18, an increase of 15 or 1.6 percent, compared to the Governor's January budget, and an increase of 9 or 1 percent, compared to the revised 2016-17 estimate.
- **Every Woman Counts (EWC) Program Caseload Estimate**
  The May Revision estimates EWC caseload of 161,000 in 2016-17, unchanged compared to the Governor's January budget. The May Revision estimates EWC caseload of 24,500 in 2017-18, a decrease of 500 or 0.2 percent, compared to the Governor's January budget, and a decrease of 136,500 or 84.8 percent, compared to the revised 2016-17 estimate. The significant decrease in 2017-18 caseload is due to the proposed transition from an accrual basis to budgeting on a cash basis.

May Revision Local Assistance Adjustments. The Administration requests the following adjustments to reflect caseload and miscellaneous adjustments:

- Item 4260-111-0001 be decreased by $4,773,000 and reimbursements be increased by $2,000
- Item 4260-114-0001 be added in the amount of $87,000

This issue, as reflected in the Governor's January budget, was heard during the subcommittee's April 27th hearing.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve these technical adjustments to the Family Health Local Assistance Estimate, with any changes necessary to conform to other actions that have been, or will be, taken.

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

1. Please provide a brief overview of the significant caseload and expenditure changes in the May 2017 Family Health Estimate.

Issue 3: California Medicaid Management Information System Legacy Operations

DOF Issue#: 4260-500-BCP-2017-MR

May Revision Issue. DHCS requests 21 positions (conversion from limited-term) and expenditure authority of $9.1 million ($2.1 million General Fund and $7 million federal funds) annually. If approved, these resources would allow DHCS to continue performing ongoing systems and business operations for the legacy California Medicaid Management Information System (CA-MMIS). These resources include $6 million for contracted services including: 1) agency oversight, 2) procurement and vendor management, 3) transition management, 4) technical and information integration, and 5) testing.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	$2,104,000
0890 – Federal Trust Fund	$-	$7,039,000
Total Funding Request:	**$-**	**$9,143,000**
Total Positions Requested:	**21.0**	

Background. DHCS contracts with a fiscal intermediary (FI), Xerox, to maintain and operate CA-MMIS, which is utilized by Medi-Cal to process approximately 200 million claims annually for payment of medical services provided to Medi-Cal members. Under the CA-MMIS contract, the FI adjudicates both Medi-Cal and non-Medi-Cal claims, and delivers other FI services to program providers, beneficiaries, and federal and state users of the system.

In October 2012, Xerox began design and development of a new CA-MMIS replacement system, "Health Enterprise" (HE). In October 2015, Xerox announced it would not complete the replacement system and entered into negotiations with DHCS on terms and conditions of a settlement to terminate its contractual obligation. In April 2016, DHCS and Xerox signed a settlement agreement to terminate design and development of the replacement system and compensate DHCS for costs incurred under the FI contract. Xerox will continue to operate and maintain the current CA-MMIS until September 30, 2019, or until the department has secured another contract for information technology (IT) maintenance and operations (M&O) services and support.

The 2016 Budget Act included one-year expenditure authority equivalent to 24 positions for DHCS to close out the replacement system activities, procure new FI contracts to conduct business operations of the legacy CA-MMIS system, and re-evaluate the procurement approach for design, development, and implementation of the CA-MMIS replacement system.

DHCS is requesting conversion of 21 of these positions to permanent and expenditure authority of $9.1 million ($2.1 million General Fund and $7 million federal funds) to continue ongoing IT M&O and business operations, take ownership of activities currently performed by the FI, transition the replacement system project from FI ownership to DHCS ownership, and plan for the development of procurements for design, development and implementation of new system modules.

Subcommittee Staff Comment and Recommendation—Approve. CA-MMIS is the primary claims payment system for providers of services to Medi-Cal fee-for-service beneficiaries. The system also provides other critical functionality essential to operation of the Medi-Cal program. Maintaining this system is still necessary while the department evaluates its options for implementing a replacement system to meet future needs. In addition, the department intends to utilize these positions and resources to administer and maintain the new system once it becomes operational. Approval of this request, funded by General Fund and federal funds, will allow the department to continue maintenance and operation of legacy CA-MMIS.

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

1. Please provide a brief overview of this proposal.

Issue 4: California Medicaid Management Information System Modernization

DOF Issue#: 4260-501-BCP-2017-MR
4260-411-BBA-2017-MR

May Revision Issue and Budget Bill Language Proposal. DHCS requests seven positions and expenditure authority of $5.8 million ($575,000 General Fund and $5.2 million federal funds) annually. If approved, these resources would allow DHCS to implement a modernization strategy for the California Medicaid Management Information System (CA-MMIS) and adopt a user-centered, iterative, modular approach to the design, development, and implementation of system modules to replace the existing legacy system. DHCS also requests budget bill language to allow for a General Fund augmentation of up to $2.5 million, upon approval by the Department of Finance and the Department of Technology, for implementation of the Advantage Collections Application, a third party liability collections information technology solution.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	$575,000
0890 – Federal Trust Fund	$-	$5,179,000
Total Funding Request:	**$-**	**$5,754,000**
Total Positions Requested:	**7.0**	

Background. DHCS contracts with a fiscal intermediary (FI), Xerox, to maintain and operate CA-MMIS, which is utilized by Medi-Cal to process approximately 200 million claims annually for payment of medical services provided to Medi-Cal members. Under the CA-MMIS contract, the FI adjudicates

both Medi-Cal and non-Medi-Cal claims delivers other FI services to program providers, beneficiaries, and federal and state users of the system.

In October 2012, Xerox began design and development of a new CA-MMIS replacement system, "Health Enterprise" (HE). In October 2015, Xerox announced it would not complete the replacement system and entered into negotiations with DHCS on terms and conditions of a settlement to terminate its contractual obligation. In April 2016, DHCS and Xerox signed a settlement agreement to terminate design and development of the replacement system and compensate DHCS for costs incurred under the FI contract. Xerox will continue to operate and maintain the current CA-MMIS until September 30, 2019, or until the department has secured another contract for information technology (IT) maintenance and operations (M&O) services and support.

DHCS intends to adopt a modular approach for the procurement, design, development, and implementation of a new system. The modular approach to system development is supported by federal guidance and regulations, which provide enhanced federal funding for system development and encourage states to adopt a modular approach by permitting certification of individual modules as opposed to entire systems.

DHCS requests seven positions and expenditure authority of $5.8 million to complete the modernization project, which will be conducted by digital service teams comprised of the requested positions, and utilizing user-centered, iterative, and agile processes.

Advantage Collections Application. DHCS also requests budget bill language to allow for a General Fund augmentation of up to $2.5 million, upon approval of the Department of Finance and the Department of Technology, for implementation of the Advantage Collections Application. The Advantage Collections Application, when completed, will perform debt collection management, accounts receivables, letter generation and reporting functionality to enable and support the Third Party Liability (TPL) business processes. Advantage Collections will replace the legacy Automated Collection Management system currently used to support the identification of fees and post-payment recovery of Medi-Cal and other TPL related debts. According to DHCS, this solution would result in increased collections that will offset General Fund expenditures in the Medi-Cal program.

Subcommittee Staff Comment and Recommendation—Approve. Termination of the Xerox system replacement project contract required DHCS to re-evaluate its approach to replacing legacy CA-MMIS. Adoption of a modular approach is consistent with federal guidance and results in an enhanced federal match for systems development. Approval of this request, funded by General Fund and federal funds, will allow DHCS to proceed with its system replacement planning.

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

1. Please provide a brief overview of this proposal.

Issue 5: SB 1004 Palliative Care Services

DOF Issue#: 4260-502-BCP-2017-MR

May Revision Issue. DHCS requests one position (conversion of limited-term to permanent) and expenditure authority of $124,000 ($62,000 General Fund and $62,000 federal funds) annually. If approved, these resources would allow DHCS to implement and provide ongoing oversight of the palliative care services program authorized by SB 1004 (Hernandez), Chapter 574, Statutes of 2014.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	$62,000
0890 – Federal Trust Fund	$-	$62,000
Total Funding Request:	**$-**	**$124,000**
Total Positions Requested:	**1.0**	

Background. SB 1004 requires DHCS, in consultation with interested stakeholders, to establish standards and provide technical assistance for Medi-Cal managed care plans to oversee delivery of palliative care services, including specified hospice services and other services determined appropriate by the department. SB 1004 also requires that: 1) DHCS establish standards for palliative care services delivered concurrently with curative services to Medi-Cal beneficiaries served by Medi-Cal managed care plans; 2) authorized providers include licensed hospice agencies and home health agencies; and 3) DHCS, to the extent practicable, oversee the delivery of palliative care services under these provisions is provided in a manner that is cost neutral to the General Fund on an ongoing basis.

The 2015 Budget Act approved a two-year, limited-term Health Program Specialist I (HPS I) to coordinate with stakeholders to develop standards and guidelines for the palliative care program and provide technical assistance to managed care plans to monitor the appropriate delivery of palliative care services. DHCS experienced delays in the development of the policy, and therefore, has not been able to deploy the policy in managed care. The anticipated finalization of the managed care policy is scheduled to occur no sooner than January 1, 2018. The HPS I serves as the subject matter expert on palliative care and the position expires June 30, 2017.

DHCS requests conversion of the HPS I from limited-term to permanent and expenditure authority of $124,000 ($62,000 General Fund and $62,000 federal funds). If approved, these resources would allow DHCS to implement the palliative care program, develop policies for the delivery of palliative care services, facilitate managed care contracting with providers, and provide technical assistance to managed care plans, providers and stakeholders.

Subcommittee Staff Comment and Recommendation—Approve. SB 1004 requires implementation of palliative care services as a managed care benefit. Approval of these resources will allow DHCS to implement this required benefit, expected to begin January 1, 2018. The subcommittee will continue to monitor the progress of implementation of this benefit and expects the department to utilize these resources to ensure this benefit is provided as scheduled to eligible Medi-Cal beneficiaries.

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

1. Please provide a brief overview of this proposal.

Issue 6: Enhanced Medi-Cal Budget Estimate Redesign (EMBER) System

DOF Issue#: 4260-503-BCP-2017-MR

May Revision Issue. DHCS requests one-time expenditure authority of $495,000 ($248,000 General Fund and $247,000 federal funds) in 2017-18. If approved, these resources would allow DHCS to procure a contract to upgrade the Enhanced Medi-Cal Budget Estimate Redesign (EMBER) system, which is utilized to produce the Medi-Cal Local Assistance Estimate.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	$248,000
0890 – Federal Trust Fund	$-	$247,000
Total Funding Request:	**$-**	**$495,000**
Total Positions Requested:	**0.0**	

Background. The Medi-Cal Local Assistance Estimate forecasts expenditures, caseload, and the impact of regulatory and policy changes in the Medi-Cal program. The Estimate forms the basis for the Medi-Cal budget and is subject to the analysis of the Department of Finance, the Legislative Analyst's Office (LAO), the Legislature, and other stakeholders. The Enhanced Medi-Cal Budget Estimate Redesign (EMBER) System is the state-owned, proprietary system used to incorporate all aspects of the Estimate. EMBER is a web-based, multi-tiered application that was developed in 2006.

The EMBER system produced its first Estimate in May 2006. Over the past 11 years, the Medi-Cal Local Assistance Estimate has grown from $33.3 billion to $105.6 billion, added an additional 130 policy changes and 836 regressions. During the same period, Medi-Cal has added over 5.6 million average monthly beneficiaries and the program continues to grow. According to DHCS, the trend towards increasing complexity in the Medi-Cal program will likely continue in the future, and the EMBER system needs to be flexible to adapt to changes in the Medi-Cal Local Assistance Estimate.

DHCS requests one-time expenditure authority of $495,000 ($248,000 General Fund and $247,000 federal funds) to secure a contractor to upgrade the EMBER system to a new software framework to enhance system stability and improve flexibility to allow for additional enhancements. According to DHCS, this upgrade will improve the accuracy and accessibility of the Medi-Cal Local Assistance Estimate. In addition, the department reports that continuing the EMBER in its current state will require more attention and potentially increase staff workload, as the system's risk of failure due to incompatibility with new software continues to grow.

Subcommittee Staff Comment and Recommendation—Approve. The Medi-Cal Local Assistance Estimate has increased significantly in complexity over recent years, particularly with implementation of major program changes such as the Optional Expansion of Medi-Cal. The EMBER system is reaching the limits of its functionality and an upgraded system will help the Estimate become more accurate and more accessible. Approval of this request, funded by General Fund and federal funds, will allow DHCS to upgrade the EMBER system to provide the necessary functionality for this purpose.

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

1. Please provide a brief overview of this proposal.

Issue 7: Federal Cures Act Opioid Targeted Response Grant

DOF Issue#: 4260-412-BBA-2017-MR
TBL# 647

May Revision Issue and Trailer Bill Language. DHCS requests expenditure authority from federal funds of $44.7 million to implement the federal Opioid State Targeted Response grant provided under the 21st Century Cures Act. This grant will allow for increased medication assisted treatment for individuals with substance use disorders. According to DHCS, these funds would be used to establish 15 "hub and spoke" systems, where a Narcotic Treatment Program would serve as a "hub" and the "spokes" are regional physicians approved to prescribe medication assisted treatment. Narcotic Treatment Programs would begin providing expanded substance use services by September 1, 2017 as required by the grant provisions. In addition, DHCS is proposing trailer bill language in order to expedite the ability to provide these funds to the receiving entities, pursuant to the timing of federal requirements for expenditure of grant funds. The trailer bill language would, for the purposes of this grant program, allow DHCS to enter into exclusive or nonexclusive contracts and be exempt from certain state contracting provisions.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0890 – Federal Trust Fund	$-	$44,700,000
Total Funding Request:	**$-**	**$44,700,000**

Subcommittee Staff Comment and Recommendation—Approve. DHCS intends to utilize these grant funds to address high-need areas, particularly rural areas in the north part of the state, with new programs for medication assisted treatment for substance use disorders. According to DHCS, the contract flexibility provided by the proposed trailer bill language is necessary to allow these programs to be operational by the time federal grant funds must be spent. Approval of this request for expenditure of federal grant funds and the accompanying trailer bill language will allow DHCS to expand availability of medication assisted treatment for substance use disorders.

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

1. Please provide a brief overview of this proposal.

Issue 8: California Childrens' Services Medical Therapy Program Medical Necessity

DOF Issue#: TBL# 642

Trailer Bill Language. DHCS requests trailer bill language to clarify that the California Children's Services (CCS) program is responsible for the delivery of occupational therapy (OT) and physical therapy (PT) services when medically necessary. Specifically, this proposal would amend the Government Code to clarify that medically necessary OT and PT services are not related services or designated instruction and services under the Individuals with Disabilities Education Act (IDEA), and that the CCS program is not responsible for providing services that are solely educationally necessary.

Recent court decisions deemed OT and PT services provided by CCS to be "related services" under IDEA and state law. DHCS has been ordered to continue the provision of all OT and PT services included in a child's written Individualized Education Program, even when the underlying medical prescription has expired, and a physician has determined that a lesser amount is medically necessary. These court rulings are expected to increase General Fund expenditures for the CCS Medical Therapy Program In addition, because these services are not medically necessary, they would not be eligible for federal financial participation.

Subcommittee Staff Comment and Recommendation—Reject. Given the challenging budget environment and the multitude of new programs, federal regulations, and other efforts, the Legislature must prioritize consideration of certain initiatives and delay others. The proposed trailer bill language is likely to impose significant changes for local school districts serving children in need of CCS services. There is insufficient time for proper legislative consideration of the impacts this proposal may have on local school districts and children who need educationally necessary or medically necessary services. The subcommittee recommends DHCS continue discussions with the Legislature and stakeholders regarding the role of CCS in providing services to children in educational settings and pursue a solution through the normal legislative policy process.

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

1. Please provide a brief overview of this proposal.

Issue 9: Contract Pharmacies in Medi-Cal 340B Program

DOF Issue#: TBL# 645

Trailer Bill Language. DHCS requests trailer bill language to correct problems regarding the use of contract pharmacies in the 340B Drug Billing program. According to DHCS, some 340B covered entities do not directly dispense medications, but instead contract with a different, non-340B pharmacy that receives a higher, non-340B price billed to the department or Medi-Cal managed care plan. The proposed trailer bill language prohibits the use of contract pharmacies in the 340B program in Medi-Cal, consistent with recent concerns raised by federal agencies. The proposal is intended to avoid inappropriate duplicate discounts by claiming federal drug rebates on already discounted drugs and prevent unnecessary overpayment in Medi-Cal.

Subcommittee Staff Comment and Recommendation—Reject. Given the challenging budget environment and the multitude of new programs, federal regulations, and other efforts, the Legislature must prioritize consideration of certain initiatives and delay others. The proposed trailer bill language is likely to impose a significant change in current operations for many 340B entities. There is insufficient time for proper legislative consideration of the impacts this proposal may have on essential Medi-Cal providers. The subcommittee recommends DHCS continue discussions with the Legislature and stakeholders regarding duplicate pharmacy rebates and pursue a solution through the normal legislative policy process.

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

1. Please provide a brief overview of this proposal.

Issue 10: Disproportionate Share Hospital Allocation Adjustments

DOF Issue#: TBL# 644

Trailer Bill Language. DHCS requests trailer bill language to make clarifying changes to disproportionate share hospital (DSH) allocations to make full use of federal funds. The existing distribution methodology for DSH assumed sufficient uncompensated costs to claim and distribute all available funding. However, recent federal guidance indicates costs incurred by a hospital-based federally qualified health center are not allowable for DSH. As a result, California may not have sufficient uncompensated costs to claim all available funds. The proposed trailer bill language would make changes to address this issue and other technical clarifications, as follows:

- Clarify the methodology to determine federal DSH allotment funding allocated to designated public hospitals (DPHs).
- Require a reduction factor to be calculated, to be used in DSH redistribution in the case that DPH costs are insufficient to draw down the DPH-allocated federal DSH allotment.
- Specify the calculation methodology for DSH fund redistribution in the case that DPH costs are insufficient to draw down the DPH-allocated federal DSH allotment.
- Specify the calculation methodology for DSH fund adjustments in the case that additional DSH funding is available after the finalization of the fiscal year.
- Authorize DHCS to determine adjustment pay timing in consultation with the affected DPHs.
- Authorize DHCS to consult with the DPH and Department of Finance to determine whether additional payment to the DPH would impact the applicable county's redirection obligation pursuant to AB 85 (Committee on Budget), Chapter 24, Statutes of 2013.

Subcommittee Staff Comment and Recommendation—Approve. These technical, clarifying changes will allow DPHs to maximize the availability of federal DSH funding.

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

1. Please provide a brief overview of this proposal.

Issue 11: Graduate Medical Education Program for Designated Public Hospitals

DOF Issue#: TBL# 643

Trailer Bill Language. DHCS requests trailer bill language to implement a graduate medical education (GME) program for Medi-Cal. 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 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 intends to submit a State Plan Amendment to allow these entities to provide the non-federal share of GME payments to draw down additional federal matching funds.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0890 – Federal Trust Fund	**$-**	$593,750,000
0995 – Reimbursements	$-	$593,750,000
Total Funding Request:	**$-**	**$1,187,500,000**

The proposed language would implement the following provisions:

- Provide additional Medi-Cal payments outside of payment obligations to Medi-Cal managed care plans or DPHs and their affiliated government entities in recognition of the Medi-Cal managed care share of GME costs.
- The direct component of GME payments would be made in recognition and support of direct costs incurred in the operation of GME programs, including salaries, benefits, physician oversight, and allocated overhead costs incurred for interns and residents in medicine, osteopathy, dentistry, podiatry, nursing, and allied health or paramedical programs.
- The indirect component of GME payments would be made in recognition and support of the increased operating and patient care costs associated with teaching programs.
- GME payments will be inflation adjusted as cost of services will fluctuate.
- DHCS would determine the maximum amount of GME payments in consultation with the DPHs.

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	

Subcommittee Staff Comment and Recommendation—Approve. If the federal government approves the department's proposed State Plan Amendment to begin providing GME payments to account for Medi-Cal managed care's share of GME costs, this new program and associated funding will help train and retain health care professionals in the state. Approval of this proposal, funded by federal funds and reimbursements from local government entities, and the accompanying trailer bill language, will allow DHCS to implement the GME payment program.

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

1. Please provide a brief overview of this proposal.

Issue 12: Covered Outpatient Drug Final Rule

DOF Issue#: TBL# 646

Trailer Bill Language. DHCS requests trailer bill language to codify a new drug ingredient reimbursement methodology and dispensing fee based on a study of pharmacy provider costs in the Medi-Cal program. Recent federal regulations impose new requirements on Medicaid programs for reimbursement of covered outpatient drugs, including a transition to an acquisition cost based reimbursement methodology and, when changing the reimbursement methodology for the ingredient cost of drugs, examination or revision of professional dispensing fees to ensure Medicaid pharmacy providers are adequately reimbursed to maintain beneficiary access to care.

Subcommittee Staff Comment and Recommendation—Approve. This proposal is consistent with federal requirements to base reimbursements and dispensing fees on actual costs and adequate access to outpatient drugs for Medi-Cal beneficiaries. In addition, transition to the new average acquisition cost methodology results in discontinuation of the ten percent reimbursement rate reductions imposed pursuant to AB 97 (Committee on Budget), Chapter 3, Statutes of 2011.

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

1. Please provide a brief overview of this proposal.

Issue 13: Erroneous Enrollment of Medicare Part A Beneficiaries in Optional Expansion

DOF Issue#: 4260-401-ECP-2017-MR (May Revision Estimate)

May Revision Issue. The May Revision includes a one-time repayment of $227.1 million General Fund to the federal government for enhanced federal matching funds for individuals erroneously enrolled in the Optional Expansion of Medi-Cal. These individuals were also enrolled in Medicare Part A, which is considered minimum essential coverage. Individuals with minimum essential coverage are ineligible for the Optional Expansion. The department must repay the federal government for the difference between the 100 percent match paid for the Optional Expansion and the 50 percent match for which these individuals were otherwise eligible. In addition, the department will recoup from managed care plans the difference between the Optional Expansion managed care capitation rate and the Dual/Partial Eligible managed care capitation rate. This recoupment is expected to be $364.8 million total funds.

Program Funding Request Summary		
Fund Source	**2016-17**	**2017-18**
0001 – General Fund	$-	$227,140,000
0890 – Federal Trust Fund	$-	($742,437,000)
Total Funding Request:	**$-**	**($515,297,000)**

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language to: 1) establish a workgroup to develop the managed care plan recoupment process, 2) require written notification of overpayment to be recouped and a method for recoupment, 3) prohibit plans from being

subject to penalties so long as plans pay back the amount owed by June 30, 2018, and 4) allow for a plan to appeal should a discrepancy arise.

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

1. Please provide a brief overview of this issue.

2. Please describe the process for recoupment from Medi-Cal managed care plans.

3. Does DHCS plan to coordinate with Medi-Cal managed care plans to help determine which beneficiaries were erroneously enrolled under Optional Expansion?

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: AIDS Drug Assistance Program (ADAP) – May Revision Update and TBL

DOF Issue#: 4265-008-ECP-2017-GB
4265-401-ECP-2017-MR
TBL# 628
TBL# 641

ADAP Local Assistance Estimate May Revision Update. The May 2017 ADAP Local Assistance Estimate reflects revised 2016-17 expenditures of $385.1 million, which is an increase of $2.6 million or 0.7 percent compared to the Governor's January budget. According to DPH, this increase is primarily due to growth in medication-only clients and continuing increases in medication prices. For 2017-18, DPH estimates ADAP expenditures of $395.7 million, an increase of $13.5 million or 3.5 percent, compared to the Governor's January Budget, and an increase of $10.6 million or 2.8 percent, compared to the revised 2016-17 estimate. According to DPH, this increase is primarily due to fewer clients than previously estimated transitioning from medication-only to private insurance with the proposed implementation of ADAP case management services.

ADAP Local Assistance Funding 2016-17 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0890 – Federal Trust Fund	$121,800,000	$184,600,000
3080 – AIDS Drug Assistance Program Rebate Fund	$240,700,000	$180,500,000
Total ADAP Local Assistance Funding – All Funds	**$362,500,000**	**$385,100,000**

ADAP Local Assistance Funding 2017-18 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0890 – Federal Trust Fund	$117,400,000	$111,400,000
3080 – AIDS Drug Assistance Program Rebate Fund	$264,800,000	$284,300,000
Total ADAP Local Assistance Funding – All Funds	**$382,200,000**	**$395,700,000**

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

Caseload by Client Group	**2016-17**	**2017-18**
Medication-Only	13,288	12,870
Medi-Cal Share of Cost	139	153
Private Insurance	7,769	10,068
Medicare Part D	8,462	8,462
Pre-Exposure Prophylaxis (PrEP) Assistance Program	0	450

Expenditures by Client Group	2016-17	2017-18
Medication-Only	$304,977,994	$308,864,703
Medi-Cal Share of Cost	$848,266	$974,171
Private Insurance	$32,142,670	$55,890,180
Medicare Part D	$19,251,895	$21,060,146
PrEP Assistance Program	$-	$310,406

Enrollment Benefits Manager (EBM) Contract Termination Update. In November 2016, the ADAP enrollment portal was unexpectedly unavailable for enrollment worker and client use due to security vulnerabilities in the new system provided by the EBM contractor, A.J. Boggs. 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 for processing.
- Client eligibility was extended until the next reenrollment or recertification period after June 30, 2017.
- Paper applications were shortened to streamline the faxed application process.
- DPH staff actively worked with enrollment sites, clients, and advocates to monitor problems and ensure continued access to medications and health insurance.
- DPH provided semi-weekly updates on the issue with enrollment workers and stakeholders
- ADAP ceased secondary, state-level review of new applications to expedite access to medications.
- DPH staff engaged consultants at Deloitte to provide an independent assessment of the security issues and future viability of the enrollment portal.

On March 1, 2017, DPH announced it was terminating its EBM vendor relationship with A.J. Boggs, citing material breach of contract as the portal does not allow for the secure exchange of data. A.J. Boggs ceased processing applications on Friday, March 3, 2017. DPH began conducting eligibility and enrollment services effective March 6, 2017, and began development of a replacement enrollment portal with minimum necessary functionality. According to DPH, ADAP program staff are working to provide all enrollment workers access to the new system, and over 57 percent of enrollment workers have begun enrolling and reauthorizing clients. DPH reports it is still evaluating options for the future of the ADAP enrollment portal, including identifying a new EBM vendor.

ADAP Data Sharing Trailer Bill Proposal. In the Governor's January budget, DPH proposed trailer bill language to allow information sharing between ADAP and other entities. This information sharing is intended to streamline the enrollment and case management activities that require partnership between ADAP and local entities. According to DPH, enhancing case management capabilities would result in

program savings due to increased enrollment of medication-only ADAP clients in comprehensive health care coverage.

PrEP Assistance Program Clarification Trailer Bill Language Proposal. In the May Revision, DPH proposes trailer bill language to clarify the PrEP Assistance Program will provide PrEP medication to uninsured clients. The 2016 trailer bill language authorizing the program provides that "*the director may expend funding from the AIDS Drug Assistance Program Rebate Fund for this HIV infection prevention program to cover the costs of prescribed ADAP formulary medications for the prevention of HIV infection and related medical copays, coinsurance, and deductibles.*" In the Governor's January budget, DPH interpreted the statutory reference to "*copays, coinsurance, and deductibles*" to require enrollment only of individuals with health care coverage. The department's proposed trailer bill language will clarify PrEP may be provided to uninsured clients and the ADAP Local Assistance Estimate makes conforming changes to caseload and expenditures for the program.

May Revision Finance Letter Adjustments. Consistent with the expenditure updates to ADAP at May Revision, DPH requests the following adjustments:

- 4265-111-0890 be decreased by $6,000,000
- ADAP Rebate Fund be increased by $19,467,000

Subcommittee Staff Comment and Recommendation—It is recommended to take the following actions:

1. **Modify May Revision ADAP Local Assistance Adjustments.** The assumed $15.5 million reduction of savings is based on halving the number of expected transitions of medication-only clients to private insurance due to a reduction of the Covered California open enrollment period from three months to six weeks, pursuant to the new federal market stabilization rule. However, a recent study suggests individuals likely to not enroll in Covered California due to a shortened open enrollment period are "healthy procrastinators", or those without significant health issues. Because ADAP clients have significant health issues, a one-to-one drop in enrollment in private insurance due to a shortened open enrollment period is unlikely. Therefore, it is recommended to increase the savings assumption by $4 million (federal funds and rebate funds) and approve the balance of the updated ADAP Local Assistance Estimate with any changes necessary to conform to other actions that have been, or will be, taken.

2. **Augment Allocation to ADAP Enrollment Workers.** Given the significant additional workload required of ADAP enrollment workers due to the failure of the enrollment portal, it is recommended to augment the programmatic allocation to enrollment workers in 2017-18 by $4 million (federal funds and rebate funds).

3. **Adopt Placeholder Trailer Bill Language**:
   - **ADAP Data Sharing Trailer Bill Language Proposal**—Adopt placeholder trailer bill language, consistent with the Governor's January budget proposal.
   - **PrEP Assistance Program Clarification Trailer Bill Language Proposal**—Adopt placeholder trailer bill language, consistent with the May Revision proposal.

In addition, the subcommittee will continue to monitor the department's management of the enrollment and eligibility determination issues caused by the termination of the EBM contract and revisit the department's planning for improvement of the enrollment process, if necessary, in the future.

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

1. Please provide a brief overview of the major changes to caseload and expenditure in the ADAP May Revision Estimate.

Issue 2: Technical Adjustments – Youth Tobacco, Emergency Preparedness, Proposition 99

DOF Issue#: 4265-411-BBA-2017-MR
4265-414-BBA-2017-MR
4265-416-BBA-2017-MR
4265-500-BBA-2017-MR

May Revision Issues. DPH requests the following technical adjustments:

- Youth Tobacco Program – DPH requests the following technical correction regarding an inadvertent General Fund reduction made in the Governor's January budget for the Youth Tobacco Program's Retail Inspection Contract:
  - Item 4265-001-0001 be increased by $1,078,000

- Office of Emergency Preparedness – DPH requests the following technical correction to correct an inadvertent retention of federal funds and positions that were limited-term and scheduled to expire July 1, 2017:
  - Item 4265-001-0890 be decreased by $9,441,000 and 76.8 positions

- Proposition 99 Adjustments – DPH requests the following technical corrections reflecting changes in Proposition 99 revenues and a shift between state operations and local assistance:
  - Item 4265-001-0231 be decreased by $1,924,000
  - Item 4265-111-0231 be increased by $1,903,000
  - Item 4265-001-0234 be increased by $2,000
  - Item 4265-001-0236 be increased by $28,000

Subcommittee Staff Comment and Recommendation—Approve. It is recommended to approve these technical adjustments.

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

1. Please provide a brief overview of these proposed technical changes.

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Mental Health Services Fund Reappropriation

DOF Issue#: None- Legislative Proposal

Budget Issue. MHSOAC requests reappropriation of Mental Health Services Act funds from items of appropriation in the Budget Acts of 2013, 2014, and 2015. These funds would allow MHSOAC to continue to support the following ongoing activities:

- IT consulting contracts
- A competitive bidding process for advocacy contracts
- Triage personnel grants
- Evaluation contracts

Subcommittee Staff Comment and Recommendation—Approve Placeholder Budget Bill and Provisional Language to reappropriate the requested funding, as requested by MHSOAC.

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, May 18, 2017
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Scott Ogus

OUTCOMES

ISSUES RECOMMENDED FOR VOTE-ONLY

Item	Department	Action
0530 California Health and Human Services Agency		
4260 Department of Health Care Services		
Issue 1: Medi-Cal Eligibility Data Systems (MEDS) Modernization		Approve (3-0)
0977 California Health Facilities Financing Authority		
Issue 1: Extension of Authority for Investment in MH Wellness Grants		Adopt Placeholder BBL (3-0)
Issue 2: HELP Funding for Small and Rural Health Ctrs.		Approve and Adopt Placeholder TBL (3-0)
4140 Office of Statewide Health Planning and Development		
Issue 1: Reversion of Health Care Workforce Funding		Approve $6m GF in 2017-18 (3-0)
4150 Department of Managed Health Care		
Issue 1: Prohibition of Surprise Balance Billing (AB 72)		Approve and Adopt Placeholder SRL (3-0)
Issue 2: Medi-Cal Interagency Agreement Reduction		Approve (3-0)
Issue 3: Consumer Participation Program Extension		Adopt Placeholder TBL (2-1)
4260 Department of Health Care Services		
Issue 1: County Administration Budgeting Methodology Staffing Extension		Approve (3-0)
Issue 2: NQI Affordability and Benefit Program Elimination		Adopt Placeholder TBL (3-0)

Issue 3: Elimination of MRMIF Proposal — Approve and Adopt Modified Placeholder TBL (3-0)
Issue 4: Delayed Implementation of Previously Chaptered Legislation — Reject (3-0)
Issue 5: Specialty Mental Health Services – Performance Outcomes System — Approve (3-0)
Issue 6: Medi-Cal 2020 Waiver Contract Resources — Approve (3-0)
Issue 7: CCI – Continue Cal MediConnect and MLTSS — Approve and Adopt Placeholder TBL (3-0)
Issue 8: Federal Medi-Cal Managed Care Regulations — Approve (3-0)
Issue 9: Medi-Cal Managed Care Ombudsman Staffing — Approve and Adopt Placeholder TBL (3-0)
Issue 10: Third Party Liability Recovery – Fifty Percent Rule — Adopt Modified Placeholder TBL (3-0)
Issue 11: Nursing Facility/Acute Hospital Waiver Implementation — Approve (3-0)
Issue 12: SF Community Living Services Benefit Transition to Assisted Living Waiver — Approve (3-0)
Issue 13: Robert F. Kennedy Farm Workers Health Plan — Adopt Placeholder TBL (2-1)
Issue 14: Medically Tailored Meals Pilot Program — Approve and Adopt Placeholder TBL (2-0)

4265 DEPARTMENT OF PUBLIC HEALTH
Issue 1: L&C: Los Angeles County Contract — Approve (2-1)
Issue 2: Long-Term Care Ombudsman Funding — Approve (3-0)
Issue 3: Tobacco Tax Initiative (Prop 56) Public Health Program Funding — Approve (3-0)
Issue 4: Center for Health Care Quality Estimate – May Revision — Approve (3-0)
Issue 5: Genetic Disease Screening Program – May Revision Update — Approve (3-0)
Issue 6: Women, Infants, and Children (WIC) Program – May Revision Update — Approve (3-0)

4260 DEPARTMENT OF HEALTH CARE SERVICES
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION
Issue 1: Mental Health Services Act Fiscal Reversion — Adopt Placeholder TBL (3-0)

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION
Issue 1: Contract Administration — Approve (3-0)
Issue 2: Prevention and Early Intervention Plan Reviews — Approve (3-0)

5180 DEPARTMENT OF SOCIAL SERVICES
Issue 1: Overtime Exemptions Proposal — Adopt Placeholder TBL (2-0)
Issue 2: Statewide Fingerprinting Imaging System — Reject and Adopt Placeholder TBL (3-0)

ISSUES RECOMMENDED FOR DISCUSSION

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT
Issue 1: May Revision – Technical Adjustment for Administration — Approve (3-0)

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Medi-Cal Local Assistance Estimate – May Revision Update — Reject Prop. 56 Allocation (3-0); Approve Balance of Estimate (2-1)
Issue 2: Family Health Estimate – May Revision Update — Approve (2-0)
Issue 3: California Medicaid Management Information System Legacy Operations — Approve (3-0)
Issue 4: California Medicaid Management Information System Modernization — Approve (3-0)
Issue 5: SB 1004 Palliative Care Services — Approve (3-0)
Issue 6: Enhanced Medi-Cal Budget Estimate Redesign (EMBER) System — Approve (3-0)
Issue 7: Federal Cures Act Opioid Targeted Response Grant — Approve (3-0)
Issue 8: California Childrens' Services Medical Therapy Program Medical Necessity — Reject (3-0)
Issue 9: Contract Pharmacies in Medi-Cal 340B Program — Reject (3-0)
Issue 10: Disproportionate Share Hospital Allocation Adjustments — Approve (3-0)
Issue 11: Graduate Medical Education Program for Designated Public Hospitals — Approve (3-0)
Issue 12: Covered Outpatient Drug Final Rule — Approve (3-0)
Issue 13: Enrollment of Medicare Beneficiaries in Optional Expansion — Adopt Placeholder TBL (3-0)

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: AIDS Drug Assistance Program (ADAP) – May Revision Update and TBL
Adjust Savings Estimate, Augment Allocation to Enrollment Workers, Adopt Placeholder TBL (3-0)
Issue 2: Technical Adjustments – Youth Tobacco, Emergency Preparedness, Prop. 99 — Approve (3-0)

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Mental Health Services Fund Reappropriation — Approve (3-0)

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

OVERSIGHT HEARING
"Achieving and Maintaining Adequate Provider Networks in Medi-Cal Managed Care"
Thursday, November 9, 2017
10 a.m.
State Capitol - Room 4203

Consultant: Scott Ogus

I. OPENING REMARKS - CHAIR

II. PRESENTATION: MEDI-CAL MANAGED CARE RATE-SETTING AND IMPLEMENTATION OF NEW STATE AND FEDERAL REQUIREMENTS
Mari Cantwell, Chief Deputy Director, Department of Health Care Services

III. PANEL: MEDI-CAL MANAGED CARE ORGANIZATIONS
Steve Melody, President - Medicaid Health Plan for CA, Anthem Blue Cross/WellPoint
Dr. Brad Gilbert, Chief Executive Officer, Inland Empire Health Plan
Alan McKay, Chief Executive Officer, Central CA Alliance for Health

IV. REACTOR PANEL: MEDI-CAL PROVIDERS AND CONSUMERS
Michelle Baca, Associate Director – Govt. Relations, California Medical Association
Jeff Conklin, Vice President - Payer & Network Strategies, Adventist Health
Meaghan McCamman, Assistant Director of Policy, California Health+ Advocates
Robert Stone, CEO, & Joseph Alvarnas, Dir. of Value Based Analytics, City of Hope
Linda Nguy, Policy Advocate, Western Center on Law and Poverty
Kiran Savage-Sangwan, Health Integration Policy Dir., CA Pan-Ethnic Health Network

V. PUBLIC COMMENT

VI. DISCUSSION AND CLOSING REMARKS

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.

Speaker Biographies

PRESENTATION: MEDI-CAL MANAGED CARE RATE-SETTING AND IMPLEMENTATION OF NEW STATE AND FEDERAL REQUIREMENTS

Mari Cantwell, Chief Deputy Director, Department of Health Care Services

On February 25, 2013, Governor Brown appointed Mari Cantwell as Chief Deputy Director of Health Care Programs for the California Department of Health Care Services (DHCS). Home to the state's Medicaid program, called Medi-Cal, DHCS administers programs to support the vital health care needs of more than 13.3 million Californians. DHCS employs more than 3,700 staff and manages total expenditures of more than $95 billion.

Mari also assumed the role of State Medicaid Director in February 2015. She is responsible for the overall management of Health Care Delivery Systems, Health Care Financing, and Health Care Benefits and Eligibility. These responsibilities allow DHCS to fulfill its primary mission of providing health benefits to Californians.

Prior to her appointment, Mari served as the Deputy Director of DHCS Health Care Financing, where she was responsible for the development, promotion, and implementation of health care delivery systems for Medi-Cal beneficiaries. Before joining DHCS, from 2005 to 2011, Mari worked as the Vice President of Finance Policy for the California Association of Public Hospitals and Health Systems.

Mari received her Master's degree in public policy from the University of California at Los Angeles, Luskin School of Public Affairs, and her Bachelor of Arts degree in public policy and American institutions from Brown University.

PANEL: MEDI-CAL MANAGED CARE ORGANIZATIONS

Steve Melody, President - Medicaid Health Plan for CA, Anthem Blue Cross/WellPoint

Steve Melody is President of California Medicaid for Anthem Blue Cross. In this role, he is responsible for the management and strategic direction of Anthem's California Medicaid programs which provide health care access and services to nearly 1.3 million members. He oversees membership, state relations, cost of care, clinical management, product development, network strategy, operations and overall profit and loss. In addition, Steve identifies, develops, oversees, and implements key initiatives that support the organization's strategic goals, including quality improvement.

Joining Anthem Blue Cross in 1997, he held numerous leadership positions and was Regional Vice President of California Medicaid before being named to his current role. Steve's previous positions include Director of Network Development and Management; Regional Vice President/Chief of Staff, Planning, Strategy and Innovation and Vice President of Health Care Management.

With nearly 30 years experience in the health care and managed care environments, he has managed and directed departmental operations and functions of Provider Contracting, Provider Services, Provider Education, Network and Regulatory Compliance throughout Northern and Southern California.

Steve received his Bachelor of Science degree in Business Administration with a concentration in Marketing from California State University, Sacramento, CA and completed the Executive Education Program at the Mendoza College of Business, University of Notre Dame. He resides in Elk Grove with his wife and they have 4 children (and 3 dogs!).

Dr. Brad Gilbert, Chief Executive Officer, Inland Empire Health Plan

Dr. Bradley Gilbert was appointed chief executive officer of Inland Empire Health Plan (IEHP) in October 2008. Since the organization's inception, he has played a pivotal role in guiding IEHP to its place as a nationally-recognized leader in public healthcare. As one of the largest public not-for-profit health plans in California, with over 1.2 million members, Dr. Gilbert is leading IEHP into the healthcare reform era.

Dr. Gilbert launched his career at IEHP in 1996 as chief medical officer, developing a Medical Services Department and helping IEHP qualify for a Knox-Keene state licensure. Later, he served as executive officer, responsible for medical management, operations and contracting/network management, marketing, human resources, and compliance.

Dr. Gilbert is also a healthcare industry leader at the state level. In 2010, he was appointed as a board member of the California Association of Health Plans (CAHP), an organization representing 39 California plans. In 2011, he was appointed chair of the CAHP State Programs Committee. Dr. Gilbert is a member of the Board for the Local Health Plans of California (LHPC), and was a member of the Medi-Cal 1115 Waiver Stakeholder Committee – a committee that helped shape the 1115 Demonstration Waiver in California, which funds hospitals and care for the low-income. He is a board member of the California Association of Public Hospitals (Safety Net Institute). Additionally, Dr. Gilbert is the chair of the Inland Empire EHR Resource Center, which is part of the Inland Empire Health Information Exchange. In July 2014, Dr. Gilbert was selected to serve on the California HealthCare Foundation (CHCF) board of directors.

His strong track record in the public health industry began as the Director of Public Health/Health Officer for Riverside County; where he gained insight into the healthcare challenges that Inland Empire residents face. He was responsible for 11 primary care clinics, assigned to special projects in managed care – including participation in development of an IPA and medical liaison to manage care contractors. He supervised communicable disease control, certain environmental health monitoring and public health protection for the county.

Dr. Gilbert attended the University of California, Berkeley, where he earned his bachelor's degree in physiology/anatomy. He received a medical degree from the University of California, San Diego and a master's degree in public policy from the University of California, Berkeley. He is Board Certified in General Preventive Medicine.

Alan McKay, Chief Executive Officer, Central CA Alliance for Health
Alan McKay has served as the Chief Executive Officer (CEO) of the Central CA Alliance for Health since the health plan's inception in Santa Cruz County in April 1995. He previously worked in Bay Area managed care for 12 years, as a Manager in Ernst & Young's San Francisco health care consulting practice from 1984 to 1987, and as Director of Managed Care at El Camino Hospital from 1987 to 1993.

Alan holds a Master of Public Health degree from University of California at Berkeley, and a Bachelor of Arts degree in Psychology from the University of California at Santa Cruz. He is a Member of the board of Local Health Plans of California (LHPC), the professional association of sixteen public, non-profit Medi-Cal health plans in California. He is a Member of the Merced County Health Care Consortium, the Monterey Regional Health Development Group, Inc. (MoreHealth), and the Health Improvement Partnership of Santa Cruz County.

REACTOR PANEL: MEDI-CAL PROVIDERS AND CONSUMERS

Michelle Baca, Associate Director – Govt. Relations, California Medical Association
Michelle Baca is an Associate Director in the Center for Government Relations at the California Medical Association. Her primary advocacy involves Medi-Cal and physician workforce issues. Prior to joining CMA, she gained nearly a decade of experience in state government, working on health and human services issues for the California Department of Finance and the California Legislature.

Jeff Conklin, Vice President - Payer & Network Strategies, Adventist Health
Mr. Conklin serves as corporate vice president, Payer & Network Strategies for Adventist Health, and president Adventist Health Managed Care. He is also president/CEO of Adventist Health Plan, Inc., a restricted license Knox-Keene plan launched in 2016 serving Medi-Cal members in Kings County, CA. A health care executive with extensive experience in senior leadership roles for health care systems, hospitals, IPAs/Medical Groups and management services organizations, Conklin possesses expertise in managed care strategy and contracting, population health, medical group management, and developing/managing physician organizations.

Meaghan McCamman, Assistant Director of Policy, California Health+ Advocates
Meaghan has nearly a decade of experience representing safety-net providers in California and across the country. She is currently Assistant Director of Policy for the California Primary Care Association (CPCA) where she is responsible for policy and advocacy on behalf of community clinics in the areas of managed care, behavioral health and health integration, 1115 Waiver, the Health Benefit Exchange, rural health, veterans issues, Medicare, and the 330 grant program. Meaghan previously led CPCA's efforts around state implementation of the Affordable Care Act, including representing community clinic interests in the development of Covered California and Medicaid expansion. She also previously served as Director of Programs for the National Rural Health Association in Washington, DC. Meaghan holds an MPA from George Mason University.

Robert W. Stone, Chief Executive Officer, City of Hope
Robert W. Stone is President and Chief Executive Officer of City of Hope, a cancer research and treatment institution dedicated to innovation in biomedical research and the delivery of compassionate, world-class patient care. Stone sets the strategic vision for City of Hope, driving business development and maximizing potential growth. He leads a diverse team of talented high-level individuals committed to humanitarian service and to ensuring access to the institution's breakthrough discoveries and specialized therapies.

In his career at City of Hope, Stone has served in a number of increasingly responsible roles. He joined City of Hope in 1996 as associate general counsel and was promoted to general counsel for the medical center in 2000. In 2003, he was named City of Hope's general counsel and corporate secretary. He became City of Hope's chief strategy and administrative officer in 2009, leading the creation and development of the organization's 10-year strategic plan.

Stone also served as president and executive officer of the City of Hope Medical Foundation, an entity launched in June 2011 to increase collaboration between physicians and staff and to enable more coordinated care for patients. In this role, Stone worked with the foundation board to plan, design and implement the foundation strategy. He was also responsible for the day-to-day management of the foundation, including overseeing the foundation-operated clinics, the management services staff of the foundation and managed-care contracting for City of Hope.

As president of City of Hope, a role he assumed in August 2012, Stone was responsible for executing the strategy for the larger institution, guiding business development and overseeing all operational, financial, human capital and strategic functions. He assumed the dual role of chief executive officer in January 2014.

Prior to City of Hope, Stone was a practicing attorney at the firms of Christa & Jackson and Hanna and Morton. He earned his law degree at the University of Chicago Law School.

Joseph Alvarnas, M.D., Director of Value Based Analytics, City of Hope
Joseph Alvarnas, M.D., is City of Hope's Director of Value Based Analytics; Associate Clinical Professor, Department of Hematology & Hematopoietic Cell Transplantation; Clinical Quality Director, Alpha Clinic; Interim Medical Director of Community Practices and a hematologist/oncologist. His areas of expertise are bone marrow and stem cell transplantation.

At City of Hope since 2008, Dr. Alvarnas earned his medical degree at University of California, San Francisco, and did fellowships in hematology and bone marrow transplantation at Stanford University Medical Center. An articulate spokesman on topics ranging from hematology to health policy, Dr. Alvarnas is also editor-in-chief of the publication, Evidence-Based Oncology. He speaks Spanish, Portugese and Italian in addition to English.

Linda Nguy, Policy Advocate, Western Center on Law and Poverty
Linda Nguy is Policy Advocate for the Western Center on Law and Poverty, specializing in health care issues that affect poor Californians. Prior to joining Western Center, Linda worked with the State of Washington and Mississippi to help establish their state-based health exchange. Specifically, she drafted the online application for subsidized and unsubsidized qualified health plans. She also worked on California's behavioral health adjudication system and as Policy Associate for the Latino Coalition for a

Healthy California. Linda received her MPP/MBA from the University of Minnesota, Twin Cities and undergraduate degree from Brown University.

Kiran Savage-Sangwan, Health Integration Policy Dir., CA Pan-Ethnic Health Network
Kiran Savage-Sangwan is the Health Integration Policy Director at the California Pan-Ethnic Health Network (CPEHN), a statewide multicultural health policy organization. In her position, she leads policy and community engagement efforts to improve access to and quality of health, mental health, and oral health care. Prior to joining CPEHN, she worked as the Director of Legislation and Advocacy for the National Alliance on Mental Illness (NAMI) California. Kiran has also worked at the American Civil Liberties Union (ACLU) of Northern California and the New York Civil Liberties Union, primarily focused on immigrants' rights.

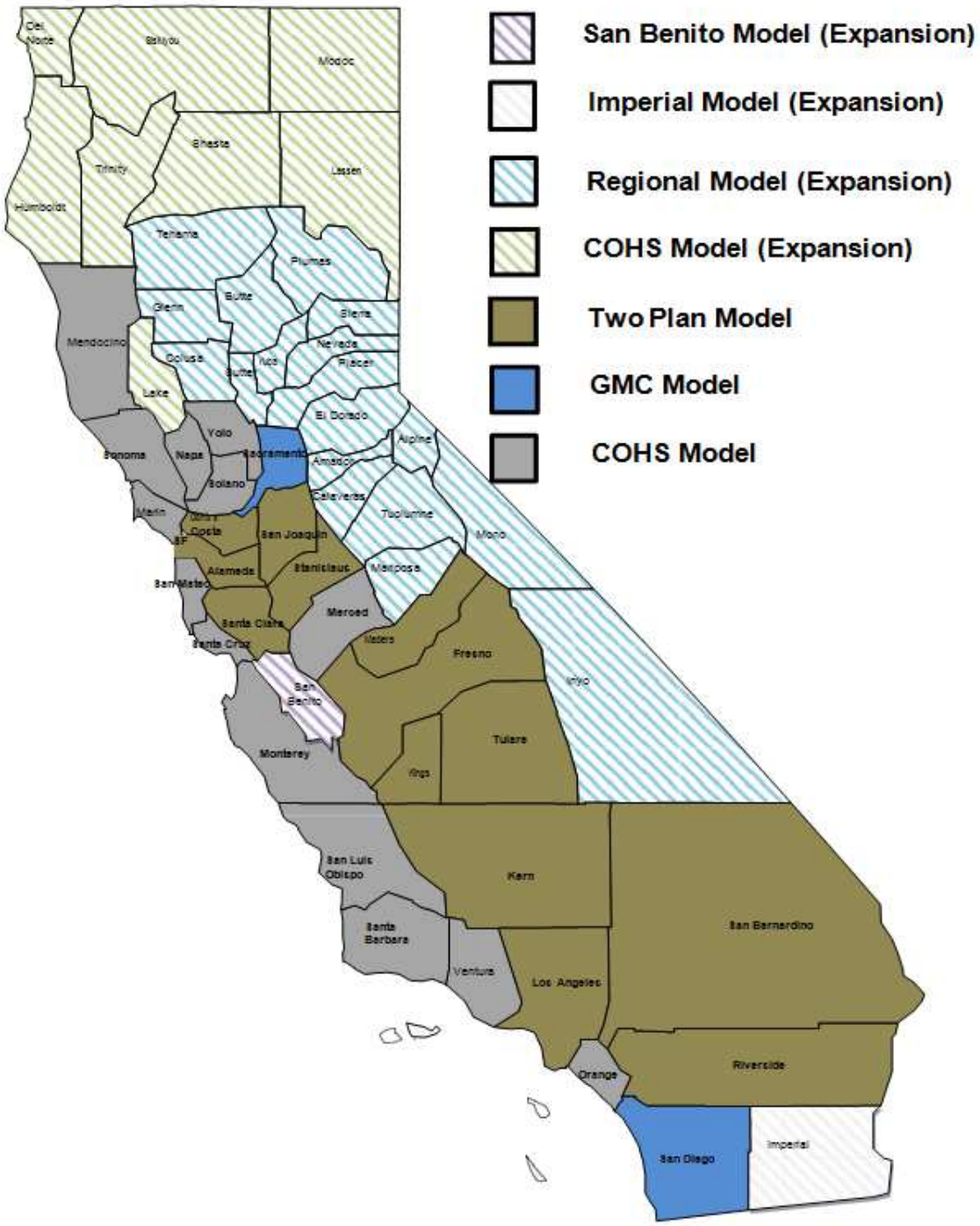
MEDI-CAL MANAGED CARE AND NETWORK ADEQUACY – BACKGROUND

Thirty-Five Years of Medi-Cal Managed Care. The managed care model of health care service delivery in California began in the 1970s with legislation that culminated in passage of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act). In addition to regulatory oversight of the commercial managed care market, the Knox-Keene Act authorized the state to license health maintenance organizations and pre-paid health plans to enroll Medi-Cal beneficiaries. Beginning in 1981, the state began licensing different models of managed care delivery for Medi-Cal beneficiaries in different counties. Today, there are four primary models of managed care delivery in the Medi-Cal program:

- *County Organized Health Systems* – In 1982, the Legislature authorized the creation of three county organized health systems (COHS), which are county-administered managed care plans. Santa Barbara and San Mateo Counties were the first COHS plans to enroll beneficiaries (a COHS was planned in Monterey, but was never implemented), while Congress approved three additional COHS (Santa Cruz, Solano, and Orange) counties in 1990. The authorization for COHS requires that they be an independent, public entity and that they meet the regulatory requirements of the state's Knox-Keene Act. However, they need not obtain a license under the Knox-Keene Act, as they are specifically exempted. There are currently twenty-two counties in the COHS model: Del Norte, Humboldt, Lake, Lassen, Marin, Mendocino, Merced, Modoc, Monterey, Napa, Orange, San Luis Obispo, Santa Barbara, Santa Cruz, San Mateo, Shasta, Siskiyou, Solano, Sonoma, Trinity, Ventura, and Yolo. Eight of these counties (Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity) were part of the expansion of Medi-Cal to rural counties described below (see *Expansion to Rural Counties,* below). Beneficiaries in these counties receive services through Partnership Health Plan of California.
- *Geographic Managed Care* – In 1992, the department designated Sacramento County as a geographic managed care (GMC) county, which allowed many plans to operate within the county to provide services to Medi-Cal beneficiaries. In 1998, San Diego also became a GMC county, and both counties currently contract with several commercial health plans with the goal of providing more choice to beneficiaries. As these plans are commercial plans, they are required to be licensed under the Knox-Keene Act. Sacramento and San Diego remain the only two GMC counties in the state.
- *Two Plan Model* – In 1995, as part of a significant expansion of Medi-Cal managed care, twelve counties were designated to participate in a new Two Plan Model for managed care delivery. Under this model, one county-developed plan, a local initiative, offers services alongside a commercial plan. Both plans are required to be licensed under the Knox-Keene Act. There are currently fourteen Two Plan Model counties: Alameda, Contra Costa, Fresno, Kern, Kings, Los Angeles, Madera, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare. Los Angeles' local initiative, L.A. Care, subcontracts with several other smaller managed care plans to provide services to Medi-Cal beneficiaries.
- *Regional Model* – AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012, authorized the expansion of Medi-Cal managed care into the twenty-eight rural counties not previously operating managed care plans. These counties phased in between November 2013 and December 2014. 8 counties transitioned into the COHS model, while twenty counties transitioned into a new regional model, including: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Imperial, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, San Benito, Sierra,

Sutter, Tehama, Tuolumne, and Yuba. Beneficiaries in these counties (except San Benito and Imperial) receive services through either Anthem Blue Cross, or California Health and Wellness. Beneficiaries in San Benito County receive services through either Anthem Blue Cross, or fee-for-service Medi-Cal, while beneficiaries in Imperial County receive services through either California Health and Wellness or Molina Health Systems.

MEDI-CAL MANAGED CARE MODELS



Source: Department of Health Care Services, Medi-Cal Managed Care Division

Most Major Beneficiary Populations Transitioned to Medi-Cal Managed Care.
In 2000, approximately half of Medi-Cal beneficiaries received services in the Medi-Cal managed care delivery system. Over the subsequent fifteen years, several populations previously exempt, enrolled in other managed care coverage, or uninsured were mandatorily enrolled in Medi-Cal managed care. As of the 2017 Budget Act, 79.64 percent of Medi-Cal beneficiaries, or 10.9 million Californians, will receive services through Medi-Cal managed care in 2017-18.

Seniors and Persons with Disabilities
The state's 2010 Section 1115 "Bridge to Reform" waiver included a proposal to provide a more organized and coordinated care delivery system for seniors and persons with disabilities (SPDs). SPDs are non-dual-eligible Medi-Cal beneficiaries who are 65 and over or who have a disability. Prior to the waiver, SPDs were only required to be enrolled in managed care for their non-long term care Medi-Cal benefits in COHS counties. The terms of the Waiver included mandatory enrollment of SPDs into managed care for non-long term care Medi-Cal benefits in all counties operating managed care models. Effective June 1, 2011, SPDs were mandatorily enrolled in managed care in two plan model and geographic managed care counties. The transition was phased-in over a 12 month period, with beneficiaries enrolled by birth month.

Healthy Families Program Transition from MRMIB
Title XXI of the Social Security Act permits states to provide health care services to children up to 250 percent of the federal poverty level, known as the Children's Health Insurance Program (CHIP). The provisions of CHIP allowed states to integrate these children into an existing state Medicaid program, or to create a stand-alone program. California, choosing the latter option, established the Healthy Families Program, which provided health, dental and vision coverage to eligible children and was administered by the Managed Risk Medical Insurance Board (MRMIB). The 2012 Budget Act, as part of a package of budget-balancing solutions, eliminated the Healthy Families Program, transferring its beneficiaries to Medi-Cal over a 12 month period. The transition began on January 1, 2013 and proceeded in four phases. The new program for these beneficiaries is known as the Optional Targeted Low-Income Children Program (OTLICP) and, as of the 2017 Budget Act, covers 865,760 children in managed care and 65,140 in fee-for-service.

Expansion to Rural Counties
AB 1467, as part of a package of budget-balancing solutions in the 2012 Budget Act, authorized the expansion of managed care to twenty-eight rural counties in which it had previously not been operative. The expansion began on November 1, 2013, with some phase-in provisions for SPDs in those counties. Eight counties transitioned into a COHS model of managed care: Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, and Trinity. Partnership Health Plan of California serves as the COHS plan for these eight counties. The remaining twenty counties transitioned into a new Regional Model, in which the department contracts with two commercial plans (except in San Benito and Imperial) to cover beneficiaries. The twenty rural expansion counties are: Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolomne, Yuba, Imperial, and San Benito.

Coordinated Care Initiative
The 2012 Budget Act included a demonstration project to better integrate the health care delivery system for individuals dually eligible for Medicare and Medi-Cal ("dual-eligibles"). SB 1008 and SB 1036 (Committee on Budget and Fiscal Review), Chapters 33 and 45, Statutes of 2012, and later SB 94

(Committee on Budget and Fiscal Review), Chapter 37, Statutes of 2013, implemented the proposal, known as the Coordinated Care Initiative. This new program passively enrolled dual-eligibles into an integrated managed care plan for both Medicare and Medi-Cal benefits, known as Cal MediConnect, in seven pilot counties. All other Medi-Cal beneficiaries in those counties, including those that opted out of Cal MediConnect, were mandatorily enrolled in managed care for their Medi-Cal benefits, including long-term services and supports like In-Home Supportive Services (IHSS) and skilled nursing facilities, which had previously been offered in the fee-for-service delivery system. Passive enrollment began in March 2014 and was completed in all seven counties in August 2016. The CCI Counties are: San Mateo, San Bernardino, Riverside, Los Angeles, Orange, San Diego, and Santa Clara.

Upon release of the 2017 Governor's Budget, the Director of Finance certified that CCI would no longer be cost-effective. Under the provisions of Section 34 of SB 94 the program will be discontinued effective January 1, 2018. However, the 2017 Budget Act continues the Cal MediConnect program and mandatory enrollment of dual-eligibles in managed care for Medi-Cal benefits including long-term services and supports (except IHSS).

Optional Expansion of Medi-Cal (Affordable Care Act)

The federal Affordable Care Act authorized states to expand their Medicaid programs to previously uninsured individuals. ABX1 1 (John A. Perez) and SBX1 1 (Hernandez), Chapters 3 and 4, Statutes of 2013, authorized California's Optional Expansion of the Medi-Cal program. The Optional Expansion, effective January 1, 2014, expanded eligibility for previously ineligible persons, primarily childless adults at or below 138 percent of the federal poverty level. Optional Expansion beneficiaries are mandatorily enrolled in managed care for their Medi-Cal benefits. The 2017 Budget Act assumes Optional Expansion enrollment of 3.9 million beneficiaries in 2017-18.

Major Managed Care Exceptions ("Carve-Outs")

1) California Children's Services (CCS) – The CCS program provides specialized health care services to children up to twenty-one years of age with certain serious diseases or health conditions. Services provided in this program are generally exempt from inclusion in managed care and are provided in the fee-for-service delivery system. However, SB 586 (Hernandez), Chapter 625, Statutes of 2016, authorizes the department to implement a Whole Child Model, which would incorporate CCS benefits into managed care in twenty-one counties. Implementation is scheduled to begin no sooner than July 2017.
2) Long-Term Care/Home and Community Based Services – Long-term care services, such as those provided by a skilled nursing facility or intermediate care facility for the developmentally disabled, are exempt from inclusion as a managed care benefit and are reimbursed in the fee-for-service delivery system, except in Coordinated Care Initiative counties. Other home and community based services, such as In-Home Supportive Services (IHSS) are also fee-for-service benefits.
3) Dental Services (except Dental Managed Care counties) – In all counties, except Sacramento and Los Angeles, dental benefits in Medi-Cal (Denti-Cal) is provided on a fee-for-service basis. The benefits are provided to beneficiaries by the department's dental fiscal intermediary, Delta Dental, which maintains provider networks and administers benefits in an at-risk arrangement that is similar to, but distinct from, a managed care plan's operations.

Federal Medicaid Regulations Require Actuarially Sound Capitation Rates. Section 1396b(m)(2)(A)(iii) of Title 42 of the United States Code requires that no federal matching funds be

paid to a state for capitation payments to a managed care plan unless, among other requirements, the "prepaid payments to the [plan] are made on an actuarially sound basis". Section 438.6(c)(1)(i) of Title 42 of the Code of Federal Regulations defines actuarially sound capitation rates as rates that:

- Have been developed in accordance with generally accepted actuarial principles and practices.
- Are appropriate for the populations to be covered and the services to be furnished under the contract.
- Have been certified, as meeting these requirements, by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

In addition, Section 1396a(a)(30)(A) of Title 42 of the United States Code requires state Medicaid programs to provide payment for available care and services "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".

DHCS' Capitated Rate Development Division (CRDD) develops capitation rates in consultation with the department's contracted actuary, Mercer. Once rates have been developed, Mercer provides the actuarial soundness certification required by federal regulations. Historically, the rate development process resulted in a rate range, which represented the minimum and the maximum actuarially sound capitation payment that could be supported by encounter and claims data. The department typically pays the minimum rate in the range, which allows for other governmental entities to provide additional nonfederal dollars up to the maximum of the rate range to draw down additional federal matching funds. New federal regulations finalized in May 2016 require certification of a single rate, which will require the department to move to a prospective rate-setting process.

Knox-Keene Act and Network Adequacy. The Knox-Keene Health Care Service Plan Act of 1975, and subsequent amendments, is one of the most robust regulatory regimes for managed care organizations in any state in the nation. In addition to requirements related to financial stability, the Knox-Keene Act imposes various network adequacy requirements on health care service plans, including Medi-Cal managed care plans (except COHS), designed to provide timely access to necessary medical care for those plans' beneficiaries. These requirements generally include the following standards for appointment availability:

1) *Urgent care without prior authorization*: **within 48 hours**.
2) *Urgent care with prior authorization*: **within 96 hours**.
3) *Non-urgent primary care appointments*: **within 10 business days.**
4) *Non-urgent specialist appointments*: **within 15 business days.**
5) *Non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness or other health condition*: **within 15 business days**.

Plans are also generally required to ensure that:

1) Primary care physicians are **located within 15 miles or 30 minutes** of a beneficiary's place of residence.
2) Plan networks include **one primary care provider for every 2,000 beneficiaries.**

Non-COHS Medi-Cal managed care plans are required to have a Knox-Keene license and are, therefore, required to be in compliance with these provisions. DHCS contracts with COHS plans to provide health care services to Medi-Cal beneficiaries in those counties. Although they are not required to have a Knox-Keene license, the department's sample contract with COHS plans includes the same or greater network adequacy and timely access requirements as the Knox-Keene Act.

Recent Medicaid Managed Care Regulations Expand Network Adequacy Requirements. In May, 2016, the federal Centers for Medicare and Medicaid Services (CMS) released a final rulemaking for state Medicaid programs with beneficiaries served by managed care organizations. One of the most significant changes imposed by the regulations is the requirement that capitation rates be set at a single rate, rather than in a range, which will change the way DHCS and Mercer calculate capitation rates for Medi-Cal managed care plans. In addition, the rules require:

- California's network adequacy standards expand from one provider type (primary care) to an additional six provider types.
- Collection of quality data to be used to improve the managed care program.
- Enhanced beneficiary supports.
- Monthly, rather than semi-annual, updates of provider directories
- Implementation of an 85 percent medical loss ratio (MLR) for Medi-Cal managed care plans.

2017 Legislation Specifies Network Adequacy Requirements for Medi-Cal Managed Care. AB 205 (Wood) and SB 171 (Hernandez), Chapters 738 and 768, Statutes of 2017, codified in state law specific requirements for Medi-Cal managed care related to implementation of the federal managed care regulations. In particular, these bills manage the implementation of the 85 percent MLR for Medi-Cal managed care plans, including the remittance process, and establish time and distance and appointment availability standards for the various classes of providers covered by the new federal rules.

Commencing January 1, 2018, the time and distance standards are as follows:

- *Primary care providers*: **10 miles or 30 minutes** from the beneficiary's place of residence.
- *Hospitals*: **15 miles or 30 minutes** from the beneficiary's place of residence.
- *Dental managed care*: **10 miles or 30 minutes** from the beneficiary's place of residence.
- *Obstetrics and gynecology*: **10 miles or 30 minutes** from the beneficiary's place of residence.

Commencing July 1, 2018, the time and distance standards are as follows:

- *Specialists*, including cardiology/interventional cardiology, nephrology, dermatology, neurology, endocrinology, ophthalmology, ear, nose, and throat/otolaryngology, OB-GYN specialty care, orthopedic surgery, gastroenterology, physical medicine and rehabilitation, general surgery, psychiatry, hematology, oncology, and pulmonology, HIV/AIDS specialists/infectious diseases, and outpatient mental health services, the following time and distance standards by county:

    1) **15 miles or 30 minutes** from the beneficiary's place of residence: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara;

2) **30 miles or 60 minutes** from the beneficiary's place of residence: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura;
3) **45 miles or 75 minutes** from the beneficiary's place of residence: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba; and,
4) **60 miles or 90 minutes** from the beneficiary's place of residence: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

- *Pharmacy services*: 10 miles or 30 minutes from the beneficiary's place of residence (all counties).

- *Outpatient substance use disorder services* other than opioid treatment programs, the following time and distance standards by county:

1) **15 miles or 30 minutes** from the beneficiary's place of residence: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara;
2) **30 miles or 60 minutes** from the beneficiary's place of residence: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura; and,
3) **60 miles or 90 minutes** from the beneficiary's place of residence: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Monterey, Mono, Napa, Nevada, Plumas, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba.

- *Opioid treatment programs*, as follows:

1) **15 miles or 30 minutes** from the beneficiary's place of residence: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara;
2) **30 miles or 60 minutes** from the beneficiary's place of residence: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura;
3) **45 miles or 75 minutes** from the beneficiary's place of residence: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba;
4) **60 miles or 90 minutes** from the beneficiary's place of residence: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

- *Skilled nursing facility and intermediate care facility services*, the following time and distance standards by county:

1) Within **five business days** of the request: Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara.
2) Within **seven business days** of the request: Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura;
3) Within **fourteen calendar days** of the request: Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba; and,
4) Within **fourteen calendar days** of the request: Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne.

- *County Drug Medi-Cal-Organized Delivery System (DMC-ODS)*: appointment within **three business days** to an opioid treatment program (all counties).

- *Dental managed care plan services*:
  Routine pediatric services: appointment within **four weeks** of a request.
  Specialist pediatric services: appointment within **thirty calendar days** of a request.

Provider Participation May Not Be Keeping Pace With Enrollment. In 2012-13, just prior to the implementation of the Affordable Care Act, 5.1 million Californians were enrolled in Medi-Cal managed care. As of the 2017 Budget Act, 2017-18 enrollment in Medi-Cal managed care was projected to be 10.9 million, an increase of 214 percent over 2012-13. While this significant increase in coverage has provided measurable health benefits to lower-income Californians, it is unclear whether Medi-Cal managed care plan provider networks have been able to keep pace with the sharp rise in enrollment. A June 2017 report from the California Health Care Foundation titled "*Physician Participation in Medi-Cal: Is Supply Meeting Demand?*" surveyed physicians renewing licensure in 2015 to gauge participation in the Medi-Cal program. The report found that, between 2013 and 2015, the percentage of physicians serving Medi-Cal patients decreased from 69 percent to 64 percent, although the overall number of full-time equivalent physicians serving Medi-Cal patients increased by nine percent, likely due to previously uninsured patients seen by these physicians gaining coverage under the Medi-Cal expansion. However, the report also found this modest increase in full-time equivalent physician participation did not keep pace with the growth in enrollment, as the number of full-time equivalent physicians for each 100,000 Medi-Cal beneficiaries declined significantly. For primary care physicians, there were 39 full-time equivalents in 2015 compared to 59 in 2013, a 33.9 percent decline. For non-primary care physicians, there were 63 full-time equivalents in 2015 compared to 91 in 2013, a 30.8 percent decline.

Medi-Cal Managed Care Plans May Have Made Significant Financial Gains From Expansion. A recent article published November 5, 2017, in the Los Angeles Times, titled "*Insurers make billions off Medicaid in California during Obamacare expansion*", used data from unaudited financial disclosures from Medi-Cal managed care plans to estimate that these plans made $5.4 billion in profits from 2014 to 2016, primarily due to higher rates paid for beneficiaries receiving coverage under the expansion of Medi-Cal pursuant to the Affordable Care Act. These findings suggest capitation rates paid to Medi-Cal managed care plans do not align with the actual utilization and provision of health care services to Medi-Cal beneficiaries during this time period.

In the article, the director of DHCS indicates that these data do not account for additional auditing, rate adjustments and retroactive recoupments that will occur in the future. DHCS is required to adjust capitation rates paid since the implementation of the expansion to account for actual encounter and utilization data reported by the plans. Downward adjustments to these capitation rates for prior periods have resulted in significant expected recoupments from Medi-Cal managed care plans. The May 2017 Medi-Cal Local Assistance Estimate indicates the department expects to begin recoupment January 2017 for the expansion population and will recoup $5.3 billion, all federal funds, for the period from July 2015 through December 2016. There may be additional recoupments for periods after December 2016. It is unclear whether the data cited in the Los Angeles Times article reflects these expected recoupments. The subcommittee will continue to analyze and monitor these data to determine what impact, if any, these rates have on whether plans are able to maintain adequate provider networks for Medi-Cal beneficiaries.