Senate Budget and Fiscal Review

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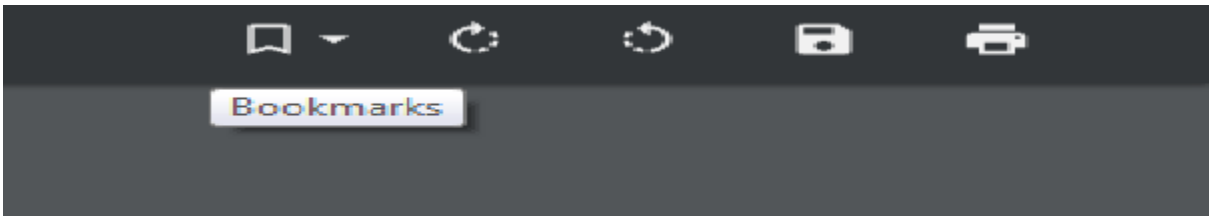

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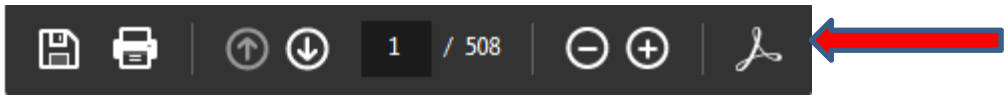

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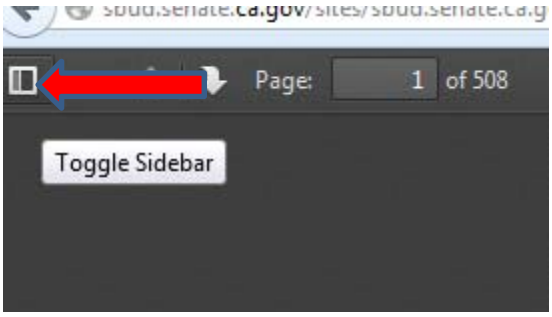

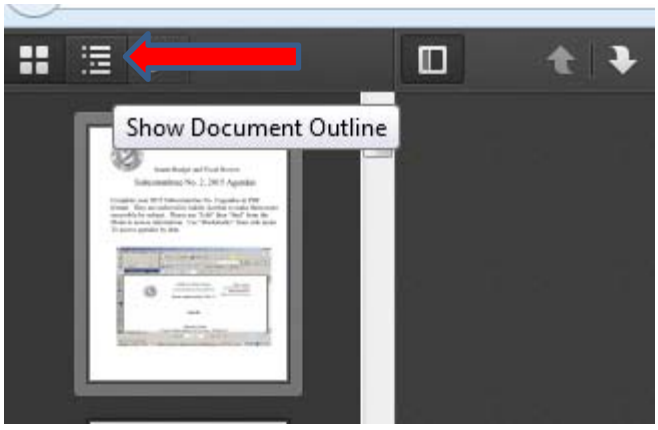

Senate Budget and Fiscal Review—Holly J. Mitchell, Chair

SUBCOMMITTEE NO. 3 Agenda

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

March 8, 2018

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

Consultant: Theresa Pena

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4170 DEPARTMENT OF AGING (CDA)

Issue 1: Overview

With a proposed 2018-19 budget of $201.5 million ($34 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.

California Department of Aging
Authority by Program

* Dollars in thousands

Grand Total By Fund	Fiscal Year	
General Fund	29,538	29,538
State HICAP Fund	2,246	2,246
Federal Fund	150,382	142,766
State Health Facility Citations Penalty Account	2,094	1,094
State Department of Public Health Licensing and Certification Program Fund	400	400
Skilled Nursing Quality & Accountability Fund	1,900	1,900
Reimbursements	5,442	5,442
Total All Funds	**192,002**	**183,386**

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. The Senior Nutrition Program is the largest OAA program in terms of funding and the most well-known. The Congregate Nutrition Program provides nutritionally-balanced meals and education to individuals age 60 or older at congregate meal sites. Approximately 27,000 meals a day were served at these sites; 6.9 million a year -- and 35% of the participants were at high nutritional risk.

The equally well known other program is the Home Delivered Meal Program, that serves older adults who are not able to attend congregate programs. Approximately 44,000 home delivered meals are provided at home for each day; 11 million annually.

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.

Long-Term Care Ombudsman. Investigates and resolves community complaints made by, or on behalf of, individual residents in long-term care facilities.

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 in the Current Year is $8.4 million and for the Budget Year is $7.3 million and includes federal and State funds from the Skilled Nursing Facility Quality Assurance Fund and the State Citation Penalties Account funds. The 2017-18 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.

Elder Abuse Prevention. Develops, strengthens, and implements programs for the prevention, detection, assessment, and treatment of elder abuse.

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. In 2016, the program provided in person counseling to 185,000 beneficiaries, provided telephone help (quick calls) to 54,000 individuals and 4,000 consumer presentations.

This program utilizes 770 trained and supervised volunteers who provide this assistance under the direction of the paid program staff. Like the Ombudsman Program and other Older Americans Act programs, trained and well supervised volunteers are key in increasing the capacity of these programs beyond the limited government funding.

Senior Community Service Employment Program (SCSEP). 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. Currently there are 14 AAAs providing Senior Community Employment, however, based on the Department of Labor's updated Equitable Distribution of slots by County, CDA is in the process of issuing a Request for Proposals (RFP) to solicit proposals for services in four existing counties.

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.

The President's Proposed Budget. On February 12, 2018, President Trump released his proposed budget for the upcoming fiscal year. These recommendations cover Federal Fiscal Year 2019 which runs from October 1, 2018 through September 30, 2019. The President's budget largely proposes level-funding or slight increases in many Older American's Act (OAA) programs, such as the Nutrition Services

Programs, Home and Community-Based Supportive Services, and Family Caregiver Support Services. However, the President's proposed budget also includes the elimination of the State Health Insurance Assistance Program (SHIP), known as HICAP in California, and the SCSEP.

Continuing Resolutions. In the absence of a full federal fiscal year budget, CDA has been operating under a series of Continuing Resolutions (CR) since October 1, 2017. This has resulted in federal funding coming to the states in smaller increments as opposed to a full year funding award. CDA kept the Area Agencies on Aging (AAA) up-to-date on the status of the federal funds awarded and the current available balance of each AAA's funds. With each CR, CDA and the AAAs continued to receive funding at the 2017 federal grant level. However, for the CRs that were less than 30 days, the Administration for Community Living (ACL) did not provide funding until the CR period exceeded 30 days.

For AAAs operating under tight fiscal constraints, CDA has been proactive and working closely with the AAA network to identify options to assist those AAAs most impacted by the delayed federal funding.

CDA continues to release funds based on the contracts with the AAAs, the request for funds and expenditure reports submitted by the AAAs, and their current available balance of funding.

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

Questions.

1. Please provide an update of the department's programs and services and current funding levels.

2. Please discuss how federal funding uncertainties are affecting programs in CDA.

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

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. The current FY 2017-18 MSSP budget is approximately $39.8 million and the proposed FY 2018-19 MSSP budget remains unchanged.

MSSP as Part of the Coordinated Care Initiative. Under California's Coordinated Care Initiative (CCI), most Medi-Cal beneficiaries in CCI counties were to 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 had entered into contracts with the participating managed care health plans to deliver MSSP waiver services to eligible plan members and were reimbursed by the health plans. In six of the seven CCI counties (Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Santa Clara; excluding San Mateo, which fully transitioned to a managed care benefit), MSSP continued to be a 1915(c) Home- and Community-Based Services waiver benefit until it transitioned to being a fully integrated managed care health plan benefit that is administered and authorized by the plan. However, the 2017-18 Governor's Budget found that the CCI was no longer cost-effective and did not meet the statutory savings requirements, and the CCI was discontinued.

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 integrates long-term services and supports (LTSS) (except In-Home Supportive Services) into managed care. MSSP will continue to operate as a waiver program in CCI counties until no sooner than January 2020. In addition, all current MSSP Waiver policies and program standards remain in effect during the transition period. After December 2019, services formerly available under the MSSP waiver will transition from a federal 1915(c) waiver to a fully integrated Medi-Cal managed care LTSS benefit in the CCI counties.

Until the MSSP transition is complete in the remaining six CCI counties, Medicare/Medicaid plans (MMPs) and managed care plans (MCPs) pay the 12 MSSP sites in these six counties a monthly all-inclusive rate of $357.08 for each MSSP Waiver participant who is enrolled with the MMP or MCP. MSSP Waiver participants in these six counties who are not enrolled with a MCP or MMP currently are receiving MSSP Waiver services from MSSP sites that are reimbursed through the Fee for Service (FFS) model.

Supplemental Reporting Language Update. Pursuant to the Supplemental Report of the 2017-18 Budget Act, the Department of Health Care Services (DHCS) and CDA provided its first biannual update to the Legislature in February. Per the MSSP SRL, items to be discussed with the Legislature include:

- A list and brief summaries of stakeholder and transition meetings to date;
- Status updates on the transition work that has been completed or is in the process of being completed by each CMC demonstration county;
- List of future tasks and activities that need to take place to effectively transition MSSP into managed care plans in all and each of the CMC demonstration counties by January 1, 2020, with estimated start and end dates and list of necessary stakeholders;
- Discussion of how the coordination and management of care will be conducted for various populations, including but not limited to individuals enrolled in a CMC plan, dual eligible beneficiaries that have opted out of CMC, Medi-Cal only seniors and persons with disabilities, and dual eligible that are ineligible for CMC, following the transition of MSSP into managed care;
- Any foreseen or potential issues or risks that may jeopardize the transition of MSSP into managed care or result in delays; and
- A discussion of the Administration's long-term vision of MSSP in the CMC demonstration counties if the pilot is discontinued, and how integration achieved thus far would be unwound without an adverse effect on the MSSP participants, as of December 31, 2019 and if the pilot continues on a more permanent basis.

Early last fall, DHCS and CDA also started the Stakeholder and Transition meetings that included the following activities:

- October 6, 2017, DHCS publically released two transition documents to the California Collaborative for Long-Term Services and Supports for public comment.
    - The *Archive Document for the Multipurpose Senior Services Program Transition: Target Updated from 2018 to 2020* is an archive document that was meant to memorialize the activities conducted and policy guidance developed during 2015 and 2016.
    - The *Transition Plan Framework and Major Milestones* document is more of a living document intended to document the activities and policy guidance developed in 2018-19, in preparation for the 2020 transition
- DHCS has also continue to hold quarterly CCI Stakeholder calls with stakeholders, advocates, health plans, MSSP sites, and other interested parties. The next call is scheduled for March 2018.

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.

2. Please provide a summary of the information provided in the SRL meeting.

Issue 3: Proposals for Investment

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

1. Senior Nutrition Program Augmentation

Budget Issue. The California Association of Area Agencies on Aging and other advocates request $12.5 million General Fund ongoing 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.

2. Long-Term Care (LTC) Ombudsman Augmentation

Budget Issue. The California LTC Ombudsman Association requests $7.3 million General Fund ongoing for the local LTC Ombudsman Programs. The breakdown of the requested funds is as follows: 1) $3.5 million to enable local programs to conduct quarterly unannounced visits to long term care facilities; 2) $420,000 to enable the program to focus on volunteer recruitment; 3) $1.1 million to enable programs to investigate and resolve additional complaints; and 4) $2.3 million to adjust the local annual program base to $100,000 (an additional $65,000 per program).

Staff Comment and Recommendation. Hold open. This program saw various cuts throughout the recession and has struggled under a growing workload. In both 2016-17 and 2017-18, the program received a one-time augmentation of $1 million from the State Health Facilities Citation Account. In 2017-18 budget bill language was also added so that program would receive up to $1 million in additional funds from the State Health Facilities Citation Account if funds were in excess of $6 million. This year, however, no additional funds are available.

3. Supplemental Rate Adjustment for MSSP sites

Budget Issue. The MSSP Site Association (MSA) requests $4.7 million General Fund ongoing to provide a supplemental rate adjustment for MSSP sites. MSA points out that MediCal funding for MSSP has been flat and was reduced during recession years, while the cost of professional staff and operations has continued to increase. The requested funds would increase the per client rate to $5,356.

Staff Comment and Recommendation. Hold open.

4. Funds for Alzheimer's disease education campaign

Budget Issue. The Alzheimer's Association requests $2.2 million General Fund one-time for the Department of Aging to build local capacity to promote early detection and diagnosis of Alzheimer's disease through a public outreach initiative. These funds would be available to use for two years.

Staff Comment and Recommendation. Hold open

4185 CALIFORNIA SENIOR LEGISLATURE (CSL)

Issue 1: Overview and Update

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. CSL spent $235,000 of this in the past year, and the remaining $265,000 were reappropriated and carried into 2017-18. Combined with the 2017-18 General Fund appropriation of $375,000, CSL has approximately $640,000 to spend in the current year. Additionally, as of January 1, 2018, CSL has approximately $71,000 from the tax check off fund. CSL has estimated their current year expenditures to be $324,000.

Three-Year Financing Plan. The Budget Act of 2017 also called for the CSL to work with the Department of Finance on a longer-term financing plan. This plan was released at the beginning of March 2018. The financing is meant to discuss ways to reduce the Department of General Services' (DGS) state contracting costs, identify ways in which organizational and program activities can be streamlined, and develop additional funding sources.

The report identified that fixed costs of Consolidated and Professional Services (C&PS) (accounting, administration, legal, etc.) Pro Rata fees, and salary and benefits make up a large and increasing portion of the CSL's budget. If current trends continue, CP&S is projected to double within the next five years, and when these are combined with salary and benefits, will consume the CSL budget in outyears.

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

Questions.

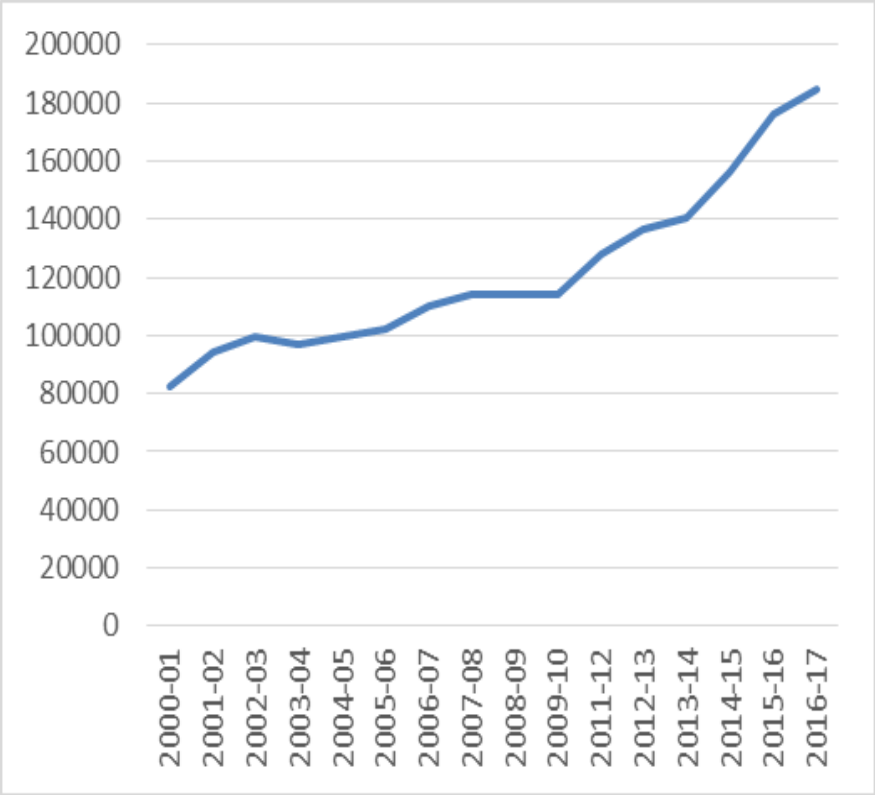
1. Please provide an overview of the three-year financing plan and important takeaways from the report.

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.

APS reports have risen by 124 percent between 2000-01 and 2016-17. The chart below shows the upward trend of reports of abuse and neglect received by APS:



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 124 percent between 2000-01 and 2015-16.

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:

- Add three new (2017-2019) contracts with the three Regional Training Academies (RTAs) (San Diego State University, UC Davis, and Cal State Fresno) 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). DSS has been working with the counties to develop a new data reporting methodology. The department will begin collecting the new data in October 2018 and will be able to report state level data on client and perpetrator demographics in the future.

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

Questions.

1. Please provide a brief update on the APS program and funding.

2. Please discuss the rising APS reports.

[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.

Issue 2: Proposals for Investment

The subcommittee has received the following proposal for investment.

- Adult Protective Services Home Safe

Budget Issue. The County Welfare Directors Association of California (CWDA), California Elder Justice Coalition, and California Commission on Aging, request $15 million General Fund in 2018-19 to establish Home Safe, a homelessness prevention demonstration grant for victims of elder and dependent adult abuse and neglect. The proposed one-time funding would allow approximately 15 county APS programs to demonstrate over three years how providing short-term housing crisis intervention can help reduce the incidence and risk of homelessness among California's older and dependent adults.

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 72,000 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 565 licensing program analysts investigate any complaints lodged, and conduct inspections of the facilities. Current year funding is displayed in the chart below:

California Department of Social Services
Community Care Licensing Division
Fiscal Year 2017-18 Funding

		2017-18*
	State Operations Total ($000s):	**$154,957**
	GF	$69,168
	FF	$47,891
	Reimb.	$6,496
	Special Funds:	$31,402
0163	Continuing Care Provider Fee Fund	$938
0270	Technical Assistance Fund	$19,999
0271	Certification Fund	$1,590
0279	Child Health And Safety Fund	$3,272
3255	Home Care Fund (AB 1217)$_1$	$5,603

The table below lists the facilities licensed by CCL.

Facility Type	Description
Child Care Facilities	
Family Child Care Home	Provides care, protection and supervision of children, in the caregiver's own home, for periods of less than 24 hours per day, while the parents or authorized representatives are away.
Child Care Center	Provides care, protection and supervision of children in a group setting, usually in a commercial building, for periods of less than 24 hours per day. Includes infant centers, preschools, extended day care facilities, and school age child care centers
Children's Residential Facilities	
Adoption Agency	Nonprofit organizations licensed to assist families with the permanent placement of children with adoptive parents.
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 residential care and supervision for children under 6 years of age, who are placed by a parent or legal guardian due to a family crisis or a stressful situation, for no more than 30 days.
Enhanced Behavioral Supports Home (Group 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 Resource Families; and identify and secure out-of-home placement for children.
Group Homes	24-hour non-medical care and supervision 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 (Group Home)	Provides voluntary, short-term, shelter and personal services to runaway or homeless youth.
Short Term Residential Therapeutic Program	Provides short-term, specialized, and intensive therapeutic and 24-hour non-medical care and supervision to children.
Foster Family Home	A home where a licensed foster parent provides care for six or fewer foster children.
Small Family Homes	A residential facility that provides 24-hour care licensee's home for 6 or less children, who have mental disorders or developmental or physical disabilities.
Transitional Housing Placement	Provides supervised transitional housing services to foster

Provider	children who are at least 16 years old to promote their transition to adulthood.
Certified Family Homes	Foster parents certified by foster family agencies to provide care for six or fewer foster children in their own home.
Resource Family Home	Individual or family that meets both the home environment assessment and the permanency assessment criteria necessary for providing care for a child who is under the jurisdiction of the juvenile court, or otherwise in the care of a county child welfare agency or probation department.
Temporary Shelter Care Facilities	Owned and operated by the county or by a private, nonprofit agency on behalf of a county providing 24-hour care for no more than 10 days for children under 18 years pending placement.
Transitional Shelter Care Facilities	County owned and operated (or non-profit organization under contract with the County) facilities providing short term non-medical care for children to a maximum of 72 hours pending placement.
Private Alternative Outdoor Programs	A group home operating a program to provide youth with 24-hour, nonmedical, residential care and supervision, which provides behavioral-based services in an outdoor living setting to youth with social, emotional, or behavioral issues.
Private Alternative Boarding Programs	A group home operating a program to provide youth with 24-hour, nonmedical, residential care and supervision, which, in addition to providing educational services to youth, provides behavioral-based services to youth with social, emotional, or behavioral issues.
Adult & Senior Care Facilities	
Adult Day Programs	Community based facility/program that provides care to persons 18+ years old in need of personal services, supervision, or assistance essential for sustaining activities of daily living or for the protection of these individuals on less than a 24-hour basis.
Adult Residential Facilities (ARF)	24-hour non-medical care and supervision for adults, either 18-59 years old or 60+ years old.
Adult Residential Facility for Persons with Special Healthcare Needs	Any adult residential facility that provides 24-hour health care and intensive support services in a homelike setting that is licensed to serve up to five adults with developmental disabilities.
Community Crisis Homes (ARF)	A facility that operates as an adult residential facility providing 24-hour non-medical care to individuals with developmental disabilities receiving regional center service, in need of crisis intervention services, and who would otherwise be at risk of admission to an acute crisis center, at a maximum capacity of eight (8) clients.
Continuing Care Retirement Communities (RCFE-CCRC)	A Residential Care Facility for the Elderly that offers a long-term continuing care contract; provides housing, residential services, and nursing care.
Enhanced Behavioral Supports Home (ARF)	A facility that operates as an adult residential facility providing 24-hour non-medical care to individuals with developmental disabilities who require enhanced behavioral supports, staffing, and supervision in a homelike

	setting, at a maximum capacity of four (4) clients.
Residential Care Facilities for the Chronically Ill	A facility that provides care and supervision to adults who have a terminal illness, AIDS or HIV.
Residential Care Facilities for the Elderly (RCFE)	A residential home for seniors aged 60 and older who require or prefer assistance with care and supervision. RCFEs are also known as Assisted Living facilities, retirement homes and board and care homes.
Social Rehabilitation Facilities	A facility that provides 24-hour-a-day non-medical care and supervision in a group setting at a total capacity that shall not exceed 16 adults recovering from mental illnesses who temporarily need assistance, guidance, or counseling.

As of January 2017, CCL has 1,266 authorized positions and 142 vacancies. There are 110 positions currently in the interview process with an additional 27 appointments in the final approval 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.

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

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 findings of the KIT analysis focused on various iterations and refinement of three versions of the KIT, and to some extent found that the third version was most effective in identifying the need for further inspections for half of the facility types. 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.

Last year, the Legislature approved Supplementary Reporting Language that required the department to meet with legislative staff and stakeholders to discuss the KIT analysis and current status of inspections, and to provide a report on the long-term plan for the use of the KIT. A meeting with the department in the summer of 2017 revealed that they were in the early stages of designing a new, comprehensive inspection tool, informed by the KIT analysis. In September 2017 the department released a report detailing its planned approach for a new tool. This will be discussed further in the next agenda item.

[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.

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 2016-17

Type of Inspection[1]	Total Number 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	6,762	5,935 (87.8%)	1,148 (19.3%)
Random Inspection	22,163	21,260 (95.9%)	1,828 (8.6%)
Required Five-Yr. Visit[1]	667	541 (81.1%)	201 (37.2%)
Required Three-Yr. Visit[2]	1,853		

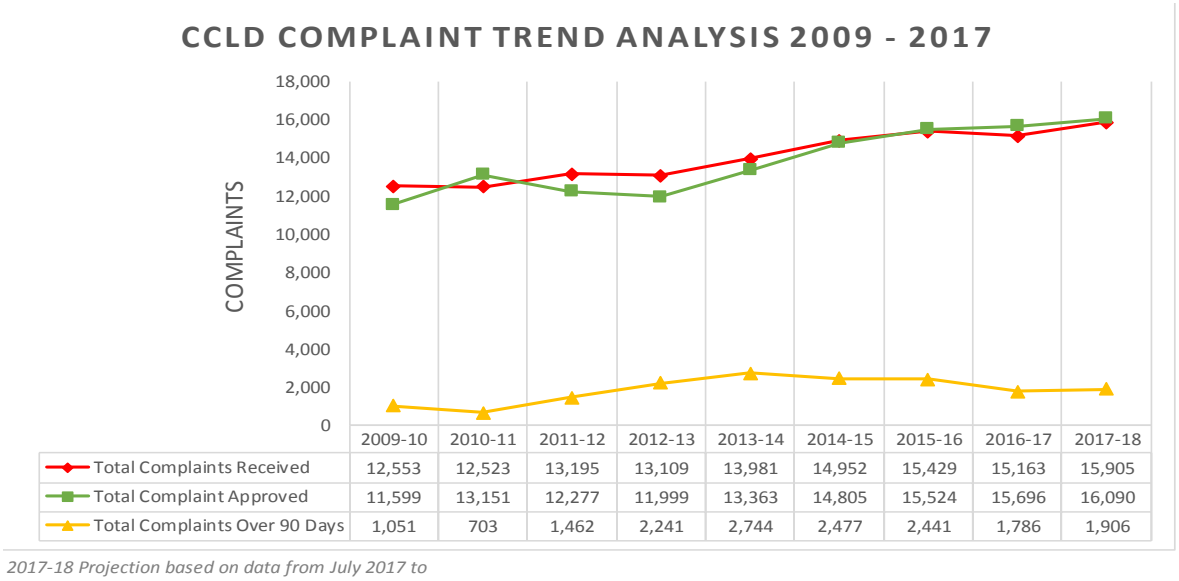
1 - In January 2017 the inspection protocol changed from 5 Years to 3 Years

2 - Data for comprehensive and triggered comprehensive inspections for Required 3 Year Inspections were not collected by FAS from January – July 2017.

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 2016-17, CCL received over 15,000 complaints. The information below provides an analysis of DSS' complaint activity for the years of 2009-10 through 2017-18.

COMMUNITY CARE LICENSING DIVISION COMPLAINT ANALYSIS 2009 - 2017						
Fiscal 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
2009-10	2,508	12,553	15,061	11,599	3,462	1,051
2010-11	3,462	12,523	15,985	13,151	2,834	703
2011-12	2,834	13,195	16,029	12,277	3,752	1,462
2012-13	3,752	13,109	16,861	11,999	4,862	2,241
2013-14	4,862	13,981	18,843	13,363	5,480	2,744
2014-15	5,480	14,952	20,432	14,805	5,627	2,477
2015-16	5,627	15,429	21,056	15,524	5,532	2,441
2016-17	5,532	15,163	20,695	15,696	4,999	1,786
2017-18[1]	4,999	15,905	20,904	16,090	4,814	1,906

1 - Projection based on data from July 2017 to January 2018



	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Total Complaints Received	12,553	12,523	13,195	13,109	13,981	14,952	15,429	15,163	15,905
Total Complaint Approved	11,599	13,151	12,277	11,999	13,363	14,805	15,524	15,696	16,090
Total Complaints Over 90 Days	1,051	703	1,462	2,241	2,744	2,477	2,441	1,786	1,906

2017-18 Projection based on data from July 2017 to

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. 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. In 2017-18, an additional $3.3 million from the Technical Assistance Fund (TAF) was approved to help complete timely complaint allegations, address the growing backlog of RCFE and Adult Residential Facilities (ARF), continue implementation efforts related to the RCFE Reform Act of 2014, and 5.5 permanent LPAs and one-half Attorney III.

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. Please discuss the complaint backlog. Has the department seen an impact from additional staffing resources?

Issue 4: Development of New Inspection Tools

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 visits were required annually for almost all facilities. In 2003, budget cuts resulted in significantly reduced funding for CCL. By 2010, the cuts had taken a toll and 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. Under the proposal, if the KIT inspection revealed concerns, a comprehensive visit would be triggered.

Since that time, the department implemented 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 findings of the reports focus on three iterations of the KIT, and to some extent point to the third KIT as the most effective in identifying the need for further inspections for half of the facility types. However, there were no definitive findings as to whether the use of the KIT ultimately saves time and allows for more inspections to take place, nor was there a comparison of the KIT to the traditional comprehensive inspection. Further, it was revealed that there was no standardized statewide tool for the comprehensive inspection; LPAs draw upon their own knowledge of statute and regulations, or use an informal tool developed at a regional office.

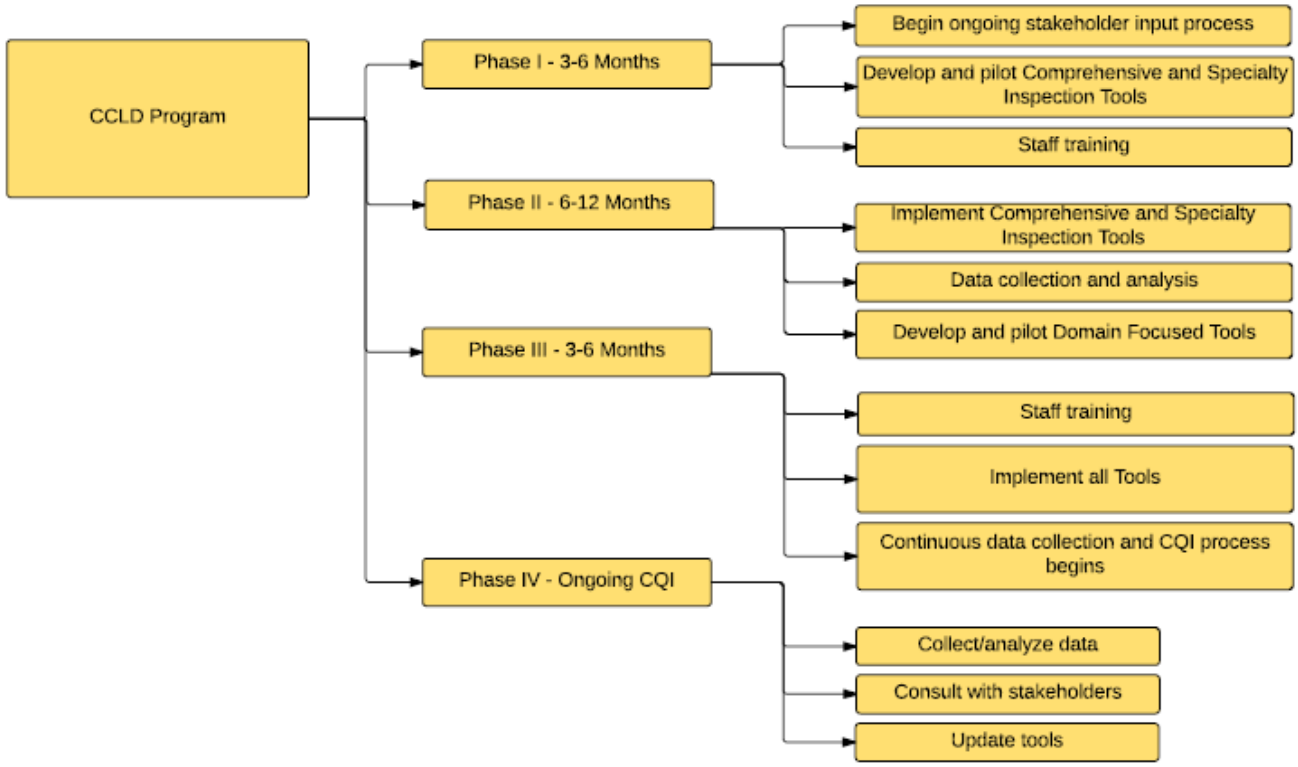
Last year, the Legislature approved Supplementary Reporting Language that required the department to meet with legislative staff and stakeholders to discuss the KIT analysis and current status of inspections, and to provide a report on the long-term plan for the use of the KIT. A meeting with the department in the summer of 2017 revealed that they were in the early stages of designing a new, comprehensive inspection tool, informed by the KIT analysis. In September 2017 the department released a report detailing its planned approach for a new tool. During the development of the new tool, all three versions of the KIT will remain in use. The KITs will be replaced on a flow basis when the standard tools for each licensing category are developed.

New Inspection Tools. In light of the absence of a standardized inspection tool, CCL has committed to developing a variety of standardized inspection tools for LPAs to improve the effectiveness and quality of the inspection process. In particular, the department will focus on prevention, and enhancing technical support to licenses from LPAs. These tools will also be developed differently for the various licensing categories, understanding that different facility types will have different statutory requirements and indicators of compliance to meet. CCL intends to adapt an Agile project management style and incorporate continuous quality improvement into the tool development process.

The department proposes three different types of tools: 1) comprehensive tools, 2) domain-focused tools, and 3) specialty tools. Comprehensive tools will be used for pre-licensing inspections, post-licensing inspections, and required annual inspections, and will contain extensive requirements in all domain areas that are relevant to the time of visits. Domain-focused tools will be developed after and based on data from comprehensive tools. These tools will replace the KITs as shortened tools for LPAs, designed for each CCL program type. Specialty tools will be used with both comprehensive and domain-focused tools if a deeper dive into a specific area is identified.

The department has indicated that the new tool may require additional resources for staffing and training.

Below is a timeline provided by the department showing the various phases of development for the development and implementation of the tools.



CCL has begun efforts to develop Comprehensive and Specialty Tools for RCFEs and ARFs, to pilot in the spring of 2018. The department has also held stakeholder meetings to gather initial input from Children's Residential and Child Care and Adult and Senior Care facility advocates. CCL will also contract with an independent entity in developing quality measurement and compliance tools.

Currently, tools are being developed with LPAs and stakeholders for the RCFE pilot. These tools will be piloted on a portion of RCFEs due for their annual inspection to allow for its effectiveness to be evaluated before a statewide implementation. The pilot will test process measures, such the duration of the inspection or the learnability of the tools, and to a lesser degree will look at the validity and reliability of the tool, particularly inter-rater reliability.

Below is a timeline of the RCFE pilot:

Target Completion Date	Milestone
March 2018	Release pilot information and draft tools for stakeholder review
June 2018	Train LPAs participating in the pilot
July 2018	Conduct pilot visits and licensee surveys
September 2018	Pilot period concludes
October 2018	Conduct focus groups with LPAs
December 2018	Present and publish pilot report to stakeholders
January 2019	Integrate feedback into tools

Staff Comment and Recommendation. Hold open.

Questions.

1. Please discuss the genesis for creating a new comprehensive tool, and provide an update on current and upcoming activities in the development of this tool.

2. How do the KIT analysis and workload study inform your development of the new tools?

3. Does the department intend to require the use of the newly developed tools in statute?

4. How does the department intend to measure the new tool, and what kind of data does the department plan to collect to evaluate the effectiveness of the tool?

Issue 5: Budget Change Proposal: Private Alternative Boarding Schools and Outdoor Programs Oversight and Policy Development

Governor's Proposal. The Administration requests 12.5 positions and $591,000 General Fund ongoing in order to implement SB 524 (Lara), Chapter 864, Statutes of 2016, which established Private Alternative Boarding Schools and Private Alternative Outdoor Programs as two new subcategories of Group Homes to be overseen by the department. Specifically, the positions requested are eight full-time Licensing Program Analysts (LPAs), one Licensing Program Manager (LPM), one and a half Office Assistant positions, and one Associate Governmental Program Analyst (AGPA). The Information Systems Division also requests $450,000 for contracts to make updates to the Licensing Information System.

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. The 2017-18 Governor's Budget proposed to modify implementation of SB 524 by making funding for its requirements contingent upon appropriation in the budget act and delaying implementation by 18 months after the appropriation of funds. The Subcommittee rejected this trailer bill, and the 2017 Budget Act provided $750,000 General Fund to begin implementation activities for SB 524.

The department estimates that there are 90 facilities (75 private alternative boarding schools and 15 private alternative outdoor programs; however, the proposal provides for a scaled-back alternative based on 60 facilities, given that it is difficult to estimate the number of these types of facilities currently operating.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

2. How did the department get to its estimate of numbers of facilities? Is the department confident in the higher or lower estimate?

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

Issue 6: 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 $11.2 billion total funds ($2.8 billion General Fund) for SSI/SSP. The state pays administration costs for SSP, around $188 million for the budget year. 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 2018-19, the estimated monthly average caseload is 869 cases for CAPI and 13,632 for 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 2018-19, the department estimates that the caseload is around 252 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. However, since 2014-15, caseloads have shown a steady decline. For the 2018-19 Governor's Budget, DSS projects that the caseload for 2017-18 will decrease by 0.5 percent and the caseload for 2018-19 will decrease by another 0.1 percent. The department attributes this slowing growth largely to program attrition and less income eligible individuals, as asset limits have not changed since 1989.

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.

SSI Cash-out. State policy provides SSI/SSP recipients an extra $10 payment in lieu of their being eligible to receive federal food benefits through California's CalFresh program. The Legislative Analyst's Office (LAO) was directed by the 2017-18 Budget Act to assess the effects of ending the cash-out. The analysis weighs the potential benefits and risks of this course of action, and ultimately illustrates how, due to serious data limitations, it is complicated in its impacts on various populations that receive SSI.

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, which provided an additional $4.63 for individuals and $11.73 for couples per month.

Grant Levels. The chart below displays the maximum monthly SSI/SSP grant for individuals and couples in 2008–09, as compared to grant levels for 2018–19. 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. Current grants are at 92 percent of the FPL.

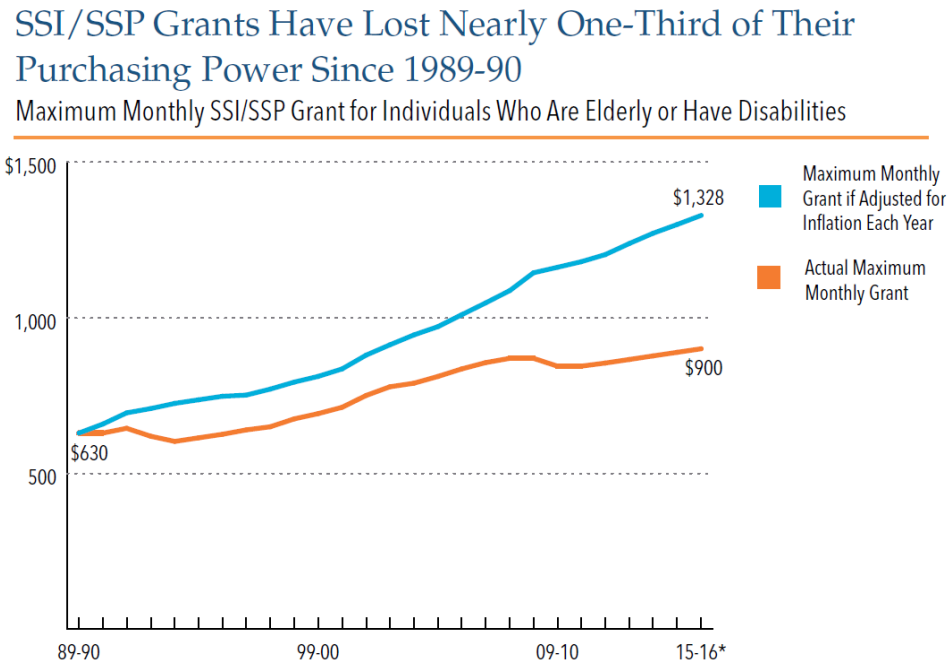
SSI/SSP Maximum Grants: Then and Now

	2008-09	2018-19 Governor's Estimates	Change From 2008-09
Maximum Grant—Individuals[a]			
SSI	$674	$770	$96
SSP	233	161	-72
Totals	**$907**	**$931**	**$24**
Maximum Grant—Couples[a]			
SSI	$1,011	$1,155	$144
SSP	568	407	-161
Totals	**$1,579**	**$1,562**	**-$17**

[a] Reflects the maximum monthly grants for aged and disabled individuals and couples living in their own households, effective as of January 1 of the respective budget year.

According to 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 2008-09. They estimate that if the 2008-09 maximum grant levels for individuals and couples had increased annually with inflation, they would be roughly $240 and $480 higher than 2018-19 levels.

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. 2016-17'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 7: Housing Disability and Advocacy Program (HDAP)

Governor's Proposal. In 2016-17, 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. HDAP has a dollar-for-dollar county match requirement. The implementation of HDAP was delayed, however, as the 2017-18 Governor's budget proposed to halt implementation. HDAP was eventually included in the final budget for 2017-18, and the $45 million is now available from July 1, 2017 through June 30, 2020.

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.

Implementation Update. In July of 2017, DSS released a request for proposals to county welfare departments. Proposals were due in the fall of 2017, and as of December 2017 a total of 41 counties applied. Currently, $41 million has been allocated to 39 counties during Phase 1, and there is an additional $3 million left for allocation in Phase 2 to be distributed among the 39 counties on a competitive basis..

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

Questions.

1. Please provide an update on HDAP implementation, and when you expect to hear feedback from counties.

2. Will the department be facilitating the spread of best practices among counties?

[3] http://economicrt.org/publication/all-alone/
[4] http://healthconsumer.org/SSIAdvocacyBestPracticesRpt.pdf

Issue 8: Proposals for Investment

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

1. Restore the SSI/SSP Grant Cuts and the COLA

Budget Issue. California's for SSI, a statewide coalition of over 200 organizations, requests that SSI/SSP grant cuts and the COLA be restored.

Staff Comment and Recommendation. Hold open. California periodically provided an SSI/SSP COLA until it was repealed in 2009. The 2016-17 budget included a one-time COLA that provided an additional $4 to individuals and $11 to couples per month.

2. SSI Cash-Out report

Budget Issue. Western Center on Law and Poverty requests that the Legislature direct the Department of Social Services to work with stakeholders on developing a plan to 1) enroll SSI recipients in SNAP; 2) develop specific "hold harmless" options; 3) identify legal steps necessary to end cash-out; and 4) identify any technology hurdles that must be solved before enrollment can begin.

Staff Comment and Recommendation. Hold open. Advocates note that according to the LAO report on the cash-out, if the cash-out were ended the state would potentially see a net gain of $205 million in federal SNAP benefits. However, given the potential for some households to lose benefits, it may be that more information is needed before a decision should be made.

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

Issue 9: Overview - IHSS

The In-Home Supportive Services (IHSS) program provides personal care services to approximately over 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 $11.2 billion ($3.6 billion General Fund) for services and administration. Of that amount, $3.5 billion ($1.8 billion General Fund) is for IHSS Basic Services. While estimates from last year to this year have decreased somewhat, primarily due to lower than anticipated Fair Labor Standards Act (FLSA) costs, costs have increased from year to year. Overall, the increased costs for IHSS in 2018-19 are due to growth in caseload of 5.1 percent, an increase in paid hours per case, the increase in the hourly minimum wage from $10.50 to $11.00, effective January 1, 2018, 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. 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. With the ending of the CCI, however, collective bargaining was returned to counties, and various new provisions related to collective bargaining were added in the 2017-18 budget, to be discussed further in the next item.

Program Funding. The average annual cost of services per IHSS client is estimated to be approximately $18,000 Total Funds for 2018-19. 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. When the CCI ended in 2017-18, a new MOE was established, which will increase annually by the county share of costs from locally negotiated wage increases and an annual adjustment factor. The new MOE will be discussed further in the next item.

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 one-time General Fund resources, and related budget bill language, to offset the seven-percent across-the-board reduction in service hours. Starting in 2016, the seven percent restoration was funded using a portion of the revenues from a restructuring of the existing Managed Care Organization (MCO) tax. The 2018-19 Governor's Budget uses $300 million General Fund to restore the seven percent across-the-board reduction. Restoration of the seven percent reduction is tied to the MCO tax, which is up for renewal in 2019.

- **Minimum wage increases and paid sick leave.** 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. As of January 1, 2018, the minimum wage is set at $11.00. The budget includes $260.3 million ($119.4 million General Fund) to reflect the impact of the increasing state minimum wage.

  SB 3 also provides eight hours of paid sick leave to IHSS providers who work over 100 hours beginning July 1, 2018. When the state minimum wage reaches $13, IHSS providers will accrue 16 hours, and when the state minimum wage reaches $15 they will receive 24 hours. $30 million General Fund is included in 20170-18 for this purpose, assuming all providers use their eight hours. Another crucial component of implementing sick leave is the provider back-up system for recipients. The department indicates it has initiated conversations with counties to ensure that recipients know how to find a back-up provider if their regular provider is sick.

- **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. $274 million General Fund is included in the current year, and $297 million General Fund is included in the budget year, for these purposes.

- **Ending of the Coordinated Care Initiative.** The CCI required health plans to coordinate medical, behavioral health, long-term institutional, and home and community-based services, and set up a MOE and collective bargaining protocol for the counties. However, if the Department of Finance found that the CCI was not cost-effective, all components of CCI and the county MOE agreement would cease operation. The 2017-18 Governor's Budget found that the CCI was no longer cost-effective and did not meet the statutory savings requirements. The Administration discontinued the CCI, which ended the IHSS MOE and returned to the prior state-county sharing ratio, and shifted collective bargaining responsibility back to demonstration counties. SB 90 (Senate Committee on Budget and Fiscal Review), Chapter 25, Statutes of 2017, enacted negotiated changes between the state, counties and labor to the MOE structure and collective bargaining, and the 2017-18 budget allocates funding to counties to mitigate costs incurred due to the ending of the CCI.

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, or escalating penalties will be incurred. Below is an estimate from the department on what the IHSS program could face in penalties if noncompliant:

FY 2018-19	$13,175,000
FY 2019-20	$29,480,000
FY 2020-21	$50,087,000
FY 2021-22	$93,898,000
FY 2022-23	$144,181,000
FY 2023-24	$179,718,000

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. IHSS consumers and stakeholders have expressed great trepidation around the prospect EVV, as it has the potential to be extremely disruptive, depending on how prescriptive federal guidance ends up being. The department has been communicating with stakeholders, and will hold a call on March 9, 2018 to discuss the results of the Request for Information (RFI) that was sent out in the fall of 2017.

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. In an effort to streamline timesheet processing, and in response to requests from IHSS stakeholders, DSS implemented online IHSS timesheets in three pilot counties in June 2017. A four-wave rollout to all counties began in August 2017 and was completed in November 2017. The online timesheet system uses technology that

is easy to use on PCs, smartphones and tablets and provides real-time data validation, which means timesheet errors can be corrected before the timesheet is submitted. Providers and recipients are 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. So far, reception of the electronic timesheets has been positive and the department is seeing participation grow. As of February 19, 2018, 90,000 providers and 99,855 recipients are enrolled to use electronic timesheets, which is a provider adoption rate of 18.6 percent. The department is also working on plans to increase the use of direct deposit as well as other electronic funds transfer options.

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. What are the options DSS is exploring around implementation? Can you share any information about the RFI?

3. Please summarize current implementation of electronic timesheets. What is the department doing to encourage providers and recipients to enroll?

4. Is the department still working to increase the use of direct deposit? If so, how are these efforts going?

5. Does the department have a statewide approach to a provider back-up system for the implementation of paid sick leave?

Issue 10: Update: IHSS MOE Changes

Budget Issue. The 2017-18 budget ended the Coordinated Care Initiative (CCI) funding structure, which in turn automatically ended the In-Home Supportive Services (IHSS) Maintenance-of-Effort (MOE) and returned to the prior state-county cost-sharing ratio, and shifted collective bargaining responsibility back to demonstration counties. SB 90 (Senate Committee on Budget and Fiscal Review), Chapter 25, Statutes of 2017, enacted negotiated changes between the state, counties and labor to the MOE structure and collective bargaining, and the 2017-18 budget allocates funding to counties to mitigate costs incurred due to the ending of the CCI.

End of the Coordinated Care Initiative. CCI required health plans to coordinate medical, behavioral health, long-term institutional, and home and community-based services. The intent of CCI was 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 MOE requirement as of July 1, 2012. Starting July 1, 2014, a 3.5 percent annual inflation factor was applied to each county's funding 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 share of cost, although with a $12.10 cap on state wage and benefit participation.

Language embedded in the CCI required the Department of Finance to annually determine if there are net General Fund savings for CCI. If CCI was not cost-effective, all components of CCI and the county MOE agreement would cease operation. The 2017-18 Governor's Budget found that the CCI was no longer cost-effective and did not meet the statutory savings requirements. The Administration discontinued the CCI, which ended the IHSS MOE and returned to the prior state-county sharing ratio, and shifted collective bargaining responsibility back to demonstration counties.

MOE Changes. The new MOE increased county IHSS costs to reflect estimated 2017-18 IHSS costs, creating a new MOE base that includes both services and administration costs. The county MOE will increase annually by an inflation factor and the counties' share of costs associated with locally negotiated wage increases. Beginning July 1, 2018, the inflation factor be five percent, and for 2018-19 is estimated to be $86,987,000. Beginning July 1, 2019, and annually thereafter, the inflation factor will be seven percent. These amounts may also change depending on 1991 realignment revenues in any given year, as they did in the current year.

The IHSS MOE for 2017-18 was established at $1,769,443,000, based on the estimated county share of IHSS services and administration costs in the 2017 May Revision budget. The Governor's Budget updates this to $1,739,753,000 based largely on lower than anticipated Fair Labor Standards Act (FLSA) costs. Below is a chart provided by the Legislative Analyst's Office displaying the difference in these numbers.

Increase in IHSS County MOE Costs

(In Millions)

	2017–18		2018–19 Governor's Budget	Change From Revised 2017–18
	Appropriation	Revised		
Total IHSS County MOE Costs[a]	**$1,768**	**$1,740**	**$1,835**	**$95**
Share of IHSS service costs	1,672	1,630	1,720	90
Share of IHSS administrative costs	96	110	115	5

[a]Total IHSS county MOE costs are partially offset by General Fund assistance provided to counties to assist them in meeting their increased IHSS MOE costs in 2017–18 ($400 million) and 2018–19 ($330 million).

IHSS = In–Home Supportive Services and MOE = maintenance–of–effort.

Changes in Administration Costs. SB 90 directed DSS, the Department of Finance, and the counties to examine the workload and budget assumptions related to the administration of the IHSS program for 2017-18 and 2018-19.While the General Fund is now expected to pay all nonfederal IHSS service costs above the counties' MOE expenditure level, the amount of General Fund that can be used for county IHSS administrative costs is capped at $220 million in 2017-18 and $208 million in 2018-19. The table above shows the county share of administration costs in 2017-18 as $110 million and in 2018-19 as $115 million. Total funding in the Governor's Budget for IHSS administrative costs in 2018-19, including federal funding, is $640 million. This includes automation costs, public authority costs, and direct service-related and fixed administrative costs. These administrative cost estimates are based on updated assumptions about average county wages and the average number of county workers needed to fulfill required activities at current caseload levels. In future years, it is expected that administrative costs will be increased according to the yearly growth in IHSS.

Counties and Public Authorities are still in conversations with the department regarding the development of budgeting methodology.

Panel. The subcommittee has requested the following panelists, in addition to the Department of Social Services, to provide comment on the changes to IHSS Administration costs and developing methodology:

- Frank Mecca, California Welfare Director's Association (CWDA)
- Karen Keeslar, California Association of Public Authorities (CAPA)

County Cost Mitigation. To help mitigate the impact of the ending of the CCI and the transition to the new IHSS MOE, the 2017-18 budget appropriates $400 million for 2017-18, $330 million for 2018-19, $200 million for 2019-20, and $150 million in 2020-21 and ongoing. These funds are a combination of General Fund and a temporary redirection of realignment funds (Vehicle License Fee growth from the Health, County Medical Services Program, and Mental Health Subaccounts). For 2017-18, the IHSS

county mitigation is $351 million General Fund, and the redirection from realignment funds is $48 million. For 2018-19, the IHSS county mitigation is $285 million General Fund, and the redirection from realignment funds is $44 million.

Below is a chart provided by the Department of Finance to provide further detail on the County IHSS Mitigation costs:

2018-19 Governor's Budget

County IHSS Mitigation
($ millions)

	2017-18	2018-19	2019-20	2020-21	2021-22
Increased County IHSS Costs[1/]	$563.9	$657.7	$786.1	$923.5	$1,070.6
Carryover of Excess Realignment Funds from Prior Year			-$13.3		
Increased County IHSS Costs Before Offsets	$563.9	$657.7	$772.8	$923.5	$1,070.6
Offsets:					
Realignment Growth Funds[2/]					
Available Sales Tax Growth	-$84.3	-$250.6	-$355.9	-$470.8	-$564.9
Redirect Mental Health VLF Growth	-$40.1	-$72.0	-$99.9	-$112.7	-$125.2
Redirect Health/CMSP VLF Growth	-$16.7	-$31.2	-$43.9	-$49.7	-$55.4
Redirect AB 85 VLF Savings	-$16.9	-$31.7	-$44.5	-$50.4	-$56.2
State General Fund[3/]	-$351.4	-$285.5	-$149.6	-$93.8	-$150.0
Total Offsets	-$509.4	-$671.0	-$693.8	-$777.4	-$951.7
Net Increase/Decrease in County Costs[4/]	$54.5	-$13.3	$79.0	$146.1	$118.9
Net Increase in County Costs at 2017 Budget Act	$141.0	$128.6	$229.8	$251.0	N/A
Change in Net County Costs from 2017 Budget Act to 2018-19 Governor's Budget	**-$86.5**	**-$141.9**	**-$150.8**	**-$104.9**	**N/A**
Total GF Impact	-$400.0	-$330.0	-$200.0	-$150.0	-$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.
[4/] Negative amount in 2018-19 indicates reserve funds that would be available in subsequent fiscal years.

Collective Bargaining Changes. Currently, collective bargaining is conducted at the county-level. SB 90 maintains that counties pay 35 percent of the nonfederal share of costs associated with negotiated wage increases, with 65 percent state participation. The state will pay its 65 percent share in county negotiated wages up to $1.10 above the hourly minimum wage set in SB 3 (Leno), Chapter 4, Statutes of 2016. For counties at or exceeding the current state participation cap of $12.10, the state would participate at its 65 percent share of costs up to a ten percent increase in wages until the state minimum wage hits $15. All wage increases will result in an adjustment to the county's IHSS MOE requirement. Total county service costs that exceed the county IHSS MOE are shifted to General Fund.

Additionally, 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 (PERB). Currently, no appeal has been made to the PERB concerning IHSS bargaining.

Recent Clarifications. AB 110 (Senate Budget and Fiscal Review Committee) makes several clarifications in order to provide further guidance to counties as they begin the negotiation process for increasing wages or benefits for IHSS providers including outlining that the wage supplement will be subsequently applied when the state minimum wage equals or exceeds the county provider wage absent the wage supplement amount, and how the wage supplement will work if a county shifts the existing amounts it pays for wages and health benefits, which was not addressed previously.

Long-term implications for Realignment. Given the complexities of realignment, layered now with the temporary redirection of a portion of these funds, the Department of Finance, in consultation with the counties and other affected parties, is statutorily required to reexamine the funding structure within 1991 Realignment and to report findings and recommendations regarding the IHSS MOE and other impacts on 1991 Realignment programs, as well as the status of collective bargaining for IHSS programs in each county, by no later than January 10, 2019.

Stakeholder Perspectives. The counties and labor organizations were actively involved in negotiating the various MOE and collective bargaining changes last year and clarifications this year. So far, no concerns have been raised with current year implementation.

Staff Comment and Recommendation. This is an informational item, and no action is required. However, the changes made to 1991 Realignment funding overall were comprehensive and it may take some time to fully understand the consequences not only to the IHSS Program but other programs that draw from the redirected realignment funds. With the required reporting due next year, the Legislature should continue to monitor implementation closely. Similarly, the Legislative Analyst's Office points out that the Legislature should consider what additional data may need to be collected to further inform efforts to modify the budget assumptions regarding IHSS administration costs for next year.

Questions.

1. Please provide a summary of the changes to the IHSS MOE and collective bargaining and an update regarding implementation. In particular, please discuss the assumptions and changes relating to the IHSS administration methodology.

2. How have stakeholders been involved in current year implementation, and what has their feedback been on the process?

3. Please share if there have been any preliminary discussions on what kind of information will be included in the report due next year.

Issue 11: Oversight – Fair Labor Standards Act (FLSA) Overtime Implementation

Governor's Proposal. The 2018-19 Governor's Budget provides $533.2 million ($246.4 million General Fund) in 2017-18 and $582.2 million in FY 2018-19 ($268.9 million General Fund) for the implementation of the federal requirements. Funding for 2017-18 is less than originally estimated, as fewer providers are working overtime, and those that are claim less additional hours. However, there is a year over year increase from current year to budget year. The Governor's budget estimates that 13 percent of providers with a single recipient and 8.2 percent of providers with multiple recipients typically work more than 40 hours per week. The total funding is allocated as follows:

- FLSA Overtime: $478.5 million in FY 2017-18 and $522.3 million in FY 2018-19
- FLSA Travel: $27.2 million in FY 2017-18 and $29.6 million in FY 2018-19
- FLSA Provider Exemptions: $14.4 million in FY 2017-18 and $17.9 million in FY 2018-19
- FLSA Administration: $8.0 million in FY 2017-18 and $8.3 million in FY 2018-19
- CMIPS II FLSA changes: $4.0 million in FY 2017-18 and FY 2018-19
- CMIPS II FLSA Provider Exemptions System Change: $1 million in FY 2017-18

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.

Exemptions. 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 disabilities 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 2017 Budget Act codified these exemptions, and required that as part of an initial IHSS assessment and any subsequent reassessments, county social workers evaluate IHSS recipients to determine if their provider is eligible for either exemption. The department is also required written notification to the provider and recipients of its approval or denial of an exemption, and to establish an appeals process through the State Hearings Division. The department is working with stakeholders on this process, and a draft All-County Letter should be sent out in March.

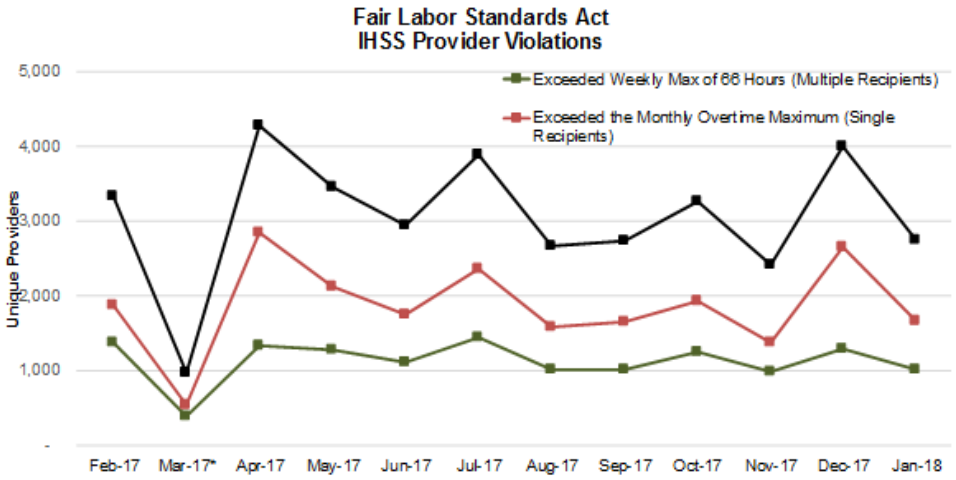
Violations Process. The first time a provider exceeds the work or travel limits, they receive a written notice. For second violations, providers will be offered a one-time opportunity to voluntarily review the instructional materials and sign a certification form stating that they understand and agree to the requirements, and their violation will be rescinded. After a second violation that is not rescinded, county staff must contact the provider. The third violation results in a three-month suspension and a fourth violation results in the provider's termination for one year.

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.

Exemption 1: As of 2/08/2018, there were 1,550 providers approved to date (1,390 have a current exemption), 755 denied, and zero pending.

Exemption 2: As of 2/08/2018, there were 121 providers approved to date (102 have a current exemption), 99 denied, and eight pending.

In 2017, an average of 3,000 providers per month received a violation. Below are two charts from DSS documenting violations data:



Violation Type	Feb-17	Mar-17*	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
Exceeded Weekly Max of 66 Hours (Multiple Recipients)	1,372	386	1,342	1,274	1,119	1,447	1,010	1,018	1,258	985	1,298	1,017
Exceeded the Monthly Overtime Maximum (Single Recipients)	1,872	545	2,843	2,128	1,750	2,359	1,585	1,651	1,937	1,374	2,647	1,662
Exceeded the Travel Maximum1	93	47	96	64	77	84	69	69	63	57	57	76
Statewide Total	**3,337**	**978**	**4,281**	**3,466**	**2,946**	**3,890**	**2,664**	**2,738**	**3,258**	**2,416**	**4,002**	**2,755**
Providers with 2 violations2	772	151	787	629	596	823	498	543	530	472	681	506
Providers with 3 violations2	239	47	240	183	167	217	147	167	152	148	184	124
Providers with 4 violations2	0	8	22	16	23	12	15	18	17	14	23	14

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 was due in April 2017.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please describe what you are seeing with the two exemptions and violations data. Do you expect these current trends to continue?

2. How many providers have been terminated or are near termination? Please discuss continued efforts to train providers.

3. Please provide an update on the creation of an appeals process for exemptions in the State Hearings Division. What is the target date for implementation?

Issue 12: Budget Change Proposal: In-Depth Monitoring of the In-Home Supportive Services Program

Governor's Proposal. The Administration requests a total of six permanent positions (one Staff Services Manager I (SSM I) and five Associate Governmental Program Analysts (AGPAs) and $780,000 ($390,000 General Fund) in 2018-19 and $712,000 ($356,000 General Fund) annually thereafter to provide in-depth monitoring and technical assistance to help improve county administration of the IHSS program.

Background. The Quality Assurance (QA) Monitoring Unit within DSS currently consists of one SSM I and eight AGPAs who perform county monitoring reviews to oversee the administration of, and compliance with, approved Quality Assurance/Quality Improvement plans, and statutes and regulations of the IHSS program. The QA Monitoring Unit also provides technical support and consultation to county QA staff to assist counties. DSS claims that due to limited resources, the QA Monitoring Unit is unable to provide in-depth monitoring and increased technical assistance to all counties. Additionally, they do not currently have the capacity to identify and address IHSS program cost trends, as the average number of hours paid per case has seen an increase of 21 percent between 2012-13 (86.3 hours) and 2015-16 (105.3 hours). DSS also points to an increased workload for QA staff due to the increased IHSS caseload and implementation of the Fair Labor Standards Act administrative changes and related overtime exemption procedures.

The Administration posits that these additional positions will allow the QA Monitoring Unit to better meet its state and federal oversight mandates by enhancing their ability to conduct annual in-depth monitoring of all counties, evaluate county administration of the IHSS program, deal with increased workload, and help to identify which specific IHSS program components are driving overall program costs.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please briefly summarize the proposal.

2. Specifically, what has activities has the QA Monitoring Unit been unable to perform, or in how many counties has it been unable to meet its statutorily required duties, with current resources?

3. Please explain in further detail what increased monitoring and technical assistance will look like.

4. What are planned next steps after workers gather information on program cost trends?

Issue 13: Proposals for Investment

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

1. Rescind the seven percent across the board cut to IHSS service hours

Budget Issue. The UDW and AFSCME Local 3930 request that the seven percent across the board cut to IHSS services hours be fully and permanently restored, regardless of the state Managed Care Organization (MCO) tax, from which the restoration is currently funded.

Staff Comment and Recommendation. Hold open. Due to a legal settlement, IHSS service hours were reduced by eight percent for all recipients for one year in 2013, with a seven percent cut annually after the first year. The cut was restored in 2016-17 using proceeds from the MCO tax, which is up for renewal in 2019. Currently in statute, the restoration of the seven percent is tied to the MCO tax; the cut will be reinstated if the MCO tax becomes inoperable.

2. Oppose Electronic Visit Verification (EVV)

Budget Issue. The UDW and AFSCME Local 3930 and the SEIU oppose the new federal requirement for personal care services programs like IHSS to implement EVV beginning January 2019 or lose federal funding for these programs.

Staff Comment and Recommendation. Hold open. Further federal guidance is forthcoming, and currently it is unclear how EVV would work. California would be at risk for approximately $13 million for noncompliance in 2018-19. It is unclear how much compliance would cost, given the lack of federal guidance.

3. Expedite IHSS Provider Enrollment

Budget Issue. The UDW and AFSCME Local 3930 and the SEIU request a modest appropriation to expedite the provider enrollment process at the county level. It can take several weeks or even months before a new IHSS provider is enrolled into the program and they are mailed their first timesheet. This delay impacts the ability of IHSS consumers to recruit and retain new workers.

Staff Comment and Recommendation. Hold open. The Department of Social Services is in discussions with counties to work on remedies for this issue.

4. Fund Health Care Benefits and establish an Employer of Record for Waiver Personal Care Services (WPCS) Providers

Budget Issue. The California Association of Public Authorities (CAPA), UDW and AFSCME Local 3930 and the SEIU request $3.5 million General Fund to establish an employer of record and provide health care benefits for approximately 700 WPCS providers in California. Currently, WPCS providers cannot receive health benefits because their hours are not covered by existing collective bargaining agreements.

Staff Comment and Recommendation. Hold open.

5. Paid Sick Leave Implementation

Budget Issue. The UDW and AFSCME Local 3930 and the SEIU request that the Administration develop a comprehensive provider back-up system by the time paid sick leave is implemented for providers in July 2018.

Staff Comment and Recommendation. Hold open.

6. Addressing the Automation Backlog in IHSS

Budget Issue. CWDA requests $2.5 million General Fund one-time to address the backlog of pending automation changes in CMIPS. CWDA asserts that counties have submitted numerous change requests to fix various problems and improve functionality in CMIPS, but these have not been implemented. Further, they claim that changes related to FLSA implementation and electronic timesheet have not been adequately funded, leaving some counties behind.

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 15, 2018
9:30 a.m., or Upon Adjournment of Floor Session
Room 4203, State Capitol

PART A

Consultant: Theresa Pena

Item	Department	Page
5160	**Department of Rehabilitation**	
Issue 1	Overview and Updates	2
	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.

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 2018-19 budget of $460.1 million ($64.7 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 2016-17.

Fund Source	2016-17 Actuals	2017-18*	2018-19*
General Fund	**$ 62,568**	**$64,604**	**$64,649**
Traumatic Brain Injury Fund	$1,060	$1,114	$892
Vending Stand Fund	$2,361	$2,361	$2,361
Federal Trust Fund	$371,541	$382,709	$384,472
Reimbursements	$7,494	$7,680	$7,680
Total Expenditures	**$445,024**	**$458,468**	**$460,054**
Positions	1,798.1	1,879	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 16 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 (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. This will be discussed in more detail later in the agenda.

- 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 (WIOA). Enacted in July 22, 2014, WIOA 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 also 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. Through collaborations with state and local partners, community rehabilitation programs, stakeholder and national experts to develop and implement new services and identify evidence based practices, the DOR has implemented or completed the following:

- Improved statewide coordination of services to youth and students with disabilities through increased collaboration with the California Departments of Education (CDE) and Social Services as well as local education agencies.

- Substantively increased work experience opportunities for students with disabilities through collaboration with local education agencies, community rehabilitation programs, America's Job Centers of California, and the Foundation for California Community Colleges.

- Improved informed choice for individuals with intellectual and developmental disabilities through the provision of career counseling and information and referral services to over 17,500 individuals working in subminimum wage employment.

- Increased opportunities for competitive integrated employment for individuals with intellectual disabilities and developmental disabilities through collaborative development of Local

Partnership Agreements that support person-centered planning and data sharing to improve outcomes.

- Improved business engagement through ongoing collaborations with statewide and local workforce boards and the establishment of a "Hot Jobs" website to further solidify DOR as a talent resource for employers seeking to hire qualified individuals with disabilities.

The Rehabilitation Services Administration (RSA) issued final WIOA regulations in September 2016 and provided technical assistance in late 2017. The DOR has achieved key milestones and expects to fully implement the final WIOA requirements before 2020. Examples of remaining requirements are final modifications to the information technology data collection system, continued transformation of services to youth and students with disabilities, and full implementation of RSA's new performance metrics. The DOR must additionally establish efficiencies to meet RSA's documentation requirements for pre-employment transition services, as these administrative activities are not allocable to the 15 percent reserve.

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 (SSA) 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 (WIP) 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, 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 $4.8 million in 2016-17. In 2017-18, these positions have generated roughly $2.5 million through September 2017.

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]

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

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), and independent living skills trainings through partnership with four ILCs.

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.

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 2017-18 and 2018-19 budget provide a transfer of $800,000 from the SPF to the TBI Fund.

The department has been seeking additional funding opportunities, such as federal grants; so far, however, the department has been unsuccessful at identifying a stable funding source for the TBI programs.

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. Together, the 28 ILCS receive approximately $22 million. Each ILC receives a different amount, based on various funding formulas for the different funding streams.

The 2017 Budget Act included a $705,000 augmentation that was provided originally in the 2016 Budget, but was suspended for that year, for three of the ILCs, including the Disability Resources Agency for Independent Living (DRAIL), serving Amador, Calaveras, Tuolumne, Mariposa, Stanislaus, and San Joaquin Counties; the Independent Living Center of Kern County (ILCKC), serving Kern County; and Placer Independent Resources Services, Inc., serving Placer, El Dorado, and Alpine Counties. Each of the ILCs received a $235,000 augmentation to their state funded base; these centers, which were established with federal VII-C funds, were originally excluded from receiving state funded base funding.

The Independent Living Network (Network), which consists of the California Foundation of Independent Living Centers (CFILC), the State Independent Living Council (SILC), the 28 ILCs, and the Department of Rehabilitation (DOR), recognizes that these funding streams are not distributed equitably among the ILCs. The Network has begun to have conversations to discuss what more equitable funding would look like.

The Network has broadly agreed that base, population, and geography are critical factors in a funding formula, that no ILC should get a reduction as a result of a new funding formula, and that a new funding formula should address periodic cost-of-living adjustments (COLAs). The Network has developed a funding concept, based on population, size of service area, and a base amount for each ILC. The concept, which is based on a formula developed and agreed upon for the distribution of American Recovery and Reinvestment Act (ARRA) funds, uses the following concepts:

- Considers the aggregate of all public funds for mandated core services, and does not consider other private funds or non-public funds that may be specific to a center.
- Allocates 40 percent of the aggregate funds for each ILC as a base, which would be established by dividing the total base by the number of ILCs.
- Allocates 50 percent of the aggregate funds that could be allocated based on the ratio of the population within each ILC catchment area to the total state population.
- Allocates 10 percent of the aggregate funds based on the geography of the catchment area.
- Allows that a percentage of funds could be specifically directed to targeted initiatives.

- For funds not allocated at the state level, equitable allocation would be achieved by adjusting state funds.

The DOR reports that this conversation regarding the future of ILC funding is continuing.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide a brief update for the department and its programs and services.

2. Please provide an update on the status of TBI funding.

3. Please provide an update on conversations with stakeholders regarding ILC funding.

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 22, 2018
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Scott Ogus

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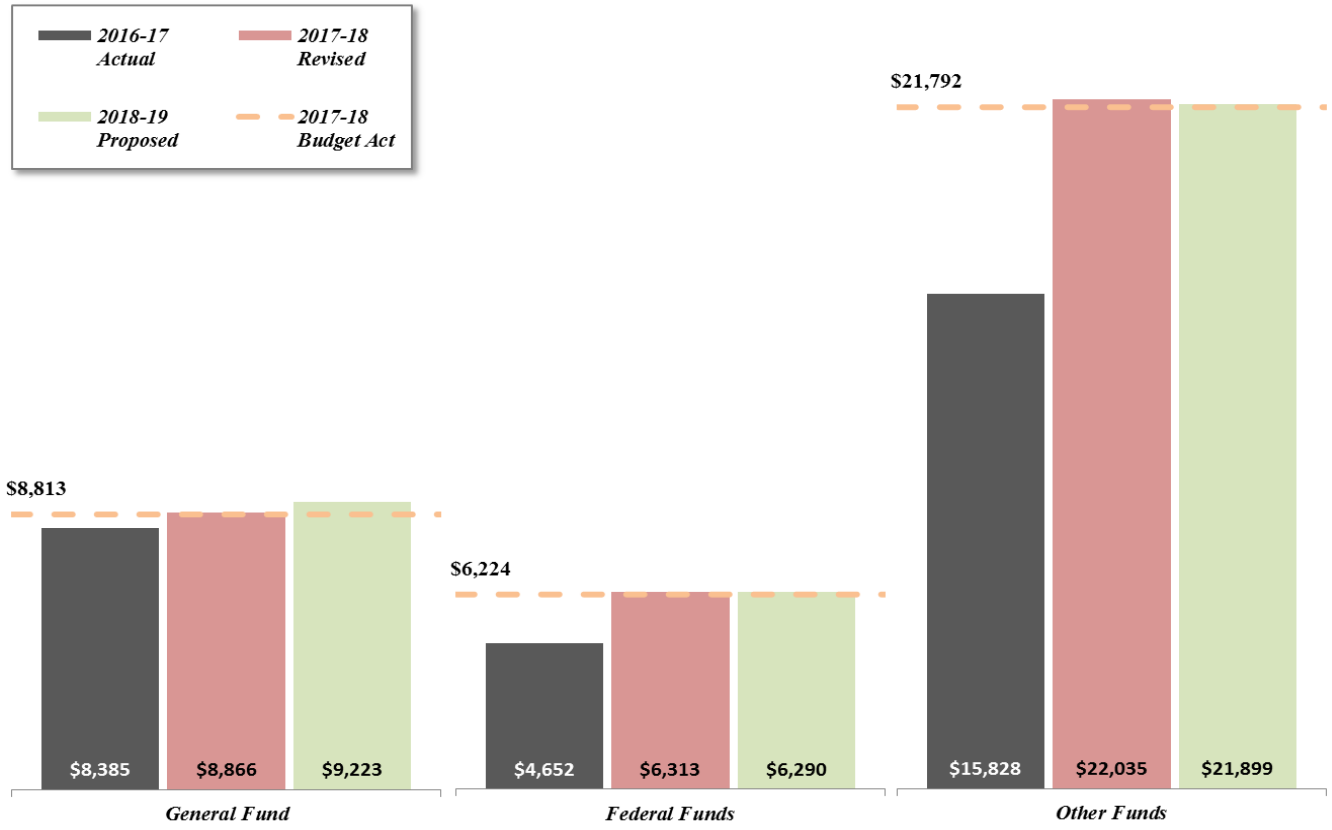
4120 EMERGENCY MEDICAL SERVICES AUTHORITY

Issue 1: Overview

Emergency Medical Services Authority – *Three-Year Funding Summary*
(dollars in thousands)



Emergency Medical Services Authority – *Department Funding Changes Since Budget Act*			
Fund Source	***2017-18 (Budget Act)***	***2017-18 (Revised)***	***2018-19 (Proposed)***
General Fund (0001)	$8,813,000	$8,866,000	$9,223,000
Federal Funds (0890)	$6,224,000	$6,313,000	$6,290,000
Other Funds (*detail below*)	$21,792,000	$22,035,000	$21,899,000
Total Department Funding:	**$36,829,000**	**$37,214,000**	**$37,412,000**
Total Authorized Positions:	**68.9**	**68.9**	**69.9**
Other Funds Detail:			
EMS Training Prog. Approval Fund (0194)	*$208,000*	*$217,000*	*$217,000*
EMS Personnel Fund (0312)	*$2,655,000*	*$2,747,000*	*$2,608,000*
Reimbursements (0995)	*$17,421,000*	*$17,518,000*	*$17,520,000*
EMT Certification Fund (3137)	*$1,508,000*	*$1,553,000*	*$1,554,000*

Background. The Emergency Medical Services Authority (EMSA), authorized by the Emergency Medical Services System and Prehospital Emergency Care Act, administers a statewide system of coordinated emergency medical care, injury preventions, and disaster medical response that integrates public health, public safety and health care services. Prior to the establishment of EMSA in 1980, California did not have a central state agency responsible for ensuring the development and coordination of emergency medical services (EMS) and programs statewide. For example, many jurisdictions maintained their own certification requirements for paramedics, emergency medical technicians (EMTs), and other emergency personnel, requiring individuals certified to provide emergency services in one county to re-test and re-certify to new standards to provide emergency services in a different county. 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 develops standards for emergency medical dispatcher training, pre-arrival emergency care instructions, and epinephrine auto-injector training.

EMS Systems Division. The EMS 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: Increased Information Technology Security Resources

Budget Issue. EMSA requests one permanent position and $356,000 General Fund in 2018-19 and $189,000 General Fund in 2019-20 and annually thereafter. If approved, these resources would allow EMSA to provide adequate staffing levels to strengthen the department's information technology (IT) infrastructure and compliance with state IT policy and regulatory requirements.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$356,000	$189,000
Total Funding Request:	**$356,000**	**$189,000**
Total Requested Positions:	**1.0**	**1.0**

* Positions and Resources are ongoing after 2019-20.

Background. AB 670 (Irwin), Chapter 518, Statutes of 2015, authorizes the California Department of Technology (CDT) to conduct independent security assessments of state departments and agencies, requiring no fewer than 35 assessments be conducted annually. AB 670 requires CDT to prioritize for assessment state departments or agencies that are at higher risk due to handling of personally identifiable information or health information protected by law, handling of confidential financial data, or levels of compliance with certain information security and management practices. Independent security assessments are conducted by the Cyber Network Defense (CND) Team at the California Military Department.

EMSA is responsible for administering a statewide system of coordinated emergency medical care, injury preventions, and disaster medical response that integrates public health, public safety and health care services. EMSA coordinates communications between state entities and local EMS agencies during disasters and other emergencies, assists local EMS agencies with planning, and oversees professional licensure of the state's paramedics and EMTs. In support of this mission, EMSA utilizes several software applications and information technology (IT) systems, including those utilized for licensing activities and the Disaster Medical Services Response Resources Unit's communication response assets. These applications and systems are currently maintained by an IT Unit comprised of a Chief Information Officer and five staff.

Independent Security Assessment. Pursuant to AB 670, EMSA underwent an independent security assessment conducted by CND in December 2016. According to EMSA, the assessment identified several deficiencies in EMSA's performance of its IT infrastructure and security responsibilities. The assessment also identified strategies and resources needed for remediation including one-time hardware and/or software upgrades and additional staff time dedicated to IT infrastructure responsibilities. In addition, EMSA currently designates one existing IT employee as the Information Security Officer (ISO), which is handled part-time as an ancillary duty. However, state information management policy prohibits ISOs from being "assigned multiple roles which present a conflict of interest, such as having direct responsibility for application development, information processing, technology operations, internal auditing functions, or for state entity programs". As a result, the assessment recommended EMSA designate a dedicated, full-time position to perform the functions of the ISO.

Information Security Officer and Recommended IT Upgrades. EMSA is requesting $356,000 General Fund in 2018-19 and one Senior Information Systems Analyst to serve as ISO and oversee planning for remediation of the deficiencies identified in the CND assessment. The 2018-19 request includes $196,000 for the one-time hardware and/or software upgrades recommended by the CND assessment to mitigate identified deficiencies. The ISO would oversee the procurement of these upgrades, as well as managing EMSA's information security and privacy planning and compliance with state IT management and security policies. In 2019-20 and annually thereafter, EMSA requests $189,000 for ongoing support of the ISO position and maintenance of the purchased hardware and/or software.

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

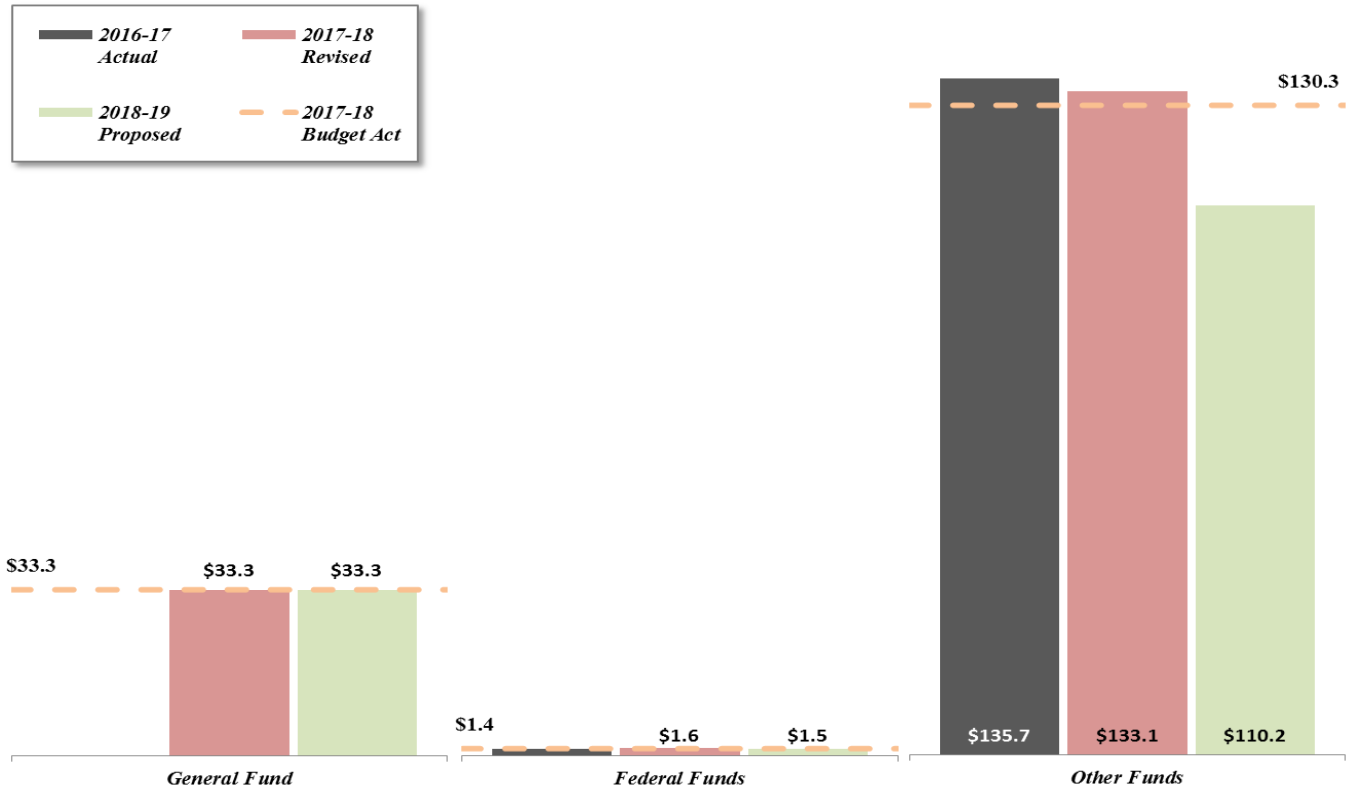
Questions. The subcommittee has requested EMSA to respond to the following:

1. Please provide a brief overview of this proposal.

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: Overview

Office of Statewide Health Planning and Development – *Three-Year Funding Summary*
(dollars in millions)



Office of Statewide Health Planning and Development - *Department Funding Summary*			
Fund Source	***2017-18 Budget Act***	***2017-18 Revised***	***2018-19 Proposed***
General Fund (0001)	$33,334,000	$33,334,000	$33,333,000
Federal Funds (0890)	$1,447,000	$1,572,000	$1,464,000
Other Funds (*detail below*)	$130,259,000	$133,062,000	$110,189,000
Total Department Funding:	**$165,040,000**	**$167,968,000**	**$144,986,000**
Total Authorized Positions:	**447.0**	**433.5**	**430.5**
Other Funds Detail:			
Hospital Building Fund (0121)	*$61,820,000*	*$63,485,000*	*$63,521,000*
CA Health Data and Planning Fund (0143)	*$30,557,000*	*$31,388,000*	*$31,752,000*
Registered Nurse Education Fund (0181)	*$2,172,000*	*$2,179,000*	*$2,180,000*
Health Fac. Const. Loan Ins. Fund (0518)	*$4,823,000*	*$4,939,000*	*$4,943,000*

Health Professions Education Fund (0829)	*$1,078,000*	*$1,099,000*	*$1,099,000*
Medically Underserved Account/Phys (8034)	*$2,302,000*	*$2,399,000*	*$2,399,000*
Reimbursements (0995)	*$863,000*	*$868,000*	*$868,000*
Mental Health Practitioner Ed. Fund (3064)	*$394,000*	*$395,000*	*$395,000*
Vocational Nurse Education Fund (3068)	*$224,000*	*$224,000*	*$224,000*
Mental Health Services Fund (3085)	*$26,026,000*	*$26,086,000*	*$2,808,000*

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 Development Division. 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.

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.

The Song-Brown program was funded exclusively with state General Fund until the 2004-05 fiscal year. Between 2004-05 and 2008-09, the program received a combination of General Fund and funding from the California Health Data and Planning Fund (Data Fund), which receives fee revenue from licensed health facilities in California. Beginning in 2008-09, the program received no General Fund resources until 2017-18. During that period, the program relied on resources from the Data Fund and a $21 million grant from the California Endowment for family medicine and family nurse practitioner/physician assistance training.

The 2017 Budget Act authorized $100 million over three years for augmentation of health care workforce initiatives at OSHPD previously approved in the 2016 Budget Act. The Legislature rejected the Administration's proposal to revert these funds to the General Fund and eliminate the health care workforce initiative augmentations permanently. The $33.3 million annual allocation provides $18.7 million for existing primary care residency slots, $3.3 million for new primary care residency slots at existing residency programs, $5.7 million for primary care residency slots at teaching health centers, $3.3 million for newly accredited primary care residency programs, $333,000 for the State Loan Repayment Program, and $2 million for OSHPD state operations costs.

According to OSHPD, the Song-Brown program awarded the following in 2017-18:

1) *Existing Primary Care Residency Slots* – $16.8 million to support 134 slots in 55 programs
2) *New Primary Care Residency Slots at Existing Programs* - $2 million to support 13 slots in seven programs
3) *Teaching Health Centers* - $5.1 million to support 30 slots in six programs
4) *Newly Accredited Primary Care Residency Programs* - $6.8 million ($3.3 million General Fund, $3.1 million Data Fund, and $273,000 California Endowment Funds) to support 59 slots in ten new programs.

OSHPD reports these resources resulted in funding for a total of 72 new residency slots supported by the Song-Brown program for 2017-18.

Workforce Education and Training (WET) Program. 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 for community services and supports, prevention and early intervention, innovative programs, workforce education and training (WET), and capital facilities and technological needs. For WET programs, Proposition 63 allocated $210 million to counties and $234.5 million to the state over a ten year period beginning in 2008. The state's WET programs were originally administered by the Department of Mental Health (DMH), which developed the first five year plan for the program. After dissolution of DMH in 2012 program responsibility was transferred to OSHPD, which developed the second five year plan for 2014-2019 in coordination with the California Mental Health Planning Council.

OSHPD's WET program provides funding for stipends and loan assumption, education capacity, consumer and family member employment, regional partnerships, recruitment and retention, and evaluation of the program. According to OSHPD, in 2016-17 the WET program awarded the following:

1) *Stipends* - $16.2 million in stipends for psychiatric mental health nurse practitioners, clinical psychologists, marriage and family therapists, and social workers in public mental health systems (PMHS).
2) *Education Capacity* - $5.6 million to increase training capacity and provide clinical rotations in PMHS for psychiatric mental health nurse practitioners and clinical psychologists.
3) *Recruitment and Retention* - $2 million for exposure and scholarship rotations in PMHS.

In addition, OSHPD awarded multi-year grants of up to $1.8 million to five Regional Partnerships between 2014-15 and 2016-17 to address regional needs in a variety of mental health disciplines. $1.1 million was provided for evaluation of various program components.

WET Program "Fifth Year" Funding Proposal. Although the second five-year plan concludes in 2019, WET funding will expire on July 1, 2018, funding only four of the five years in the plan. OSHPD reports the WET program will begin to close out its existing funding awards as the expiration of funding approaches. Although no funding is allocated beyond 2018, OSHPD is still required by law to develop a five-year plan for the 2019-2024 period. OSHPD indicates it will develop strategic goals in this report without identifying funding sources. The California Council of Community Behavioral Health Agencies (CBHA) requests $25.4 million General Fund to provide funding for 2018-19 to completely fund the fifth year of the five-year plan. According to CBHA, this funding will allow existing WET programs to continue while OSHPD and stakeholders work together on options for funding and implementing a new five-year plan.

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. According to OSHPD, the SLRP made 70 awards totaling $2 million in 2016-17.

Health Professions Education Foundation. OSHPD administers the Health Professions Education Foundation (HPEF), a 501(c)(3) non-profit public benefit corporation established in 1987 through legislation. The HPEF offers scholarships and loan repayments for students and graduates willing to practice in underserved areas. The HPEF manages the following six scholarship and seven loan repayment programs:

Program(s)	Eligible Professions
Allied Healthcare Scholarship (AHSP) Allied Healthcare Loan Repayment (AHLRP)	Community Health Worker, Medical Assistant, Medical Imaging, Occupational Therapy Assistant, Pharmacy Technician, Physical Therapy Assistant, Radiation Therapy Technician, Radiologic Technician
Vocational Nurse Scholarship (VNSP) Licensed Vocational Nurse Loan Repayment (LVNLRP)	Vocational Nurses
LVN to Associate Degree Nursing Scholarship (LVN to ADN)	Licensed Vocational Nurses
Associate Degree Nursing Scholarship (ADNSP)	Nursing (Associate Degree students)
Bachelor of Science in Nursing Scholarship (BSNSP) Bachelor of Science in Nursing Loan Repayment (BSNLRP)	Nursing (Bachelor's Degree students)

Advanced Practice Healthcare Scholarship (APHSP) Advanced Practice Healthcare Loan Repayment (APHLRP)	Certified Nurse Midwives, Clinical Nurse Specialists, Dentists, Nurse Practitioners, Occupational Therapists, Pharmacists, Physical Therapists, Physician Assistants, Speech Language Pathologists
Licensed Mental Health Services Provider Education (LMHSPEP)	Psychologists, Postdoctoral Psych. Assistants, Postdoctoral Psych. Trainees, Marriage and Family Therapists, Clinical Social Workers, Professional Clinical Counselors
Mental Health Loan Assumption (MHLAP)	Determined by counties
Steven M. Thompson Physician Corp Loan Repayment (STLRP)	Primary care physicians (65 percent), geriatric physicians (15 percent), specialty physicians (up to 20 percent)

In 2016-17, the HPEF awarded 1,839 scholarships and loan repayments in its 13 programs for a total award amount of $22.9 million. These programs are funded by a combination of foundation grant funding and licensing fees collected by professional licensing boards for the professions benefitting from HPEF training programs. Foundations providing funding include the California Endowment, the California Medical Services Project, the California Wellness Foundation, and Kaiser Permanente California Community Benefit Foundation.

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 (Alquist 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 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 476 general acute care and acute psychiatric hospitals comprised of 3,066 hospital buildings and 88,126 licensed beds 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 skilled nursing facilities and intermediate care facilities. The Facilities Development Division receives funding from fees paid by hospitals and skilled nursing facilities for plan review and building permits of construction projects, as follows:

1) 1.95 percent of construction costs for collaborative phased plan review
2) 1.64 percent of construction costs for hospitals
3) 1.5 percent of construction costs for skilled nursing facilities

Cal-Mortgage Loan Insurance Division. OSHPD's Cal-Mortgage Loan Insurance 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 November 30, 2017, Cal-Mortgage insures 82 loans with a total value of approximately $1.5 billion.

Information Services Division. The Information Services Division (ISD) collects and disseminates timely and accurate healthcare quality, outcome, financial, and utilization data, and produces data analyses and other products.

Information Technology Services and Support. The division supports operations, data collection, and reporting functions through maintenance of technical infrastructure and enterprise systems, including IT customer support, project portfolio management, and enterprise architecture.

Data Collection and Management. 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.

Healthcare Data Analytics. 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.

Engagement and 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 provide a brief update on the status of implementation and awards of funding provided for primary care workforce programs in the 2017 Budget Act.

Issue 2: Prescription Drug Cost Transparency Implementation Plan (SB 17)

Budget Issue. OSHPD requests three positions and expenditure authority from the California Health Data and Planning Fund of $500,000 in 2018-19, $850,000 in 2019-20, and $800,000 in 2020-21 and annually thereafter. Beginning in 2019-20, OSHPD also requests an additional 2.5 positions for a total of 5.5 permanent positions. If approved, these positions and resources would allow OSHPD to implement prescription drug price transparency initiatives required by SB 17 (Hernandez), Chapter 603, Statutes of 2017. Pursuant to SB 17, the resources requested from the California Health Data and Planning Fund are funded by revenue transfers from the Managed Care Fund, administered by the Department of Managed Health Care, and the Insurance Fund, administered by the California Department of Insurance.

Program Funding Request Summary			
Fund Source	**2018-19**	**2019-20**	**2020-21***
0143 – CA Health Data and Planning Fund	$500,000	$850,000	800,000
Total Funding Request:	**$500,000**	**$850,000**	**$800,000**
Total Requested Positions:	**3.0**	**5.5**	**5.5**

* Positions and Resources ongoing after 2020-21.

Revenue Transfers to CA Health Data and Planning Fund (0143)			
Fund Source	**2018-19**	**2019-20**	**2020-21***
0217 – Insurance Fund	$35,000	$60,000	$56,000
0933 – Managed Care Fund	$465,000	$790,000	$744,000
Total Funding Request:	**$500,000**	**$850,000**	**$800,000**

* Revenue Transfers ongoing after 2020-21.

Background. Approved by the Legislature in 2017, SB 17 was intended to provide drug cost transparency in response to the significant growth in expenditures for prescription drugs by public health care programs, commercial health plans, and the general public. These increased expenditures have been attributable to both blockbuster drugs newly brought to market, such as new treatments for hepatitis C, and existing drugs, often no longer under patent protection, for which a single manufacturer controls the drug's supply and substantially increases its price. SB 17 requires drug manufacturers to provide notice to health care purchasers and publicly report to OSHPD certain information regarding price increases for existing drugs exceeding 16 percent and for new drugs priced above certain federally established thresholds.

Implementation of OSHPD's SB 17 Responsibilities. OSHPD's primary responsibilities for implementation of SB 17 include the following:

Significant Price Increases for Existing Drugs – Notice to Purchasers of Health Care Services. SB 17 requires a drug manufacturer to report to certain public and private sector purchasers of health care services if the price of one of its manufactured drugs increases by more than 16 percent. The required notice must be provided at least 60 days prior to the price increase and must include cumulative price increases over the prior two years, the date of the expected increase, the current price, the dollar amount of the expected increase, and information about whether a change or improvement in the drug

necessitates the price increase. Prior to receiving price increase reports from drug manufacturers, a public or private sector purchaser must first register with OSHPD. OSHPD provides the list of registered purchasers to manufacturers to enable distribution of required notices of drug price increases exceeding the 16 percent threshold. These requirements took effect on January 1, 2018. OSHPD currently has an online submission form on its website for purchasers to register as well as a link to the list of registered purchasers for download by drug manufacturers.

Significant Price Increases for Existing Drugs – Quarterly Reporting. SB 17 also requires, effective no earlier than January 1, 2019, drug manufacturers subject to notice requirements due to price increases over the 16 percent threshold to report quarterly to OSHPD the following information:

1. A description of the factors used to make the decision to increase the price of the drug, the amount of the increase, and an explanation of how these factors explain the price increase.
2. A schedule of price increases for the drug for the previous five years if the drug was manufactured by the company.
3. If the drug was acquired by the manufacturer within the previous five years, all of the following information:
    a. The price of the drug at the time of acquisition and the calendar year prior to acquisition.
    b. The name of the company from which the drug was acquired, the date acquired, and the purchase price.
    c. The year the drug was introduced to market and the price of the drug at the time of introduction.
    d. The patent expiration date of the drug if it is under patent.
    e. If the drug is a multiple source drug, an innovator multiple source drug, a noninnovator multiple source drug, or a single source drug, as defined in federal regulations.
    f. A description of the change or improvement in the drug, if any, that necessitates the price increase.
    g. Volume of sales of the manufacturer's drug in the United States for the previous year.

OSHPD is required to post the information received from drug manufacturers quarterly and within 60 days of receipt on its website. OSHPD is also responsible for directing drug manufacturers on the format and timing of quarterly reporting requirements under these provisions of SB 17.

New High-Cost Drugs. Beginning January 1, 2019, for newly introduced drugs, SB 17 requires manufacturers to notify OSHPD within three days after release if the price exceeds the threshold set for a specialty drug for the Medicare Part D program. No later than 30 days after submitting the notification, manufacturers must provide the following information to OSHPD:

1. A description of the marketing and pricing plans used in the launch of the new drug in the United States and internationally.
2. The estimated volume of patients that may be prescribed the drug.
3. If the drug was granted breakthrough therapy designation or priority review by the federal Food and Drug Administration prior to final approval.
4. The date and price of acquisition if the drug was not developed by the manufacturer.

OSHPD is required to post this information quarterly on its website on a per-drug basis that allows identification of the drug. OSHPD is also responsible for enforcement of the reporting requirements

contained within SB 17 including authority to impose civil penalties of $1,000 per day required information is not reported after the end of the required reporting period.

OSHPD's current SB 17 implementation plan timelines are as follows:

Projected Time Period	OSHPD Activities
November – December 2017*	Compile a registry of state purchasers, healthcare service plans, health insurers, and pharmacy benefit managers that wish to receive 60-day notices of future increases, above the threshold specified, of the wholesale acquisition cost of prescription drugs.
December 1, 2017*	Open portal on OSHPD website for purchasers to register to receive 60-day notice.
January 1, 2018*	Registry to be available to drug manufacturers on OSHPD website.
January – March 2018	Begin outreach to stakeholders.
March 15, 2018	Conduct public workshop with data users.
April 11, 2018	Conduct public workshop with data submitters.
July 2018	Open rulemaking period and conduct public forum for comment.
September - December 2018	Release preliminary information reporting requirements and information collection format to drug manufacturers and share with stakeholders.
April – June 2018	Draft regulations that will take effect January 2019.
September – December 2018	Release information reporting requirements and information collection format to drug manufacturers.
January 1, 2019	Formally adopt regulations.
January 2019	Begin collecting information related to new prescription drugs from drug manufacturers. OSHPD to publish this information quarterly on its website beginning Spring 2019.
April 2019	Begin collecting first quarter 2019 prescription drug cost increase information for existing drugs from drug manufacturers.
By June 2019	Publish first quarter 2019 drug cost increase information for existing drugs on OSHPD website.

***** Activity Completed

OSHPD is requesting positions and funding as follows:

For 2018-19: Three positions and $500,000 from the California Health Data and Planning Fund.

- *One Staff Services Manager I (SSM I)* would establish a new unit in OSHPD's Accounting and Reporting Systems Section to coordinate collection and reporting of drug price information from manufacturers.

- *One Staff Information Systems Analyst* would be added to OSHPD's Information Technology (IT) Planning Group to oversee the implementation of IT systems necessary to collect and manage drug pricing and penalty collection data.
- *One Attorney III* would draft regulations to support implementation of the SB 17 program, establish support policies, procedures and appeals processes, as well as manage program enforcement.

For 2019-20: 2.5 additional positions and $350,000 from the California Health Data and Planning Fund.

- *Two Associate Governmental Program Analysts* would support the SSM I proposed for 2018-19 to coordinate collection and reporting of drug price information from manufacturers.
- *0.5 Staff Programmer Analyst* in OSHPD's IT Operations Branch to perform complex analysis, design, programming, and integration tasks for the development and ongoing maintenance of IT systems required for collection and reporting of drug price information.

Funding Provided by Managed Care Fund and Insurance Fund. SB 17 provides funding to support OSHPD's activities from the Managed Care Fund and the Insurance Fund. The Managed Care Fund, administered by the Department of Managed Health Care, collects fees from health care service plans regulated under the Knox-Keene Health Care Service Plan Act of 1975. The Insurance Fund, administered by the California Department of Insurance, collects fees from insurers regulated by the department. SB 17 governs the transfers from these two funds into the California Health Data and Planning Fund, which are based on the relative shares of covered lives in health care service plans (for the Managed Care Fund share) or health insurance products (for the Insurance Fund share). Based on this formula, seven percent of the funding for this request is provided by the Insurance Fund and 93 percent by the Managed Care Fund.

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

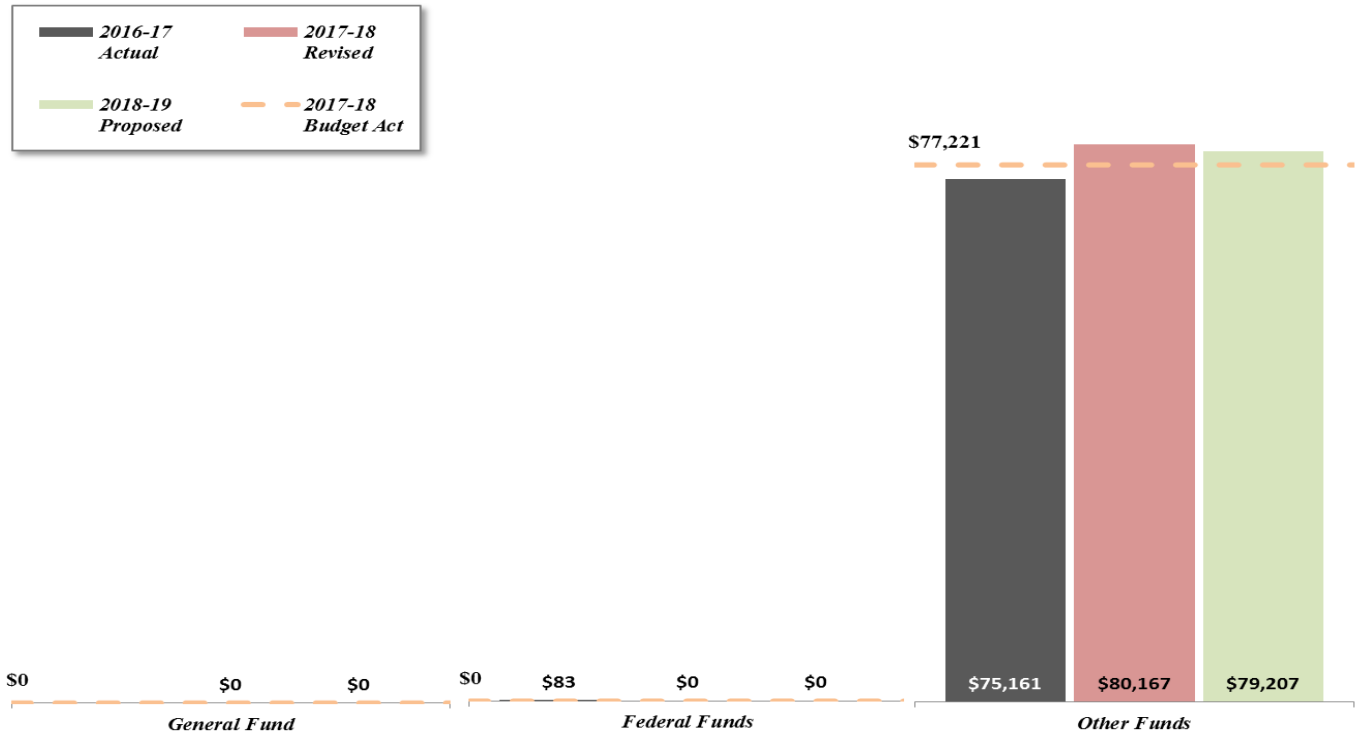
Questions. The subcommittee has requested OSHPD to respond to the following:

1. Please provide a brief overview of this proposal.

4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 1: Overview

Department of Managed Health Care – *Three-Year Funding Summary*
(dollars in thousands)



Department of Managed Health Care - *Department Funding Summary*			
Fund Source	***2017-18 Budget Act***	***2017-18 Revised***	***2018-19 Proposed***
General Fund (0001)	$0	$0	$0
Federal Funds (0890)	$0	$0	$0
Other Funds (*detail below*)	$77,221,000	$80,167,000	$79,207,000
Total Department Funding:	**$77,221,000**	**$80,167,000**	**$79,207,000**
Total Authorized Positions:	**416.6**	**416.6**	**417.6**
Other Funds Detail:			
Managed Care Fund (0933)	*$77,050,000*	*$79,996,000*	*$79,036,000*
Reimbursements (0995)	*$171,000*	*$171,000*	*$171,000*

Background. The Department of Managed Health Care (DMHC) is the primary regulator of the state's 137 health care service plans, which provide health, mental health, dental, vision, and pharmacy services to more than 26 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 contributed to the submission of erroneous reports. The widespread inaccuracy of the data submissions made it impossible for DMHC to analyze whether plans were in compliance with timely access standards for 2015. In response, DMHC required the use of a department-approved vendor to monitor data accuracy for the 2016 calendar year submissions.

In February 2018, DMHC published its timely access report for calendar year 2016. According to DMHC, although it required health plans to use an approved external vendor to perform validation and quality assurance review of data collection, much of the data for the 2016 report had already been collected under prior methodological standards. Although the submitted data contained fewer errors than the 2015 report, there were still analytical challenges due to non-standardized data collection methods and insufficient sample sizes. The data the department was able to report included the results of surveys regarding how often providers in health plan networks had appointment availability within the required timeframes. According to DMHC, it is working with statisticians to quantify how that percentage translates into a reliable estimate of an enrollee's ability to obtain timely appointments.

Prohibition of Surprise Balance Billing (AB 72). 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.

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.

According to DMHC, no claim disputes have been received since the IDRP was established.

Consumer Outreach and Assistance Program. Section 1368.05 of the Health and Safety Code requires DMHC to contract with community-based organizations to assist consumers in navigating private and public health care coverage. Since 2012, DMHC has contracted with the Health Consumer Alliance (HCA) through the Consumer Outreach and Assistance Program (COAP) to advocate for health care consumers confronting barriers to eligibility, coverage, or obtaining services by providing free legal assistance. HCA is a statewide collaborative of consumer assistance programs operated by community-based legal services organizations, including: Bay Area Legal Aid, California Rural Legal Assistance, Central California Legal Services, Greater Bakersfield Legal Assistance, Legal Aid Society of Orange County, Legal Aid Society of San Diego, Legal Aid Society of San Mateo, Legal Services of Northern California, Neighborhood Legal Services of Los Angeles County, the National Health Law Program, and the Western Center on Law and Poverty.

According to HCA, COAP has been funded by $2.5 million from the Managed Care Fund since 2014. The program receives an explicit allocation through provisional budget language of $660,000, but HCA reports DMHC provides additional funding through redirection of other allocations within its overall appropriation from the Managed Care Fund. HCA requests an explicit allocation of $2.6 million from the Managed Care Fund, which includes continued funding of the program at its current level and a cost-of-living adjustment of $100,000.

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. Please summarize the findings of the 2016 Timely Access Report. Was the department able to determine whether health plans were complying with timely access standards?

3. What steps is DMHC taking to ensure the 2017 Timely Access Report and future reports provide useful information about compliance with required timely access standards?

4. How frequently do non-contracting providers offer services in contract hospitals? Has there been any change in contracting practices for these providers since implementation of AB 72?

5. How does the use of non-contracting providers in contract hospitals factor into the evaluation of a plan network's ability to provide timely access to care?

Issue 2: Federal Mental Health Parity Compliance Review Resources Extension

Budget Issue. DMHC requests permanent extension of expiring, limited-term expenditure authority from the Managed Care Fund of $529,000 in 2018-19 and annually thereafter. If approved, these resources will allow DMHC to continue to review health care service plan filings for compliance with the mental health parity requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0933 – Managed Care Fund	$529,000	$529,000
Total Funding Request:	**$529,000**	**$529,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2019-20.

Background. The federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) prevents group health plans and health insurance issuers that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical or surgical benefits. The federal Affordable Care Act (ACA) and the state legislation governing ACA implementation extended the parity requirements of MHPAEA to individual and small group products, as well. In November 2013, the federal Department of Health and Human Services released its final rule on MHPAEA compliance, including specific requirements on health plans to conduct parity analyses. DMHC is responsible for ensuring health plan compliance with MHPAEA.

MHPAEA Compliance Review Process. DMHC's MHPAEA compliance reviews consist of two components:

1) Front-end: reviews of documentation submitted by plans to determine MHPAEA compliance.
2) Back-end: onsite reviews to verify plans are operating in accordance with compliance filings.

The MHPAEA final rules require review of the health plans' processes and justifications for classifying benefits within the following six permissible classifications:

1. Inpatient, In-Network
2. Inpatient, Out-of-Network
3. Outpatient, In-Network, including:
   a. Outpatient Office Visits
   b. Outpatient Other Items and Services
4. Outpatient, Out-of-Network, including:
   a. Outpatient Office Visits
   b. Outpatient Other Items and Services
5. Emergency Care
6. Prescription Drugs

After classifying all benefits into one of these categories, health plans must determine parity for:

1) Financial requirements, such as deductibles, copays, or coinsurance.
2) Quantitative treatment limitations (QTLs), such as number of visits or days of treatment.
3) Non-quantitative treatment limitations (NQTLs), including subjective limitations on treatment, such as utilization management.

DMHC conducts complex reviews for all new commercial product filings, including an analysis of classification of benefits, financial requirements, QTLs, and NQTLs. In addition to complex reviews, DMHC expects to conduct focused reviews on plans that have already undergone complex reviews, but have changed any aspect of previously approved compliance methods or factors. Focused reviews are more narrow in scope and require less time than complex reviews.

Resource History for MHPAEA Compliance Activities. The 2014 Budget Act included a one-time augmentation of $369,000 (Managed Care Fund) for clinical consulting services to conduct initial front-end compliance reviews to ensure oversight of California's implementation of the MHPAEA and five positions to enforce these requirements. The 2015 Budget Act authorized additional resources to further support onsite medical surveys of the plans subject to MHPAEA. The 2016 Budget Act authorized limited-term expenditure authority from the Managed Care Fund of $529,000 for two years to fund clinical consultants to perform the clinical aspect of MHPAEA compliance reviews.

DMHC requests permanent extension of the previously approved expenditure authority scheduled to expire on June 30, 2018. According to DMHC, the MHPAEA clinical consultant workload is permanent in nature as certain clinical assessments, such as classification of benefits and NQTLs in a plan's coverage disclosure documentation, cannot be performed by existing civil service classifications.

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

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

1. Please provide a brief overview of this proposal.

Issue 3: Prescription Drug Cost Transparency (SB 17)

Budget Issue. DMHC requests one position and expenditure authority from the Managed Care Fund of $307,000 in 2018-19 and $281,000 in 2019-20 and annually thereafter. If approved, these resources would allow DMHC to compile health plan information on prescription drug costs pursuant to SB 17 (Hernandez), Chapter 603, Statutes of 2017.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0933 – Managed Care Fund	$307,000	$281,000
Total Funding Request:	**$307,000**	**$281,000**
Total Requested Positions:	**1.0**	**1.0**

* Position and Resources ongoing after 2019-20.

Background. Approved by the Legislature in 2017, SB 17 was intended to provide drug cost transparency in response to the significant growth in expenditures for prescription drugs by public health care programs, commercial health plans, and the general public. These increased expenditures have been attributable to both blockbuster drugs newly brought to market, such as new treatments for hepatitis C, and existing drugs, often no longer under patent protection, for which a single manufacturer controls the drug's supply and substantially increases its price. SB 17 requires health care service plans to publicly report to DMHC certain information regarding expenditures on prescription drugs on behalf of beneficiaries.

Implementation of DMHC's SB 17 Responsibilities. DMHC's primary responsibilities for implementation of SB 17 include the following:

Health Plan Expenditures on High Cost and High Utilization Drugs – SB 17 requires health plans that file certain rate information to report by October 1 of each year the following information for all covered prescription drugs:

- The 25 most frequently prescribed drugs.
- The 25 mostly costly drugs by total annual plan spending.
- The 25 drugs with the highest year-over-year increase in total annual plan spending.

SB 17 also requires DMHC by January 1 of each year to compile and publish this information by plan in a report for the public and legislators that demonstrates the overall impact of drug costs on health care premiums. The report data is required to be aggregated so that information specific to individual health plans remains confidential. SB 17 requires DMHC to include the report as part of its annual public meeting on aggregate trends in the large group market.

Large Group Expenditures on Prescription Drugs – SB 17 requires health plans that file annual large group rate information to include the following information:

- The percent of premium attributable to drug costs for each category of prescription drugs (e.g. generic, brand name, and brand name/generic specialty).
- The year-over-year increase, as a percentage, in per member, per month costs for each category.

- The year-over-year increase in per member, per month costs for drug prices compared to other components of the health care premium,
- The specialty tier formulary list.
- The percentage of the premium attributable to prescription drugs administered in a doctor's office that are covered under the medical benefit as separate from the pharmacy benefit, if available.
- Information on use of a pharmacy benefits manager (PBM), if any, including which components of prescription drug coverage are managed by the PBM.

DMHC requests one Associate Life Actuary in its Division of Premium Rate Review to modify reporting formats and instructions, review health plan and large group rate information filing, and compile the annual report on high cost and high utilization drugs. In addition, DMHC requests consultant funding of $50,000 annually to assist with preparation of the report and public meetings, $25,000 annually for public meeting venue costs and $18,000 one-time for development of online forms for health plan data submission. The total requested expenditure authority from the Managed Care Fund is $307,000 in 2018-19 and $281,000 in 2019-20 and annually thereafter.

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

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

1. Please provide a brief overview of this proposal.

4150 DEPARTMENT OF MANAGED HEALTH CARE
4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Oversight Item: Managed Care Timely Access to Care Enforcement

Background. Health care service plans that operate in the state of California are regulated by the Department of Managed Health Care for compliance with the Knox-Keene Health Care Service Plan Act of 1975 and other state and federal requirements. In addition, health care service plans that provide coverage in the Medi-Cal managed care delivery system must adhere to state and federal Medicaid requirements contained in statute, regulations, and the terms of managed care contracts. These regulatory programs, among other protections, require a health care service plan to ensure timely access to necessary medical care for its beneficiaries.

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 county organized health systems (COHS), designed to provide timely access to necessary medical care for those plans' beneficiaries. These requirements, under the enforcement and oversight of DMHC, 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 its contracted actuary 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.

Alternative Access Standards. AB 205 allows DHCS to permit Medi-Cal managed care plans to adhere to alternative access standards that deviate from any of the required time and distance requirements if either of the following occur:

1. The plan has exhausted all other reasonable options to obtain providers to meet the applicable standard.
2. The department determines the plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.

In February 2018, DHCS released an All Plan Letter (18-005) that outlines the process for plans to request an alternative access standard. Plans must submit requests no later than 105 days prior to the beginning of the contract year and requests must be submitted for specific zip codes and provider types. The application requires plans to include a variety of information related to provider availability in the affected regions, including the impacted provider types, geographic information about the nearest in-network and out-of-network providers to affected beneficiaries, number of beneficiaries impacted, and the proposed alternative standards for time and/or distance.

The Knox-Keene Act also allows DMHC to permit health care service plans to adhere to an alternative access standard. According to DMHC, the Knox-Keene Act allows a health plan to request an alternate geographic access standard when it is unable to provide enrollee access to a primary care physician or a hospital within 15 miles or 30 minutes from where enrollees live or work. This occurs most frequently in rural areas of the state. DMHC considers alternate geographic access requests in accordance with the numerous factors set forth in timely access regulations, including but not limited to analyses of established patterns of practice in the marketplace, as well as the existence of geographically closer providers.

Subcommittee Staff Comment. This is an informational item.

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

DMHC

1. Please detail the department's enforcement activities and processes for determining health plan compliance with timely access standards under the Knox-Keene Act and other state and federal regulatory requirements. Specifically:

   a. What documentation is required from plans regarding compliance with appointment availability and time and distance requirements?
   b. How does DMHC evaluate a plan's compliance documentation? (e.g. desk reviews, auditing, provider surveys, etc.)
   c. How does DMHC respond if, after review, plan documentation indicates insufficient compliance with required standards?
   d. What enforcement actions does DMHC undertake to sanction or correct non-compliance?
   e. Does DMHC undertake independent analysis of verification of network adequacy and provider availability, such as geo-mapping, secret shopper or availability verification phone calls?
2. How does DMHC evaluate plan requests for alternative access standards under the Knox-Keene Act?
3. How many alternative access standards are currently in place?
4. How long does it take to approve or deny an alternative access request and what is the process?
5. What factors must exist preventing a plan from meeting the Knox-Keene timely access standards that would qualify the plan for approval of alternative access standards?
6. How does/will DMHC evaluate whether a plan will be allowed to operate under an alternative access standard?
7. Will DMHC make any adjustments in its process or standards as a result of the new Medi-Cal managed care rules?
8. How will DMHC handle complaints from Medi-Cal plans?

DHCS

1. Please detail the department's enforcement activities and processes for determining Medi-Cal managed care plan compliance with timely access standards contained in the new federal managed care regulations, the terms of managed care plan contracts, and codified in AB 205. Specifically:
   a. What documentation is currently, or will be, required from plans regarding compliance with appointment availability and time and distance requirements?
   b. How does/will DHCS evaluate a plan's compliance documentation? (e.g. desk reviews, auditing, provider surveys, etc.)
   c. How does/will DHCS respond if, after review, plan documentation indicates insufficient compliance with required standards?
   d. What enforcement actions does/will DHCS undertake to sanction or correct non-compliance?
   e. Are there plans for additional monitoring and verification, such as secret shopper or random calls to verify provider availability for Medi-Cal enrollees?
2. County Organized Health Systems (COHS) are not required to obtain Knox-Keene licensure. How do timely access requirements contained in DHCS' contracts with COHS compare to similar requirements under the Knox-Keene Act? How are they enforced?
3. How does/will DHCS evaluate plan requests for alternative access standards under the new requirements?
4. How many alternative access requests has DHCS received to date?
5. What factors must exist preventing a plan from meeting the statutory and regulatory standards that would qualify the plan for approval of alternative access standards?

6. Does/will DHCS coordinate with DMHC to compare alternative access requests and the data that is submitted?
7. How does/will DHCS evaluate whether a plan will be allowed to operate under an alternative access standard?

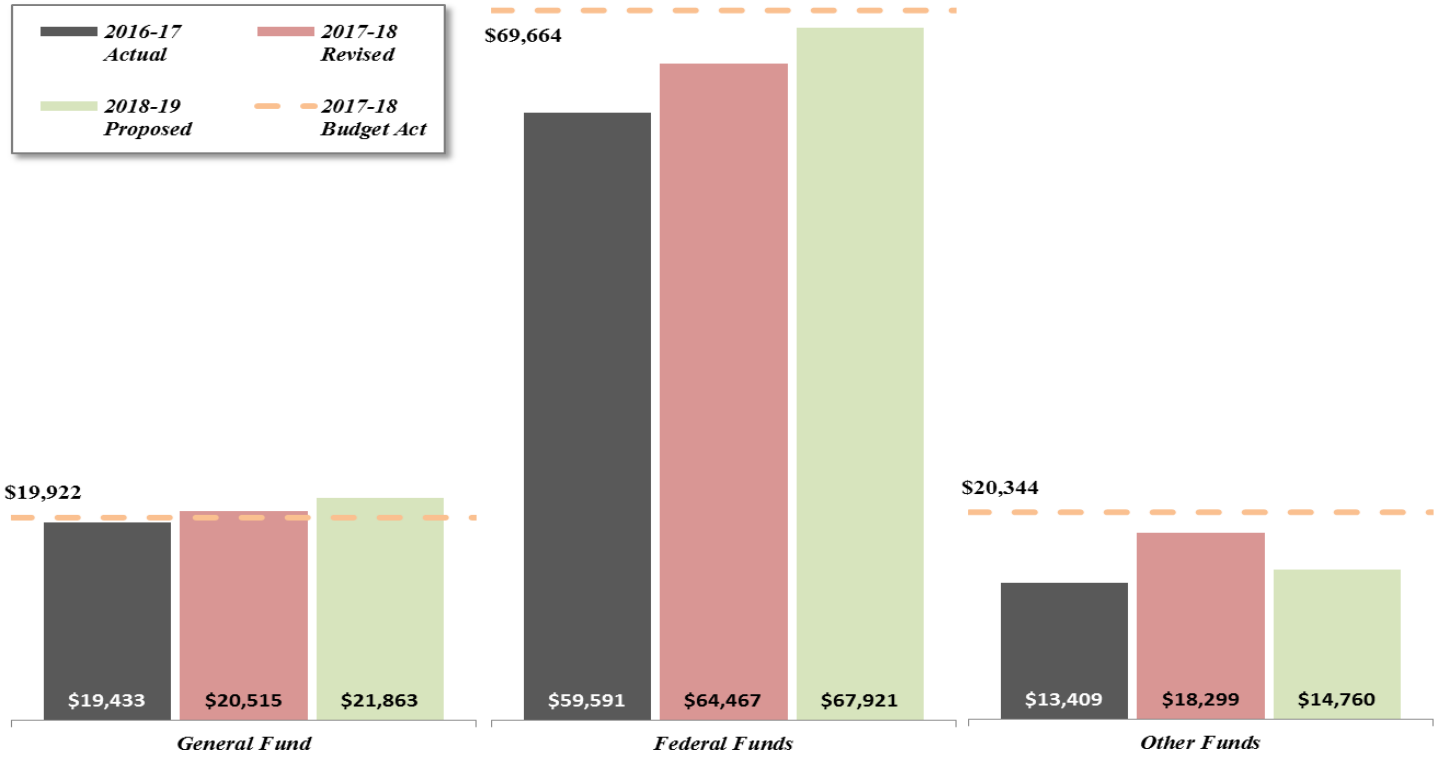
DMHC and DHCS

1. Non-COHS Medi-Cal managed care plans are generally required to obtain Knox-Keene licensure. These plans are subject to requirements and responsibilities under both the Knox-Keene Act and Medi-Cal requirements pursuant to state and federal Medicaid laws, regulations, and contract terms. Please describe how DHCS and DMHC coordinate on enforcement of timely access requirements under both regulatory structures. Specifically:
   a. How does/will oversight and enforcement activities for DHCS differ from similar activities by DMHC?
   b. How does/will the two departments coordinate to avoid duplication of oversight and enforcement efforts?
2. How do the two departments coordinate on corrective action plans? Specifically, when a plan is found out of compliance with one or both departments' regulatory structures, what are the areas of overlap of sanctions or corrective action requirements and what areas are different?

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Overview

Department of Health Care Services – *Three-Year Funding Summary*
(dollars in millions)



Department of Public Health - *Department Funding Summary*			
Fund Source	***2017-18 Budget Act***	***2017-18 Revised***	***2018-19 Proposed***
General Fund	$19,922,319,000	$20,514,661,000	$21,862,524,000
Federal Funds	$69,664,489,000	$64,466,719,000	$67,921,295,000
Other Funds	$20,344,119,000	$18,298,528,000	$14,759,646,000
Total Department Funding:	**$109,930,927,000**	**$103,279,908,000**	**$104,543,465,000**
Total Authorized Positions:	**3430.0**	**3364.1**	**3395.6**
Other Funds Detail:			
Breast Cancer Control Account (0009)	*$11,519,000*	*$11,613,000*	*$11,692,000*
Childhood Lead Poisoning Prev Fund (0080)	*$867,000*	*$867,000*	*$867,000*
DUI Program Licensing Trust Fund (0139)	*$1,806,000*	*$1,861,000*	*$1,212,000*
Hospital Svc. Account, Prop 99 (0232)	*$111,400,000*	*$103,682,000*	*$75,580,000*
Physician Svcs. Account, Prop 99 (0233)	*$40,220,000*	*$33,320,000*	*$21,732,000*
Unallocated Account, Prop 99 (0236)	*$72,071,000*	*$61,153,000*	*$45,117,000*

Narc Treatment Prog Lic Trust Fund (0243)	*$1,734,000*	*$1,778,000*	*$1,757,000*
Perinatal Insurance Fund (0309)	*$11,363,000*	*$14,511,000*	*$19,924,000*
Major Risk Medical Ins Fund (0313)	*$0*	*$0*	*$0*
Audit Repayment Trust Fund (0816)	*$67,000*	*$67,000*	*$67,000*
Medi-Cal Inpt Payment Adj Fund (0834)	*$177,556,000*	*$220,792,000*	*$150,533,000*
Special Deposit Fund (0942)	*$56,317,000*	*$73,139,000*	*$68,031,000*
Reimbursements (0995)	*$5,035,931,000*	*$3,700,586,000*	*$1,672,183,000*
County Health Init Matching Fund (3055)	*$176,000*	*$176,000*	*$176,000*
Childrens Med Services Rebate Fund (3079)	*$16,000,000*	*$18,000,000*	*$14,088,000*
Mental Health Services Fund (3085)	*$1,353,598,000*	*$1,840,710,000*	*$1,836,412,000*
Priv Hospital Supplemental Fund (3097)	*$9,150,000*	*$9,150,000*	*$19,500,000*
Mental Heath Facility Lic Fund (3099)	*$375,000*	*$375,000*	*$375,000*
Residential/Outpatient Prog Lic Fund (3113)	*$6,771,000*	*$6,967,000*	*$6,903,000*
Childrens Health/Human Svcs Fund (3156)	*$428,017,000*	*$428,731,000*	*$0*
Hosp Qual Assurance Revenue Fund (3158)	*$6,384,246,000*	*$5,035,239,000*	*$4,381,598,000*
SNF Quality & Accountability Fund (3167)	*($1,899,000)*	*($1,900,000)*	*($1,900,000)*
Emerg Air Trans/Children's Fund (3168)	*$7,890,000*	*$7,890,000*	*$8,525,000*
Public Hosp Invest, Improve, Inc Fund (3172)	*$800,000,000*	*$885,500,000*	*$760,000,000*
LIHP/MCE Out-of-Network Fund (3201)	*$116,250,000*	*$0*	*$0*
LongTerm Care Qual Assurance Fund (3213)	*$482,975,000*	*$539,842,000*	*$504,609,000*
Health and Human Svcs Spec Fund (3293)	*$2,392,507,000*	*$2,367,559,000*	*$2,519,214,000*
Healthcare Treatment Fund, Prop 56 (3305)	*$1,257,166,000*	*$1,070,558,000*	*$850,925,000*
Health Plan Fines/Penalties Fund (3311)	*$57,479,000*	*$58,874,000*	*$5,794,000*
Medi-Cal Emerg Med Transport Fund (3323)	*$0*	*$0*	*$1,003,000*
Whole Person Care Pilot Spec Fund (8107)	*$360,000,000*	*$290,910,000*	*$323,365,000*
Global Payment Program Spec Fund (8108)	*$1,152,567,000*	*$1,044,787,000*	*$1,066,905,000*
Desig Public Hosp GME Spec Fund (8113)	*$0*	*$471,791,000*	*$393,459,000*

Department of Health Care Services – *Changes to State Operations and Local Assistance*				
Fiscal Year:	**2016-17**	**2017-18**	**2018-19**	**BY to CY**
STATE OPERATIONS				
Fund Source	***Actual***	***Revised***	***Proposed***	***Change***
General Fund	$190,756,000	$220,828,000	$219,075,000	($1,753,000)
Federal Funds[1]	$309,486,000	$399,920,000	$414,138,000	$14,218,000
Special Funds/Reimb	$39,801,000	$58,649,000	$52,061,000	($6,588,000)
Total Expenditures	**$540,043,000**	**$679,397,000**	**$685,274,000**	**($5,877,000)**
Total Auth. Positions	**3458.1**	**3364.1**	**3395.6**	**31.5**

LOCAL ASSISTANCE (*MEDI-CAL AND OTHER PROGRAMS)*				
Fund Source	***Actual***	***Revised***	***Proposed***	***Change***
General Fund	$19,242,332,000	$20,293,833,000	$21,643,449,000	$1,349,616,000
Federal Funds[1]	$59,281,854,000	$64,066,799,000	$67,507,157,000	$3,440,358,000
Special Funds/Reimb	$13,369,053,000	$18,239,879,000	$14,707,585,000	($3,532,294,000)
Total Expenditures	**$91,893,239,000**	**$102,600,511,000**	**$103,858,191,000**	**$1,257,680,000**
[1]*Federal Funds include Funds 0890, 7502, and 7503*				

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 13.5 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 2017 Medi-Cal Estimate - Overview

Budget Issue. The November 2017 Medi-Cal Local Assistance Estimate includes $100 billion ($20.1 billion General Fund, $63.7 billion federal funds, and $16.3 billion special funds and reimbursements) for expenditures in 2017-18, and $101.5 billion ($21.6 billion General Fund, $67.1 billion federal funds, and $12.8 billion special funds and reimbursements) for expenditures in 2018-19.

Medi-Cal Local Assistance Funding Summary			
Fiscal Year:	**2017-18**	**2018-19**	**BY to CY**
Benefits			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$18,866,694,000	$20,388,693,000	$1,521,999,000
Federal Funds	$60,011,965,000	$63,651,192,000	$3,639,227,000
Special Funds/Reimbursements	$16,284,778,000	$12,767,374,000	($3,517,404,000)
Total Expenditures	**$95,163,437,000**	**$96,807,259,000**	**$1,643,822,000**
County Administration			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$1,030,976,000	$1,083,553,000	$52,577,000
Federal Funds	$3,384,520,000	$3,280,762,000	($103,758,000)
Special Funds and Reimbursements	$11,994,000	$4,960,000	($7,037,000)
Total Expenditures	**$4,427,490,000**	**$4,369,275,000**	**($58,215,000)**
Fiscal Intermediary			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$160,741,000	$116,846,000	($43,895,000)
Federal Funds	$288,451,000	$211,277,000	($77,174,000)
Special Funds and Reimbursements	$-	$-	$-
Total Expenditures	**$449,192,000**	**$328,123,000**	**($121,069,000)**
TOTAL MEDI-CAL LOCAL ASSISTANCE EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$20,058,411,000	$21,589,092,000	$1,530,681,000
Federal Funds	$63,684,936,000	$67,143,231,000	$3,458,295,000
Special Funds and Reimbursements	$16,296,772,000	$12,772,334,000	($3,524,438,000)
Total Expenditures	**$100,040,119,000**	**$101,504,657,000**	**$1,464,538,000**

Caseload. In 2017-18, the budget assumes annual Medi-Cal caseload of 13.5 million, a decrease of 1.6 percent compared to assumptions for the 2017 Budget Act. The department estimates 81 percent of

Medi-Cal beneficiaries, or 10.9 million, will receive services through the managed care delivery system while 19 percent, or 2.6 million, will receive services through the fee-for-service delivery system.

In 2018-19, the budget assumes annual Medi-Cal caseload of 13.5 million, a 0.05 percent increase compared to the revised caseload estimate for 2017-18. The department estimates 81.3 percent of Medi-Cal beneficiaries, or 11 million, will receive services through the managed care delivery system while 18.7 percent, or 2.5 million, will receive services through the fee-for-service delivery system.

Significant General Fund Adjustments. The November 2017 Medi-Cal Local Assistance Estimate includes the following significant adjustments to General Fund expenditures:

2017-18 General Fund Deficiency - The budget includes increased expenditures in the Medi-Cal program of $543.7 million General Fund compared to the 2017 Budget Act. The current year increase is primarily attributable to cost-shifts and adjustments related to pharmacy rebates, caseload-related adjustments to managed care expenditures, retroactive managed care and dental payments, and reduced General Fund savings from the Hospital Quality Assurance Fee. (For more information, see *Issue 3: Medi-Cal Unanticipated Costs – 2017-18 Deficiency*)

Medi-Cal Optional Expansion – The budget includes $17.7 billion ($1.4 billion General Fund, $14.8 billion federal funds, and $1.5 billion other funds and reimbursements) in 2017-18 and $22.9 billion ($1.6 billion General Fund, $20.5 billion federal funds, and $756 million other funds and reimbursements) in 2018-19 for the optional expansion of Medi-Cal eligibility to childless adults up to 138 percent of the federal poverty level pursuant to the federal Affordable Care Act. The state assumed a six percent share of cost for the optional expansion population in calendar year 2018, will assume a seven percent share in calendar year 2019, and a ten percent share in calendar year 2020 and beyond.

Proposition 56 Supplemental Provider Payments - The budget includes $169.4 million to support new growth in Medi-Cal expenditures compared to the 2016 Budget Act. The budget allocates $1.1 billion ($360.1 million Proposition 56 funds and $788.2 million federal funds) in 2017-18 and $2 billion ($649.9 million Proposition 56 funds and $1.4 billion federal funds) in 2018-19 for supplemental provider payments for services provided by physicians, dentists, women's health providers, intermediate care facilities for individuals with developmental disabilities, and AIDS Waiver providers. The 2018-19 allocation represents an increase of $289.8 million over the Administration's revised 2017-18 estimate, but is only $103.9 million over the amounts appropriated for this purpose in the 2017 Budget Act. Of the increased amount over the revised 2017-18 estimate, the Administration proposes to allocate approximately $163 million for physician payments and $70 million for dental payments.

Home Health Rate Increase - The budget includes $64.5 million ($31.6 million Proposition 56 funds and $32.9 million federal funds) for a 50 percent rate increase and associated increases in utilization for home health providers that provide medically necessary in-home services to children and adults in the fee-for-service system or through home and community-based services waivers.

Full Restoration of Adult Dental Benefits - The budget includes $84.7 million ($31.7 million General Fund and $53.1 million federal funds) in 2017-18 and $212.2 million ($79.5 million General Fund and $132.7 million federal funds) in 2018-19 to restore full dental services for adult beneficiaries in the Medi-Cal program, effective January 1, 2018. While approval from the federal Centers for Medicare

and Medicaid Services for the restoration is still pending, the department has notified providers they may begin claiming for restored services.

Children's Health Insurance Program (CHIP) Reauthorization - Effective October 1, 2015 through September 30, 2019, the federal Affordable Care Act (ACA) increased the program's federal share of cost from the historical rate of 65 percent to 88 percent. The budget includes additional General Fund costs of $300.6 million in 2017-18 and $599.8 million in 2018-19 reflecting an 88 percent federal share through December 31, 2017, and 65 percent beginning January 1, 2018. The budget assumes the program would be reauthorized at a 65 percent federal share effective January 1, 2018. In January 2018, Congress approved the Healthy Kids Act, which extended authorization and federal funding for the CHIP program for six years. The Healthy Kids Act also extends the enhanced federal match for CHIP of 88 percent until September 30, 2019, reduces the match to 76.5 percent until September 30, 2020, and reduces the match to its traditional 65 percent thereafter. Because the Healthy Kids Act was approved after release of the budget, the May Revision will reflect reduced General Fund expenditures in Medi-Cal to account for the additional federal matching funds.

Medi-Cal County Administration Cost-of-Doing-Business Adjustment – SB 28 (Hernandez), Chapter 244, Statutes of 2013, requires DHCS to develop and implement a new budgeting methodology for Medi-Cal county administration base costs no sooner than 2015-16. DHCS reports it was unable to secure a vendor to develop the new budgeting methodology. In the interim, the budget proposes a cost-of-doing-business adjustment for county eligibility workload of $54.8 million ($18.5 million General Fund and $36.3 million federal funds) in 2018-19. The adjustment was calculated based on adjusting the existing level of funding by the California Price Index, which is currently 2.8 percent. A similar increase will be applied in 2019-20 and 2020-21 as the county eligibility systems move to a single Statewide Automated Welfare System. (For more information, see *Issue 4: County Administration Estimate and Budget Proposals*)

Hospital Quality Assurance Fee Extension - On November 8, 2016, voters passed Proposition 52, which amends the state Constitution to permanently extend the existing Hospital Quality Assurance Fee. The budget assumes General Fund savings of $852 million in 2017-18 and $885 million in 2018-19 from the hospital fee. This reflects a decrease of approximately $168.7 million General Fund compared to the 2017 Budget Act due to federal changes to upper payment limit requirements.

School-Based Medi-Cal Administrative Activities and Local Education Agency Billing Option Program - The budget includes General Fund costs of $58.4 million in 2017-18 and $163.4 million in 2018-19 for repayments to the federal government resulting from overpayments to local education agencies for administrative activities related to Medi-Cal. To the extent a local education agency has an outstanding balance owed to the federal government, the budget withholds one-time discretionary funding from the agency's Proposition 98 appropriation in the 2018-19 fiscal year to repay the General Fund for the outstanding balance owed to the federal government.

Drug Medi-Cal Organized Delivery System Pilot - The budget includes $372.9 million ($76.2 million General Fund and $296.7 million federal funds) in 2017-18 and $1 billion ($209.8 million General Fund and $829.8 million federal funds) for the five-year pilot program for participating counties using an organized delivery system to provide expanded substance use disorder services to eligible Medi-Cal

beneficiaries. Five counties implemented the waiver in 2016-17, 15 counties are expected to implement the waiver in 2017-18, and 20 counties are expected to implement the waiver in 2018-19.

Managed Care Mental Health Parity - The budget includes $21.3 million ($3 million General Fund and $18.2 million federal funds) for counties to comply with the 2016 federal Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and Children's Health Insurance Program, which requires restrictions or limits on mental health and substance use disorder services not be applied more stringently than those applied for medical and surgical services.

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 2018-19 fiscal year.

Issue 3: Medi-Cal Unanticipated Costs – 2017-18 Deficiency

Budget Issue. The Administration estimates unanticipated increases in Medi-Cal program expenditures in 2017-18 will exceed its 2017 Budget Act appropriation, resulting in a current year General Fund deficiency of approximately $543.7 million.

Background. The 2017 Budget Act appropriated $19.5 billion of General Fund for the Medi-Cal program in 2017-18. According to DHCS, updated estimates of Medi-Cal expenditures for 2017-18 will be $20.1 billion, an increase of $543.7 million over the 2017 Budget Act appropriation. DHCS reports this substantial increase in General Fund expenditures is primarily due to the following factors:

1) Shifting of retroactive drug rebate adjustments from prior years.
2) Offsetting increased drug rebates based upon recent actual data.
3) Corrections to the proportions of dual-eligibles and non-dual-eligibles in managed care.
4) Increases in retroactive managed care and dental payments.
5) Reduced General Fund savings from Hospital Quality Assurance Fee (QAF).

Retroactive Federal Recoupment of Drug Rebates and Additional Drug 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 94 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 and the adjustment was reflected in the 2017 Budget Act.

The budget includes General Fund expenditures of $303.1 million for federal repayment of additional ACA and CHIP rebate claims received during the April 2015 through June 2016 period and for ACA and CHIP rebate claims for the period between January and March 2017. These federal repayments were made in 2017-18.

The budget also includes offsetting General Fund savings of $280.7 million for additional drug rebates based on reconciliation with actual claims data. These savings are reflected in the November 2017 Estimate and include rebates for the Breast and Cervical Cancer Treatment Program (BCCTP), Family Planning, Access, Care, and Treatment (Family PACT), Federal Drug Rebates, State Supplemental Rebates, and Managed Care Drug Rebates.

Correction of Proportion of Dual-Eligibles and Non-Dual Eligibles in Managed Care. The budget assumes approximately 81 percent of Medi-Cal beneficiaries will receive benefits through the managed care delivery system. For each Medi-Cal managed care plan and each category of aid, DHCS and its contracted actuary, Mercer, develop capitation rates paid on a monthly basis to each plan for the care of each plan's enrolled beneficiaries. When DHCS budgets for capitation payments to Medi-Cal managed care, it calculates estimates of monthly caseload for each of the different categories of aid, including those dually eligible for Medi-Cal and Medicare (dual-eligible), and multiplies those caseload figures by the capitation rates for the relevant period to arrive at total expenditures.

According to DHCS, the 2017 Budget Act caseload assumptions for the 2017-18 fiscal year overestimated the proportion of beneficiaries enrolled in managed care that were dual-eligibles. The department corrected the proportion of beneficiaries that are dual-eligible compared to non-dual-eligibles in the November 2017 Estimate. As a result, the budget includes a General Fund adjustment of approximately $200 million in the managed care base to reflect the increased costs of non-dual-eligibles consistent with this change in caseload assumptions.

Retroactive Managed Care and Dental Payments. The budget includes General Fund expenditures of $335 million for retroactive managed care rate adjustments for Coordinated Care Initiative beneficiaries for prior contract years, a $143.6 million increase from the amount included in the 2017 Budget Act. In addition, the budget includes General Fund expenditures of $73.4 million for retroactive adjustments to dental managed care and dental fee-for-service rates for prior fiscal years, a $64.3 million increase from the amount included in the 2017 Budget Act. These retroactive adjustments result in a combined increase of General Fund expenditures in 2017-18 of $207.9 million.

Reduced General Fund Savings from Hospital QAF. The budget includes an increase in General Fund expenditures of $168.7 million in 2017-18 due to reduced savings amounts received from the Hospital QAF. According to DHCS, these reduced savings are due to including a new Private Hospital Directed Payments methodology in managed care, conducting an Upper Payment Limit (UPL) review on prior years' expenditures, and removal of prior fee-for-service Hospital QAF payments.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended this issue be held open pending further updates to Administration estimates of the 2017-18 deficiency at the May Revision.

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

1. Please provide a brief overview of the deficiency related to the retroactive federal repayments of drug rebates.

2. Please provide a brief overview of the deficiency related to recalculation of the proportion of dual-eligibles and non-dual-eligibles enrolled in managed care.

3. Please provide a brief overview of the deficiency related to reduced Hospital QAF savings.

Issue 4: County Administration Estimate and Budget Proposals

Budget Issue. The budget includes $2 billion ($979 million General Fund and $979 million federal funds) in 2017-18 and $2 billion ($1 billion General Fund and $1 billion federal funds) for the base allocation to counties for eligibility determinations for Medi-Cal beneficiaries. The base allocations include $655.3 million ($327.7 million General Fund and $327.7 million federal funds) in 2017-18 and $673.7 million ($336.8 million General Fund and $336.8 million federal funds) in 2018-19 allocated for costs related to eligibility determinations for newly eligible beneficiaries under the federal Affordable Care Act (ACA). Beginning in 2018-19 the budget combines the base allocation with the allocation for ACA, which had previously been reflected separately in the Medi-Cal estimate. The combined base allocation for county administration in 2017-18 is unchanged from the amount included in the 2017 Budget Act. Included in these allocations is $54.8 million ($18.5 General Fund and $36.3 million federal funds) in 2018-19 for a cost-of-doing-business adjustment for county eligibility workload.

County Administration Funding Summary			
Fiscal Year:	**2017-18**	**2018-19**	**BY to CY**
County Administration Base			
Fund Source	***Revised***	***Proposed****	***Change***
0001 – General Fund	$651,341,500	$669,579,000	$18,237,500
0890 – Federal Trust Fund**	$651,341,500	$669,579,000	$18,237,500
Total Expenditures	**$1,302,683,000**	**$1,339,158,000**	**$36,475,000**
Implementation of ACA			
Fund Source	***Revised***	***Proposed****	***Change***
0001 – General Fund	$327,655,000	$336,829,500	$9,174,500
0890 – Federal Trust Fund**	$327,655,000	$336,829,500	$9,174,500
Total Expenditures	**$655,310,000**	**$673,659,000**	**$18,349,000**

*Beginning in 2018-19, the County Administration Base includes the ACA, and will no longer be reflected separately in the budget. In this display, the two figures are reflected separately for comparison purposes.

** Federal fund adjustments for ACA and CHIP beneficiaries are budgeted separately. In this display, funding reflects a 50 percent federal match.

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. According to DHCS, the practice of reallocating unspent funds to other counties will be discontinued.

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. Beginning in 2018-19, these additional amounts are included in the base allocation for county administration.

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, was meant to reflect 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 were 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 a contractor to perform time/motion studies and make other estimates of county costs to assist in the development of the new methodology.

The 2017 Budget Act authorized 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 work with counties and a 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 a contractor to develop the new budgeting methodology.

Cost-of-Doing-Business-Adjustment in 2018-19. DHCS reports it was unable to secure a vendor to develop the new budgeting methodology required by SB 28. The budget includes $54.8 million ($18.5 General Fund and $36.3 million federal funds) in 2018-19 for a cost-of-doing-business adjustment for county eligibility workload. This cost-of-doing-business-adjustment is intended as an interim solution as the Administration and its county partners evaluate next steps for implementation of a budgeting methodology. The adjustment was calculated based on adjusting the existing level of funding by the California Price Index, which is currently 2.8 percent. A similar increase will be applied in 2019-20 and 2020-21 as the county eligibility systems move to a single Statewide Automated Welfare System.

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 was the department unable to secure a vendor for implementation of a county administration budgeting methodology? What is the department's plan going forward? If development of the methodology is not moving forward, how is the department utilizing the positions and resources approved for this purpose in the 2017 Budget Act?

3. Please explain the department's rationale for restricting the reallocation of unspent county administration funds between counties during the reconciliation process.

Issue 5: Stakeholder Proposals: Expansion of Medi-Cal Eligibility and Enrollment

Background. Medi-Cal covers 13.5 million Californians, including more than five million children, at a total estimated cost of $100 billion in 2017-18 and $101.5 billion in 2018-19. Of that amount, the federal government is expected to contribute $63.7 billion in 2017-18 and $67.1 billion in 2018-19 as a share of health care-related expenditures for Medi-Cal beneficiaries. The rate at which federal matching funds are provided to states is dependent on a state's per capita income. California has traditionally received a federal match of 50 percent, the minimum percentage allowable, due to the state's high per capita income relative to other states. Certain beneficiary populations and categories of Medi-Cal expenditures are eligible for higher federal matching rates, such as children eligible for the Children's Health Insurance Program (CHIP), adults eligible for the expansion of Medi-Cal under the Affordable Care Act (ACA), family planning expenditures, and improvements to information technology systems.

Affordable Care Act Expanded Medi-Cal Coverage to 3.9 million Newly Eligible Californians. The ACA authorizes states to expand their Medicaid programs to previously uninsured individuals. ABX1 1 (Pérez) 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. States received a federal match of 95 percent for calendar year 2017, and will receive a federal match of 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, and a six percent General Fund share beginning January 1, 2018. 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 $17.7 billion ($1.4 billion General Fund, $14.8 billion federal funds, and $1.8 billion county and other funds) in 2017-18 and $22.9 billion ($1.6 billion General Fund, $20.5 billion federal funds, and $756 million county and other funds) in 2018-19 for coverage of the optional expansion population. The department estimates optional expansion enrollment of approximately 3.9 million beneficiaries in 2017-18 and 2018-19.

Medi-Cal Eligibility for Children Regardless of Immigration Status. SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015, expanded 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 estimated 250,000 undocumented children under age 19 would become eligible under the expansion. As of December 2017, a total of 218,571 undocumented children have enrolled in full-scope Medi-Cal, in two distinct populations:

1. *Restricted-Scope Medi-Cal Beneficiaries* As of December 2017, 120,614 undocumented children previously enrolled in restricted-scope Medi-Cal coverage have transitioned into full-scope Medi-Cal coverage.
2. *Not Previously Enrolled* DHCS estimated 130,924 undocumented children that were eligible for, but not enrolled in, restricted-scope Medi-Cal would be eligible for full-scope coverage under the expansion of eligibility. As of December 2017, 97,957 children in this category have enrolled in full-scope benefits, or 74.8 percent of the department's estimate of eligible children.

Proposals to Expand Medi-Cal Eligibility and Promote Medi-Cal Enrollment. Stakeholders have expressed interest in expanding Medi-Cal coverage to individuals not currently eligible due to immigration status or because income limits for those eligible due to age or disability differ from those of other populations. In addition, stakeholders have expressed interest in expanding outreach and assistance efforts to enroll individuals that are currently eligible, but not enrolled. These proposals are as follows:

Expand Full-Scope Medi-Cal to Otherwise Eligible Adults Regardless of Immigration Status. The California Immigrant Policy Center, Health Access California, and a coalition of 80 organizations request General Fund resources, likely in the low billions of dollars, to fund expansion of full-scope Medi-Cal services to otherwise eligible adults regardless of immigration status. According to the coalition, California's robust implementation of the Affordable Care Act (ACA) has brought the uninsured rate to a historic low of 6.8 percent. In 2015, California showed great leadership by investing in access to full-scope Medi-Cal for all income eligible children under the age of 19, regardless of immigration status, which has provided comprehensive care to over 200,000 undocumented children. Through these efforts, California now provides near-universal coverage for children. However, their parents and other undocumented adult Californians still face exclusions to health care access. Of the nearly three million uninsured Californians, 58 percent are undocumented adults who are locked out of health care access simply because of their immigration status. Any effort to achieve universal health coverage in California must include immigrant communities who shape our state and who call California home.

Aged and Disabled Program Eligibility. AB 2877 (Thomson), Chapter 93, Statutes of 2000, established the Aged and Disabled program, which extends full-scope Medi-Cal coverage to individuals with income under 100 percent of the federal poverty level (FPL) and who are over age 65 or are disabled. The statute also provided for an income disregard of $230 for an individual or $310 for a couple, raising the effective level of eligibility to those with income higher than 100 percent of the FPL, currently about 124 percent of the FPL. This income disregard has not been updated since the program was implemented. Prior to AB 2877, aged and disabled individuals could qualify for the Medically Needy program, which imposes a monthly share of cost, which must be paid prior to receiving Medi-Cal benefits. Today, aged and disabled individuals whose incomes exceed 100 percent of the FPL plus the income disregard are still eligible under the Medically Needy program and must pay a monthly share of cost, which is the difference between eligible income and the Maintenance Need Income Level, a fixed dollar amount in statute intended to provide for food, rent and utilities. This level is $600 for an individual and $934 for a couple.

The Western Center on Law and Poverty (WCLP), Disability Rights California, Justice in Aging, and a coalition of 50 organizations request approximately $30 million General Fund annually 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. While the Administration reports it does not possess sufficient data to provide a specific estimate of the costs of this proposal, its fiscal analyses of previous versions of this proposal estimate ongoing General Fund costs in the tens of millions of dollars, consistent with the budget request from the coalition.

According to the coalition, when the aged and disabled program was established, the income standard was equivalent to 133 percent FPL, the same level as most other adults enrolled in Medi-Cal. However, the disregards lose real value every year, because they are specific dollar amounts rather than percentages of FPL. Today, these unchanged dollar amounts place the resulting income standard at 123 percent FPL. When a senior has even a small increase in their income that puts them over 123 percent FPL, they are forced into the Medi-Cal Medically Needy program with a high share of cost.

Express Lane Eligibility for Women, Infants, and Children (WIC) Program Participants. SBX1 1 required the state to participate in a federal option to simplify the Medi-Cal enrollment process for those receiving benefits in the Supplemental Nutrition Assistance Program (SNAP), known in California as CalFresh. As of the 2015 Budget Act, DHCS estimated approximately 209,000 individuals would take up Medi-Cal coverage through Express Lane Eligibility related to CalFresh participation. In addition to CalFresh, federal guidance allows states to establish Express Lane programs within agencies capable of making a finding regarding one or more programmatic eligibility requirements, using information the Express Lane agencies already collect. One of the allowable programs under this federal guidance is the Women, Infants, and Children (WIC) program, which is administered in California by the Department of Public Health and 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.

A coalition of five children's advocacy organizations requests General Fund resources of $9 million to establish an Express Lane program for children and a presumptive eligibility program for pregnant women participating in the WIC program. Approximately $1 million would fund needed administrative expenses to establish the program, while $8 million would fund health care services for the additional children and pregnant women enrolled in Medi-Cal as a result of the program. According to the coalition, the WIC eligibility system currently checks participants' Medi-Cal enrollment by linking to the Medi-Cal Eligibility Data System. About 90,000 WIC children and 13,000 WIC pregnant women do not have Medi-Cal, despite eligibility. Federal Express Lane Eligibility authority allows WIC income eligibility findings to be used to determine Medicaid enrollment for children. State statute authorizes a WIC automated enrollment gateway but requires a budget appropriation. Express enrollment for pregnant women would require a federal waiver. However, with a state plan amendment, WIC pregnant women could be determined presumptively eligible for Medi-Cal while a full application is completed.

Funding for Medi-Cal Enrollment Assistance and Outreach. Beginning in January 2014 DHCS received a $12.5 million contribution from the California Endowment for purposes of implementing an enrollment and outreach program to supplement county efforts to enroll eligible but not enrolled individuals into the Medi-Cal program. Among other program requirements, grants were provided for efforts that place special emphasis on one or more of the following populations:

1) Persons with mental health disorder needs
2) Persons with substance use disorder needs
3) Persons who are homeless
4) Young men of color
5) Persons who are in county jail, state, prison, on state parole, on county probation, or under post release community supervision
6) Families of mixed-immigration status
7) Persons with limited English proficiency

According to DHCS, the cumulative progress of Enrollment and Outreach (O&E) is as follows:

	Totals
Amount Invoiced	$22,388,499
Number of AB 82 individuals reached by O&E efforts	1,801,991
Number of AB 82 individuals assisted with enrollment into Medi-Cal	202,461
Number of approved Medi-Cal applications resulting from Medi-Cal O&E efforts	87,678
Number of AB 82 beneficiaries that retained Medi-Cal coverage as a result of the O&E efforts	30,683

Source: DHCS - O&E Quarterly Progress Report: Outreach, Enrollment, and Retention - Cumulative Totals

Maternal and Child Health Access and a coalition of ten organizations request $53 million ($26.5 million General Fund and $26.5 million federal funds) to continue outreach, enrollment and trouble-shooting for health coverage programs for low-income Californians. The funds would be allocated to counties on the basis of a funding formula and administered by counties, as occurred under AB 82 (Committee on Budget), Chapter 23, Statutes of 2013.

According to the coalition, between 2014 and 2018, statewide outreach and enrollment efforts were funded through a combination of legislative and foundation efforts and federal matching funds under Medi-Cal and CHIP. Most of the non-federal funding will come to an end, however, at the end of June 2018. For community agencies in Fresno County over $1 million in outreach and enrollment resources are about to end. In Sacramento, local groups face a loss of nearly $900,000, as do partners in Santa Clara County. The combined cut for four participating North Coast counties (Del Norte, Mendocino, Sonoma and Marin) would be over $562,480, and $697,000 on the Central Coast (Monterey, San Luis Obispo and Santa Cruz).

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

Questions. The subcommittee has requested advocates to present these proposals and respond to questions from subcommittee members.

Issue 6: Discontinuation of 340B Drug Reimbursement – Panel Discussion

Trailer Bill Language. DHCS requests trailer bill language to restrict the scope of the use of the 340B Program within the Medi-Cal program to comply with existing federal requirements. According to DHCS, these restrictions would help protect program integrity, prevent unnecessary overpayments, result in additional drug rebate savings, as well as serve to mitigate the amount of time and resources expended to resolve drug rebate disputes related to 340B claims.

Background. The federal Veterans Health Care Act of 1992 established the 340B Drug Pricing Program (340B Program), which requires drug manufacturers that participate in Medicaid to offer significantly reduced prices to certain safety net health care providers, known as covered entities. According to the federal Health Resources and Services Agency (HRSA), which oversees the 340B Program, these discounts enable covered entities to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services. Health care organizations eligible to be covered entities are defined in federal statute and include HRSA-supported health centers and look-alikes (e.g. federally qualified health centers), Ryan White clinics and state AIDS Drug Assistance programs, Medicare/Medicaid Disproportionate Share Hospitals, children's hospitals, and other safety net providers.

Prescription Drug Rebates in Medi-Cal. The federal Omnibus Budget Reconciliation Act of 1990 established the Medicaid Drug Rebate Program, which requires drug manufacturers to pay rebates to state Medicaid programs for drugs dispensed to Medicaid beneficiaries. These rebates are shared between states and the federal government according to the relevant federal matching rate for the beneficiaries to whom the drugs were dispensed. In addition to the federal rebate program, California law requires DHCS to enter into contracts with drug manufacturers to provide supplemental rebates for drugs dispensed to Medi-Cal beneficiaries in the fee-for-service delivery system or enrolled in county organized health systems (COHS). These rebates are in addition to those received through the federal rebate program. In 2010, the federal Affordable Care Act further extended eligibility for the federal rebate program to drugs dispensed to beneficiaries enrolled in non-COHS Medi-Cal managed care plans. The budget includes General Fund savings from drug rebates of approximately $1.4 billion in 2017-18 and $1.5 billion in 2018-19 through the federal rebate program, state supplemental rebate program, from managed care beneficiaries, and beneficiaries in the Family Planning Access, Care, and Treatment (Family PACT) program and Breast and Cervical Cancer Treatment Program (BCCTP).

In general, federal law prohibits states from receiving federal drug rebates for Medicaid beneficiaries if the drugs dispensed were already discounted as part of the 340B Program. Rebates inappropriately claimed under both programs are known as "duplicate discounts". HRSA provides guidance to 340B covered entities and states to prevent duplicate discounts, including the Medicaid Exclusion File (MEF), a provider level data source that compiles the National Provider Identification (NPI) Number or Medicaid Provider Number of covered entities which dispense 340B discounted drugs to Medicaid beneficiaries. The MEF is available for preventing duplicate discounts in fee-for-service. However, HRSA has encouraged covered entities to work with states to develop strategies to prevent duplicate discounts for drugs dispensed to managed care beneficiaries.

Contract Pharmacies. HRSA permits covered entities to dispense drugs purchased in the 340B Program through off-site contract pharmacies, often commercial retail pharmacies. These arrangements

are permitted only if the covered entity, the contract pharmacy, and the State Medicaid agency have established an arrangement to prevent duplicate discounts. The covered entity must report any such arrangement to HRSA. The HRSA guidance establishing this requirement did not apply to drugs dispensed to managed care beneficiaries. However, federal regulations on Medicaid managed care organizations released in May 2016 required states to include managed care contract provisions requiring plans to establish procedures for excluding 340B claims from utilization data provided to states for rebate collection.

Trailer Bill Language Proposal Discontinues 340B Reimbursement in Medi-Cal. According to DHCS, legislation is needed to provide DHCS the authority to restrict the scope of the use of the 340B Program within the Medi-Cal program in order to comply with existing federal statutory requirements. Such restrictions would help protect program integrity, prevent unnecessary overpayments, result in additional drug rebate savings, as well as serve to mitigate the amount of time and resources expended to resolve drug rebate disputes related to 340B claims.

The proposed trailer bill language would:

1. Repeal state law requiring 340B covered entities to dispense only 340B inventory to Medi-Cal beneficiaries and bill at average acquisition cost for those drugs.
2. Require DHCS to seek federal approval to prohibit covered entities from dispensing or administering a 340B drug to a Medi-Cal beneficiary.
3. Require DHCS, in the event federal approval is not obtained to prohibit dispensing or administering a 340B drug to a Medi-Cal beneficiary, to seek federal approval to limit the use of contract pharmacies by a covered entity; and/or, to prohibit or limit which covered entities, and which specified drugs, can be dispensed or administered to a Medi-Cal beneficiary.
4. Allow DHCS to apply those prohibitions and limitations to the entirety of the Medi-Cal program, or a segment thereof, including but not limited to the Medi-Cal fee-for-service and managed care delivery systems, and any other program eligible for federal drug rebates.
5. Require a covered entity subject to the limitations proposed to bill DHCS or a managed care plan their usual and customary charge.
6. Require that covered entities bill the Medi-Cal program at their acquisition cost, plus the appropriate dispensing fee for the applicable delivery system (fee-for-service or managed care) in which they operate.
7. Allow that, if a covered entity required to use 340B drugs is unable to purchase a specific 340B drug, the covered entity may dispense a drug purchased at regular drug wholesale rates to a Medi-Cal beneficiary. The covered entity is required to maintain documentation of their inability to obtain the 340B drug, in the form and manner specified by DHCS.
8. Require a covered entity to identify a 340B drug on the claim submitted to the Medi-Cal program or to a managed care plan for reimbursement.
9. Require DHCS, upon federal approval, to implement these changes on a prospective basis at least 90 days from the date federal approval is obtained, but no sooner than January 1, 2019.
10. Allow DHCS to implement changes without taking regulatory action, but commits DHCS to adopting regulations within five years.

According to DHCS, the budget includes no additional General Fund savings as a result of this proposal. However, the Administration indicates it expects General Fund savings beginning in 2019-20 after federal approvals are received and the program is implemented.

Previous Administration 340B Proposal Not Approved. DHCS submitted a trailer bill language proposal accompanying the 2017 May Revision to correct problems regarding the use of contract pharmacies in the 340B 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 under fee-for-service or to a Medi-Cal managed care plan. The proposed trailer bill language prohibited the use of contract pharmacies in the 340B program in Medi-Cal, consistent with recent concerns raised by federal agencies and a federal audit. The proposal was intended to avoid inappropriate duplicate discounts by claiming federal drug rebates on already discounted drugs and prevent unnecessary overpayment in Medi-Cal. Due to the likelihood that the proposed language would have imposed significant changes on current operations for many 340B entities, as well as the lack of sufficient time for proper legislative consideration of the impacts of the proposal on essential Medi-Cal providers, the Legislature did not adopt this proposal.

The current trailer bill language proposal includes provisions that allow DHCS, should it not receive federal approval to prohibit dispensing of 340B drugs to Medi-Cal beneficiaries, to subsequently submit a proposal for federal approval to prohibit or limit the use of contract pharmacies to dispense 340B drugs to Medi-Cal beneficiaries. This subsequent proposal provided for by the current trailer bill language is substantially similar to the department's 2017 proposal that was not approved.

Panel Discussion. The subcommittee has requested the following panelists, in addition to the Department of Health Care Services and the Department of Finance, to comment on this proposal:

- **Denise Foreman**, Director of Pharmacy Services, Woodland Health Care
- **Dr. Susan Ehrlich,** Chief Executive Officer, Zuckerberg San Francisco General Hospital
- **Britta Guerrero,** Chief Executive Officer, Sacramento Native American Health Center
- **Francis Pickford,** Vice President of Finance, Planned Parenthood of the Pacific Southwest

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

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

1. Please provide a brief overview of this proposal.

2. How does DHCS currently track 340B claims to prevent duplicate discounts in fee-for-service? How does it track 340B claims in managed care?

3. What factors prevent sufficient tracking of 340B claims to avoid duplicate discounts?

Issue 7: Federal Managed Care Regulations Implementation

Budget Issue. DHCS requests ongoing extension of nine expiring, limited-term positions and expenditure authority of $3.1 million ($1.5 million General Fund, $1.5 million federal funds). If approved, these resources would allow DHCS to continue efforts to implement the federal Medicaid managed care regulations. Included in the resource request is $1.3 million ($650,000 General Fund and $650,000 federal funds) for the department's contract with an External Quality Review Organization to perform quarterly access assessments.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$1,547,000	$1,547,000
0890 – Federal Trust Fund	$1,547,000	$1,547,000
Total Funding Request:	**$3,094,000**	**$3,094,000**
Total Requested Positions:	**9.0**	**9.0**

* Positions and Resources ongoing after 2019-20.

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 80 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.

Compliance-Related Resources Received in 2016-17 and 2017-18. 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. The limited-term expenditure authority is equivalent to an additional 19 positions. 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.

The 2017 Budget Act approved 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. The four-year, limited–term expenditure authority is equivalent to an additional 40 positions. The approved resources also included contract funding for external quality review, language accessibility compliance, and technical infrastructure and assistance. The resources were received by the following DHCS divisions:

1. Managed Care Quality and Monitoring Division – Limited-term resources equivalent to four positions to manage increased managed care compliance, including monitoring network adequacy and performance, and ensuring quality of data submitted by two new managed care plans.
2. Managed Care Operations Division – Limited-term resources equivalent to seven positions to manage contract changes, ensure monthly updates to provider directories and consistent enrollee communications, and implement payment system control changes.
3. Medi-Cal Dental Services Division – Limited-term resources equivalent to seven positions to collect and report data, monitor network adequacy, promulgate necessary regulations, ensure program integrity, and implement quality improvement strategies for dental managed care plans.
4. Enterprise Innovation and Technology Services – Limited-term resources equivalent to five positions to manage required data reporting to the federal government.
5. Information Management Division – Limited-term resources equivalent to two positions to collect, report, analyze, and manage data to be reported to the federal government.

6. Office of HIPAA Compliance – Limited-term resources equivalent to five positions to ensure HIPAA compliance, quality and integrity of the data being reported to the federal government.
7. Office of Legal Services – Limited-term resources equivalent to two positions to provide legal support to compliance activities for dental managed care plans and mental health plans.
8. Mental Health Services Division – 11 permanent positions and limited-term resources equivalent to three positions to oversee provider network adequacy, monitor and certify compliance and manage other required quality and regulatory compliance for county mental health plans.
9. Substance Use Disorder – Program, Policy and Fiscal Division – Four permanent positions and limited-term resources equivalent to one position to 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.

Permanent Extension of Limited-Term Resources Approved in 2016-17. The limited-term expenditure authority approved in the 2016 Budget Act included resources equivalent to 19 positions, as well as funding for the EQRO, which expires on June 30, 2018. DHCS requests permanent extension of nine of these expiring positions, and limited-term extension of resources equivalent to four positions, including resources in the following divisions:

1. Managed Care Quality and Monitoring Division – Five Associate Governmental Program Analysts (AGPA), one Health Program Specialist I and one Research Program Specialist II to continue required monitoring and reporting requirements on health care encounters and performance measures, reporting on access and network adequacy, development of guidance documents, development of enhanced policies related to program integrity, and strengthened efforts to improve the delivery systems that serve Medi-Cal beneficiaries. In addition, these resources allow the division to continue its contract with the EQRO to perform quarterly access assessments of each of the 22 Medi-Cal managed care plans and two specialty health plans.
2. Managed Care Operations Division – One AGPA and one Associate Information Systems Analyst to review documentation and oversee standardization for provider directories, provider network review and certification, enhance beneficiary protection and beneficiary support systems
3. Integrated Systems of Care Division – Limited-term resources equivalent to one AGPA to manage incorporation of managed long-term services and supports (MLTSS) delivery requirements including analyses of housing initiatives for applicability and compliance with MLTSS delivery, and review and respond to queries, concerns, or questions received both internally and externally in relation to MLTSS delivery and housing.
4. Office of Legal Services – One Attorney III and limited-term resources equivalent to two Attorneys to support ongoing program monitoring, quality of care, and timely access for Medi-Cal managed care beneficiaries.

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

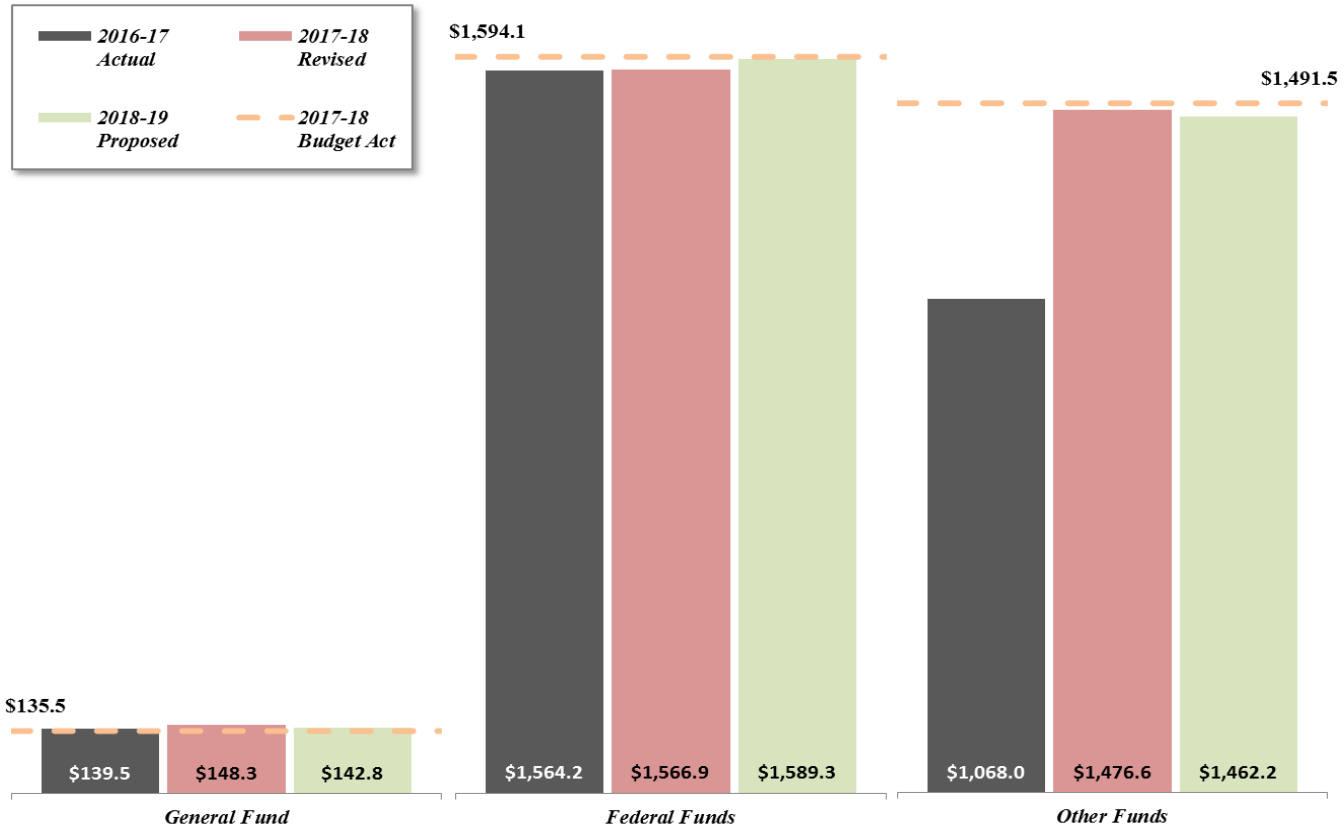
Questions. The subcommittee has requested DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Overview

Department of Public Health – *Three-Year Funding Summary*
(dollars in millions)



Department of Public Health - *Department Funding Summary*			
Fund Source	***2017-18 Budget Act***	***2017-18 Revised***	***2018-19 Proposed***
General Fund	$135,537,000	$148,300,000	$142,789,000
Federal Funds	$1,594,078,000	$1,566,944,000	$1,589,349,000
Other Funds (*detail below)*	$1,491,465,000	$1,476,642,000	$1,462,221,000
Total Department Funding:	**$3,221,080,000**	**$3,191,886,000**	**$3,194,359,000**
Total Authorized Positions:	**3605.2**	**3563.7**	**3608.2**
Other Funds Detail:			
Breast Cancer Research Account (0007)	*$1,098,000*	*$1,098,000*	*$2,104,000*
Nuclear Planning Assessment Acct (0029)	*$979,000*	*$984,000*	*$984,000*
Motor Vehicle Acct, Trans. Fund (0044)	*$1,446,000*	*$1,491,000*	*$1,493,000*
Sale of Tobacco to Minors Ctrl Acct (0066)	*$1,105,000*	*$702,000*	*$1,104,000*

Other Funds Detail (continued):			
Occup. Lead Poisoning Prev Acct (0070)	*$3,405,000*	*$3,517,000*	*$3,653,000*
Medical Waste Management Fund (0074)	*$2,590,000*	*$2,785,000*	*$2,767,000*
Radiation Control Fund (0075)	*$25,413,000*	*$26,307,000*	*$25,704,000*
Tissue Bank License Fund (0076)	*$593,000*	*$620,000*	*$630,000*
Childhood Lead Poisoning Prev Fund (0080)	*$31,447,000*	*$31,946,000*	*$31,588,000*
Export Document Program Fund (0082)	*$699,000*	*$722,000*	*$758,000*
Clinical Lab. Improvement Fund (0098)	*$11,758,000*	*$12,195,000*	*$12,096,000*
Health Statistics Special Fund (0099)	*$25,911,000*	*$26,921,000*	*$27,380,000*
Dept. of Pesticide Regulation Fund (0106)	*$298,000*	*$321,000*	*$321,000*
Air Pollution Control Fund	*$285,000*	*$297,000*	*$297,000*
CA Health Data and Planning Fund (0143)	*$240,000*	*$240,000*	*$240,000*
Food Safety Fund (0177)	*$10,206,000*	*$10,603,000*	*$10,777,000*
Genetic Disease Testing Fund (0203)	*$131,586,000*	*$132,382,000*	*$132,924,000*
Health Education Account, Prop 99 (0231)	*$42,223,000*	*$40,599,000*	*$36,551,000*
Research Account, Prop 99 (0234)	*$4,148,000*	*$4,193,000*	*$5,813,000*
Unallocated Account, Prop 99 (0236)	*$2,825,000*	*$2,862,000*	*$3,245,000*
Infant Botulism Treatment/Prev Fund (0272)	*$6,113,000*	*$6,192,000*	*$6,302,000*
Child Health and Safety Fund (0279)	*$551,000*	*$551,000*	*$551,000*
Registered Enviro. Health Spec Fund (0335)	*$403,000*	*$427,000*	*$427,000*
Indian Gaming Spec Dist Fund (0367)	*$8,198,000*	*$8,236,000*	*$8,238,000*
Vectorborne Disease Account (0478)	*$179,000*	*$187,000*	*$194,000*
Toxic Substances Control Acct (0557)	*$754,000*	*$786,000*	*$439,000*
Domestic Violence Training/Ed Fund (0642)	*$621,000*	*$632,000*	*$605,000*
CA Alzheimers Research Fund (0823)	*$777,000*	*$782,000*	*$871,000*
Special Deposit Fund (0942)	*$5,506,000*	*$5,506,000*	*$5,421,000*
Reimbursements (0995)	*$193,475,000*	*$205,290,000*	*$208,291,000*
Drug and Device Safety Fund (3018)	*$6,996,000*	*$6,217,000*	*$7,135,000*
Tobacco Settlement Fund (3020)	*$600,000*	*$1,200,000*	*$0*
WIC Manufacturer Rebate Fund (3023)	*$236,711,000*	*$233,307,000*	*$230,852,000*
Medical Marijuana Program Fund (3074)	*$190,000*	*$160,000*	*$191,000*
AIDS Drug Assistance Program Fund (3080)	*$286,888,000*	*$293,824,000*	*$307,651,000*
Cannery Inspection Fund (3081)	*$2,604,000*	*$2,707,000*	*$2,748,000*
Mental Health Services Fund (3085)	*$50,217,000*	*$11,839,000*	*$42,384,000*
Licensing and Certification Fund (3098)	*$147,669,000*	*$152,809,000*	*$156,153,000*
Gambling Addiction Program Fund (3110)	*$150,000*	*$150,000*	*$150,000*
Birth Defects Monitoring Prog Fund (3114)	*$4,334,000*	*$4,383,000*	*$4,208,000*
Lead-Related Construction Fund (3155)	*$632,000*	*$690,000*	*$659,000*

Other Funds Detail (continued):			
Cost/Impl Acct, Air Poll. Ctrl Fund (3237)	*$358,000*	*$358,000*	*$358,000*
Cannabis Control Fund (3288)	*$13,161,000*	*$13,501,000*	*$16,022,000*
State Dental Program Acct., Prop 56 (3307)	*$37,500,000*	*$37,500,000*	*$30,000,000*
Tobacco Law Enforc Acct., Prop 56 (3308)	*$7,500,000*	*$7,500,000*	*$0*
Tobacco Prev/Control Acct., Prop 56 (3309)	*$181,123,000*	*$181,123,000*	*$0*
DPH Tobacco Law Enforc, Prop 56 (3318)	*$0*	*$0*	*$6,000,000*
DPH, Tobacco Prev/Ctrl, Prop 56 (3322)	*$0*	*$0*	*$125,942,000*

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 primarily 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 aides, 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 needs during emergencies. The program also administers federal and state funds the support DPH emergency preparedness activities.

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: Alzheimer's Disease Program Grant Awards

Budget Issue. DPH requests expenditure authority of $3.2 million ($3.1 million General Fund and $104,000 CA Alzheimer's Disease and Related Disorders Research Fund) in 2018-19 and $3 million ($3.1 million General Fund and a reduction of $138,000 CA Alzheimer's Disease and Related Disorders Research Fund) in 2019-20 and annually thereafter. If approved, these resources would allow DPH to fund research related to the study of Alzheimer's disease and related disorders.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$3,115,000	$3,115,000
0823 – CA Alzheimer's Disease & Related Disorders Fund	$104,000**	($138,000)
Total Funding Request:	**$3,219,000**	**$2,997,000**

* Resources ongoing after 2019-20.
** Consists of a reduction of $138,000 State Operations offset by an increase in $242,000 for Local Assistance grants

Background. The Alzheimer's Disease Program (ADP), established in 1984, seeks to reduce the human burden and economic costs associated with Alzheimer's Disease and related dementias. The program, currently funded by individual voluntary contributions by taxpayers on state tax returns, performs two primary functions:

1. *California Alzheimer's Disease Centers.* ADP established and administers a statewide network of ten California Alzheimer's Disease Centers (CADCs) at university medical centers. These Centers provide diagnostic and treatment services; professional training for medical residents, postdoctoral fellows, nurses, interns, and medical students; and community education such as caregiver training and support.
2. *Alzheimer's Disease and Related Disorders Research Fund Grants.* ADP established and administers the Alzheimer's Disease and Related Disorders Research Fund (ADRDF), which awards grants through a competitive process to scientists in California engaged in the study of Alzheimer's disease and related disorders.

California Alzheimer's Disease Centers. The ADP established ten CADCs across the state, which serve as Centers of Excellence for the diagnosis and treatment of Alzheimer's Disease and related disorders. Individuals with symptoms of memory loss, disorientation, or confusion are eligible to receive a comprehensive assessment at a CADC, which may include medical, neurological, psychological, and psychosocial evaluations, laboratory tests and imaging. Services are provided by a multidisciplinary clinical team which may include neurologists, psychiatrists, physician assistants, psychologists, nurse specialists, neuropsychologists and social workers. Most services are covered by Medicare, Medi-Cal or private insurance. The ten CADCs are:

- UC Davis (Sacramento)
- UC Davis (East Bay)
- UC San Francisco (San Francisco)
- UC San Francisco (Fresno)
- Stanford University
- UCLA

- Univ. of Southern California (Los Angeles)
- Univ. of Southern California (Rancho Los Amigos)
- UC Irvine
- UC San Diego

Alzheimer's Disease and Related Disorders Research Grants. Since its creation, ADP has provided more than $22 million of funding for 134 research projects to contribute to the better understanding, care, and support of patients and families affected by Alzheimer's Disease and related disorders. Past research grants have contributed to significant breakthroughs including: identifying a novel specific plasma biomarker for Alzheimer's Disease, improving differential diagnosis and training, and providing definitive evidence of how amyloids contribute to the basic pathophysiological abnormalities typical of Alzheimer's and other neurodegenerative diseases.

ADP has funded between five and seven research grants in recent years. The most recent grant cycle funded seven grants in the broad areas of biomarkers and early detection, caregiving, epidemiology, and health disparities. The seven research grants currently funded are as follows:

BIOMARKERS AND EARLY DETECTION:

- University of California, Los Angeles - "Plasma Neuronal Pentraxins as Markers of Synaptic Dysfunction in Alzheimer's Disease"
- University of California, Los Angeles - "Diagnostic and Prognostic Test for Alzheimer's Disease"
- University of California, Davis - "Lipopolysaccharide and Bacterial Molecules in Alzheimer's Disease Brains"

CAREGIVING:

- University of Southern California, in consortium with Family Caregiver Alliance - "Pilot Test and Evaluation of Online Multi-Component Support Program for Caregivers of Adults with Alzheimer's Disease and Related Dementias"
- University of California, San Francisco - "Elucidating the Effects of Alzheimer's Caregiving Using the Brain Health Registry"

EPIDEMIOLOGY:

- University of California, San Francisco - "Late Life-Span Use of Alcohol: Prospective Effects on Dementia Risk and Cognitive Functioning"

HEALTH DISPARITIES:

- University of California, San Diego - "Cognitive Decline in Hispanic versus non-Hispanic Alzheimer Caregivers"

Mistakenly Awarded Research Grants. DPH reports the Alzheimer's Disease Program mistakenly awarded research grants during the most recent grant cycle that exceeded the program's budget authority from the ADRDF by $242,000. While DPH indicates the program is taking steps to avoid mistakes in the grant process in the future, including establishing additional layers of review and oversight, the program has committed to funding that exceeds its currently appropriated resources. DPH proposes to

increase the program's local assistance funding by $242,000 to cover the cost of these commitments, while reducing state operations funding by $138,000. The net increase in funding from the ADRDF would be $104,000 in 2018-19. While the local assistance grant increase is only for 2018-19, the $138,000 reduction in state operations would be ongoing.

Additional General Fund Allocation for Research Grants. DPH also proposes to increase funding for grants funded by the ADP with an additional, ongoing allocation of $3.1 million from the state's General Fund. According to DPH, these resources will fund six additional research projects. The average value of each of these new grants will be higher than previously funded grants. After consultation with stakeholders, the program concluded larger grants would be more appropriate to assist grantees to build research infrastructure.

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

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

1. Please provide a brief overview of this proposal.

Issue 3: Expanded Lead Testing for California Children (AB 1316)

Budget Issue. DPH requests two positions and expenditure authority from the Childhood Lead Poisoning Prevention Fund of $276,000 in 2018-19 and annually thereafter. If approved, these resources would allow DPH to develop regulations and perform additional blood lead testing and analysis under an expanded standard of care required by AB 1316 (Quirk), Chapter 507, Statutes of 2017.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0080 – Childhood Lead Poisoning Prevention Fund	$276,000	$276,000
Total Funding Request:	**$276,000**	**$276,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and Resources ongoing after 2019-20.

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.

Expanded Standards for Determining Lead Poisoning Risk. AB 1316 requires DPH to adopt regulations by July 1, 2019, establishing a new expanded standard of care to determine whether a child is at risk for lead poisoning. including consideration of the following environmental risk factors:

- Time spent in a home, school, or building built before 1978.
- Proximity to a former lead or steel smelter or an industrial facility that historically emitted or currently emits lead.
- Proximity to a freeway or heavily traveled roadway.
- Other potential risk factors for lead exposure and known sources of lead contamination.

The regulations must also include questions to be asked by health care providers to assess the risk of lead exposure, including the new environmental risk factors and potential sources of exposure in the expanded standard of care. According to DPH, these questions would be incorporated into existing lead screening questionnaires after consultation with medical experts, environmental experts, professional organizations, and the public. DPH expects the regulatory process to take a minimum of two years.

AB 1316 also requires DPH to report certain data on its website. Specifically, DPH must report every March 1, beginning in 2019, information that evaluates the department's progress in meeting the goals of the Childhood Lead Poisoning Prevention Act. In addition, AB 1316 requires a list of census tracts in which children test positive at a rate higher than the national average for blood lead levels.

DPH requests one Health Program Specialist I and one Research Scientist II (Epidemiology/Biostatistics) to convene stakeholders to review and update regulations regarding blood lead screening, educate local health care providers and jurisdictions about the changed testing requirements, and report and analyze additional blood lead tests.

According to DPH, these changes to risk factors will likely increase the number of blood tests by 300,000 per year, or nearly 43 percent. DPH also estimates that, as a result, approximately 20 percent more children will be identified as cases of lead poisoning and receive necessary treatment services. DPH reports it cannot estimate the level of additional follow-up workload that will result from a higher level of identification of lead poisoning cases and indicates it will request additional resources, if needed, in future budget requests.

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

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

1. Please provide a brief overview of this proposal.

Issue 4: Program Update: Oral Health Program

Background. The current 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 and a State Oral Health Plan in 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.

The Oral Disease Burden Report was published in April 2017 and the California Oral Health Plan for 2018-2028 was published in January 2018. The Oral Disease Burden Report, among other findings, indicated: 1) nearly one-third of children have untreated tooth decay, 2) there are significant disparities in the prevalence of tooth decay and other dental disease by race and income levels, and 3) among the more than 5 million children receiving dental services through Medi-Cal, only 44 percent of beneficiaries enrolled for at least 90 continuous days received a least one dental service.

Based on the findings of the Oral Disease Burden Report, the Oral Health Plan identified five key goals for improving oral health and achieving oral health equity in California:

1. Goal 1: Improve the oral health of Californians by addressing determinants of health and promote healthy habits and population-based prevention interventions to attain healthier status in communities.
2. Goal 2: Align the dental health care delivery system, payment systems, and community programs to support and sustain community-clinical linkages for increasing utilization of dental services.
3. Goal 3: Collaborate with payers, public health programs, health care systems, foundations, professional organizations, and educational institutions to expand infrastructure, capacity, and payment systems for supporting prevention and early treatment services.
4. Goal 4: Develop and implement communication strategies to inform and educate the public, dental teams, and decision makers about oral health information, programs, and policies.
5. Goal 5: Develop and implement a surveillance system to measure key indicators of oral health and identify key performance measures for tracking progress.

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 was allocated 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."

The ongoing allocation of resources from Proposition 56 is intended to create a comprehensive public health infrastructure to support oral health education, prevention, surveillance, and treatment of dental disease. The funding helps expand the capacity of the Oral Health Program, local health jurisdictions, and Denti-Cal to implement the goals, objectives, strategies, and activities of the 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 will be evaluated through analysis of: 1) oral health surveys 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) surveys of dental practitioners.

The 2017 Budget Act authorized 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 the Oral Health Program, including 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.

Local Health Jurisdiction Grant Funding. Proposition 56 funding for the Oral Health Program is intended, in part, to provide funding to local oral health programs in 61 local health jurisdictions in California. According to DPH, the goal of the program is to create and expand capacity at the local level to educate, prevent, and provide linkages to treatment programs, including dental disease caused by the use of cigarettes and other tobacco products. Local health jurisdictions are expected to establish or expand upon existing local oral health programs by providing education, disease prevention, linkage to treatment, case management and surveillance, with a priority on underserved areas and populations. The anticipated start date of the grants was January 2018.

Stakeholder Trailer Bill Language Proposal for Local Health Jurisdiction Funding Flexibility. The California Health Executives Association of California, the California Dental Association, and a coalition of eight organizations request trailer bill language to allow flexibility to local health jurisdictions to expend Proposition 56 funds received under the Oral Health Program. According to application documents for Oral Health Program funding, of the annual funding amounts for local health jurisdictions, "[u]nexpended funds cannot be rolled-over or carried forward from year-to-year". The coalition reports this restriction is inconsistent with other local health jurisdiction grant programs, such as the Tobacco Prevention Program. According to the coalition, "without the flexibility to distribute funds in a timely manner and access these dollars in subsequent fiscal years, we are concerned that the Oral Health Program, CDPH and potentially local health jurisdictions will be dictated by restrictive policies and timelines instead of strategic disbursements, creating delays and missed opportunities to fully realize the benefit of the funding voters intended to improve the oral health of all Californians."

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

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

1. Please provide a brief overview of the Oral Health Program, including regulatory responsibilities, organizational structure, and major programs.

2. Please summarize how the Oral Health Program is meeting the five goals identified in the California Oral Health Plan?

3. What is the status of grant awards to local health jurisdictions? How many grants were awarded? Please summarize the types of programs that were funded?

Issue 5: Public Beaches Inspection for Contaminants (SB 1395)

Budget Issue. DPH requests General Fund expenditure authority of $354,000 in 2018-19, $242,000 in 2019-20, $370,000 in 2020-21, and $125,000 in 2021-22 and 2022-23. If approved, these resources would allow DPH to finalize development of guidelines approving the use of new rapid test methods to replace current conventional culture methods for determining closures of public beaches, pursuant to the provisions of SB 1395 (Block), Chapter 928, Statutes of 2014. Staff funded by these resources would be redirected from other divisions within DPH.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$354,000	$242,000
Total Funding Request:	**$354,000**	**$242,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested: 2020-21: $370,000; 2021-22 and 2022-23: $125,000.

Background. To protect visitors to California beaches from water-borne diseases, the Beach and Bay Water Quality Monitoring Program requires county public health departments to perform beach water sampling and testing and close beaches or post warning signs if water quality falls below standards set by DPH. Currently approved water quality tests that detect total coliform, fecal coliform, and *Enterococcus* are culture-based, requiring time for bacterial cultures to grow. As a result, testing to determine the safety of California beaches can be delayed by up to two days, increasing the potential for exposure of beachgoers to water-borne diseases during the interim testing period.

SB 1395, approved in 2014, requires DPH to develop guidelines for approving the use of new rapid test methods at specific beaches as alternatives to slower, culture-based methods. Beginning in 2012, the United States Environmental Protection Agency (EPA) released a quantitative polymerase chain reaction (qPCR) method for detection of *Enterococcus* in recreational water, such as beaches. Since 2012, EPA has approved two additional qPCR-based tests and a new droplet digital PCR (ddPCR) test, which can return results in approximately four hours. Utilization of these rapid testing methods could allow beach closures and public notifications in response to unsafe water contamination to occur more quickly, reducing the potential for exposure.

Resource History and Implementation of SB 1395 Requirements. The 2015 Budget Act authorized one three-year, limited-term position to begin implementation of SB 1295, including: 1) developing guidance documents for application of qPCR methods, 2) developing validation criteria and quality control for site specific applications, 3) developing defined standards to compare effectiveness of qPCR methods to existing culture methods, 4) developing lab accreditation criteria for qPCR testing, and 5) consulting and engaging with county public health departments and various stakeholders.

Since approval of these resources, DPH has been working with local jurisdictions to validate rapid testing methods for specific beach sites. Each of California's beaches has different environmental and ecological conditions that require site-specific validation of testing methods to ensure proper controls for local variations in background contaminants. Keller Beach in the San Francisco Bay/Sacramento-San Joaquin Estuary was the first site of study and provided preliminary findings. According to DPH, the

next phase of site-specific testing validation will take place at 46 Southern California beaches over a year-long period.

DPH requests General Fund expenditure authority of $354,000 in 2018-19, $242,000 in 2019-20, $370,000 in 2020-21, and $125,000 in 2021-22 and 2022-23. If approved, these resources would fund staff, redirected from other divisions, to fulfill the requirements of SB 1395, including the following activities:

1. Develop the experimental plan for the study of 46 Southern California beaches.
2. Conduct the study in cooperation with the County of San Diego Environmental Health Department and the San Diego County Public Health Laboratory.
3. Complete reporting and data on the Keller Beach study, as well as future reporting and data on the Southern California beach study.
4. Develop training materials on PCR techniques in recreational water quality monitoring, requirements for quality assurance and quality control of PCR techniques, auditing checklists, and training for laboratories and laboratory auditors.
5. Develop PCR guidance documents in collaboration with stakeholders.

In addition to funding redirected staff resources, the request includes General Fund expenditure authority of $197,000 in 2018-19 and $87,000 in 2019-20 and 2020-21 for laboratory equipment, reagents, and supplies.

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

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

1. Please provide a brief overview of this proposal.

2. Please summarize the status of utilization of new rapid testing methods by local health departments to measure beach contamination.

3. With utilization of rapid testing, have any local health departments made progress in reducing the time between collection of samples and test results that lead to beach closures or public notices?

Issue 6: Oversight: California Safe Cosmetics Program

Background. SB 484 (Migden), Chapter 729, Statutes of 2005, authorized the California Safe Cosmetics Program (CSCP) in DPH to provide information to consumers and other users of cosmetics regarding the presence of certain toxic ingredients. Under the program, cosmetics manufacturers are required to report to CSCP if they sell products in California and those products contain ingredients that have been identified by authoritative bodies as known or suspected of causing cancer or reproductive or developmental toxicity. The authoritative bodies upon which CSCP relies to determine which ingredients must be reported include:

1) Proposition 65 List of Chemicals Known to Cause Cancer or Reproductive Toxicity.
2) United States Environmental Protection Agency.
3) National Toxicology Program (NTP) - Office of Health Assessment and Translation.
4) National Toxicology Program (NTP) – Report on Carcinogens (RoC).
5) International Agency for Research on Cancer.

Ingredient reporting to the CSCP began in 2009 and, in 2014 the program launched an online searchable database, which provides the public with access to the ingredient information reported by cosmetics manufacturers. To date, 77 unique ingredients have been reported in over 57,000 products by nearly 500 companies. These products are in the following categories:

Product Categories	Number of Products	Percentage[11]
Makeup Products (non-permanent)	38,896	63%
Nail Products	7,979	13%
Skin Care Products	5,012	8.1%
Sun-Related Products	3,715	6.0%
Bath Products	2,077	3.3%
Hair Coloring Products	1,391	2.2%
Hair Care Products (non-coloring)	1,038	1.7%
Tattoos and Permanent Makeup	691	1.1%
Personal Care Products	577	0.9%
Fragrances	397	0.6%
Oral Hygiene Products	217	0.3%
Shaving Products	161	0.3%
Baby Products	33	0.1%
Total[12]	**62,184**	

Source: DPH, *Cosmetics Containing Ingredients Linked to Cancer or Reproductive Harm.* August 2016.
Note: Some products are in more than one category

According to DPH, the program was implemented in response to limitations to existing regulatory authority, public concern about safety and the right to know about ingredients, potential health impacts on vulnerable populations, and the opportunity for safer chemical substitutions. The program reports to date that 151 companies have removed chemical ingredients known or suspected to cause cancer or reproductive or developmental toxicity from 1,765 products.

The program is currently funded with approximately $370,000 annually from the state's General Fund. These resources fund one Research Scientist III, who serves as the program lead, and one Associate Governmental Program Analyst to support data collection and analysis. According to DPH, the program has no enforcement authority and responds to potential non-compliance by sending reminder letters to companies regarding their responsibility to report under the program. The authorizing statute does not include enforcement penalty authority.

Stakeholder Proposal: Fee and Penalty Authority for Enforcement and Program Improvements. Breast Cancer Prevention Partners and a coalition of companies manufacturing safer cosmetics, public health and environmental health organizations request General Fund expenditure authority of up to $1.5 million to increase staffing and for enforcement and program improvement activities. The coalition also requests implementation of a $30 fee for each reportable product and penalty authority of $10,000 per company or $1,000 per product for failure to report covered products to the CSCP for inclusion in the database. The fee and penalty revenue would be used to reimburse the General Fund for the increased funding request.

According to the coalition, increased funding would provide the following:

- Increase staffing of the program to fulfill its statutory mandates and fully implement the law.
- Enable the program to address underreporting by manufacturers.
- Enable the program to address the industry abuse of "trade secret" designations which businesses have used to conceal hundreds of toxic chemicals from public view.
- Initiate investigations into the safety of ingredients and products.
- Refer investigations that find potential harm to Cal/OSHA to protect California's salon workers.
- Allow for increased awareness and use of the Safe Cosmetics Database and regular outreach to consumers and salon workers.
- Require companies to report to the state's database whether their products are intended for professional salon use or consumer use.
- Overhaul and modernize the SCP's outdated platform to address database malfunctioning.

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

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

1. Please provide a brief summary of the data collection and reporting activities of the Safe Cosmetics Program.

2. How does the Safe Cosmetics Program verify that all cosmetics products containing chemicals known or suspected of causing cancer, birth defects, or reproductive toxicity are being reported to the program?

3. Please describe what remedies are available to the program if a product is discovered containing a reportable chemical and the product has not been reported to the program's database?

Issue 7: Women, Infants, and Children (WIC) Local Assistance Estimate

Budget Issue. The November 2017 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of $1.2 billion ($1.1 billion federal funds and $233.3 million WIC manufacturer rebate funds) in 2017-18 and $1.2 billion ($1.1 billion federal funds and $230.9 million WIC manufacturer rebate funds) in 2018-19. The federal fund amounts include state operations costs of $63.5 million in 2017-18 and $63.7 million in 2018-19.

Women, Infants, and Children (WIC) Funding Summary			
	2017-18	**2018-19**	**BY to CY**
Fund Source	***Revised***	***Proposed***	***Change***
0890 – Federal Trust Fund			
State Operations:	$63,463,000	$63,684,000	$221,000
Local Assistance:	$899,152,000	$889,131,000	($10,021,000)
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$233,307,000	$230,852,000	($2,455,000)
Total WIC Expenditures	**$1,195,922,000**	**$1,183,667,000**	**($12,255,000)**

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 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	2017 Budget Act	SFY 2017-18			SFY 2018-19		
		November Estimate	Change from 2017 Budget Act		November Estimate	Change from 2017 Budget Act	
Pregnant	63,379,000	59,344,000	(4,035,000)	-6.37%	56,986,000	(6,393,000)	-10.09%
Breastfeeding	58,188,000	53,928,000	(4,260,000)	-7.32%	53,586,000	(4,602,000)	-7.91%
Non-Breastfeeding	29,309,000	28,202,000	(1,107,000)	-3.78%	27,618,000	(1,691,000)	-5.77%
Infants	321,211,000	319,084,000	(2,127,000)	-0.66%	314,878,000	(6,333,000)	-1.97%
Children	376,717,000	346,813,000	(29,904,000)	-7.94%	342,190,000	(34,527,000)	-9.17%
Reserve	25,464,000	24,221,000	(1,243,000)	-4.88%	23,858,000	(1,606,000)	-6.31%
Total Food Expenditures	**874,268,000**	**831,592,000**	**(42,676,000)**	**-4.88%**	**819,116,000**	**(55,152,000)**	**-6.31%**
Food Expenditures Paid from Rebate Funds	*236,711,000*	*233,307,000*	*(3,404,000)*	*-1.44%*	*230,852,000*	*(5,859,000)*	*-2.48%*
Food Expenditures Paid from Federal Funds	*637,557,000*	*598,285,000*	*(39,272,000)*	*-6.16%*	*588,264,000*	*(49,293,000)*	*-7.73%*
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)	**938,424,000**	**899,152,000**	**(39,272,000)**	**-4.18%**	**889,131,000**	**(49,293,000)**	**-5.25%**
State Operations (Federal NSA)	63,463,000	63,463,000	-	0.00%	63,684,000	221,000	0.35%

The budget assumes 1,075,108 average monthly WIC participants in 2017-18, a decrease of 64,197 or 5.6 percent from the assumptions in the 2017 Budget Act. The budget assumes 1,024,382 average monthly WIC participants in 2018-19, a decrease of 50,726 or 4.7 percent from the revised 2017-18 caseload estimate.

Food Expenditures Estimate. The budget includes $831.6 million in 2017-18 for WIC program food expenditures, a decrease of $42.7 million or 4.9 percent, compared to the 2017 Budget Act. According

to DPH, this decrease is due to lower than projected participation levels. Of these expenditures, federally funded food expenditures are $598.3 million, a decrease of $39.3 million from the 2017 Budget Act, and WIC Manufacturer Rebate Fund food costs are $233.3 million, a decrease of $3.4 million from the 2017 Budget Act.

The budget includes $819.1 million in 2018-19 for WIC program food expenditures, a decrease of $55.2 million or 6.3 percent from the revised 2017-18 food expenditures estimate. According to DPH, this decrease is due to the continued downward trend of total participation in the program. Of these expenditures, federally funded food costs are $588.3 million, a decrease of $49.3 million from the revised 2017-18 food expenditure estimate, and WIC Manufacturer Rebate Fund food costs are projected to be $230.9 million, a decrease of $5.9 million from the revised 2017-18 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 2017-18 and 2018-19, which is unchanged from the level assumed in the 2017 Budget Act. The budget also includes $63.5 million for state operations expenditures in 2017-18, also unchanged from the level assumed in the 2017 Budget Act. The budget includes $63.7 million for state operations expenditures in 2018-19, an increase of $221,000 or 0.4 percent compared to the revised 2017-18 estimate. According to DPH, the increase in 2018-19 is attributed to a $2.9 million increase in expenditures for the eWIC Electronic Benefit Transfer (EBT) and Management Information System (MIS) Project, offset by a $2.7 million decrease in expenditures due to miscellaneous technical adjustments.

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

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

1. Please provide a brief overview of the caseload and expenditure changes for the WIC program.

2. Please provide an update on participation in the program as a percentage of eligible individuals in the state.

3. What is DPH doing to maximize participation in the WIC program to make full use of available federal WIC funding?

Issue 8: Infant and Early Childhood Home Visiting Program

Budget Issue. DPH requests permanent extension of 27 expiring, limited-term positions and federal fund expenditure authority of $903,000 in 2018-19 and $21.8 million in 2019-20. Of the 27 positions, 11 would be renewed in January 2019, and 16 would be renewed in July 2019. If approved, these resources would allow DPH to continue operation of the California Home Visiting Program (CHVP).

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0890 – Federal Trust Fund		
State Operations	$903,000	$4,000,000
Local Assistance	$-	$17,800,000
Total Funding Request:	**$903,000**	**$21,800,000**
Total Requested Positions:	**11.0**	**27.0**

* Positions and Resources ongoing after 2019-20.

Background. The California Home Visiting Program (CHVP), established in 2010 by authority contained in the federal Affordable Care Act, provides voluntary, evidence-based home visiting services to pregnant and newly parenting families who have one or more of the following risk factors: domestic violence, inadequate income, unstable housing, education less than 12 years, substance abuse, and depression and/or mental illness. Services are provided by a public health nurse or paraprofessional in the family's home and may begin prenatally or right after the birth of a baby up to age three.

Two Evidence-Based Models for Service Delivery. CHVP home visiting services are provided to eligible families by 23 local health jurisdictions (LHJ). Each uses one of the following evidence-based models, based on the specific needs of the local area:

1) Healthy Families America (HFA)
    a. Serves low-income families who must be enrolled within the first three months after an infant's birth.
    b. A trained paraprofessional provides one-on-one home visits to parents and their babies primarily up to age three.
    c. Uses a strength-based approach.
    d. Uses motivational interviewing to build on the parents' own interests.

   HFA Counties (8): Tehama, Butte, Nevada, Yolo, Merced, Madera, Imperial, Los Angeles*

2) Nurse Family Partnership (NFP)
    a. Serves low-income, first-time mothers who must be enrolled by the 28th week of pregnancy.
    b. A public health nurse provides one-on-one home visits to parents and their babies up to age two.
    c. Uses a strength-based approach.
    d. Uses motivational interviewing to build on the parents' own interests.

NFP Counties (16): Del Norte, Humboldt, Shasta, Sonoma, Solano, Sacramento, San Francisco, Contra Costa, Alameda, San Mateo, Stanislaus, Fresno, Kern, Riverside, San Diego, Los Angeles*

*Los Angeles offers services under both the HFA and NFP models.

According to DPH, the CHVP is a high-yield investment that strengthens parent-child relationships, increases language and literacy skills, and reduces child abuse, neglect, poor health, academic failure and crime. According to a fact sheet developed by the Pacific Institute for Research and Evaluation[1], the Nurse-Family Partnership model resulted in the following outcomes in 2010:

Present Value of Benefits and Costs per Family Served by Nurse-Family Partnership, California, 2010 Benefits of NFP	**Per Case**
Reduced Smoking While Pregnant	$3
Reduced Preeclampsia	$670
Fewer Preterm First Births	$1,664
Fewer Subsequent Births	$435
Fewer Subsequent Preterm Births	$1,309
Fewer Infant Deaths	$24,324
Fewer Child Maltreatments:	
Substantiated Cases	$3,756
Indicated & Unreported Cases	$6,598
Fewer Nonfatal Child Injuries	$889
Fewer Remedial School Services	$90
Fewer Youth Crimes:	
Arrests	$1,440
Crimes	$9,892
Reduced Youth Substance Abuse	$29
More Immunizations:	
Savings Net of Immunization Cost	$105
Total Benefits	$51,204
Resource Cost Savings	$10,947
Intangible Savings (work, quality of life)	$40,257
Cost of NFP	$12,075
Net Cost Saving	**$39,129**
Resource Cost Savings Net of Program Costs	-$1,128
Benefit-Cost Ratio	4.2

According to DPH, as of October 2017, CHVP completed 141,091 home visits and served over 7,554 families at its 23 local sites.

Resource History and Status of Federal Funding. CHVP is fully supported by federal funds provided by the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program grant. MIECHV was initially funded for its first five years, from 2010 through 2014, at $1.5 billion nationwide. The

[1] Miller, T.R. 2017. Societal Return on Investment in Nurse-Family Partnership Services in California. Fact Sheet. Pacific Institute for Research and Evaluation, Beltsville, MD.

Protecting Access to Medicare Act of 2014 funded the program at $400 million nationwide in 2015, and separated the program from the balance of the Affordable Care Act. The Medicare and CHIP Reauthorization Act extended funding until September 30, 2017 at $372 million nationwide. The Bipartisan Budget Act of 2018, approved in February 2018, funded the program at $400 million nationwide for an additional five years, until September 30, 2022.

California's federal funding from MIECHV since 2010 has been as follows:

Federal Fiscal Year (Oct.-Sept.)	2010	2011	2012	2013	2014	2015	2016	2017
California Funding Level (*millions*)	$8.2	$20.9	$20.9	$20.2	$20.6	$22.6	$22.2	$22.0

After DPH was awarded funding from MIECHV Program grants in 2010-11 and 2011-12 to establish the CHVP, the 2010 and 2011 Budget Acts authorized a total of 36 five-year, limited-term positions to develop appropriate home visiting models, develop reporting and compliance procedures and manage the program. The 2015 Budget Act extended 27 of these positions for an additional three years. DPH requests to reauthorize the program's staff on a permanent basis. Based on the success of home visiting programs nationally and bipartisan federal support, DPH expects to continue to receive federal MIECHV Program grants for the CHVP. The current program staff positions proposed for permanent extensions consist of the following classifications:

Classification	***2018-19***	***2019-20***
Office Technician	1.0	1.0
Associate Accounting Analyst	1.0	1.0
Staff Services Manager II (Supvry)	1.0	1.0
Associate Governmental Program Analyst	1.0	3.0
Research Scientist I	0.0	3.0
Research Scientist II	1.0	4.0
Research Scientist III	1.0	2.0
Research Scientist IV	1.0	1.0
Research Scientist Supervisor I	1.0	1.0
Research Scientist Manager	1.0	1.0
Public Health Medical Officer III	1.0	1.0
Health Program Specialist I	0.0	3.0
Health Program Specialist II	1.0	5.0
TOTAL	**11.0**	**27.0**

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

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

1. Please provide a brief overview of this proposal.

Issue 9: Genetic Disease Screening Program (GDSP) Local Assistance Estimate

Budget Issue. The November 2017 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of $132.3 million ($27.7 million state operations and $104.7 million local assistance) in 2017-18, and $132.9 million ($29.5 million state operations and $103.5 million local assistance) in 2018-19.

Genetic Disease Screening Program (GDSP) Funding Summary			
	2017-18	**2018-19**	**BY to CY**
Fund Source	***Revised***	***Proposed***	***Change***
0203 – Genetic Disease Testing Fund			
State Operations:	$27,650,000	$29,451,000	$1,801,000
Local Assistance:	$104,732,000	$103,473,000	($1,259,000)
Total GDSP Expenditures	**$132,382,000**	**$132,924,000**	**$542,000**

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 currently $130.25. Beginning July 1, 2018, the NBS program fee will increase by $12 to $142.25 to support workload for addition of MPS-I and Pompe disease to the screening panel.

Caseload Estimate: The budget estimates NBS program caseload of 480,607 in 2017-18, a decrease of 1,744 or 0.4 percent, compared to the 2017 Budget Act. The budget estimates NBS program caseload of 478,321 in 2018-19, an increase of 2,287 or 0.5 percent, compared to the revised 2017-18 estimate. These estimates are based on state projections of an increase in the number of live births. DPH assumes 99.4 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 measure 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 343,933 in 2017-18, a decrease of 4,504 or 1.3 percent, compared to the 2017 Budget Act. The budget estimates PNS program caseload of 342,297 in 2018-19, a decrease of 1,636 or 0.5 percent, compared to the revised 2017-18 estimate. These estimates are based on state projections of an increase in the number of live births. DPH assumes 71.1 percent of births will participate in the PNS program annually.

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

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

1. Please provide a brief overview of the 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 10: New Genetic Disorders (SB 1095) and Second Tier Testing

Budget Issue. DPH requests 18 positions and expenditure authority from the Genetic Disease Testing Fund of $2.7 million. If approved, these resources would allow DPH to comply with expanded testing requirements pursuant to SB 1095 (Pan), Chapter 363, Statutes of 2016, including new screening for Mucopolysaccharidosis type I (MPS-I), Pompe disease, and any future additions to the Recommended Uniform Screening Panel (RUSP).

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0203 – Genetic Disease Testing Fund		
State Operations:	$2,690,000	$2,690,000
Local Assistance**:	[($460,000)]	[($460,000)]
Total Funding Request:	**$2,690,000**	**$2,690,000**
Total Requested Positions:	**18.0**	**18.0**

* Positions and Resources ongoing after 2019-20.

** Local Assistance reductions are non-add and are reflected in the GDSP Local Assistance Estimate.

Background. GDSP administers a statewide genetic disorder screening program for pregnant women and newborns 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 disease 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. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of this proposal.

Issue 11: Additional Proposals for Investment

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

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

Stakeholder Proposal to Implement Systems of Care for Amyotrophic Lateral Sclerosis (ALS). The ALS Association requests $3 million General Fund to help support the critical System of Care, both clinic- and community-based, for ALS patients and their caregivers. According to the ALS Association, ALS, often referred to as Lou Gehrig's disease, is a progressive and fatal neuro-degenerative disease. When motor neurons die, the ability of the brain to initiate and control muscle movement is lost. The result is that people with ALS lose the ability to move, speak, swallow and breathe. The life expectancy of a person diagnosed with ALS is 2 to 5 years, and there is no effective treatment or cure. There are only two drugs approved by the FDA for ALS, neither are proven to extend life by more than 2 to 4 months. The only way to meaningfully extend the length and quality of life for people diagnosed with ALS is to provide them with access to the ALS Association's evidence-based model of care. This model of care involves the seamless integration of community and clinic based multidisciplinary services. This "wraparound" model of care is proven to help people diagnosed with ALS to live significantly longer and better than the only FDA approved drugs.

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

Questions. The subcommittee has requested advocates to present these proposals and respond to questions from subcommittee members.

Senate Budget and Fiscal Review—Holly Mitchell, Chair

JOINT HEARING SUBCOMMITTEES No. 1 and 3

Subcommittee No. 1
Senator Anthony Portantino, Chair
Senator Hannah-Beth Jackson
Senator John M. W. Moorlach

Subcommittee No. 3
Senator Richard Pan, Chair
Senator William M. Monning
Senator Jeff Stone

Thursday, April 5, 2018
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Elisa Wynne

Item	Department	
6100	**Department of Education**	
5180	**Department of Social Services**	
Issue 1	Governor's Budget Funding Proposals	6
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Issue 4	CalWORKs Participation Update (Information Only)	15
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	Public Comment	

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6100 DEPARTMENT OF EDUCATION
5180 DEPARTMENT OF SOCIAL SERVICES

Child Care and Early Education Background Information

Generally, programs in the early care and education system have two objectives: to support parental work participation and to support child development. Children, from birth to age five, are cared for and instructed in child care programs, State Preschool, transitional kindergarten, and the federal Head Start program.

Child Care. California provides child care subsidies to some low-income families, including families participating in CalWORKs. Families who have participated in CalWORKs are statutorily guaranteed child care during "Stage 1" (when a family first enters CalWORKs) and "Stage 2" (once a county deems a family "stable", defined differently by county). In the past, the Legislature has funded "Stage 3" (two years after a family stops receiving cash aid) entirely. Families remain in Stage 3 until their income surpasses a specified threshold or their child ages out of the program. For low-income families who do not participate in CalWORKs, the state prioritizes based on income, with lowest-income families served first. To qualify for subsidized child care: (1) parents demonstrate need for care (parents working, or participating in an education or training program); (2) family income must be below 85 percent of the most recent state median income (SMI) calculation; and (3) children must be under the age of 13.

California State Preschool Program. State Preschool provides both part-day and full-day services with developmentally-appropriate curriculum, and the programs are administered by local educational agencies (LEAs), colleges, community-action agencies, and private nonprofits. State preschool can be offered at a child care center, a family child care network home, a school district, or a county office of education (COE). The State Preschool program serves eligible three- and four-year old children, with priority given to four-year olds whose family is either on aid, is income eligible (family income may not exceed 85 percent of the SMI), is homeless, or the child is a recipient of protective services or has been identified as being abused, neglected, or exploited, or at risk of being abused, neglected or exploited.

Transitional Kindergarten. SB 1381 (Simitian), Chapter 705, Statutes of 2010, enacted the "Kindergarten Readiness Act" and established the transitional kindergarten program, beginning in 2012-13, for children who turn five between September 1 and December 1. Each elementary or unified school district must offer developmentally-appropriate transitional kindergarten and kindergarten for all eligible children, regardless of family income. Transitional kindergarten is funded through an LEA's Local Control Funding Formula allocation. LEAs may enroll children in transitional kindergarten that do not meet the age criteria if they will turn five by the end of the school year, however, these students will not generate state funding until they turn five.

State Child Care and Preschool Programs

Program	Description
CalWORKs Child Care	
Stage 1	Child care becomes available when a participant enters the CalWORKs program.
Stage 2	Families transition to Stage 2 child care when the county welfare department deems them stable.
Stage 3	Families transition to Stage 3 child care two years after they stop receiving cash aid. Families remain in Stage 3 until the child ages out (at 13 years old) or they exceed the income-eligibility cap.
Non-CalWORKs Child Care	
General Child Care	Program for other low-income, working families.
Alternative Payment	Another program for low-income, working families.
Migrant Child Care	Program for migrant children from low-income, working families.
Care for Children with Severe Disabilities	Program for children with severe disabilities living in the Bay Area.
Preschool	
State Preschool	Part-day, part-year program for low-income families. Full-day, full-year program for low-income, working families.
Transitional Kindergarten	Part-year program for children who turn five between September 2 and December 2. May run part day or full day.

Source: Legislative Analyst's Office

Funding. California provides child care and development programs through vouchers and contracts.

- **Vouchers.** The three stages of CalWORKs child care and the Alternative Payment Program are reimbursed through vouchers. Parents are offered vouchers to purchase care from licensed or license-exempt caregivers, such as friends or relatives who provide in-home care. Families can use these vouchers at any licensed child care provider in the state, and the value of child care vouchers is capped. The state will only pay up to the regional market rate (RMR) — a different amount in each county and based on regional surveys of the cost of child care. The RMR is currently set to the 75th percentile of the 2016 RMR survey. If a family chooses a child care provider who charges more than the maximum amount of the voucher, then a family must pay the difference, called a co-payment. Typically, a Title 22 program – referring to the state Title 22 health and safety regulations that a licensed provider must meet — serves families who

receive vouchers. The Department of Social Services (DSS) funds CalWORKs Stage 1, and county welfare departments locally administer the program. The California Department of Education (CDE) funds the remaining voucher programs, which are administered locally by Alternative Payment (AP) agencies statewide. Alternative Payment agencies (APs), which issue vouchers to eligible families, are paid through the "administrative rate," which provides them with 17.5 percent of total contract amounts.

- **Contracts.** Providers of General Child Care, Migrant Child Care, and State Preschool – known as Title 5 programs for their compliance with Title 5 of the California Code of Regulations — must meet additional requirements, such as development assessments for children, rating scales, and staff development. Title 5 programs contract with, and receive payments directly from, CDE. These programs receive the same reimbursement rate (depending on the age of the child), no matter where in the state the program is located. The rate is increased by a stautory adjustment factor for infants, toddlers, children with exceptional needs, severe disabilities, cases of neglect, and English learners. Since July 1, 2017, the standard reimbursement rate (SRR) is $45.44 per child per day of enrollment.

For license-exempt care, reimbursement rates are set at seventy percent of the regional reimbursement rate established for family child care homes, except for hourly rates, which are set by dividing the weekly rate by 45 hours, to arrive at a rate that can in some cases be around 25 percent of the family child care home hourly rate.

Child care and early childhood education programs are generally capped programs, meaning that funding is provided for a fixed amount of slots or vouchers, not for every qualifying family or child. The exception is the CalWORKs child care program (Stages 1 and 2), which are entitlement programs in statute.

Subsidized child care programs are funded by a combination of non-Proposition 98 state General Fund and federal funds. Until the 2011-12 fiscal year, the majority of these programs were funded from within the Proposition 98 guarantee for K-14 education. In 2012, funding for state preschool and the General Child Care Programs were consolidated; all funding for the part-day/part-year state preschool is now budgeted under the state preschool program, which is funded from within the Proposition 98 guarantee. For LEA-run preschool, wrap-around care to provide a full day of care for working parents is provided with Proposition 98 funding, while non-LEA state preschool providers receive General Fund through the General Child Care program to support wrap-around care. In contrast, transitional kindergarten, is funded with Proposition 98 funds through the Local Control Funding Formula (LCFF) based on Average Daily Attendance (ADA). A local district receives the same per ADA funding for a transitional kindergarten student as for a kindergarten student.

California also receives funding from the federal Child Care and Development Fund (CCDF), which is comprised of federal funding for child care under the Child Care and Development Block Grant (CCDBG) Act and the Social Security Act and from federal TANF funds.

From 2009-2013, overall funding for child care and preschool programs decreased by $984 million; and approximately 110,000 slots, across all programs, were eliminated. During this time, the state also froze provider rates, cut license-exempt provider payments, and lowered income eligibility for families. Since 2013, the state has invested a total of $1.2 billion into child care and early education

($600.8 million non-Proposition 98 General Fund and $600 million Proposition 98 General Fund). These increases are a combination of increased provider rates, increased child care and state preschool slots and access, and investments in the quality of programs. The summary of subsidized slots provided in the system is displayed below.

Child Care and Preschool Subsidized Slots

	2016-17 Revised[a]	2017-18 Revised[a]	2018-19 Proposed	Change from 2017-18 Amount	Change from 2017-18 Percent
CalWORKs Child Care					
Stage 1	40,949	38,795	38,760	-35	-0.1%
Stage 2[b]	51,083	52,913	53,840	927	1.8%
Stage 3	34,770	33,516	36,089	2,573	7.7%
Subtotals	**(126,802)**	**(125,224)**	**(128,689)**	**(3,465)**	**(2.8%)**
Non-CalWORKs Child Care					
General Child Care[c]	28,737	28,563	28,427	-136	-0.5%
Alternative Payment Program	30,614	29,804	31,997	2,192	7.4%
Migrant Child Care	3,064	3,046	3,037	-9	-0.3%
Care for Children with Severe Disabilities	104	106	103	-3	-3.1%
Subtotals	**(62,519)**	**(61,519)**	**(63,564)**	**(2,045)**	**(3.3%)**
Preschool					
State Preschool–part day	101,598	101,101	102,721	1,620	1.6%
State Preschool–full day	62,005	64,528	66,599	2,071	3.2%
Transitional Kindergarten	82,580	82,596	82,357	-239	-0.3%
Subtotals	**(246,183)**	**(248,226)**	**(251,677)**	**(3,452)**	**(1.4%)**
Totals	**435,504**	**434,968**	**443,930**	**8,961**	**2.1%**

Source: LAO

Note: Generally derived based on budget appropriation and annual average rate per child. Except where noted, slot numbers reflect DSS estimates for CalWORKs Stage 1; DOF estimates for CalWORKs Stage 2 and 3, General Child Care, Migrant Child Care, and Care for Children with Severe Disabilities; and LAO estimates for all other programs. For Transitional Kindergarten, reflects preliminary estimates, as enrollment data not yet publicly available for any year of the period. Table does not include slots funded through emergency bridge program for foster children.

[a] Reflects actuals for all stages of CalWORKs in 2016-17 and updated DSS estimates for Stage 1 in 2017-18.

[b] Does not include certain community college child care slots (1,300 to 1,800 slots annually).

[c] State Preschool wraparound slots for non-LEAs (funded by General Child Care) are shown in State Preschool–full day.

DSS = Department of Social Services. DOF = Department of Finance. LEAs = local education agencies.

Issue 1: Governor's Budget Funding Proposals

Panel:

- Sara Cortez, Legislative Analyst's Office
- Brianna Bruns, Department of Finance
- Debra Brown, Department of Education

Background:

The 2016 Budget Act included the first year of a multi-year increase in early childhood education programs, including increased provider reimbursement rates and additional slots for the California State Preschool Program. The agreement includes a total investment of an ongoing $527 million by 2019-20. In addition, $53 million in one-time funding was included to hold-harmless for two years (2016-17 and 2017-18), providers whose payments would otherwise be negatively impacted by the use of an updated 2014 RMR survey in the calculation of rates. These increases were generally designed to keep pace with increases to the state's minimum wage.

In 2016-17 and 2017-18, the following changes were made:

- An increase of the Standard Reimbursement Rate (SRR), paid to center-based care and preschools by 10 percent beginning January 1, 2017 and increase of the rate by an additional six percent, beginning July 1, 2017.

- An increase to the regional market rate (RMR) for voucher-based child care to the 75th percentile of the 2014 survey for that region, or at the RMR for that region as it existed on December 31, 2016, whichever is greater, beginning January 1, 2017. The 2017 budget act updated the RMR to the 75th percentile of the 2016 RMR survey effective July 1, 2017. This includes a temporary hold harmless provision so no provider receives less in 2017-18 than it receives under current rates (through December, 2018).

- License-exempt rates were increased from 65 percent to 70 percent of the Family Child Care Home rate beginning January 1, 2017.

- Expanded preschool by 8,877 full-day preschool slots over three years (2,959 added each year).

The 2017 budget act also amended income eligibility rules to use the most recent calculation of state median income, based on census data and adjusted for family size, for determining initial and ongoing eligibility for subsidized child care services. In addition, the 2017 budget agreement specified that families who meet eligibility and need requirements for subsidized child care services shall receive services for not less than 12 months, and makes related changes.

Governor's Budget Proposal:

The Governor's proposed child care and early education budget includes increases that total approximately $400 million, for a total of $4.4 billion in state and federal funds. This reflects an increase of nine percent from 2017-18. Major changes are described below:

The Governor proposes $60.7 million ($32.3 million non-Proposition 98 General Fund and $28.4 million Proposition 98 General Fund) to fund the full-year costs of rate and slot increases implemented midway in 2017-18 related to the 2016-17 agreement and other policy changes made in 2017-18, such as enactment of the emergency child care bridge program. Finally, the budget proposes $8 million for an additional 2,959 full-day Preschool slots beginning April 1, 2019.

In addition the Governor proposes approximately $14 million in the budget year and $34.2 million in future years to make the RMR hold harmless provision permanent (under current law the provision would expire December 31, 2018).

The Governor also proposes $31.6 million in Proposition 98 General Fund and $16.1 million in non-Proposition 98 General Fund to increase the SRR by approximately 2.8 percent.

The Governor includes $50 million for a 2.51 percent cost-of-living adjustment for non-CalWORKs child care and state preschool programs and decreases slots by $9 million to reflect a decrease in the birth to age four population.

The Governor proposes several adjustments to reflect changes in the CalWORKs child care caseload and cost of care, totaling a $4 million increase in Stage 1, a $16 million decrease in Stage 2, and a $12 million increase in Stage 3.

Finally, the Governor also includes an increase of $41 million (for a total of $779 million Proposition 98 General Fund) for Transitional Kindergarten, reflecting ADA growth and cost-of-living adjustments. This funding is included within LCFF totals as discussed in previous subcommittee hearings.

2018-19 Child Care and Early Education Budget Changes

(in Millions)	General Fund			
Change	**Prop. 98**	**Non-Prop. 98**	**Federal Funds**	**Total**
Reimbursement Rates				
Provide 2.51 percent COLA to certain child care and preschool programs	$28	$22	—	$50
Increase Standard Reiumbursment Rate (SRR) 2.8 percent starting July 1, 2018	$32	$16	—	$48
Annualize Regional Market Rate (RMR) increase initiated January 1, 2018	—	$20	$4	$24
Permanently extend RMR hold harmless provision[a]	—	$13	$1	$14
Subtotals	**($59)**	**($71)**	**($5)**	**($136)**
Caseload and Cost of Care				
Annualize cost of State Preschool slots initiated April 1, 2018	$19	—	—	$19
Provide 2,959 full-day State Preschool slots at LEAs starting April 1, 2019	$8	—	—	$8
Make CalWORKs caseload and average cost of care adjustments	—	$6	-$6	—
Reduce non-CalWORKs slots by 0.48 percent[c]	-$5	-$4		-$9
Subtotals	**($22)**	**($2)**	**-($6)**	**($19)**
Other				
Fund one-time early education expansion grants	$125	—	$42	$167
Adjust Transitional Kindergarten for increases in attendance and LCFF funding rate	$41	—	$0	$41
Provide one-time increase to quailty services	—	—	$9	$9
Annualize funding for bridge program for foster children initiated January 1, 2018	—	$15	$5	$20
Replace federal funds with state funds (accounting adjustment)	—	$59	-$59	—
Make other technical adjustments	$9	-$2	—	$7
Subtotals	**($175)**	**($73)**	**-($4)**	**($244)**
Totals	**$257**	**$146**	**-$4**	**$399**

Source: Legislative Analyst's Office

a Under current law, the RMR hold harmless provision expires December 31, 2018. Preliminary LAO estimate of Stage 1 CalWORKs hold harmless costs.

b Less than $500,000.

c Reflects statutory adjustment based on the projected decrease in the birth-through-four population.

LAO Analysis:

The LAO generally has no concerns with the increases included in the Governor's budget proposal for early care and education that are related to increasing rates and slots and other changes in accordance with the multi-year agreement from 2016-17 and policy changes agreed to in the 2017-18 budget.

The LAO notes that LEAs provide about two-thirds of all State Preschool slots and non-LEAs, typically nonprofit agencies, provide the other one-third. Because of the differences in funding (LEAs receive Proposition 98 funds for State Preschool and wrap care to provide a full day of care, whereas non-LEAs receive General Fund for the wrap portion of the care), slots are not offered or taken up at the same rate by LEAs and non-LEAs. With the addition of slots over the past few years, the CDE has had to run multiple rounds of applications, offering full-day slots first to LEAs and only to non-LEAs in the second or third rounds. As a result, the LAO recommends the Legislature shift all of the non-LEA wrap care into Proposition 98 to fund all State Preschool programs similarly and offer slots to all interested providers, both LEAs and non-LEAs.

The LAO also notes that the Governor's proposal to make the hold harmless for RMR providers permanent perpetuates inequities in access and reimbursement rates across the state, by allowing families in some areas of the state to access a greater percentage of providers in their area than families in other areas of the state. As a result, the LAO recommends rejecting the Governor's proposal and allowing the hold harmless provisions to expire at the end of 2018. The LAO also notes that the $14 million saved by rejecting the proposal could be used to provide 1,500 additional Alternative Payment slots.

The LAO's analysis of the Inclusive Early Education Planning Grant proposal is discussed in Issue 3 later in this agenda.

Staff Comments:

Staff notes that as mentioned in the background piece included in the agenda, the recently passed federal appropriations bill (March 2018) included an increase of almost $2.37 billion in total for the Child Care and Development Block Grant. According to the CDE, California generally can expect to receive around ten percent of this increase or approximately $237 million. Authorization for expenditure of new federal funds is not included in the Governor's budget due to timing. In Issue 5, CDE will update the subcommittee on the new funding, the timing for receiving funds, and the determination of the use of funds.

Suggested Questions:

- Can the CDE provide an update on the utilization of state preschool slots? How does the CDE plan to release the additional slots? Has there been feedback from the field, particularly LEAs on whether they will be able to take these slots?

Staff Recommendation. Hold Open.

Issue 2: Licensing Flexibility

Panel:

- Edgar Cabral, Legislative Analyst's Office
- Brianna Bruns, Department of Finance
- Debra Brown, Department of Education

Background:

State Preschool programs must be licensed and follow the Community Care Licensing (CCL) health and safety standards under the Department of Social Services (DSS), known as Title 22 regulations. Some of these licensing requirements include that classrooms are clean and sanitary, children are constantly supervised, teachers are vaccinated and trained in first aid and medication, and cleaning supplies are stored out of reach. The CCL division visit sites every three years to monitor compliance. Any complaints of violation are filed with the CCL, and the CCL must visit the facility within 10 days. State Preschool programs are also required to complete an environmental rating scale every three years, known as the Early Childhood Environment Rating Scale (ECERS), and are required to achieve a minimum score of "good" in each area.

State Preschool providers must also meet developmental standards, often referred to as Title 5, that include health, safety, and programmatic requirements. Title 5 requirements are monitored by the Department of Education (CDE). Under this monitoring, providers conduct annual self-evaluations, and the CDE conducts monitoring visits every three years. In addition, State Preschool providers are subject to the K-12 Uniform Complaint Procedure (UCP) process for Title 5 requirements. Under UCP, an LEA must investigate a complaint and issue a decision within 60 days.

In the 2017-18 Governor's budget, the Administration proposed to exempt state preschool programs from Title 22 licensing requirements if they operate in K-12 buildings that meet K-12 building standards. Programs would still be subject to Title 5 requirements. The 2017 Budget act ultimately included language that adopted this proposal beginning in July 2019. However, trailer bill language also required the Legislative Analyst's Office (LAO) to convene a stakeholder working group to discuss whether additional statute or regulations are necessary to ensure that state preschool programs would still meet basic health and safety standards under the exemption. Specifically the group was asked to address, but not limited to: 1) outdoor shade structures, 2) access to age-appropriate bathroom and drinking water facilities, and 3) processes for parent notifications and resolution of violations. The LAO was required to report back to the Legislature on the group's findings by March 15, 2018.

LAO Report and Analysis:

In their recent publication, *The 2018-19 Budget: Proposition 98 Education Analysis*, the LAO reported back on the stakeholder group's recommendations. The group recommended that the following new requirements are added to Title 5 standards:

- Providers must have outdoor shade that is safe and in good repair.
- Drinking water must be accessible and readily available throughout the day.

- Facilities must have one toilet and handwashing fixture for every 15 children. Facilities must be safe and sanitary.
- Restrooms must only be available for preschoolers and kindergartners.
- Staff must maintain visual supervision of children.
- Indoor and outdoor space must be properly contained or fenced and provide sufficient space for the number of children using the space at any given time. Playground equipment must be safe, in good repair, and age appropriate.

The stakeholder group also recommended that the existing UCP process be used to address complaints involving preschool health and safety issues with timelines similar to those of *Williams* complaints. This would allow members of the public to submit complaints anonymously, require complaints to be resolved within 30 days, and require complainants to be notified of a decision within 45 days. The group also recommended requiring LEAs to begin investigating complaints within 10 days of submittal. In addition, the stakeholder group recommended requiring LEAs to post in each State Preschool classroom information regarding health and safety standards and the process for filing a complaint.

The LAO notes that the stakeholder group recommendations are reasonable, and that adding a small fraction of existing Title 22 requirements to Title 5 would still meet the intent of providing significant flexibility to LEAs. The LAO also believes that the use of the UCP process, with similar requirements as the *Williams* UCP process is a reasonable approach. The LAO does note that the CDE may face some additional one-time workload increases related to developing new regulations and guidance if the stakeholder recommendations are adopted. In addition, the CCL division at DSS may experience some workload decreases and the LAO recommends staffing levels are monitored over the next few years.

One additional issue that was raised during the workgroup discussions is that there is a lack of clarity under the flexibility provisions in law in regards to which LEAs would be exempt from licensing requirements. Specifically, state law is not clear on whether preschool classrooms, funded through a combination of State Preschool and other sources (for example, federal Head Start or fees from private-pay families) are exempt from licensing. The LAO did not provide a recommendation, but notes that Legislature could clarify that flexibility is provided for a mixed funding classroom that serves at least one State Preschool student, or limit the exemption to only classes fully supported by State Preschool funds.

Suggested Questions:

- What is the process for the CDE to move forward with regulations related to this issue?

- Does CDE or DOF have a recommendation on clarifying the law in regards to mixed funding classrooms?

Staff Recommendation: Hold Open.

Issue 3: Inclusive Early Education Grant

Panel:

- Sara Cortez, Legislative Analyst's Office
- Brianna Bruns, Department of Finance
- Debra Brown, Department of Education

Background:

Subsidized child care and preschool are available for families who meet income qualifications, and transitional kindergarten is available for families regardless of income level. While there may be multiple options for children between the ages of three and five between the various programs, care for infants and toddlers in particular may be more difficult to find given the additional staffing and facilities requirements.

Children with disabilities may be served through the state's subsidized child care or State Preschool programs. From birth through age two, children with exceptional needs generally receive support through regional developmental centers or sometimes through local educational agencies (LEAs). This support may be a full-day program or a targeted intervention that a child would be provided on a regular basis with families potentially also utilizing mainstream options for child care. When children with disabilities turn three years of age, they are able to participate in programs provided by their LEA either through special day programs, generally for more intensive support, or with targeted support such as speech therapy. For children ages three through five with identified special needs, 39 percent are served in mainstream programs, 34 percent are served in special day classes, 13 percent split their time between mainstream and special day classes, and 14 percent receive targeted therapy or home visits. Providers who serve children with special needs do so at a higher reimbursement rate, an adjustment factor to the rate of 1.2 for children with exceptional needs, and 1.5 for severely disabled children.

Child Care Facilities Revolving Fund (CCFRF). The CCFRF is an existing program that provides interest-free loans to child care providers to be repaid over an up to ten-year period. Loans are available for the purchase of new facilities or the upgrading of additional facilities. While the fund balance can fluctuate as a result of loans being paid back at any one time, according to the CDE, the CCFRF began 2016–17 with an initial available fund balance of $26.6 million. In 2016–17 the CDE received zero new applications for funding under the CCFRF. In reaching out to providers, the CDE identified the following factors that contribute to a lack of applicants: the SRR is too low such that contractors cannot afford to pay back a loan; land is unavailable, even on LEA campuses; and the Maximum Funding Allowance (MFA) is too low ($210,000). In 2016–17, the CDE increased the MFA from $210,000 to $420,000.

Governor's Budget Proposal:

The Governor proposes to provide a total of $167 million in one-time funding ($125 million Proposition 98 funding and $42 million federal TANF funding). These funds would be available for competitive grants to LEAs and non-LEAs to increase the availability of inclusive early care and education settings for children from birth to five years old in low-income and high-need communities. Grantees must provide a one dollar match, which may include in-kind contributions, for every two

dollars received from the grant. Grants may be used for one-time infrastructure costs, including, but not limited to adaptive facility renovations, adaptive equipment, and professional development. Grantees must quantify the number of additional subsidized children to be served, include a plan to sustain spaces or programs past the grant period, and include a set-aside of resources to invest in professional development in effective inclusive practices and fiscal sustainability. Proposition 98 funds would be available for LEAs, although LEAs are permitted to apply on behalf of a consortium of providers within the LEA's program area, including those providers who serve this population on behalf of the LEA.

LAO Analysis:

The LAO's recent publication, *The 2018-19 Budget: Proposition 98 Education Analysis*, notes that the Governor's proposal may not address the ongoing issues of improving outcomes for students with exceptional needs. They do comment that to the extent child care and preschool providers do not feel able to address the needs of children with exceptional needs, professional development may help, however with high staff turnover in the field in general, one-time funding may not address the need. The LAO therefore recommends rejecting the Governor's proposal.

The LAO also notes that to the extent that the Legislature would like to increase professional development, existing quality improvement funds could be reallocated to prioritize special education-related training (either for providers already serving children with exceptional needs in mainstream settings or those who agree to increase the number served in these settings). In addition, the Legislature could provide more ongoing funding for this type of professional development.

Finally, the LAO notes that the Legislature could use the existing CCFRF program to expand access to loans and or grants to include renovations that would make spaces more accessible to children with exceptional needs.

Staff Comments:

Focusing on ensuring that children from zero to five with exceptional needs have access to inclusive early care and education settings is a worthy goal. However there are many dimensions to this issue. Stakeholders note that there are not enough infant and toddler slots in general across the state, and providers may be reluctant to add more slot for this population based on the rates (cost of care for infants and toddlers is high) and need for special facilities. There may also be additional barriers to making sure children with exceptional needs can access care. This proposal appears to try to address a variety of issues, without focusing on solving any particular one. If the goal is to increase access for all children age zero to five, the state could add additional slots (particularly in the child care area as preschool slots have increased over the last few years), increase rates for infants and toddlers and children with exceptional needs, and develop or increases sources of funding for facility and professional development needs. If the goal is to focus on increasing the numbers of children with exceptional needs in mainstream settings, the grants could be more specific such that they require an increase in serving children with exceptional needs. These are one-time funds and staff appreciates the proposal to use one-time funds for one-time purposes, but this would be better paired with some ongoing investments to address some of the issues this proposal raises that would help to sustain the benefits of the one-time investments.

Staff also notes that there have been some questions over the ability to use TANF funds for facilities. The DOF notes they are looking at TANF regulations and guidance to ensure the proposal meets the allowable use of these funds.

Suggested Questions:

- How does the DOF proposal ensure that additional children with exceptional needs are served under this proposal?

- What is the target provider population? With most of the funding being Proposition 98, do we anticipate LEAs will apply mostly on behalf of State Preschool Programs?

- Has the DOF considered changes to the CCFRF program to supplement their proposal? Does the CDE have a suggestion on how to increase the uptake of the CCFRF program moving forward?

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Staff Recommendation: Hold Open.

Issue 4: CalWORKs Participation Update

Panel:

- Kim Johnson, Branch Chief, Child Care and Refugee Program, Department of Social Services

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 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 (AP) Program 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

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. See the below table for the most recent summary of the participation of families in Stage 1 child care. The increase in 2015-16 is partially due to a change in the way data is collected.

CalWORKs Stage 1 Child Care Participation Rates

Year	Cases Participating in a WTW Activity with an Age Eligible Child (under 13 years old)[1]	Stage One Families[2]	Stage One Participation Rate [3]	CDE TANF Families[4]	Child Care Participation Rate[5] (CDSS and CDE TANF Families)
FY 2013-14	78,711	17,303	22%	18,071	45%
FY 2014-15	80,865	17,555	22%	19,371	46%
FY 2015-16	75,310	20,526	27%	18,566	52%
FY 2016-17	62,751	18,041	29%	17,927	57%

1 Based on the Unduplicated Count from the WTW 25 report. Excludes cases exempt from WTW participation. These cases are participating in a WTW activity and have a need for Child Care (WTW 25A data not included). The number of adults participating in a WTW activity that have an age eligible child is calculated using the total number of cases participating in a WTW activity multiplied by the percentage of families with age eligible children based on FY 2016-17 MEDS data. This is adjusted to deduct cases of Two-Parent families in which the one parent is participating while the second parent is expected to provide care.

2 Stage One families: excludes Safety Net or No Longer Aided families and Two-Parent families (CW 115A data not included)

3 Participation Rate was calculated by taking total number of Stage One families divided by the number of adults participating in a WTW activity with an age eligible child. This is not adjusted for cases who do not need care, for example, school-aged children who do not need care due to school schedule. This is adjusted to deduct cases of Two-Parent families in which the one parent is participating while the second parent is expected to provide care. This methodology does not account for families participating across multiple child care programs.

4 The specified monthly average of CDE Child Care program cases that are receiving TANF. This includes CalWORKs Stage 2, CalWORKs Stage 3, California Alternative Payment Program, California Resource and Referral Program, California Migrant Alternative Payment, California General Migrant Child Care, California Family Child Care Homes, California Severely Handicapped, California Center-Based Child Care, and California State Preschool Program. The percentage of TANF Two-Parent families is assumed to mirror the percentage of Stage One Two-Parent cases as the Two-Parent family breakdown is unavailable from CDE. The percentage calculated was deducted from the total TANF Child Care Families population to calculate the cases of TANF All Families cases.

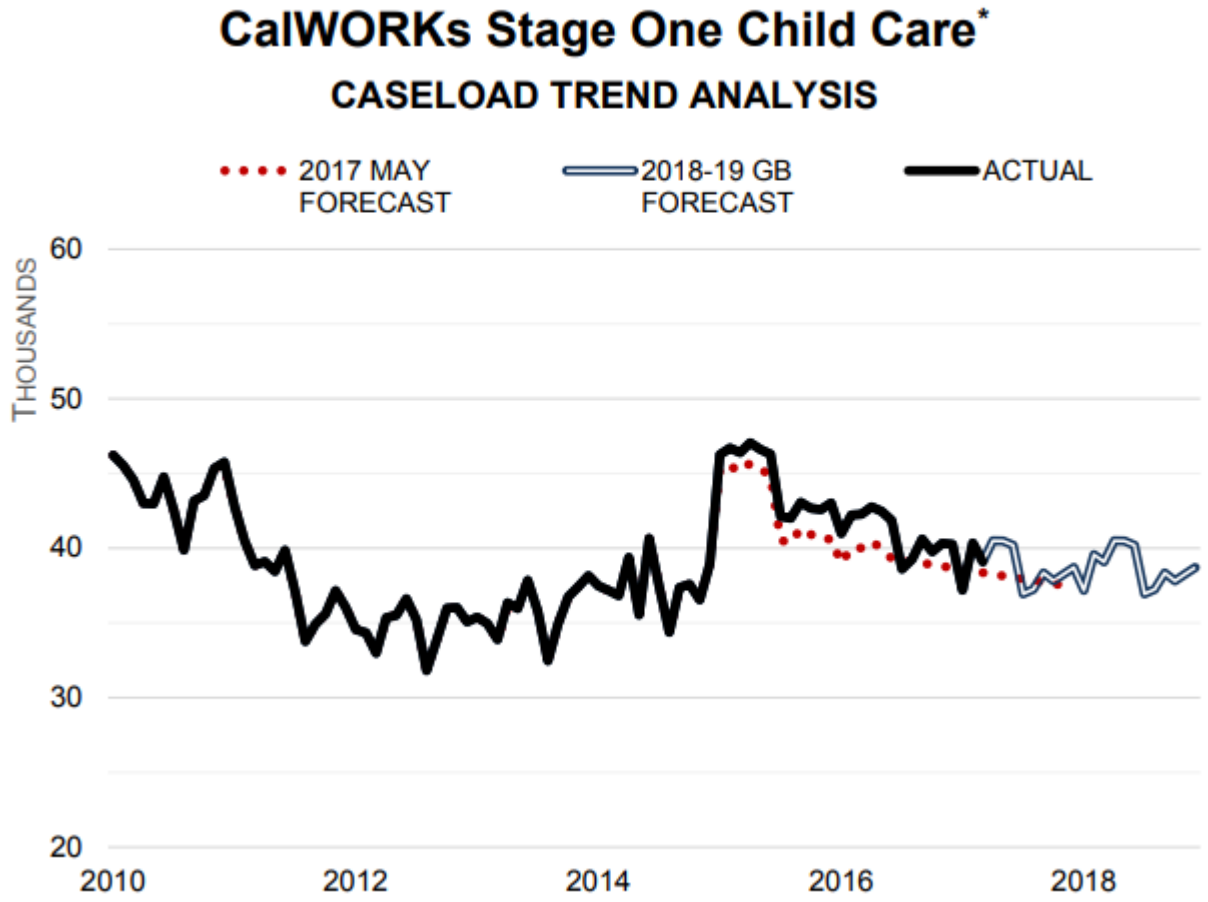
5 Participation Rate was calculated by taking total number of Stage One families and CDE Child Care TANF families, divided by the number of adults participating in a WTW activity with an age eligible child. This is not adjusted for cases who do not need care, for example, school-aged children who do not need care due to school schedule. This is adjusted to deduct cases of Two-Parent families in which the one parent is participating while the second parent is expected to provide care. This methodology does not account for families participating across multiple child care programs.

NOTE: This table displays one methodology for determining the child care participation rate based on WTW cases with age eligible children, excluding Two Parent cases. The participation rates in the table may represent a different rate than what the counties are tracking. Additional child care programs, such as; Early Head Start & Head Start Programs, after school programs, locally funded subsidies, transitional kindergarten, are not included in the above chart.

Source: DSS

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 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, which limited the ability of the department to track care provided accurately across the year.



Source: Department of Social Services
*Note: The spike in 2015 reflects a shift in data collection rather than an actual increase in caseload.

DSS is also analyzing data in greater depth for CalWORKs Stage 1 and notes that approximately 82 percent of children in CalWORKs are older than age two, meaning they are eligible for a variety of other state and federal child care and education programs. DSS staff has continued to conduct a series of site visits to counties to observe processes and practices in providing CalWORKs child care. DSS notes that 22 site visits or phone conferences have been conducted at the following counties: Alameda, Contra Costa, El Dorado, Fresno, Kings, Lake, Los Angeles, Marin, Mendocino, Orange, Placer, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Siskiyou, Stanislaus, Yolo, and Tuolumne. DSS continues to do this type of outreach to follow-up and provide training related to a DSS All County Notice released last year that addressed best practices around access, enrollment, funding, and transferring of care.

Suggested Questions:

- What information did DSS gather from site visits with counties? Are best practices wide-spread? What are the most common areas of growth for counties?

- What data is available on where families with Stage 1 child care eligible children are being served, if not through CalWORKs child care?

Staff Recommendation: Information Only.

Issue 5: Child Care and Development Block Grant and Quality Investments

Panel:

- Debra Brown, Department of Education

Background:

The federal Child Care and Development Block Grant (CCDBG) supports subsidized child care programs, direct service, and alternative payment contract types, including CalWORKs Stage 3 and General Child Care. In 2017-18, California received $617.4 million in CCDBG funding. On November 19, 2014, President Obama reauthorized the CCDBG. Some of the provisions of the reauthorized CCDBG include: annual monitoring inspections of both licensed and license-exempt providers; implementing 12-month eligibility for children in subsidized child care; increasing the Regional Market Rate to the reimbursement ceilings identified in the most recent market rate survey; increasing opportunities for professional development; adding topics to health and safety trainings; and creating a disaster preparedness plan.

The recently passed federal appropriations bill (March 2018) included an increase of almost $2.37 billion in total for the CCDBG. According to the CDE, California generally can expect to receive around ten percent of this increase or approximately $237 million. Authorization for expenditure of new federal funds is not included in the Governor's Budget due to timing.

State Plan. Each state must complete a triennial Child Care Development Fund (CCDF) State Plan, which describes how requirements are met, or the process by which states plan to meet the requirements. The submission deadline for the final CCDF State Plan Fiscal Year (FY) 2019–21 is June 30, 2018 to the federal government. Currently CDE is engaging in a stakeholder process to collect input for this next version of the state plan. CCDBG required state plans to document the level of compliance with, and plans for compliance with, new federal requirements. California's 2016-18 CCDF plan noted many areas that had not been fully implemented in California.

Examples of policy changes. Numerous policy changes included in the reauthorization pose significant potential policy shifts and budgetary action, including:

- Regional Market Rate (RMR) Survey. All states must conduct a statistically valid and reliable survey of the market rates for child care services every two years that reflects variations in the cost of child care services by geographic area, type of provider, and age of child. States must demonstrate how they will set payment rates for child care services in accordance with the results of the market rate survey. As of the 2018 budget act, the RMR is set to the 75th percentile of the 2016 RMR survey.

- Annual Monitoring Inspections. In California, the Department of Social Services Community Care Licensing (CCL) issues licenses for child care facilities. Many providers are license-exempt, such as neighbors, kith, or kin. The CCDBG reauthorization requires that licensed providers and facilities paid for with CCDF funds must receive at least one pre-licensure inspection for compliance with health, safety, and fire standards, as well as annual

unannounced inspections of each child care provider and facility in the state for compliance with all child care licensing standards. Non-relative license-exempt providers and facilities must have at least one annual inspection (Section 658E(c)(2)(K)(i)). Currently, CCL must visit a facility at least once every three years – a frequency that does not meet the new federal requirement. Currently, there is not a state agency charged with conducting inspections of homes of the approximately 3,500 non-relative license-exempt providers in the state.

- 12-Month Eligibility. The reauthorization of CCDBG includes a new provision, Protection for Working Parents, in which a minimum period of 12-month eligibility will be available for each child that receives assistance. States must also establish a process for initial determination and redetermination of eligibility to take into account irregular fluctuations in earnings; not unduly disrupt parents' employment in order to comply with state requirements for redetermination; and develop policies and procedures to allow for continued assistance for children of parents who are working or attending a job training or education program and whose family income exceeds the state's income limit to initially qualify for assistance if the family income does not exceed 85 percent of the State median income. As of the 2018 budget act, the state has established 12 month eligibility and updated the eligibility ceiling to the 85 percentile of the State median income.

Many of the changes required to meet federal standards would require legislative action, and CDE is currently working with federal officials on how to proceed with the state plan. Finally, CCDBG statute allows for states to request waivers if they are unable to comply with federal requirements under specified circumstances. CDE has received a waiver in regards to statewide child care disaster plan (state coordination), developmental screenings, group size requirement, annual provider inspections, criminal background checks, defined career pathways, and payment practices and timeliness of payments to providers through September of 2018.

Supporting Quality in Early Education and Child Care

California is required to spend a certain percentage of federal and state matching funds on quality improvement activities. In 2016-17, the state was required to spend 10 percent of the total federal and state matching funds, or approximately $78 million, on quality activities. Of this, three percent (out of the 10 percent set-aside) is required to be expended on programs for infants and toddlers.) The required set-aside for quality activities is set to increase over the next few years, reaching 12 percent by 2020-21. Allowable expenditures include activities such as training for child care and preschool providers, developing materials for providers, enforcing licensing requirements and providing support for parents about child care options. The state currently provides funding for about 30 different quality improvement programs, covering both state-level activities and county-level activities, each with their own set of requirements. The budget provides CDE with some discretion on how these funds are allocated, the CDE reports these expenditures through a Quality Improvement Expenditure Plan,

The Governor's budget includes $9 million in one-time federal funds for quality improvement. The CDE reports that they are working on the 2018-19 Quality Improvement Expenditure plan. A summary of the programs included in the 2017-18 plan is listed below.

2017-18 Quality Improvement Expenditure Plan

CCDF Leadership and Coordination with Relevant Systems	
Local Child Care and Development Planning Councils	$3,400,000
Consumer and Provider Education	
800-KIDS-793 Phone Line for Parents	$91,000
Resource and Referral Programs	$22,574,266
Ensuring the Health and Safety of Children in Child Care	
Health and Safety Training Grants and Regional Trainers	$2,655,000
License Enforcement for Child Care Programs	$8,000,000
Training and Professional Development	
Subsidized TrustLine Applicant Reimbursement	$460,647
Early Learning And Development Guidelines	
Development of Infant/Toddler Resources	$180,000
Development of Early Learning Resources	$500,005
Faculty Initiative Project	$400,000
Quality Rating and Improvement (QRIS)	
Core I - Child Development and School Readiness	
Desired Results System for Children and Facmilies	$1,024,800
Desired Results Field Training	$666,845
Program for Infant/Toddler Care Institutes (PITC)	$970,000
PITC Inclusion of Infants and Toddlers with Disabilities	$839,500
PITC Partners for Quality Regional Support Network	$4,441,674
California Preschool Instructional Network	$4,000,000
Inclusion and Behavior Consultation Network	$920,000
Map to Inclusive Child Care and CSEFEL	$750,000
Developmental Screening Network	$175,500
Core II - Teachers and Training	
California Early Childhood Mentor Program	$2,866,295
California Early Childhood Online	$290,000
Child Care Initiative Project	$3,027,444
Child Development Training Consultation	$2,891,920
Family Child Care at Its Best Project	$766,704
Child Care Retention Program	$10,750,000
Child Development Teacher and Supervisor Grant Program	$226,000
Stipend for Permit	$435,000
Infant and Toddler QRIS Block Grants	$10,385,200
California Migrant QRIS Block Grant	$800,000
CA-QRIS Certification Grants	$1,500,000
Core III - Program and Environment	
California Strengthening Families Trainer Coordinator	$40,000
Community College PITC Demonstration Sites	$594,200

Other	
Evaluation of Quality Improvement Activities	$570,000
Total:	**$87,252,000**

Quality Rating Improvement System. In 2012-13, California received a $75 million federal grant to develop and fund a Quality Rating Improvement System (QRIS). Some of these funds were used to develop a matrix for rating child care and preschool providers based on indicators, including staff qualifications, ratios and environment. The remaining funding went to local QRIS consortia to rate programs and provide additional support services to improve program quality. These services vary by consortium, but could include stipends for teachers to take early education classes, coaching or grants to improve classroom environment.

The state provides $50 million in ongoing Proposition 98 funding for QRIS for State Preschool. In 2015-16, the state provided $24 million in one-time General Fund for QRIS for infants and toddlers (to be used over three years). Additionally, First 5 California has made QRIS a priority in recent years and dedicated $25 million in 2016-17 for QRIS for all types of programs. Because much of the funding has been dedicated to QRIS for State Preschool, the majority of programs participating in QRIS are preschool programs. This funding for QRIS is not counted towards meeting the federal quality improvement expenditure requirements.

Staff Recommendation: Information Only.

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, April 12, 2018
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.

The Governor's budget provides $846.1 million ($261.2 million General Fund) for 2017-18 and $846.7 million ($261.3 million General Fund) for 2018-19. Total distributed child support collections and revenues are projected to be $2.46 billion ($171.9 million General Fund) in 2017-18 and $2.5 billion ($170.8 million General Fund) for 2018-19.

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 2016-17)	
Wage Withholding	$1.65 billion
IRS federal income tax refund	$134.2 million
FTB state income tax refund	$37.1 million
Unemployment Insurance Benefits	$40 million
Collections from other IV-D states	$98.5 million
Non-custodial parents regular payments	$357.6 million
Other sources* (Liens, workers' compensation, disability insurance benefits offset, California insurance intercepts, and full collections program without wage levies)	$111.1 million

Total child support distributed collections are $2.5 billion for the budget year ($2.1 billion non-assistance payments; $407 million assistance payments). According to the Administration, wage withholding continues to be the most effective way to collect child support, constituting 68 percent ($1.7 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.

New Customer Payment Options. In an effort to establish alternative payment methods for child support obligors, DCSS implemented MoneyGram and PayNearMe in 2015. These alternative payment methods offer transfer and payment services of child support through a wide network of retail locations. In 2017, there were 24,784 MoneyGram transactions resulting in $6.4 million in collections and there were 30,850 PayNearMe transactions resulting in $6.9 million in collections.

DCSS also installed self-service kiosks at LCSA offices, county court buildings, and other community facilities. From January 1, 2017 through December 1, 2017, $41.1 million in collections have been processed via the self-service kiosks.

More recently, DCSS partnered with Value Payment Systems (VPS) to implement PayPal as a payment option, effective March 1, 2018. The department anticipates a continued growth in the utilization of alternative payment options as customers gain awareness of their availability.

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.

[1] Title IV-D of the Social Security Act is a federally required program providing parentage and support establishment and support enforcement services.

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 $125 million ($110 million CSE; $15 million SDU).

The following chart displays the total CCSAS CSE actual and projected costs through 2018-19.

TASKS	ACTUAL 2003-04 thru 2013-14	ACTUAL SFY 2014-15	BUDGET SFY 2015-16	BUDGET SFY 2016-17	BUDGET SFY 2017-18	BUDGET SFY 2018-19	TOTAL
Development	902,073,292	-	-	-	-	-	$ 902,073,292
Operations	555,629,865	59,646,913	71,072,440	71,860,440	74,642,440	74,674,440	$ 907,526,538
Local Technical Support	671,403,274	30,867,766	35,007,994	35,007,994	35,007,994	35,007,994	$ 842,303,016
TOTAL CCSAS COST	$ 2,129,106,431	$ 90,514,679	$ 106,080,434	$ 106,868,434	$ 109,650,434	$ 109,682,434	$ 2,651,902,846

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 94.3 percent in FFY 2017. 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 91.2 percent for FFY 2017. 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 66.5 percent for FFY 2017. 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 66.4 percent for FFY 2017. 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 $2.52 for FFY 2017, unchanged from the previous year. The federal minimum performance level is $2.00.

DCSS estimates that California will be entitled to $42.5 million in federal incentive funds for fiscal year 2016-17 and $43.4 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 2016-17 data, DCSS found that revenue stabilization funds maintained statewide child support collections. Specifically, the stabilization funds have assisted in retaining:

- 207 child support caseworkers
- $137.9 million in total distributed collections.
- $14.6 million in net total assistance collections.
- $6.9 million General Fund share of assistance collections.
- $123.3 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 currently evaluating some of the discretionary provisions of the Final Rule related to the additional services available for FFP, additional case closure reasons, and the ability to provide limited services in paternity-only cases. DCSS will be evaluating the provisions related to the Child Support Guideline in the context of the current Guideline Quadrennial review, which is a federally-required review of state child support order setting guidelines. DCSS, together with LCSAs and the Judicial Council of California, will meet beginning April 2018 through the fall of 2018 to review both the Final Rule provisions related to Guideline, and the Quadrennial Review report.

Staff Comment and Recommendation. Informational only. No action required.

Questions.

1. Please provide a brief update on the department's budget and any new program changes.

Issue 2: Proposal for Investment

The subcommittee has received the following DCSS-related proposal for investment.

1. Equitable Funding for County Child Support Departments

Budget Issue. Representatives of the counties of Fresno, Glenn, Kern, Kings, Los Angeles, Madera, Merced, Riverside, Sacramento, San Bernardino, San Joaquin, Stanislaus and Tehama request an ongoing increase of $42.8 million General Fund (to be matched with $83.2 million Federal Funds) to be allocated to the 14 counties, which have been underfunded relative to the rest of the counties. These 14 counties receive less than $630 per case.

Proponents of this proposal point out that despite efforts to restructure how federal and state funds flow to county child support departments, no changes have been made by the state. They also point out that the state's average return on investment for every dollar spent funding child support staff and operations returns $2.51.

Staff Comment and Recommendation. Hold open. Staff notes that base funding for child support programs has not increased since 2002-03, with the exception of one-time funding of $6.4 million General Fund in 2009-10.

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 $6.3 billion ($517 million General Fund) for 2017-18, and $6.2 billion ($433 million General Fund) for 2018-19.

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 16 years. Caseload has declined more than 47 percent from 108,159 in 2000 to 56,254 in 2016. The department attributes part of the caseload decline to prevention efforts for out-of-home care and back-end efforts for permanency placements. As of October 2017, approximately 60,000 children were in foster care.

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.

- 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, until December 2018). 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. 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 2018-19, based on data from DSS, which shows caseload movement from group homes.

Table 1. HBFC Rate Caseload - 2018-19 Governor's Budget

		FY 2016-17 Caseload	FY 2017-18 Caseload	FY 2018-19 Caseload	FY 2019-20 Caseload	FY 2020-21 Caseload	Assumed Final Distribution
Total FC Caseload (Excl. AAP/-GAP/ARC)		**41,530**	**41,530**	**41,530**	**41,530**	**41,530**	
FFA		12,735	12,735	12,735	12,735	12,735	
FFH/Relative		23,268	23,268	23,268	23,268	23,268	
Prospective AAP		1,924	6,870	13,465	20,060	26,655	
Prospective Kin-GAP		185	661	1,295	1,929	2,563	
Prospective Fed-GAP		256	915	1,794	2,673	3,552	
ARC		4,627	4,607	4,968	5,380	5,642	
Total GH RCL 1-9	*593*						
GH RCL 1-9 Shifting to ISFC		-	-	27	30	30	5%
GH RCL 1-9 Shifting to STRTP		-	-	-	-	-	0%
GH RCL 1-9 Shifting to FFA		9	30	137	296	296	50%
GH RCL 1-9 Shifting to FFH		-	10	55	148	148	25%
GH RCL 1-9 Shifting to Relative		-	10	55	119	119	20%
GH not moving		584	544	320	-	-	0%
Total GH RCL 10-12	*4,410*						
GH RCL 10-12 Shifting to ISFC		-	147	610	882	882	20%
GH RCL 10-12 Shifting to STRTP		64	514	1,626	2,117	2,205	50%
GH RCL 10-12 Shifting to FFA		-	37	203	441	441	10%
GH RCL 10-12 Shifting to FFH		-	37	203	529	441	10%
GH RCL 10-12 Shifting to Relative		-	37	203	441	441	10%
GH not moving		4,345	3,638	1,564	-	-	0%
Total GH RCL 14	*524*						
GH RCL 14 Shifting to ISFC		-	17	73	144	144	28%
GH RCL 14 Shifting to STRTP		11	70	242	307	307	59%
GH RCL 14 Shifting to FFA		-	-	24	47	47	9%
GH RCL 14 Shifting to FFH		-	-	12	13	13	3%
GH RCL 14 Shifting to Relative		-	-	12	13	13	3%
GH not moving		513	437	162	-	-	0%

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. In the 2016 Federal review, counties and the state were found to be out of conformity with all seven outcomes and five of seven systemic factors. The state met two systemic factors (Statewide Information System and Agency Responsiveness to the Community). As a result, DSS engaged with counties to jointly develop a Program Improvement Plan (PIP). This plan has been submitted in draft form to the federal Administration for Children and Families (ACF). It is expected to be formally submitted for approval within the next few weeks.

The new PIP capitalizes on change initiatives already underway, such as CCR. To the extent possible, the strategies to achieve required improvements are the same activities being conducted for CCR including implementation of Child and Family Teams and Foster Parent Recruitment/Support. Some items were also added to address deficiencies where existing initiatives do not (such as ongoing social worker training requirements). ACF, the County Welfare Directors Association (CWDA), and DSS are committed to an implementation team to oversee the work of the PIP. This implementation team will consist of county child welfare deputies and DSS management. ACF will also provide support from the Capacity Building Center for States to assist with developing implementation strategies.

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).

Federal Families First Prevention Services Act (FFPSA). The FFPSA was passed as part of the Bipartisan Budget Act of 2018, and includes new preventive service options and requirements for foster care placement settings, amends existing provisions within Title IV-B and Title IV-E of the Social Security Act, as well as reauthorizes several existing programs through 2021. Title I of the Act is optional for states, and provides federal matching funding for prevention services including mental health, substance abuse prevention and treatment, and in-home parenting supportive and skill-building programs. Title II of FFPSA additionally sets out new criterion for non-foster home placement settings allowable for IV-E Foster Care Maintenance Payments. Generally, the new provisions in Title IV-E align to the state's Continuum of Care Reform (CCR) efforts geared toward reducing the use of congregate care through utilization of trauma-informed or child and family-centered modalities of short-term residential care and increasing the availability and placement of youth in Resource Families, kinship or legal guardianship care, or adoption placements; however, there are some differences regarding the definition of youth eligible for IV-E reimbursed for placements in Short-Term Residential Treatment Programs, definitions of acceptable assessment processes, and nursing/contracting requirements. DSS, alongside federal partners and stakeholders, continue to analyze the potential impact

on and explore solutions to support CCR efforts and the broader California child welfare and foster care system.

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 2017 Child Welfare Services Realignment Report[2] 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 56,254 in 2016.

- Between 2011 and 2016, the number of children for whom the first placement is with a relative/kin increased from 20 percent to 27 percent, while the proportion of children placed in group homes decreased from 15 percent to 12 percent.

[2] The full report can be accessed here: http://www.cdss.ca.gov/Portals/9/Child%20Welfare%20Services%20Performance%20Outcome%20Measures%20May%202017.pdf?ver=2017-05-31-142050-967

- 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 32.2 percent in 2015.

- The proportion of children re-entering foster care within a year decreased from 11.9 percent in 2009 to 11.8 percent in 2014.

The department is currently drafting the 2018 Realignment Report.

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.

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 or alter 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.

  In 2017-18, the Legislature provided an additional $5 million General Fund, for a total of $19 million for the CSEC program (proposed funding for 2018-19 remains the same). The 38 participating counties reported serving a total of 3,061 victims and 4,579 youth at-risk of CSEC statewide. According to the CSEC Program 2017 Report to the Legislature, the most common and promising CSEC service interventions supported by the state funding include mental health services and case management with a particular focus on trauma-informed services, specialized community-based CSEC advocates for youth, a continuum of safe and stable placement options, addressing gang affiliation, fiscal and vocational/life skills training, and a diverse range of additional supports.

- **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 (Committee on Budget) 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 allocated funds in May 2017 to the following 12 county child welfare agencies: Kings, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Luis Obispo, Santa Clara, Santa Cruz, Solano, Sonoma, and Yolo. DSS has hosted two mandatory Learning Forums for BFH funded counties in June 2017 and February 2018 to provide an opportunity for counties to learn from the experts in the field and hear about best practices. DSS also offers a monthly BFH call which provides counties the opportunity to learn from each other.

- **Emergency Child Care Bridge for Foster Children (Bridge) Program.** The Bridge Program, created by SB 89 (Committee on Budget and Fiscal Review), Chapter 27, Statutes of 2017, aims to increase the capacity of child care programs to meet the needs of the foster care children in their care, and maximize funding to support the child care needs of eligible families. The Bridge Program consists of three components: 1) the emergency child care voucher, where eligible families may receive a time-limited voucher or payment to help for child care costs for foster

children; 2) a child care navigator, to assist families in finding and securing a child care provider, and developing a long-term plan for child care; 3) trauma-informed care training for child care programs participating in the Bridge Program. $15.5 million is provided in the current year, with implementation beginning on January 1, 2018, and $31 million is provided ongoing.

The department issued an All County Letter (ACL) in October 2017. 42 counties have opted in for 2017-18. Most of the counties are subcontracting the voucher component to the local Alternative Payment Program. An ACL with final award amounts was issued in January 2018, and DSS currently holds monthly technical assistance calls.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide brief overview the proposed budget, caseload trends, and any new or significant program updates.

2. Please provide an update on federal performance measures, and any other important issues at the federal level.

3. Please provide an update on the CSEC program, the BFH program, and the Emergency Child Care Bridge program.

Issue 2: Budget Change Proposal: Case Reviews Oversight Assistance

Governor's Proposal. The Administration requests $1.1 million ($247,000 General Fund) in 2018-19 and $1.0 million ($231,000 General Fund) ongoing for eight Associate Governmental Program Analysts (AGPAs) and one Staff Services Manager I to allow for the department to provide increased coordination with and technical assistance to the counties to develop or improve mental and physical health services for vulnerable children ages zero to five, and to conduct required qualitative case reviews for rural child welfare and probation agencies who have been unable to conduct their own reviews.

Background. Under the federal Child and Family Service Review (CFSR), the population of children ages zero to five has been identified as underserved in targeted mental health services, including new federal requirements that require states to apply policies and procedures to identify, facilitate access to services, and monitor plans of safe care, for infants born affected by substance abuse symptoms, withdrawal symptoms, or a Fetal Alcohol Spectrum Disorder and their affeced family or caregiver. Additionally, a number of small, rural counties have struggled to meet the federal mandate to conduct a qualitative Case Review process.

The department notes that these new resources will allow the department to provide increased technical assistance to counties in an effort to reduce the percentage of children ages zero to five who are in foster care longer than 24 months from the current 40 percent to the federal standard of 30.3 percent, reduce the infant mortality rate, and conduct the necessary qualitative case reviews for rural counties, and ultimately bring the state into compliance with federal standards and avoid potential penalties.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

Issue 3: Budget Change Proposal: Psychotropic Medication Oversight in Foster Care

Governor's Proposal. The Administration requests $1.4 milion ($375,000 General Fund) split over two years to continue meeting statutory mandates of SB 484 (Beall), Statutes of 2015, Chapter 540. This is the equivalent of six positions.

Background. SB 484 mandated additional review and increased standards regarding psychotropic medication usage in group homes, which created new data collection and notification requirements for the Community Care Licensing Division in DSS, and required that DSS annually develop a methodology for quantifying psychotropic medication usage to identify facility outliers. The bill also required DSS to publish a statewide summary of the information gathered during these inspections in order to review and evaluate the use of psychotropic medications among youth in group home care.

The department originally identified 206 facilities and redirected 22 Licensing Program Analysts (LPAs) for these purposes. However, over time, the department found that the time it took to complete these inspections was 7.2 hours per facility, which is 2.5 times the average time it takes to complete a group home inspection. Some of the additional workload includes an extensive review of a child's trauma history, case files, employee files, and conducting in-depth interviews of staff and children.

The department notes that these new resources will ensure that there is transparency regarding psychotropic drug utilization in group homes, and that the department will be able to better protect the health and safety of these children by facilitating increased oversight.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

2. Please discuss what resources were provided originally for SB 484. Why weren't these resources sufficient?

Issue 4: Proposals for Investment

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

1. Eliminating Barriers to Enter or Re-enter Extended Foster Care

Budget Issue. The Alliance for Children's Rights, California Coalition for Youth, Children's Law Center, and others request a modest increase to Extended Foster Care to ensure youth who are in need of services but were unable to enter or re-enter foster care are able to do so. This proposal is a result of recent issues raised by appellate courts. The changes are narrow and technical in nature. The LAO estimates that this proposal would cost between $800,000 General Fund to $1.7 million General Fund.

Staff Comment and Recommendation. Hold open. The department is working with advocates to determine the scope of the proposal and its costs.

2. Fostering Success: Building community health-based response for supporting vulnerable youth

Budget Issue. The National Center for Youth Law requests an investment of approximately $7.6 million General Fund for three years that, through counties with the facilities making the most calls to law enforcement, would fund nonprofits and community organizations to 1) provide trauma-informed, culturally relevant training to law enforcement and professionals interacting with vulnerable youth populations; 2) collaborate with public agencies to expand local youth diversion programs and deliver developmentally-appropriate services in under-served communities. The program would be overseen by DSS.

Staff Comment and Recommendation. Hold open.

3. Pilot Program – Designated Coaches for Resource Family Support and Retention

Budget Issue. Students of the McGeorge School of Law Legislative and Public Policy Clinic request $4.75 million for the implementation of a two-year family coaching pilot project in 3-5 counties. The pilot will allow 20 qualified workers to be trained as coaches and provide designated support specifically to kinship and foster families for two years to improve foster parent retention and support.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – CHILD WELFARE SERVICES (CWS)
4260 DEPARTMENT OF HEALTH CARE SERVICES (DHCS)

Issue 1: Oversight – Continuum of Care Reform (CCR) Implementation

Governor's Proposal. The 2018-19 Governor's budget proposes $238.2 million ($179.7 million General Fund) to continue implementation of CCR activities.

The table below provides a high-level summary of changes between the 2017-18 Budget Act and the 2018-19 Governor's budget. The 2017-18 revised budget provides additional General Fund to give counties time to reevaluate their Specialized Care Increment (SCI) programs and costs in consideration of the incremental increase provided by the higher level of care rates.

Funding (in millions)	FY 2017-18 Appropriation	FY 2017-18 Revised Budget	FY 2018-19 Governor's Budget	FY 2017-18 Change from Appropriation	FY 2018-19 Change from Appropriation
Total*	$11.3	$87.7	$38.6	$76.4	$27.3
Federal/ TANF	0.0	13.3	4.5	13.3	4.5
State	11.0	74.3	33.7	63.3	22.7

The table below provides a detailed breakdown of the proposed funding.

Total CCR Program costs

CCR Components (values in 000s)	FY 2017-18 Total	FY 2017-18 Federal[1]	FY 2017-18 Non-Fed	FY 2018-19 Total	FY 2018-19 Federal[2]	FY 2018-19 Non-Fed
Home-Based Family Care Rate[3]	$87,687	$13,279	$74,408	$38,557	$4,473	$34,084
Accreditation	2,827	1,414	1,413	0	0	0
Contracts (budgeted in CCR Administration)	6,044	1,934	4,110	8,354	2,689	5,665
Contracts (budgeted in Child Welfare Training)	6,014	3,775	2,239	5,787	3,548	2,239
Second Level Administration Review	29	6	23	244	47	197
Child and Family Teams	63,644	12,467	51,177	64,518	12,575	51,943
Foster Parent Recruitment, Retention, and Support	54,372	11,112	43,260	27,076	5,446	21,630
RFA	27,406	8,850	18,556	34,149	11,004	23,145
Automation	500	250	250	0	0	0
SAWS	5,020	2,921	2,099	0	0	0
CDSS Local Assistance Total	**$253,543**	**$56,008**	**$197,535**	**$178,685**	**$39,782**	**$138,903**

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 Continuum of Care Reform (CCR) began by trying to find solutions to these problems, but eventually broadened the effort into a more comprehensive set of changes for the whole foster care system. The Child Welfare Services (CWS) branch of the Department of Social Services (DSS), along with the counties, is responsible for overseeing this large-scale overhaul of the foster care system.

In 2012, the Legislature passed SB 1013 (Budget and Fiscal Review Committee), Chapter 35, Statutes of 2012, which authorized the CCR 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 (Stone), Chapter 773, Statutes of 2015, to implement the CCR, which codified the recommendations; in subsequent year, AB 1997 (Stone), Chapter 612, Statutes of 2016, and AB 404 (Stone), Chapter 732, Statutes of 2017, further established requirements for mental health certification of STRTPs, made changes to the RFA process, and provided additional oversight to foster homes, in addition to numerous technical amendments and policy clarifications.

Ultimately, the CCR is expected to result in savings due to CCR-related caseload movement, and it was predicted to be cost-neutral in 2019-20.

Some of the main components of the CCR are:

- The creation of Short-Term Residential Treatment Placements (STRTPs), which are intended to replace group homes and provide short-term, therapeutic services to stabilize children so that they may quickly return to a home-based family care setting.

- Additional integration between child welfare and mental health services is expected, and STRTPs and Foster Family Agencies (FFAs), which are private, nonprofit corporations intended to provide treatment and certify placement homes for children with higher level treatment needs, will be required to ensure access to specialty mental health services and strengthen their permanency placement services.

- 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.

- A new Home-Based Family Care (HBFC) rate structure. Prior to CCR, group home facilities were organized under a system of rate classification levels ranging from 1-14 that are based on levels of staff training and ratios. Reimbursement rates for 14 separate group home levels have been replaced by the HBFC Rate Structure that is based on the needs of the child. In order to implement the HBFC rate structure, a tool must be developed to aid county social workers on how to assess foster youth and place them in the appropriate Level of Care (LOC). Below is the new rate structure:

Home-Based Family Care Rate Structure for FY 2018-19
Based on Level of Care[1]

Pay to Resource Family	Basic Level	LOC-2	LOC-3	LOC-4
Basic Rate	$960	$1,068	$1,177	$1,285

Pay to Foster Family Agency	Basic Level	LOC-2	LOC-3	LOC-4
Basic Rate[2]	$960	$1,068	$1,177	$1,285
Social Worker	$340	$340	$340	$340
Social Services & Support	$156	$200	$244	$323
RFA	$48	$48	$48	$48
Administration	$672	$672	$672	$672
Total	**$2,176**	**$2,328**	**$2,481**	**$2,668**

Pay to Resource Family for Intensive Services Foster Care	
Intensive Services Foster Care Rate	$2,507

Pay to Foster Family Agency for Intensive Services Foster Care (including Administration)	
Intensive Services Foster Care Administration	$3,482
Intensive Services Foster Care Social Services & Support	$200
Total	**$6,189**

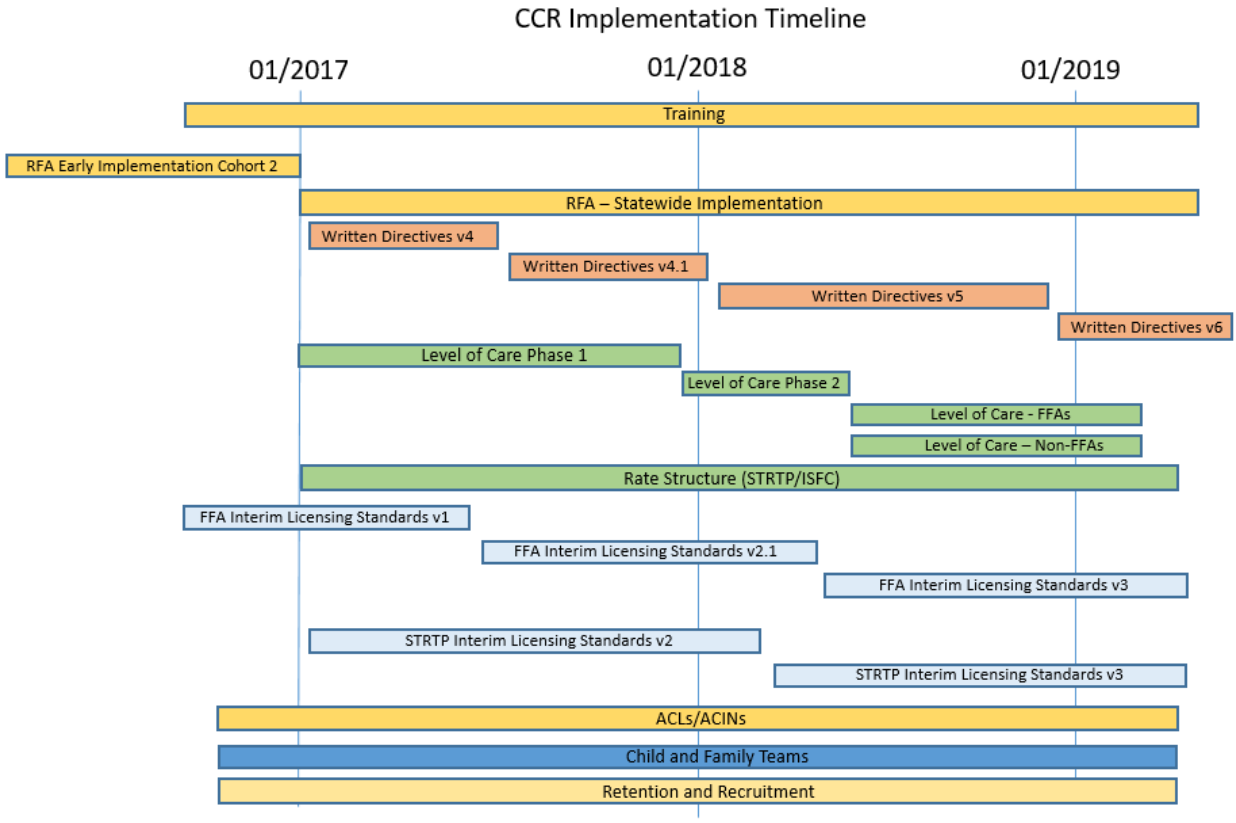
Pay to Short-Term Residential Therapeutic Program	
Short-Term Residential Therapeutic Program Rate[2]	$13,003

Pay to Foster Family Agency or Community-Based Organizations for Services Only	
Total Rate[2]	$833

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 began implementation on February 1, 2017, and includes the use of all LOCs of the HBFC rate structure.

Implementation is an ongoing, evolving effort that will take at least several years to successfully roll out all components. The below graphic shows a timeline of implementation activities:



DSS, 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. DSS has written and disseminated several All-County-Letters (ACLs), including instructions on how to record CFTs in the Child Welfare Services/Case Management System (CWS/CMS), that provides information on a range of CFT topics. DSS also continues to work with CFT specialists at UC Davis to develop a state-approved CFT curriculum, with an anticipated release in February 2018. Several brochures about CFT meant to inform youth, parents, and professionals about the CFT process have also been developed with the help of stakeholders and should be posted to the DSS websites. DSS will extract a quarterly data report in April 2018 from the Child Welfare System/Case Management System. In addition, DSS is in the process of conducting initial qualitative data outreach to all child welfare and juvenile probation agencies to obtain information around CFT implementation efforts. As of March 23, 2018, thirty county child welfare agencies have been contacted regarding CFT implementation efforts. Most counties are reporting that children, youth, and families are attending CFT meetings and providing input to case plans and placement decisions.

Rates Implementation and Assessment Tools. Long-term, the department has selected the well-known and piloted Child and Adolescent Needs and Strengths (CANS) tool after a multi-month selection process. However, the CANS will not be able to fully implement as a tool to guide placements in counties for at least two years. Consequently, the department has worked on an interim tool, or the LOC Protocol. This tool has piloted in several counties, and is scheduled for full statewide implementation in May 2018. In general, even the basic LOC rate is higher than under the old rate system.

Specialized Care Increments (SCIs) are payments provided by counties on top of the LOC payment if a county determines that the LOC rate the child was placed in does not cover all of the child's needs. Counties have been using SCIs under the old rate structure, and will be able to continue using them with the new rate structure. It is assumed that starting April 1, 2018, counties will reduce their SCI investments in amounts consistent with the incremental difference between the old age-based rate structure and the new HBFC rate structure, and this offset will be used to reduce the General Fund investment amounts. Currently, SCI rates vary widely from county to county.

Counties are still awaiting specific instruction on how to implement the LOC Protocol with the HBFC rate structure, and to figure out how to adapt SCI payments with the new tool and rates. After hearing stakeholder concerns about the readiness of the LOC Protocol, the department has come to the recent decision of delaying the full county implementation of the HBFC rates and LOC protocol tool on February 1, 2018, and instead will facilitate a limited implementation in FFAs beginning March 1, 2018 through May 1, 2018. During this two month time period, the department will contract with researchers to closely monitor the effects of the new rates and interim tool on foster youth and families, and will work with counties to fix any problems in real-time. On May 1, 2018, full county implementation, informed by lessons learned from the FFA implementation, will occur. The department will be communicating closely with legislative staff during the FFA implementation process to assess whether the May 1 implementation date is feasible.

The department will also release an ACL in early February regarding the implementation of the Intensive Services Foster Care (ISFC) Program. Certified foster parents and approved resource parents in an existing Intensive Treatment Foster Care Program (ITFC) program should already be receiving the current ISFC rate.

RFA. All counties began using RFA 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. Many identified the length of the process as an issue. More recently, it seems that in many counties the RFA process is taking as long as six months – far beyond the goal of 90 days. However, many FFAs are claiming that they are able to finish the RFA process within the 90 day timeframe. Below is a county-submitted data snapshot on where families are currently at in the RFA process. Based on this data, it is clear that there is a large backlog of families slowing counties down:

Statewide (44 counties)

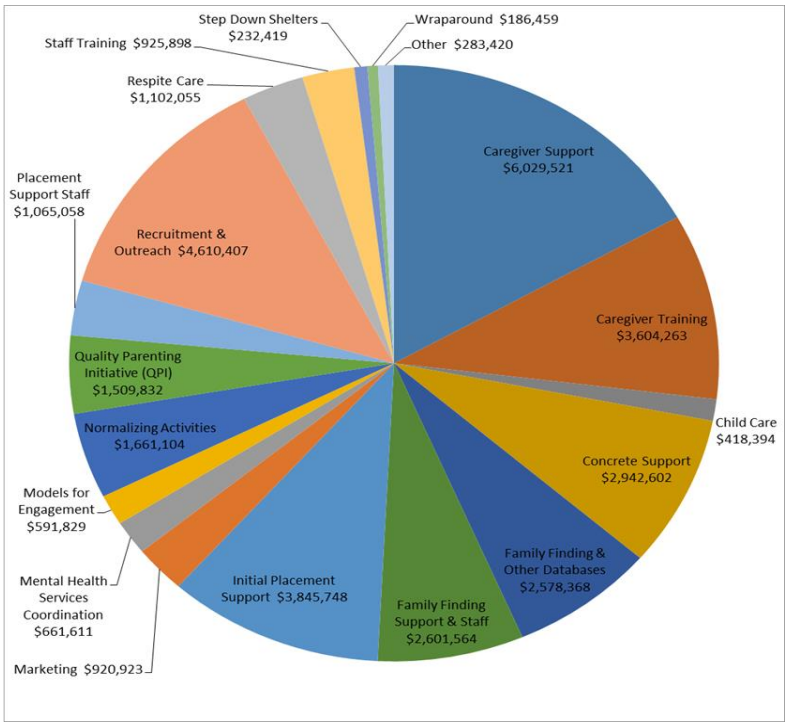
	# of RFA apps approved since 1/1/17	**# of RFA apps denied since 1/1/17**	**# of RFA apps withdrawn since 1/1/17**	**# of RFA apps pending since 1/1/17**	**Total # of RFA apps received since 1/1/17**	**Total # of over 90 days for approval**	**Total # of over 90 days pending**
Total	4,163	101	3,140	8,831	16,263	1,795	4,872

All county child welfare directors and probation chiefs will receive a letter in early February requesting a county assessment and plan to address barriers to timely approval.

Due to the fact that many families are going unpaid, the Legislature and the Administration included a short-term fix for families in an urgency bill, AB 110 (Committee on Budget), Chapter 8, Statutes of 2018. This provides at least 90 days of payments to be made to caregivers who already have a child

placed in their homes on an emergency basis while RFA approval is pending. The fix is only in place through the end of June 2018, in order to give the Administration, the Legislature, and counties more time to work on a longer-term approach to the problems with the RFA.

Foster Parent Recruitment Retention and Support (FPPRS). From January 1, 2016 to June 30, 2016, 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 uses for FPPRs funds for counties in 2017-18.



Examples of activities include providing respite care for caregivers, subsidizing required caregiver health screenings, providing initial placement supports to buy items such as diapers, and counseling. Many counties also provided direct financial support for "normalizing experiences" for foster youth such as recreational class fees or sports equipment, or furnished items for caregivers such as car seats and gas cards.

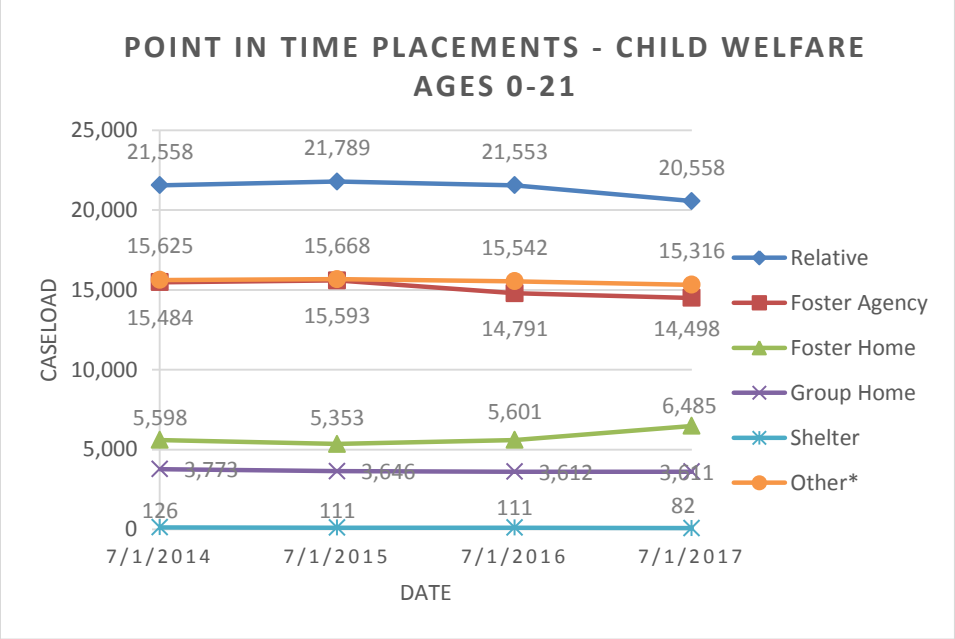
Mental Health. Legislative staff has spent time during the fall of 2017 to work with DSS and the Department of Health Care Services (DHCS) on gaining a more thorough understanding of what data DHCS collects on Specialty Mental Health Services (SMHS), and to discuss what other data might be important to begin to collect. DSS and DHCS continue to work together to produce reports on SMHS utilization on a quarterly basis. Both departments are conducting regional county convenings in 2018 to support counties in their implementation efforts and initiatives related to SMHS for children and youth.

STRTPs. 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), and the ability to grant extensions expires in December 2018 (except for group homes that serve probation youth if there is a significant risk to the safety of the youth or the public). The foster youth in group home care will transition to alternative placements.

In 2018-19, the department assumes that 710 group home placements will move to an intensive services foster care placement; 1,868 group home placements will move to an STRTP placement; and 904 group home placements will move to a family-based setting. The remaining 2,046 group home placements will not yet transition. Although this is a higher projection than current year estimate, the transition of group home placements to lower levels of care is progressing slower than originally projected. As of November 2017, there were 62 STRTPs with licensure from DSS, and combined have a total of almost 1,000 beds.

An STRTP has 12 months from the date of licensure to obtain a mental health program approval, or the license is invalid. Final program approval requirements are pending release from DHCS, although interim requirements have been released. DHCS reports receiving 20 applications from STRTPs seeking a mental health program approval, and 14 of the 20 have already been licensed by DSS.

Below is a table reflecting placements over the past few years through July 2017.



Intensive Services Foster Care (ISFC). Effective January 1, 2018, the Intensive Services Foster Care licensure category was established to care for children with high medical, developmental or behavioral needs. The ISFC is a home-based family care program for children whose needs require specially trained resource parents and intensive professional services in order to avoid group care, institutionalization or out-of-state placement. ISFC expands on existing Intensive Treatment Foster Care. Both are meant to be used as a step-down or diversion from an STRTP. DSS has not yet released regulations. Counties and providers are both worried about the lack of available skilled foster parents to provide treatment homes.

Out-of-State Placements.Children and youth whose needs are too great to be cared for in California may be placed in an out-of-state treatment facility or group home. California law requireds out-of-state facilities that take foster youth to comply with California standards for care and treatment, which means they will have to switch to STRTP standards by December 31, 2018. There is concern that this could diminish out-of-state placements options for foster youth. During 2017, the state reported that 238 foster youth were placed in out-of-state settings, more than double the 95 youth in similar settings in 2014. Many of these youth have significant mental health issues or a need for a unique specialized program not provided in California.

Automation. The Child Welfare Services – California Automated Response and Engagement System (CWS-CARES) will replace the Child Welfare Services/Case Management System (CWS/CMS) and 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. The CWS-CARES 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.

While the CWS-CARES remains in its early stages, various changes to the CWS/CMS and licensing systems are required to implement CCR, including what is necessary for the automation of foster care payments. Below is a chart reflecting these changes.

System	Current Status	Next Step	Next Step Due Date
SAWS	Phase 2 was completed in November 2017 and implemented in all three of the SAWS.	Phase 2 was the final phase of the SAWS automation and implementation. There are no more updates scheduled at this time.	N/A
Administrative Action Records System (AARS)	The AARS has been in production for 4 months with few problems being reported by users. As of 11/20/2017: • 1,087 users have been registered to access the system. 47 Notice of Action (NOA's) have been uploaded to the database.	All development of additional enhancements have been placed on hold to the DSS IT resource constraints. A Request For Offer (RFO) to hire a contractor for the remaining enhancements requested by the customer has been developed and is in the review process. When finalized this contract will fund the development of all remaining customer requirements.	January, 2018
CWS/CMS	Release 8.1 is scheduled for deployment into production on January 6, 2018. This release includes additional Background Check information for caregiver approval, the ability to document when Mental Health needs meet the definition of medical necessity, and new processes to ease data entry and more accurately record history when existing licensed homes go through resource family approval.	Complete Release 8.1 testing before rollout of the CCR Phase 3 code changes for the CWS/CMS application. This release will complete the requested CWS/CMS changes to support RFA / CCR.	January 6,2018
Child Welfare Digital Services (CWDS)	Case Management Module is currently in the development phase. The CANS assessment tool was chosen and the CWDS is exploring options for automation.	CWDS will work with CDSS to plan New System functionality that limits or prevents duplicative data entry for the county social workers.	TBD

Advocate Concerns. Various concerns have been raised about the implementation of CCR.

- *Long-term solution for the RFA backlog.* Both anecdotally and through the results of the department's own satisfaction survey given to RFA participants in early implementing counties, it appears that the RFA process is taking far longer than anticipated. This has potential harmful impacts on children and families, particularly for relative caregivers who must take in children on an emergency basis, and do not receive funding until the RFA process is completed. While the short-term solution provided by AB 110 to fund families until the end of June 2018 is a step in the right direction, counties are still dealing with the backlog and other issues with RFA implementation that need to be addressed.

- *Concerns regarding the LOC Protocol and readiness of full HBFC Rate implementation.* Advocates have raised several concerns about the LOC Protocol: 1) The CANS assessment is rolling out statewide at the same time as the LOC Protocol; this will only serve to confuse and overburden social workers and children who will be assessed twice; 2) Counties have not had time to figure out how their SCIs will work with the LOC Protocol, and this could result in children not receiving the full array of services they need; 3) The LOC Protocol has not demonstrated its reliability; advocates worry that the LOC Protocol is weighted towards assessing the majority of children at the lowest levels of care, regardless of their actual level of need. The LAO also points out that the Governor's Budget does not provide funding for county social workers to carry out the LOC assessment.

- *Readiness to implement the CANS.* CANS implementation begins July 1, 2018, and phase in for all counties is to be completed by July 1, 2019. Stakeholders are concerned that this workload is largely underfunded. All children currently in care and newly entering care will require at least one CANS assessment, and CANS assessments are required at least every six months.

- *Family recruitment and STRTP capacity.* The LAO points out that there are concerns over the availability and the capacity of home-based family placements, and particularly for children with elevated needs. Families are the principal underpinning of the success of the CCR, especially as group home-like settings are phased out and used only in limited circumstances. There is significant concern as to what will happen to foster youth currently in group homes if there is not enough STRTP capacity when the December 2018 deadline for group home extensions hits.

- *Lack of funding for FPPRs activities.* The Governor's budget proposes a 50 percent reduction in General Fund for FPPRs in 2018-19 as compared to 2017-18. Stakeholders point out that current successful FPPRs uses in some counties could be undermined, while other counties were never able to begin to fully utilize FRRPs dollars as they had to redirect funds towards RFA efforts.

Panels. The Subcommittee has requested the following two panels, 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:

Panel 1:

- Frank Mecca, County Welfare Directors Association of California
- Kirsten Barlow, County Behavioral Health Directors Association of California

Panel 2:

- Brien Banks, Social Worker, Los Angeles County
- Bobby Cagle, DCFS Director, Los Angeles County
- Vanessa Hernandez, Policy Director, California Youth Connection
- Foster Youth Representative, California Youth Connection
- Carroll Schroeder, California Alliance of Child and Family Services

Staff Comment and Recommendation. Hold open. While it is expected that such a large and multi-faceted rollout would face challenges in its early implementation, it is critical to continue to course-correct and attempt to anticipate future road blocks to ensure that the CCR will ultimately succeed in its goals. The Legislature should consider the concerns of stakeholders as it takes a closer look at the various components of CCR implementation, monitor the various implementing components closely and communicate often with DSS, county partners, and advocates to ensure that any issues that come up are resolved quickly, and that ultimately children and families are not bearing the brunt of a rushed implementation.

Questions.

1. Please provide an update on the current status of CCR implementation.

2. Please discuss how the short-term solution for RFA is going, and what the current plan is for a longer-term solution.

3. Please discuss the LOC protocol pilot and the readiness of counties to fully implement in May. Why wasn't additional funding provided for county social workers to carry out the LOC assessments?

4. Why did the Administration reduce FPPRs funding by half its current level for 2018-19? Does the Administration see a need for continued FPPRS funding?

5. Please provide an update on how mental health is integrating with CWS under CCR. How are DHCS and DSS tracking whether mental health services are being provided to all children who need these services?

6. Please discuss the overall recruitment of foster families and the capacity of STRTPs. Does the Administration believe that they are on track to have enough families and placements for all foster youth, including those with the most needs? What additional efforts does the department have in place to ensure that there are enough foster families?

Issue 2: Proposals for Investment

The subcommittee has received the following CCR-related proposal for investment.

1. Additional Funding for Continuum of Care Reform

Budget Issue. The California State Association of Counties (CSAC), County Welfare Directors Association of California (CWDA) and the Service Employees International Union of California (SEIU) request $54.8 million General Fund in 2018-19 to address county workload associated with implementation of the CCR. This funding would be allocated as follows: 1) $8 million General Fund in one-time funding to clear the RFA backlog; 2) $8.8 million General Fund for new county workload associated with LOC assessments for 2018-19; 3) $38 million General Fund for new county workload to implement the CANS assessment tool.

Staff Comment and Recommendation. Hold open.

2. Continued Foster Parent Retention, Recruitment & Support Funding

Budget Issue. The Alliance for Children's Rights, California Alliance of Caregivers, Children Now, and others request that FPPRs funding continue at its current level for 2018-19, as the Governor's budget proposes a decrease in funding next year.

Staff Comment and Recommendation. Hold open.

3. Family Urgent Response System (FURS)

Budget Issue. CWDA, Children Now, and the County Behavioral Health Directors Association (CBHDA) request $15 million in 2018-19 and $30 million ongoing, to provide foster youth and their caregivers with immediate support by: 1) establishing a statewide, toll-free hotline available 24 hours a day, seven days a week; and 2) requiring counties to establish mobile response teams to provide in-home response to a crisis.

Staff Comment and Recommendation. Hold open.

4. RFA Funding at Time of Placement

Budget Issue. The Alliance for Children's Rights requests that the interim solution provided in AB 110 be made permanent and to clarify that funding should start as of the date of placement, to ensure that there is no gap in funding between the end of this fiscal year and the start of the new fiscal year for families. AB 110 uses the Approved Relative Caregiver (ARC) and Emergency Assistance (EA) programs to provide funding to families at the time of placement through the end of June 2018.

Staff Comment and Recommendation. Hold open.

5. Delay LOC Implementation

Budget Issue. The Alliance for Children's Rights, California Alliance of Caregivers, John Burton Advocates for Youth, and others request a delay in further implementation of the LOC Protocol, and that DSS engage stakeholders in creating a system that includes a single standardized assessment to determine the appropriate rate, services, and supports for children and families and a statewide specialized rate system.

Staff Comment and Recommendation. Hold open.

6. Funding to cover three years of up-front county costs resulting from implementation of AB 1299

Budget Issue. The California Alliance of Child and Family Services is an organization of 130 accredited, private, nonprofit organizations providing behavioral health, child welfare, juvenile justice and special education services to children and youth, and their families. The Alliance requests $75 million to offset up-front costs related to implementation of AB 1299 (Ridley-Thomas), Chapter 603, Statutes of 2016, which removed barriers to mental health services for foster youth placed out-of-county. The Alliance envisions the funding as a short-term cost pool administered by the Department of Finance for a minimum of three years, and that a true-up mechanism would also be developed by which the funding could be repaid over time.

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

Thursday, April 12, 2018
9:30 a.m., or Upon Adjournment of Floor Session
State Capitol, Room 4203
PART A

Consultant: Theresa Pena

OUTCOMES

Item	Department	Action
5175	**Department of Child Support Services**	
Issue 1	Overview	Hold Open
Issue 2	Proposal for Investment	Hold Open
5180	**Department of Social Services – Child Welfare Services**	
Issue 1	Overview	Hold Open
Issue 2	BCP: Case Reviews Oversight Assistance	Hold Open
Issue 3	BCP: Psychotropic Medication Oversight in Foster Care	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
Issue 2	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, April 12, 2018
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

Issue 1: Community Mental Health - Overview

Community Mental Health – *Three Year Funding Summary*			
Fund Source	**2016-17**	**2017-18**	**2018-19**
1991 Realignment (base and growth):			
Mental Health Subaccount	$129,099,000	$129,099,000	$129,099,000
2011 Realignment (base and growth):			
Mental Health Subaccount	$1,130,387,000	$1,130,982,000	$1,130,648,000
Behavioral Health Subaccount	$1,235,358,000	$1,333,722,000	$1,438,034,000
Realignment Total	**$ 2,494,844,000**	**$2,593,803,000**	**$2,697,781,000**
Medi-Cal SMHS Federal Funds	**$2,319,625,000**	**$2,998,853,000**	**$2,809,387,000**
Medi-Cal SMHS General Fund	**$ 150,849,000**	**$181,861,000**	**$199,565,000**
MHSA Local Expenditures	**$1,827,038,000**	**$1,827,038,000**	**$1,827,038,000**
Total Funds	**$ 6,792,356,000**	**$7,601,555,000**	**$7,533,771,000**

Background. California's system of community mental health treatment was first established in 1957 after passage of the Short-Doyle Act. Prior to Short-Doyle, the state was primarily responsible for the care and treatment of Californians with mental illness or developmental disabilities in fourteen regional psychiatric hospitals throughout the state. Short-Doyle was enacted to allow individuals with mental illness to be treated in a community-based setting nearer to friends and family to support more successful treatment outcomes, and resulted in a significant shift of the locus of treatment out of the state's psychiatric hospitals and into the community. Covered Short-Doyle benefits included treatment and rehabilitation services in primarily outpatient settings, as well as community education and training for professionals and staff in public entities to address mental health problems early.

Mental Health Services in Medi-Cal. Medi-Cal, California's state Medicaid program, was established in 1966 and covered specific mental health-related benefits including psychiatric inpatient hospital services, nursing facility care, and professional services provided by psychiatrists and psychologists. In 1971, many of the benefits provided by local Short-Doyle community mental health programs were also included in the scope of benefits provided to Medi-Cal beneficiaries. During this period, beneficiaries could access mental health services through Short-Doyle Medi-Cal (SD/MC) or through direct fee-for-service Medi-Cal providers (FFS/MC).

State-Local Realignment Funding for Community Mental Health. In 1991, in response to a state General Fund deficit, many state programs and funding streams were realigned to local governments

including community mental health programs. The Bronzan-McCorquodale Act (1991 Realignment) provided that county mental health departments would be responsible for community mental health services for Medi-Cal beneficiaries, for payments to state hospitals for treatment of individuals civilly committed under the Lanterman-Petris-Short Act (LPS), and for Institutions for Mental Disease (IMDs) that provide short-term nursing level care to individuals with serious mental illness. Funding for these programs is provided by redirection of sales tax and vehicle license fee revenues to counties.

In 2011, additional mental health responsibilities were realigned to counties in a package primarily focused on major public safety programs (2011 Realignment). Additional sales tax and vehicle license fee revenue was allocated to counties to fund these programs, which included responsibility for Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children in Medi-Cal. Funding for the 1991 Mental Health Subaccount, up to $1.12 billion, was redirected to fund maintenance of effort requirements for the California Work Opportunities and Responsibility for Kids (CalWORKs) program. This redirection of funding was replaced by $1.12 billion of 2011 Realignment revenue deposited in the 2011 Realignment Mental Health Subaccount for community mental health programs. Consequently, realignment funding for community mental health services is derived primarily from 2011 Realignment funding allocations.

Affordable Care Act Expansion of Mental Health Benefits. The federal Affordable Care Act expanded certain mental health benefits available to Medi-Cal beneficiaries. SBX1 1 (Hernandez), Chapter 4, Statutes of 2013, implemented these new benefit requirements. These benefits are provided to individuals with mild to moderate levels of impairment by Medi-Cal managed care plans, rather than community mental health plans.

Medi-Cal Mental Health. There are three systems that currently 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 federal 1915(b) 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 EPSDT benefit for persons under age 21. County mental health plans are responsible for the provision of SMHS and 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 expanded the scope of Medi-Cal mental health benefits, pursuant to the federal Affordable Care Act, 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 for 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:

1. **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 establish, through a stakeholder process, a listing of programs for which these funds will be used. Of total annual revenues, 80 percent is allocated to this component.

2. **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.

3. **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.

4. **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 provided to counties and the Office of Statewide Health Planning and Development (OSHPD). Counties and OSHPD have until June 30, 2018, to spend these funds.

5. **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.

Counties are required to submit annual revenue and expenditure reports to DHCS and the Mental Health Services Oversight and Accountability Commission (MHSOAC). DHCS monitors county's use of MHSA funds to ensure the county meets the MHSA and Mental Health Services Fund requirements.

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

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

1. Please provide an overview of community mental health programs overseen by DHCS.

Issue 2: Mental Health Services Division Policy Implementation

Budget Issue. DHCS requests 10 positions and expenditure authority of $1.3 million ($665,000 General Fund and $664,000 federal funds) in 2018-19 and $1.3 million ($638,000 General Fund and $637,000 federal funds) in 2019-20 and annually thereafter. If approved, these resources would allow DHCS to provide additional monitoring, oversight and external review of county mental health programs and short-term residential therapeutic programs.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$665,000	$638,000
0890 – Federal Trust Fund	$664,000	$637,000
3085 – Mental Health Services Fund**	[$500,000]	[$500,000]
Total Funding Request:	**$1,329,000**	**$1,275,000**
Total Positions Requested:	**10.0**	**10.0**

* Positions and Resources are ongoing after 2019-20.

** Mental Health Services Fund resources are non-add, as resources, but not positions, were previously approved.

Background. DHCS is responsible for the oversight and administration of California's community mental health system, including ensuring county mental health plans comply with state and federal laws and regulations, as well as performance and other requirements of contracts with the state for the provision of specialty mental health services. As part of its oversight responsibilities, DHCS monitors county mental health plan compliance with the provisions of the Mental Health Services Act (MHSA), which provides funding from a one percent tax on incomes over $1 million for the provision of specialty mental health services.

MHSA and subsequent amendments require DHCS to monitor annual revenue and expenditure reporting, compliance with performance contracts, critical performance issues referred by the Mental Health Services Oversight and Accountability Commission (MHSOAC), and withholding of funds or imposition of corrective action plans on county mental health plans found to be out of compliance. DHCS is also responsible for providing regulations and guidance to county mental health plans for compliance with state and federal law and regulations governing provision of Medi-Cal eligible services, accounting for MHSA expenditures, compliance with mental health and substance use parity requirements, and other state and federal requirements.

DHCS is also required by federal rules to contract with an external quality review organization (EQRO) to analyze information related to quality, timeliness, and access to specialty mental health services for Medi-Cal beneficiaries. The EQRO publishes individual reports on county mental health plans, an annual statewide summary of county-specific reviews, and quarterly reports on performance improvement projects. AB 1291 (Beall), Chapter 844, Statutes of 2016, requires annual monitoring of each county mental health plan, expands the review to include minor and non-minor dependents in foster care, and requires corrective action plans for deficiencies identified by the EQRO.

DHCS also is responsible for the approval process for certain short-term residential therapeutic programs (STRTPs), a new category of residential facility providing specialized intensive care and

supervision services and supports, treatment, and short-term, 24-hour care and supervision to children. These responsibilities were implemented under the provisions of AB 501 (Ridley-Thomas), Chapter 704, Statutes of 2017. AB 501 permits STRTPs to operate as a Children's Crisis Residential Program (CCRP), which serves children experiencing a mental health crisis as an alternative to psychiatric hospitalization. The Department of Social Services (DSS) is responsible for the licensing of STRTPs to become CCRPs. DHCS or a county mental health plan must approve a CCRP to begin providing services to Medi-Cal beneficiaries.

DHCS requests 10 positions and expenditure authority of $1.3 million ($665,000 General Fund and $664,000 federal funds) in 2018-19 and $1.3 million ($638,000 General Fund and $637,000 federal funds) in 2019-20 and annually thereafter for the following activities related to its various oversight and administration responsibilities for the community mental health system.

MHSA Program Monitoring, Oversight, and Program Policies

- **Two Health Program Specialist I positions** and **two Associate Governmental Program Analysts (AGPAs)** will perform monitoring of county mental health plans for compliance with MHSA. These staff will conduct program reviews of county mental health plans including compliance with requirements for operation of a local stakeholder process, serving MHSA target populations, community collaboration, cultural competence, and full service partnership program requirements such as appropriate staffing levels, 24/7 coverage, and personal service coordination. According to DHCS, it expects to conduct reviews of approximately 20 county mental health plans annually, consistent with its triennial review cycle.

  According to its response to a recent state audit, DHCS hired these positions in January 2018 with funding previously appropriated from the Mental Health Services Fund. DHCS reports these staff are complying with audit findings related to monitoring and performance review of county mental health plans. In this request, DHCS seeks permanent position authority for the staff previously hired for this purpose.

Mental Health Fiscal Policy Development

- **Two Health Program Specialist II positions** will analyze changes in state and federal law and support the development and implementation of regulations governing the various requirements of the community mental health program.

External Quality Review Organization Reporting.

- **Permanent expenditure authority of $443,000 ($222,000 General Fund and $221,000 federal funds)** for new workload for the EQRO contractor to meet the expanded evaluation requirements of AB 1291. According to DHCS, the new workload includes additional site reviews, data analysis, and administrative support, administrative oversight, insurance costs, and supply costs. DHCS also indicates that workload related to other requirements of AB 1291, such as publication of county mental health plans' corrective action plans, will be absorbed by DHCS within existing resources.

Short-Term Residential Treatment Facility Programs.

- **Three AGPAs** and **one Attorney III** to manage the approval process for CCRPs, including tracking the approval process, coordinating reviews with DSS and county mental health plans,

coordinating and providing assistance to facility providers, and managing complaint investigations and reviews. The Attorney III will provide in-house counsel support on legal questions related to the CCRP approval process, and provide other legal advice and research. DHCS expects 54 foster care group homes will convert to STRTPs in 2017-18 and 30 will be approved as CCRPs in 2017-18. Ultimately, DHCS expects all 56 county mental health plans will have contracts with one or more CCRPs.

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

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

1. Please provide a brief overview of this proposal.

2. Please identify the source of the original Mental Health Services Fund appropriation that funds the four requested positions hired in January 2018 for MHSA Program Monitoring, Oversight, and Program Policies.

Issue 3: Drug Medi-Cal and Specialty Mental Health: FQHCs and RHCs (SB 323)

Budget Issue. DHCS requests five positions and expenditure authority of $891,000 ($446,000 General Fund and $445,000 federal funds) in 2018-19, and $3 million ($1.5 million General Fund and $1.5 million federal funds) in 2019-20, $3.2 million ($1.6 million General Fund and $1.6 million federal funds) in 2020-21, $1.2 million ($581,000 General Fund and $580,000 federal funds) in 2021-22, and $595,000 ($298,000 General Fund and $297,000 federal funds) in 2022-23 and annually thereafter. If approved, these resources would allow DHCS to provide oversight, implement system changes, and audit reimbursement rate changes for federally qualified health centers and rural health clinics to provide specialty mental health or Drug Medi-Cal services to eligible beneficiaries pursuant to SB 323 (Mitchell), Chapter 540, Statutes of 2017.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$446,000	$1,509,000
0890 – Federal Trust Fund	$445,000	$1,509,000
Total Funding Request:	**$891,000**	**$3,018,000**
Total Positions Requested:**	**5.0**	**5.0**

* Additional fiscal year resources requested: 2020-21: $3,233,000; 2021-22: $1,161,000; 2022-23 (ongoing): $595,000
** Limited-term expenditure authority equivalent to: 2018-20: 2.0 positions; 2019-21: 16.0 positions; 2020-22: 3.0 positions

Background. The Medi-Cal program reimburses federally qualified health centers (FQHCs) and rural health clinics (RHCs) 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 323 allows FQHCs and RHCs to be reimbursed directly from DHCS or a county for providing Drug Medi-Cal services or specialty mental health services (SMHS). Drug Medi-Cal services may be provided under contract with a county pursuant to the terms of the Drug Medi-Cal Organized Delivery System Waiver (DMC-ODS), if the county is participating, or under direct contract with the county or

DHCS if the county is not participating in the DMC-ODS Waiver. Specialty mental health services may be provided under contract with a county mental health plan that provides services to Medi-Cal beneficiaries pursuant to a contract with DHCS. Reimbursement for Drug Medi-Cal or specialty mental health services must be provided separately from the clinic's PPS rate and any clinic seeking to be reimbursed separately must apply to DHCS for a change in scope of service request. According to DHCS, some clinics' PPS rates include provision of these realigned services because their rates were calculated prior to the 2011 realignment of Drug Medi-Cal and certain specialty mental health services to the counties and have not been updated to reflect current allowable costs.

According to DHCS, an uncertain number of FQHCs and RHCs currently offer substance use disorders treatment services that could be claimed under a separate billing structure for Drug Medi-Cal. Because these services are offered within the clinics' PPS reimbursement rate structure, they are not enrolled as Drug Medi-Cal providers and are not regulated by DHCS for the provision of these services. Clinics that elect to begin providing Drug Medi-Cal services separately would be required to enroll and become certified as Drug Medi-Cal providers through the department's Provider Enrollment Division.

FQHCs and RHCs may also provide mild-to-moderate mental health services, which are reimbursed under a clinic's PPS rate structure by Medi-Cal managed care plans and DHCS, which provides a wrap payment for the portion of the PPS rate not covered by the managed care plan's contracted reimbursement rate. According to DHCS, specific services reimbursed by a Medi-Cal managed care plan as mild-to-moderate may be the same as services that could be provided to a Medi-Cal beneficiary receiving care from a county mental health plan under specialty mental health because the distinction between the two modes of treatment are determined by whether a patient meets medical necessity criteria for specialty mental health services. Medi-Cal managed care plans may deny claims for services if the beneficiary receiving services meets medical necessity criteria for specialty mental health. SB 323 clarifies the process by which clinics may elect to become contracted specialty mental health services providers.

Resources for Provider Enrollment and CSOSR Audits. DHCS requests five positions and expenditure authority of $891,000 ($446,000 General Fund and $445,000 federal funds) in 2018-19, and $3 million ($1.5 million General Fund and $1.5 million federal funds) in 2019-20, $3.2 million ($1.6 million General Fund and $1.6 million federal funds) in 2020-21, $1.2 million ($581,000 General Fund and $580,000 federal funds) in 2021-22, and $595,000 ($298,000 General Fund and $297,000 federal funds) in 2022-23 and annually thereafter. The additional expenditure authority is equivalent to an additional 21 limited-term positions allocated for two-year periods between July 2018 and June 2022. The requested resources are as follows:

1. Substance Use Disorder Program, Policy, and Fiscal Division (SUD-PPFD)
    a. **Two permanent Associate Governmental Program Analysts (AGPAs)** to provide technical assistance and process enrollment and certification applications for FQHCs and RHCs to become Drug Medi-Cal providers. These positions will also provide ongoing support for monitoring and claims payments for these providers.
2. Audits and Investigations (A&I) Unit
    a. **Limited-Term resources equivalent to 15 Health Program Auditor III positions** to perform audits of cost reports from FQHCs and RHCs associated with a change in scope of service request. The department estimates 180 (15 percent) of the 1,200 clinics

statewide will choose to separately bill for Drug Medi-Cal and/or specialty mental health services and will submit a change in scope of service request under SB 323.

3. Office of Legal Services (OLS) and Office of Administrative Hearings and Appeals (OAHA)
   a. **Limited-Term resources equivalent to one Attorney IV, one Attorney I, one Health Program Auditor IV, and one Administrative Law Judge III** to manage and adjudicate appeals and hearings of rate determinations made during the audit and PPS rate determination process required by clinics submitting a change in scope of service request under SB 323.
4. Mental Health Services Division (MHSD)
   a. **Three permanent AGPAs** to perform oversight and monitoring of FQHCs and RHCs that choose to become billable providers of specialty mental health services.
   b. **Limited-term resources equivalent to two AGPAs** for initial provider enrollment and validation activities for FQHCs and RHCs that choose to become billable providers of specialty mental health services.

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

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

1. Please provide a brief overview of this proposal.

Issue 4: 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.

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	$220,546	$5,966	$166,313	$48,267	49,067
Outpatient Drug Free Treatment Services	$29,548	$841	$24,501	$4,206	35,976
Intensive Outpatient Treatment Services	$9,847	$1,404	$8,293	$150	6,252
Residential Treatment Services	$1,830	$39	$1,277	$514	361
Organized Delivery System Waiver	$426,342	$76,172	$296,693	$53,477	-
Drug Medi-Cal Cost Settlement	$3,000	$100	$2,900	$-	-
Drug Medi-Cal County Administration	$6,496	$-	$3,248	$3,248	-
County Util. Review/Quality Assurance	$9,131	$-	$6,278	$2,853	-
TOTAL	**$706,740**	**$84,522**	**$509,503**	**$112,715**	**91,656**
Regular Total	$678,509	$84,272	$490,884	$103,353	90,313
Perinatal Total	$9,604	$150	$6,193	$3,261	1,343
Other Total	$18,627	$100	$12,426	$6,101	-

2018-19 Drug Medi-Cal Program Funding Summary (dollars in thousands)					
Service Description	**2018-19**				
	Total Funds	**General Fund**	**Federal Funds**	**County Funds**	**Case-load**
Narcotic Treatment Program	$230,979	$8,216	$173,261	$49,502	50,133
Outpatient Drug Free Treatment Services	$31,207	$1,162	$25,686	$4,359	36,784
Intensive Outpatient Treatment Services	$10,029	$1,503	$8,373	$153	6,323
Residential Treatment Services	$1,924	$53	$1,344	$527	370
Organized Delivery System Waiver	$1,199,462	$209,808	$829,760	$159,894	-
Drug Medi-Cal Cost Settlement	$-	$-	$-	$-	-
Drug Medi-Cal County Administration	$6,496	$-	$3,248	$3,248	-
County Util. Review/Quality Assurance	$23,177	$-	$15,934	$7,243	-
TOTAL	**$1,503,274**	**$220,742**	**$1,057,606**	**$224,926**	**93,610**
Regular Total	$1,452,843	$220,405	$1,025,562	$206,876	92,238
Perinatal Total	$20,758	$337	$12,862	$7,559	1,372
Other Total	$29,673	$-	$19,182	$10,491	-

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 counties be reimbursed by the state for mandates imposed after September 2012, 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 5: 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 $220.5 million ($6 million General Fund, $166.3 million federal funds, and $48.3 million county funds) in 2017-18 and $231 million ($8.2 million General Fund, $173.3 million federal funds, and $49.5 million county funds) in 2018-19 for NTP services. In 2017-18, NTP caseload is expected to be 49,067, a decrease of 602 (1.2 percent) compared to the 2017 Budget Act. In 2018-19, NTP caseload is expected to be 50,133, an increase of 1,066 (2.2 percent) compared to the revised 2017-18 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 $29.5 million ($841,000 General Fund, $24.5 million federal funds, and $4.2 million county funds) in 2017-18 and $31.2 million ($1.2 million General Fund, $25.7 million federal funds, and $4.4 million county funds) in 2018-19 for ODF services. In 2017-18, ODF caseload is expected to be 35,976, a decrease of 1,227 (3.3 percent) compared to the 2017 Budget Act. In 2018-19, ODF caseload is expected to be 36,784, an increase of 808 (2.2 percent) compared to the revised 2017-18 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 $9.8 million ($1.4 million General Fund, $8.3 million federal funds, and $150,000 county funds) in 2017-18 and $10 million ($1.5 million General Fund, $8.4 million federal funds, and $153,000 county funds) in 2018-19 for IOT services. In 2017-18, IOT caseload is expected to be 6,252, an increase of 278 (4.7 percent) compared to the 2017 Budget Act. In 2018-19, IOT caseload is expected to be 6,323, an increase of 71 (1.1 percent) compared to the revised 2017-18 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 ($39,000 General Fund, $1.3 million federal funds, and $514,000 county funds) in 2017-18 and $1.9 million ($53,000 General Fund, $1.3 million federal funds, and $527,000 county funds) in 2018-19 for RTS. In 2017-18, RTS caseload is expected to be 361, a decrease of 82 (18.5 percent) compared to the 2017 Budget Act. In 2018-19, RTS caseload is expected to be 370, an increase of 9 (2.5 percent) compared to the revised 2017-18 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. Subcommittee staff recommends holding this item open to allow continued discussions in advance of the May Revision.

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

1. Please provide a brief overview of the caseload and expenditure changes in the base Drug Medi-Cal estimate.

Issue 5: Drug Medi-Cal – Organized Delivery System Waiver

Budget Issue. The budget includes $426.3 million ($76.2 million General Fund, $296.7 million federal funds, and $53.5 million county funds) in 2017-18 and $1.2 billion ($209.8 million General Fund, $829.8 million federal funds, and $159.9 million county funds) in 2018-19 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.

2017-18 DMC-ODS Waiver Program Funding Summary (dollars in thousands)				
	Total Funds	**General Fund**	**Federal Funds**	**County Funds**
Organized Delivery System Waiver Total	**$426,342**	**$76,172**	**$296,693**	**$53,477**
Regular Total	$420,163	$76,104	$292,987	$51,072
Perinatal Total	$6,179	$68	$3,706	$2,405

2018-19 DMC-ODS Waiver Program Funding Summary (dollars in thousands)				
	Total Funds	**General Fund**	**Federal Funds**	**County Funds**
Organized Delivery System Waiver Total	**$1,199,462**	**$209,808**	**$829,760**	**$159,894**
Regular Total	$1,182,260	$209,582	$819,477	$153,201
Perinatal Total	$17,202	$226	$10,283	$6,693

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, five counties began providing services under the DMC-ODS Waiver in 2016-17: San Mateo, Riverside, Santa Clara, Marin, and Contra Costa. 15 counties are expected to begin providing services in 2017-18 and 20 counties are expected to being providing services in 2018-19. The department reports a total of 40 counties are participating or planning to participate in the DMC-ODS Waiver. 18 counties are not expected to participate.

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

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

1. Please provide an update on the implementation of the DMC-ODS Waiver.

Issue 6: Additional Proposals for Investment

Children Exposed to Community Violence. The Los Angeles City Attorney requests up to $2 million for a pilot project to fund service providers with the support of the local police department and governmental agencies to provide therapeutic services to children exposed to community violence and suffering from trauma. Service providers would focus on areas with economic and racial disparity where access to trauma therapy is either not known, difficult to access or not utilized because of lack of education on the issue of trauma. The intervention team would include the service provider including trauma-focused therapists, police trained to identify children suffering from trauma, community advocates/interventionists, local community based prosecution teams, and others whose goal is to intervene and respond to children exposed to violence so these children do not end up in the criminal justice system due to unresolved trauma. The pilot would identify 5-10 target areas with an allocation of $200,000 per year for three years for each project.

Drug and Alcohol Counselors in Emergency Departments. The California chapter of the American College of Emergency Physicians (CalACEP) requests $20 million total funds to create a statewide pilot program that places a certified drug and alcohol counselor in each of the roughly 400 emergency departments (EDs) throughout California. Data would be gathered during the pilot to measure the efficacy of treatment and the cost savings to the Medi-Cal program and other payers.

According to CalACEP, a variety of studies have shown direct referrals to treatment have enrollment rates as high as 50 percent. In New Jersey, the newly established Opioid Overdose Recovery Program provides ED intervention for patients who experience an opioid overdose. In the first six months of implementation, over 80 percent of patients accepted bedside intervention, while 40 percent of those patients accepted recovery support services, and 45 percent accepted detox, substance use disorder treatment and/or recovery. Over 60 percent of the overdose patients were Medicaid beneficiaries.

The University of California, Davis Medical Center ED applied for a grant through the Office of the President over a year ago to employ a certified drug and alcohol counselor to provide interventions in their ED and has also shown impressive results. Over a 12 month period, the Medi-Cal patients who received a brief intervention and referral to treatment experienced a 60 percent decline in ED utilization.

Screening, Brief Intervention, Referral, and Treatment (SBIRT) Expansion. The County Behavioral Health Directors Association requests $8.4 million ($2.6 million General Fund and $5.8 million federal funds) to expand the Medi-Cal benefit for alcohol misuse, screening and counseling to include screening for overuse of opioids and other illicit drugs such as heroine and methamphetamine. The program for screening, brief intervention, referral, and treatment (SBIRT) has traditionally focused on alcohol misuse and has been shown to reduce hazardous drinking across diverse populations when implemented according to established best practices. This request seeks to expand screening to detect use of opioids and other drugs as an important step to combatting the current crisis and save lives.

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

Questions. The subcommittee has requested advocates to present these proposals and respond to questions from subcommittee members.

4260 DEPARTMENT OF HEALTH CARE SERVICES
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Mental Health Services Act Fiscal Reversion and Program Administration

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 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 and underserved populations.

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

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

MHSA also required counties to spend a portion of their revenues on two additional components to build the infrastructure to support mental health programs:

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. 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 provided to counties and the Office of Statewide Health Planning and Development (OSHPD). Counties and OSHPD have until June 30, 2018, to spend these funds.

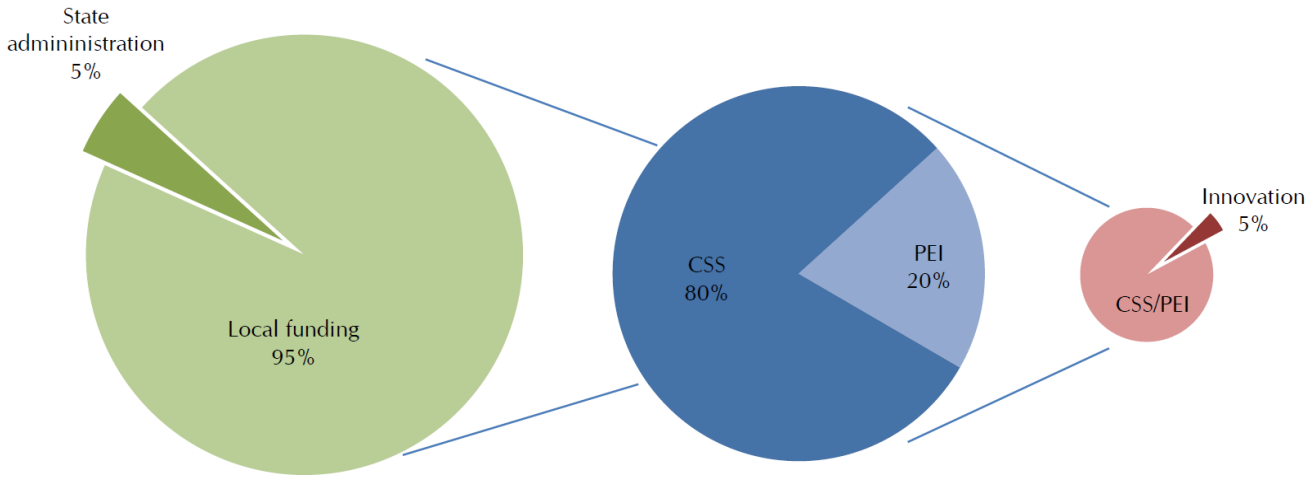
5. *Capital Facilities and Technological Needs:* This component finances necessary capital and infrastructure to support implementation of other MHSA programs. It includes funding to improve or replace technology systems and other capital projects.

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. In recent years, mental health advocates expressed concerns that counties were retaining MHSA funds that could be reverted and reallocated to the provision of additional mental health services. However, counties 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.

2017 Budget Act Implemented Transparency Requirements for MHSA Reversion. In an effort to address the concerns from stakeholders and counties regarding the MHSA reversion process, the Legislature adopted several reforms in trailer bill language as part of the 2017 Budget Act. AB 114 (Committee on Budget), Chapter 38, Statutes of 2017, implemented the following changes:

1. Holds counties harmless for reversion prior to 2017-18, with funds reallocated to the counties of origin for the originally allocated purposes (e.g. prevention and early intervention, or innovative programs).

2. By July 1, 2018, requires DHCS and counties to report on the amounts owed prior to 2017-18 and requires counties to submit a plan to spend these funds by July 1, 2020.

3. Extends reversion period from three to five years for small counties (population under 200,000).

4. Requires DHCS to annually post by each October 1, the amount of each county's funds subject to reversion and when the funds will revert.

5. After July 1, 2017, requires reverted funds be reallocated to other counties for the purposes originally allocated (e.g. prevention and early intervention, or innovative programs).

6. Upon approval of an innovation plan by the Mental Health Services Oversight and Accountability Commission, allows funds allocated for innovative programs to re-start the three year period, after which the funds would be subject to reversion (five year period for small counties).

AB 114 provided clarity regarding counties' treatment of funds previously subject to reversion, provided timelines for DHCS to report annually to counties and the public regarding MHSA funds subject to reversion, and ensured MHSA funds allocated to each of the expenditure components required by the act (CSS, PEI, and Innovation) remain allocated to those components after reversion to other counties.

State Audit of MHSA Oversight by DHCS and MHSOAC. In response to similar concerns that prompted the Legislature to adopt the reforms contained in AB 114, the Joint Legislative Audit Committee requested the State Auditor to review the funding and oversight of the MHSA by DHCS and MHSOAC. After review of both entities and a sample of three county mental health programs (Alameda, Riverside, and San Diego), the Auditor released Report 2017-117: "*Mental Health Services Act: The State Could Better Ensure the Effective Use of Mental Health Services Act Funding"*, which made the following findings and recommendations:

DHCS Findings

1. DHCS has not developed a process to recover unspent MHSA funds subject to reversion, with counties accumulating a total of $231 million unspent funds as of 2015-16.
   Auditor Recommendation: DHCS should develop an MHSA fiscal reversion process.
2. DHCS has not provided guidance to counties regarding proper expenditures of interest earned on MHSA funds on deposit, with counties accumulating a total of $81 million in unspent interest as of 2015-16.
   Auditor Recommendation: DHCS should clarify that interest on MHSA funds is subject to the same reversion requirements as the MHSA funds counties receive.
3. DHCS has not established a formal process to govern how much of a county's MHSA funds may be held in reserve, with counties holding a total of $535 million in reserve, or 47 percent of total prior-year CSS funds, as of 2015-16.
   Auditor Recommendation: DHCS should establish and enforce an MHSA reserve level that allows county programs to maintain sufficient funds for providing mental health services during times of economic hardship, but does not result in holding reserves that are excessive. Under a conservative approach, the level could be set at 33 percent of prior year CSS expenditures, which is equal to the highest one-year decline in CSS allocations since 2007-08.

4. DHCS has not analyzed or accounted for a $225 million fund balance that existed in the Mental Health Services Fund when it was transferred from the former Department of Mental Health in 2012.
   Auditor Recommendation: DHCS should complete its analysis of the $225 million fund balance by May 1, 2018, and allocate unspent funds to counties accordingly. DHCS should also regularly scrutinize the fund to determine reasons for any excess fund balances.
5. DHCS has made minimal efforts to ensure county mental health programs submit their required annual reports on time, hampering DHCS' ability to calculate MHSA reversion amounts and properly oversee MHSA spending.
   Auditor Recommendation: DHCS should publish its proposed fiscal regulations, which will include provisions governing the annual report process, by June 2018 and subsequently implement a process that will enable it to withhold MHSA funds from counties that fail to submit reports on time.
6. DHCS has been slow to implement oversight of counties' MHSA spending and programs. Although DHCS developed an MHSA fiscal audit process in 2014, it has limited the audits' usefulness because it focused its reviews on data and processes contained in its Short-Doyle Medi-Cal cost reports, which are at least seven years old.
   Auditor Recommendation: DHCS should publish its proposed fiscal regulations, which will include provisions governing the fiscal audit process, by June 2018 and subsequently develop and implement an MHSA fiscal audit process, independent of Short-Doyle Medi-Cal reviews, to review revenues and expenditures for the most recent fiscal year.
7. DHCS has not developed regulations to establish an appeals process for county mental health programs to challenge findings. DHCS has also not implemented a program review process to evaluate the effectiveness of counties' MHSA projects.
   Auditor Recommendation: DHCS should establish a process for conducting comprehensive program reviews and begin conducting those reviews by July 2018.

MHSOAC Findings

8. MHSOAC has not provided clear guidance to counties regarding the Innovation plan approval process, which may have contributed to local mental health agencies holding unspent Innovation funds of $146 million as of 2015-16.
   Auditor Recommendation: MHSOAC should continue its efforts to help county mental health programs understand the types of Innovation projects that commissioners believe are appropriate. These efforts should include engagement and dialogue with county mental health programs through events and forums about the types of innovative approaches that would meet the requirements of the MHSA. MHSOAC should use meetings of its Innovation subcommittee or a similar mechanism to evaluate progress of its efforts to reduce unspent Innovation funds and the need for continued engagement and dialogue with county mental health programs.
9. MHSOAC has required county mental health programs to submit annual reports for PEI programs beginning December 2017, as required by legislation approved in 2013, but has not completed an internal process for reviewing and analyzing these reports to ensure submission of timely and reliable data.
   Auditor Recommendation: MHSOAC should finalize its review processes for reviewing and analyzing PEI program status reports no later than July 2018. MHSOAC should also continue its efforts to launch data tools to track county mental health programs' funding, services, and outcomes.

10. MHSOAC has not developed metrics to evaluate the outcome of triage grants approved by the Legislature and designed to expand the number of mental health personnel available at emergency rooms, jails, homeless shelters, and clinics.
    Auditor Recommendation: MHSOAC should require county mental health programs to uniformly report data on their use of triage grants and establish statewide metrics to evaluate the impact of triage grants by July 2018.

DHCS Response to Audit Findings and Recommendations. DHCS indicates that it agrees with most of the findings and recommendations contained in the audit. According to DHCS, in response to the provisions of AB 114, it released Mental Health/Substance Use Disorders (MHSUDS) Information Notice 17-059, which provides guidance to county mental health programs regarding the treatment of funds subject to reversion prior to July 1, 2017. This guidance includes information regarding how it will determine funds subject to reversion for each MHSA component including the disposition of earned interest, consequences for failure to submit timely annual reports, the appeals process for determinations of funds subject to reversion by fiscal year, and requirements for counties to prepare plans to spend these funds. DHCS also reports it is in the process of submitting fiscal regulations for the prospective oversight of MHSA funds subject to reversion after July 1, 2017, which will contain provisions substantially similar to the requirements contained in MHSUDS Information Notice 17-059. These regulations are expected to be submitted for public comment by January 2019. DHCS also reports it has completed development of a process with the State Controller's Office to withhold funds from county mental health programs that fail to submit timely annual reports.

DHCS indicates its MHSUDS Information Notice 17-059, its forthcoming fiscal regulations, and its withholding process with the Controller address the following recommendations:
Recommendation #1: Develop a fiscal reversion process
Recommendation #2: Clarify the treatment of earned interest
Recommendation #3: Establish an appropriate reserve level
Recommendation #5: Process for withholding MHSA funds for failure to submit timely reports

While DHCS agreed with the need to establish an appropriate reserve level (Recommendation #3), DHCS disagreed with the Auditor's recommended reserve level of no more than 33 percent. DHCS reports it contracted with a fiscal consultant who recommended a prudent reserve level of between 64 and 82 percent. DHCS believes this reserve level properly takes into account changes in expenditures over time and inflation.

In response to Recommendation #4 (Analyze $225 million Mental Health Services Fund balance), DHCS reports it has identified the $225 million 2004 Mental Health Services Fund balance as an appropriation amount, rather than unexpended MHSA revenues, and no funds are available to distribute to counties.

DHCS disagrees with Recommendation #6 (Develop MHSA fiscal audit process independent of Short-Doyle Medi-Cal reviews). DHCS believes it cannot conduct a separate audit of MHSA expenditures without Short-Doyle cost report audits because, if the amount of available federal financial participation is unknown, the amount of non-federal expenditures for which MHSA funds would be required would also be unknown. However, DHCS indicates it is updating its fiscal audit and program oversight activities through regulations that are expected to be submitted by Spring 2019.

In response to Recommendation #7 (Establish process for comprehensive program reviews), DHCS indicates it has hired four staff to begin conducting onsite program reviews beginning September 2018. DHCS is requesting permanent position authority for these staff in its budget change proposal, *Mental Health Services Division Policy Implementation*, heard earlier by the subcommittee.

MHSOAC Response to Audit Findings and Recommendations. MHSOAC indicates it agrees with all of the findings and recommendations contained in the audit. In response to Recommendation #8 (Engagement and education to improve counties' Innovation plans), MHSOAC indicates it is committed to an ongoing process of engagement with county agencies and stakeholders to improve awareness of Innovation project proposals, approvals, and evaluation results. MHSOAC is separately requesting resources to hire a private contractor to assist counties in developing Innovation plans, with particular emphasis on diversion programs for individuals referred to a State Hospital as incompetent to stand trial.

In response to Recommendation #9 (Develop review process for PEI services), MHSOAC indicates it is providing support to a statewide learning community, which was scheduled to begin meeting on March 1, 2018, and will focus on policies, procedures, and strategies for counties to gather, report, and evaluate data collected to meet the PEI annual reporting requirements.

In response to Recommendation #10 (Statewide evaluation of triage grants), MHSOAC indicates it authorized $10 million in January 2018 to contract with a third party to perform statewide evaluations of the triage grants.

Questions About Oversight of MHSA Expenditures and Program Outcomes Persist. While DHCS, MHSOAC and county mental health programs are making progress on providing additional transparency regarding MHSA expenditures and programs, there are still areas of concern for the oversight of MHSA expenditures and program outcomes. While the Auditor's recommendations focused primarily on MHSA funds subject to reversion and recommended levels of prudent reserves, the audit highlights that the 59 mental health agencies had a total ending MHSA balance of more than $2.5 billion, which includes amounts subject to reversion, as well as funding that may be retained within the three year reversion period. Many counties may not be spending MHSA revenues until the second or third year after receipt. While the three year reversion period was meant to encourage expenditures of funds within a reasonable timeframe, it is unclear the extent to which counties are utilizing the three year reversion period as an additional source of fund reserves.

In addition to concerns about these additional fund balances, the timeliness of DHCS' oversight of the broader community mental health system also raises questions. In particular, DHCS indicates that auditing of Short-Doyle Medi-Cal cost reports are often several years in arrears. For this reason, according to DHCS, auditing of more recent MHSA expenditures is not possible. DHCS also indicates that, in addition to certain counties failing to submit required annual reports for MHSA expenditures, some have failed to submit Short-Doyle Medi-Cal cost reports in a timely manner, as well. While DHCS indicates that adjustments resulting from cost report auditing is exempt from federal claiming time limits, and therefore no federal funding is at risk from the lack of timely cost report submission, the Legislature may wish to consider whether this extended reconciliation period is permissive of robust fiscal oversight of both MHSA funding and the broader community mental health system.

Statewide Evaluation of MHSA Funded Programs. The California Behavioral Health Directors Association (CBHDA) notes there has never been a comprehensive, statewide evaluation of MHSA funded programs. In response, CBHDA proposes to require DHCS to contract with a non-profit educational institution to develop a methodology to implement a rigorous, statewide evaluation of all MHSA expenditures. CBHDA proposes that all non-mandated MHSA State Administration expenditures be frozen until the evaluation methodology has been implemented.

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

Panel Discussion. The subcommittee has requested the following panelists to comment on the findings and recommendations of the state audit:

- **John Baier**, Audit Principal, and **Rick Weisberg**, Legal Counsel, California State Auditor
- **Jennifer Kent,** Director, Department of Health Care Services
- **Toby Ewing,** Exec. Director, Mental Health Services Oversight and Accountability Commission
- **Kirsten Barlow,** Executive Director, County Behavioral Health Directors Association

Questions. The subcommittee has requested the Auditor's Office, DHCS, MHSOAC, and CBHDA to respond to the following:

1. Auditor: Please briefly present the findings and recommendations of the recent state audit: "*Mental Health Services Act: The State Could Better Ensure the Effective Use of Mental Health Services Act Funding"*

2. DHCS: Please briefly present the department's response to the findings and recommendations of the audit related to DHCS.

3. DHCS: Please describe in detail the status of development of the process for fiscal reversion, both for funds subject to reversion prior to July 1, 2017, and funds subject to reversion prospectively. Specifically:

    a. How will the department and counties calculate amounts subject to reversion?
    b. What opportunities will counties have to appeal determinations of amounts owed or other adverse findings?
    c. How will the department operationalize the reversion process to receive amounts owed?
    d. What is the status of development of a process to withhold funds from counties that fail to provide timely annual reporting?
    e. What steps would occur between a county's missed deadline and withholding of funds?
    f. How much of a county's allocation would be withheld and for how long?

4. DHCS: What is the status of the $225 million fund balance identified by the audit in the Mental Health Services Fund? Are there unexpended funds available for distribution to counties?

5. DHCS: Please describe the department's view of the appropriate level of prudent reserves for counties' MHSA funds. How does the department's recommended prudent reserve level account for funds counties retain during a significant portion of the three year period prior to reversion?

6. DHCS: Please describe how the department provides fiscal oversight of MHSA expenditures in the context of its fiscal audit process for Short-Doyle Medi-Cal. Given the long time-frame for reconciliation of these cost reports, how can the department manage effective fiscal oversight of expenditures that may have occurred several years in the past?

7. Auditor: Please describe any concerns that remain regarding DHCS' response to the audit's findings and recommendations. Does the Auditor's office have any follow-up recommendations in light of DHCS' responses to the audit?

8. MHSOAC: Please briefly present the commission's response to the findings and recommendations of the audit related to MHSOAC.

9. MHSOAC: Please describe the status of review of prevention and early intervention programs and the results, if any, of the commission's March 1, 2018 learning community meeting on this topic.

10. MHSOAC: Please describe the details of the $10 million contract to develop a statewide evaluation of the effectiveness of triage grants.

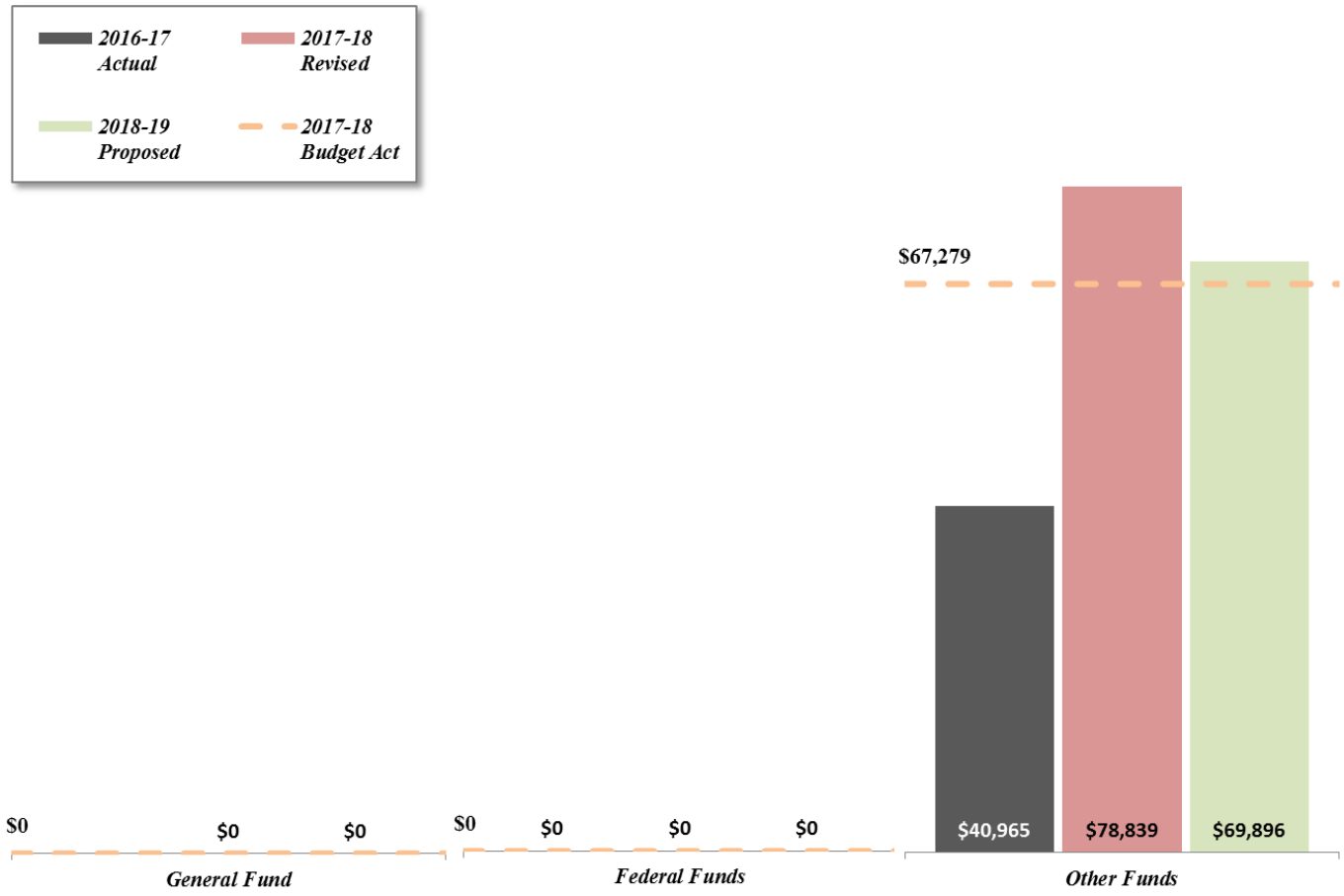
11. CBHDA: Please respond to the findings and recommendations of the audit related to the specific counties reviewed, as well as impacts on county mental health programs of the findings of the audit related to both DHCS and MHSOAC.

12. CBHDA: Do county mental health programs have any concerns about DHCS' actions to date regarding fiscal reversion? What challenges exist for counties in providing timely annual reports of MHSA revenues and expenditures?

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Overview

Mental Health Services Oversight & Accountability Commission – *Three-Year Funding Summary*
(dollars in thousands)



Mental Health Svcs Oversight & Accountability Commission - *Department Funding Summary*			
Fund Source	***2017-18 Budget Act***	***2017-18 Revised***	***2018-19 Proposed***
General Fund	$0	$0	$0
Federal Funds	$0	$0	$0
Other Funds	$67,279,000	$78,839,000	$69,896,000
Total Department Funding:	**$67,279,000**	**$78,839,000**	**$69,896,000**
Total Authorized Positions:	**29.0**	**26.6**	**26.6**
Other Funds Detail:			
Reimbursements (0995)	*$22,000,000*	*$22,000,000*	*$22,000,000*
Mental Health Services Fund (3085)	*$45,279,000*	*$56,839,000*	*$47,896,000*

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.

Stakeholder Advocacy Contracts for Mental Health Issues Among Immigrants and Refugees. The California Pan-Ethnic Health Network (CPEHN) and the California Immigrant Policy Center (CIPC) request $1.3 million from the Mental Health Services Fund for MHSOAC to develop stakeholder advocacy contracts to support the mental health and engagement of immigrants and refugees. According to CPEHN and CIPC, the Trump Administration's continued scapegoating and attacking of immigrants has created a hostile atmosphere for many in our communities. The state has taken legislative action to limit the reach of the federal government and invested additional resources in support of immigrant legal services. Immigrants and refugees continue to show their strength and resiliency in weathering these attacks, but the cumulative impact takes a toll on the health and well-being of communities. As part of the MHSA, MHSOAC can support key partnerships, programs, and planning to meet the mental health needs of Californians and their families. In addition, pursuant to Welfare and Institutions Code Section 5892(d), the Mental Health Services administrative fund must include funds to promote stakeholder engagement in decisions concerning the public mental health system. The 2015 Budget Act included funds to increase stakeholder engagement among diverse racial and ethnic communities and among veterans, and the 2016 Budget Act included funds to increase stakeholder engagement among LGBTQ communities. CPEHN and CIPC request funding for stakeholder contracts to include mental health issues among immigrant and refugee communities.

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

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

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

2. Please briefly comment on the proposal for stakeholder advocacy contracts for mental health issues among immigrants and refugees.

Issue 2: County Mental Health Innovation Planning

Budget Issue. MHSOAC requests expenditure authority from the Mental Health Services Fund of $2.5 million in 2018-19 and 2019-20. If approved, these resources would allow MHSOAC to contract with a private entity to provide support to counties in developing plans for innovative programs under the Mental Health Services Act, specifically to address community mental health diversion efforts for individuals found incompetent to stand trial.

Program Funding Request Summary (Budgeting Methodology BCP)		
Fund Source	**2018-19**	**2019-20**
3085 – Mental Health Services Fund	$2,500,000	$2,500,000
Total Funding Request:	**$2,500,000**	**$2,500,000**

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

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

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

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

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

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

final Innovation plan, including a budget, to the MHSOAC, which reviews the proposal and provides technical assistance to make any necessary modifications to address questions or concerns. Finally, counties present the Innovation plan to the MHSOAC, which approves or rejects the proposal.

Incompetent to Stand Trial Community Mental Health Diversion. Mental Health Diversion – In the Governor's January budget, the Administration proposed a mental health diversion package of $117.3 million ($114.8 million General Fund and $2.5 million Mental Health Services Fund) to increase the state-county partnership to address the growing number of people in the criminal justice system found incompetent to stand trial due to mental health impairments. Specifically, the proposal includes:

- $100 million General Fund spent over three years for community alternatives to increase diversion from the criminal justice system for people who are mentally ill.
- $14.8 million General Fund for a partnership between the Department of State Hospitals and Los Angeles County to provide treatment in the community for up to 150 people who have been found incompetent to stand trial.
- $2.5 million from the Mental Health Services Fund for MHSOAC to provide two years of consulting services to assist counties in developing diversion programs.

This request for resources from MHSOAC is a component of the Administration's package of IST diversion proposals.

Challenges for County Implementation of Innovative Programs. While MHSA provided significant new funding to counties for mental health programs, the funds are required to be expended within three years. Funds not expended within three years are subject to reversion to the state for redistribution to other counties. According to a recent state audit, $230.8 million of MHSA funds were subject to reversion as of June 2016. Of that figure, $145.6 million (63.1 percent) were funds allocated for Innovation.

According to MHSOAC, 52 counties (88 percent) have presented an Innovation plan since 2013. The details of Innovation plan submissions by fiscal year are as follows:

Fiscal Year:	# of Counties	# of Projects	Total INN Dollars	Total INN Extensions
2013-14	8	14	$7,867,712	$-
2014-15	16	26	$127,742,348	$1,111,054
2015-16	15	17	$46,920,919	$5,587,378
2016-17	18	27	$66,347,688	$2,008,608
2017-18	10	21	$88,557,465	$5,172,606

Technical Assistance for Innovation Plans for IST Diversion. MHSOAC requests expenditure authority from the Mental Health Services Fund of $2.5 million in 2018-19 and 2019-20 to contract with a private consultant to provide technical assistance to counties in developing innovation plans, with a particular focus on IST diversion. According to MHSOAC, the consultant will bring together experts from health care, technology, communications, and translational science and management sectors to improve utilization of Innovation funds. Counties would not be required to participate or use the services provided by the contractor. However, those counties that do participate will benefit from a collaborative process with the contractor and MHSOAC in developing successful Innovation plans

focused on diversion programs to reduce the number of individuals referred to state hospitals as incompetent to stand trial.

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

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

1. Please provide a brief overview of this proposal.

2. Please provide examples of what types of programs for community mental health diversion for the IST population or other justice-involved populations could be funded by existing or future MHSA Innovation funds.

3. If Innovation funds are part of a county's proposal to DSH for an IST diversion grant, how would MHSOAC collaborate with DSH to ensure timely approval of both the Innovation component and the IST diversion component? What would be the expected timeframe for approval?

4440 DEPARTMENT OF STATE HOSPITALS
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Incompetent to Stand Trial (IST) Population – Overview

Background. The Department of State Hospitals (DSH) admits individuals found incompetent to stand trial (IST) under Section 1370 of the Penal Code, typically for felony offenses, and provides clinical and medical services to restore these individuals to competency. Because of capacity constraints within the state hospital system, 840 individuals in the IST population are housed in county jails because they are awaiting placement into a state hospital bed or jail-based competency program. This backlog, which has grown 40 percent in the last year, places operational and fiscal stress on county jails and may violate the rights of individuals in custody for longer than a reasonable time to evaluate their potential for restoration to competency.

Incompetent to Stand Trial Referrals. Under California law "[a] person cannot be tried or adjudged to punishment or have his or her probation, mandatory supervision, post-release community supervision, or parole revoked while that person is mentally incompetent." IST patients are referred to DSH under Section 1370 of the Penal Code if a court has determined they are unable to understand the nature of criminal proceedings or assist counsel in their defense. IST patients receive competency-based treatment and are returned to court once able to participate in court proceedings. If a defendant's attorney raises concerns about his or her competency to stand trial, the judge in the case may order a mental health evaluation by a psychiatrist or clinical psychologist. If the evaluation finds substantial evidence the defendant is incompetent, a competency hearing is scheduled with additional expert testimony and an opportunity for the defendant to respond to or refute the findings of the evaluation. If the court finds a defendant incompetent to stand trial, the local community health director determines whether the defendant is best treated in a local facility, an outpatient facility, or at a state hospital. Misdemeanants are typically treated in an outpatient setting or released, while felonies are typically referred for treatment at a state hospital. If a bed is not available in a state hospital, the defendant remains in the custody of the county until a bed becomes available. Capacity constraints in the state hospital system have resulted in ongoing backlogs of defendants deemed IST in county jails for extended periods awaiting treatment.

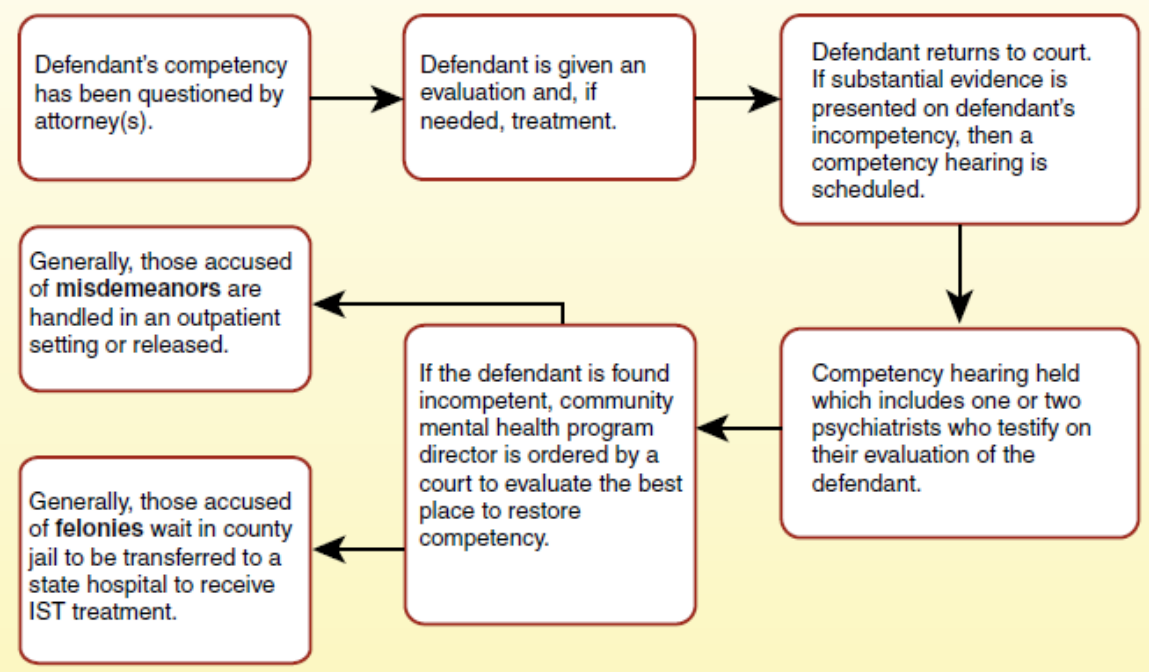


Figure 1: Incompetent to Stand Trial Commitment Process
Source: "*An Alternative Approach:Treating the Incompetent to Stand Trial", Legislative Analyst's Office, Jan 2012*

Long-Standing Issues with IST Backlog. Since the 2007-08 fiscal year, the backlog of IST referrals awaiting treatment in state hospitals has grown from between 200 and 300 to 840 as of December 2017. In 1972, the United States Supreme Court found in *Jackson v. Indiana* that a person committed on account of his or her incapacity to proceed to trial cannot be held for longer than the reasonable period of time necessary to determine whether the individual is likely to attain capacity. California law requires state hospital or outpatient facility staff to report to the court within 90 days on the status of the defendant's restoration to competency. Based on this 90 day requirement, several court rulings have recommended that a "reasonable" time to transfer IST patients for treatment is no more than 30 to 35 days. Many IST patients remain in county custody for longer, which may violate these patients' due process rights. In addition, the housing of IST patients in county jails while they await availability of treatment beds in state hospitals places stress on county jail systems.

Administration Proposals to Increase IST Capacity in State Hospitals. Over recent years, the Administration has proposed a series of projects to expand capacity in State Hospitals for the treatment of IST patients. These proposals were in response to the growing backlog of IST patients in county jails over the last ten years. In addition to a $117.5 million package to promote community-based diversion of those at risk for being referred as IST, the budget includes several proposals that implement previously approved capacity expansions at State Hospitals.

Metropolitan State Hospital Secured Bed Capacity Increase. DSH requests 346.1 positions and General Fund expenditure authority of $53.1 million in 2018-19 and 473.4 positions and General Fund expenditure authority of $69 million in 2019-20 and annually thereafter to activate newly secured units at Metropolitan State Hospital to provide increased capacity for the treatment of IST patients. The 2016 Budget Act included capital outlay construction funding to securely enclose existing patient buildings

that currently house civilly committed patients under the Lanterman-Petris-Short (LPS) Act. Once secured, the LPS patients currently housed in these units will be transferred to non-secured buildings elsewhere on the Metropolitan campus and allow for additional secured capacity for the treatment of IST patients currently in county jails awaiting state hospital treatment. This request activates and provides staff for approximately 236 forensic beds over the course of 2018-19 to treat IST patients.

Metropolitan State Hospital Per Patient Operating Equipment and Expenses. DSH requests General Fund expenditure authority of $3.7 million annually to fund the operating equipment and expenses associated with the activation of the additional 236 beds for the treatment of IST patients at Metropolitan State Hospital.

Jail-Based Competency Treatment Program Activation. DSH requests General Fund expenditure authority of $516,000 in 2017-18, $8.1 million in 2018-19, and $8.3 million in 2019-20 and annually thereafter to activate jail-based competency treatment (JBCT) beds for the treatment of IST patients in county jails, pursuant to approval of program expansions in previous budget requests. DSH contracts with county jail facilities to provide restoration of competency services in jails, treating IST patients with lower acuity and that are likely to be quickly restored to competency. The current system-wide census of IST patients receiving JBCT services is 173 as of June 30, 2017. This request nets savings from delayed implementation of existing JBCT contracts in Mendocino, Sacramento, and Stanislaus counties with additional costs for the activation of five JBCT beds in Riverside and 50 beds in San Bernardino.

Coalinga State Hospital MDO Bed Activation. DSH requests 81.2 positions and General Fund expenditure authority of $11.5 million in 2018-19 and 96.9 positions and General Fund expenditure authority of $13.7 million in 2019-20 to increase capacity for the treatment of mentally disordered offenders (MDOs) at Coalinga State Hospital. This increased capacity is intended to allow transfer of MDOs from other State Hospitals to create additional capacity in those State Hospitals for the treatment of IST patients. Coalinga has already increased its MDO capacity by 25 beds. This request will allow for a two-phase activation of an additional 80 beds during 2018-19.

Kern Admission, Evaluation, and Stabilization Center. DSH reports a reduction in General Fund expenditures in 2017-18 of $1.7 million related to delays in negotiation and execution of a contact with Kern County to establish an Admission, Evaluation, and Stabilization (AES) Center at the Lerdo Pre-Trial Facility located in Bakersfield. The Kern AES Center is expected to receive and treat IST patients committed to State Hospitals directly from nearby catchment counties.

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

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

1. Please provide a brief overview of treatment of the IST population in State Hospitals.

2. Please detail implementation of capacity expansions related to treatment of IST patients contained in the 2018-19 Estimate.

3. Please provide historical background for the backlog of individuals referred as IST housed in county jails and efforts to increase capacity for this population.

4. What, if any, evidence exists that may suggest a cause for the continued increase in this population over the last several years?

Issue 2: IST Diversion Proposals – County Mental Health Treatment Partnerships

Budget Issue and Trailer Bill Language. DSH requests two positions and expenditure authority of $117.3 million ($114.8 million General Fund and $2.5 million Mental Health Services Fund) in 2018-19 to contract with counties to develop new or expand existing diversion programs for individuals with serious mental illness with potential to be found incompetent to stand trial (IST) on felony charges.

Program Funding Request Summary (Budgeting Methodology BCP)		
Fund Source	**2018-19**	**2019-20**
0001 – General Fund	$114,800,000	$376,000
3085 – Mental Health Services Fund*	$2,500,000	$2,500,000
Total Funding Request:	**$117,300,000**	**$2,876,000**
Total Positions Requested:**	**2.0**	**2.0**

* Mental Health Services Fund is also separately reflected in the MHSOAC budget request.
** Positions are limited-term and would be authorized through 2020-21.

Background. DSH admits individuals found incompetent to stand trial (IST), typically for felony offenses, and provides clinical and medical services to restore these individuals to competency. Because of capacity constraints within the state hospital system, 840 individuals in the IST population are housed in county jails because they are awaiting placement into a state hospital bed or jail-based competency program. This backlog, which has grown 40 percent in the last year, places operational and fiscal stress on county jails and may violate the rights of individuals in custody for longer than a reasonable time to evaluate their potential for restoration to competency. The budget includes the latest in a series of Administration proposals over recent years to address the IST backlog. While previous Administration IST proposals have focused primarily on increasing capacity within State Hospitals and jail-based competency treatment (JBCT) programs, these proposals focus primarily on community-based treatment and diversion of IST patients or individuals with serious mental illness at risk of future referral for IST treatment due to potential involvement with the criminal justice system.

State-County Partnerships for Diversion of Potential IST Offenders. DSH requests trailer bill language and General Fund expenditure authority of $100 million to contract with counties to develop new or expand existing diversion programs for individuals with severe mental illnesses. These programs would be primarily focused on individuals diagnosed with schizophrenia, shizoaffective disorder, or bipolar disorder with the potential to be found IST on felony charges. Programs components would include:

- Evidence-based community mental health treatment and wrap around services, such as forensic assertive community treatment teams, crisis intervention teams, forensic alternative centers, intensive case management, criminal justice coordination, peer support, supportive housing, and vocational support.
- Targeting of individuals with serious mental illnesses where a nexus exists between the illness and the alleged criminal activity, there is significant evidence of mental illness at the time of the alleged crime, the crime is driven by conditions of homelessness, and the individual does not pose a significant safety risk if treated in the community.

Counties would be required to contribute matching funds of 20 percent of the program costs and provide outcomes data on the success of the program towards the goal of reducing IST referrals by 30 percent. In addition to funding for county diversion contracts, DSH requests one Chief Psychologist and one Health Program Specialist I position on a three-year, limited-term basis to provide diversion and risk assessment expertise and to review and provide technical assistance for county diversion proposals.

Los Angeles County Community Mental Health Treatment of IST Offenders. DSH requests General Fund expenditure authority of $14.8 million to contract with Los Angeles County for 150 beds to treat IST patients in community settings, based on the county's experience in treating misdemeanor IST patients in similar settings. The contract, currently under negotiation to begin July 2018, would provide a coordinated continuum of mental health placements including five beds in a locked acute psychiatric hospital, 45 beds in a locked Institute for Mental Disease or mental health rehabilitation center, and 100 beds in residential facilities with clinical and supportive services. Los Angeles County has approximately 185 IST offenders awaiting state hospital placement. The contract will also include $2.5 million of funding for Los Angeles County staffing resources for 10-12 positions, including a clinical team of six to eight staff members, which would provide patient support by stabilizing patients on medications and preparing them for community placement, and a navigation team of two to three staff members to support connections to social services and other needs.

	Locked Inpatient	Locked IMD type IMD Type	Unlocked, secured, Clinically Enhanced Type
Proposed # of Beds	5	45	100
Facility Type	General Acute Care Hospital or Acute Psychiatric Hosptial -- likely Olive View Medical Center	Low acuity hospital, and/or Nursing facility; licenses as an Institute for Mental Disease facility or a Mental Health Rehabilitation Center	Residential site with clinical and supportive services on-site
Facility Bed Capacity	18 total beds with 5 set aside for this project	2 different facilities: 1st up to 15 beds in San Fernando Valley part of LA County; 2nd with up to 35 beds in southern LAC or San Diego County	3-5 sites across LA County with 20-40 beds each
Security	Locked unit	Locked facilities	Open, but gated and with staff and security cameras monitoring entrance/exit
Staffing	24/7 nursing and MD staff, full-time clinical SW and support staff	24/7 nursing staff, M-F and on call MD staff, full-time clinical SW and support staff	24/7 case management and security staff, full-time clinical social work and nursing staff; potentially nurse practitioner on call
Treatment	Stabilization of Acute Mental Health or Medical symptoms	Sub-acute stablization of patients who do not require acute care, but who are not clinically ready for outpatient care and restoration of competency treatment.	Outpatient treatment, maintenance of stabilization, on-site psychiatric care, medication support and monitoring, group and individual therapy and restoration of competency treatment.

Figure 1: Los Angeles County IST Restoration in Community Mental Health Treatment Placements
Source: *2018-19 Department of State Hospitals Governor's Budget Proposals and Estimate*

MHSOAC Funding for Coordination of Innovative Programs for Diversion. MHSOAC requests $2.5 million from the state administration account of the Mental Health Services Fund for a consultant to evaluate existing county plans and innovative strategies to address local mental health needs, coordinate with the state and counties to utilize existing resources and programs to support mental health treatment, and assist counties with coordination of programs to support IST diversion efforts. This issue will be heard separately by the subcommittee (see also MHSOAC *Issue 2: County Mental Health Innovation Planning*).

Stakeholder Proposal – Community Mental Health Diversion for IST and State Prisoners. Stanford Law School's Three Strikes Project requests trailer bill language to expand upon the Administration's IST diversion proposal to address unmet mental health needs among both State Hospital patients and individuals incarcerated in state prisons. Modeled on similar incentive-based funding programs, such as SB 81 (Committee on Budget and Fiscal Review), Chapter 175, Statutes of 2007, and SB 678 (Leno), Chapter 608, Statutes of 2009, this proposal requires the Department of Finance, in consultation with other law enforcement agencies and entities, to calculate the state costs of incarceration in state prisons or restoration of competency treatment in State Hospitals and share 35 percent of those costs with counties for every individual with mental illness diverted to community-based treatment below a certain baseline threshold.

According to the Three Strikes Project, more than 30 percent of California prisoners currently receive treatment for a serious mental disorder, which represents a 150 percent increase since 2000. In addition, the severity of psychiatric symptoms of state prisoners has risen dramatically over the last five years. Defendants with mental illness receive longer prison sentences, on average, and some counties send a disproportionate number of defendants with mental illness to state prison.

While the Administration's proposed investment in community mental health diversion programs is a necessary component of addressing unmet mental health needs in the community that may lead to involvement in the justice system, the solitary focus on IST referrals ignores the equally challenging public health problem and fiscal impacts of individuals with severe mental illness sentenced to state prisons. The Three Strikes Project proposal, which is also contained in SB 142 (Beall) and would be combined with the Administration's current IST community mental health diversion proposal, incorporates financial incentives for counties to divert more at-risk individuals for community treatment and provides an ongoing funding source for diversion programs.

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

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

1. Please provide a brief overview of the three proposals to address diversion and treatment of IST patients or individuals at risk of referral as IST.

2. The Legislature previously approved $68 million of funding for infrastructure grants, administered by the California Health Facilities Financing Authority (CHFFA), to support community mental health diversion programs. How is DSH working with CHFFA to

coordinate its current infrastructure funding efforts with the programs envisioned by DSH as eligible for funding under its community-based mental health diversion proposal?

3. The community-based diversion proposal provides $100 million for three years for these state-county partnerships. Are county programs expected to utilize these funds for one-time expenditures, or for an ongoing program? How would counties be expected to sustain programs without ongoing funding?

4. Counties would be expected to provide outcomes data for funded diversion programs. How would DSH hold counties accountable for meeting the objectives of these programs, particularly the goal of diverting 30 percent of current IST referrals for treatment in the community?

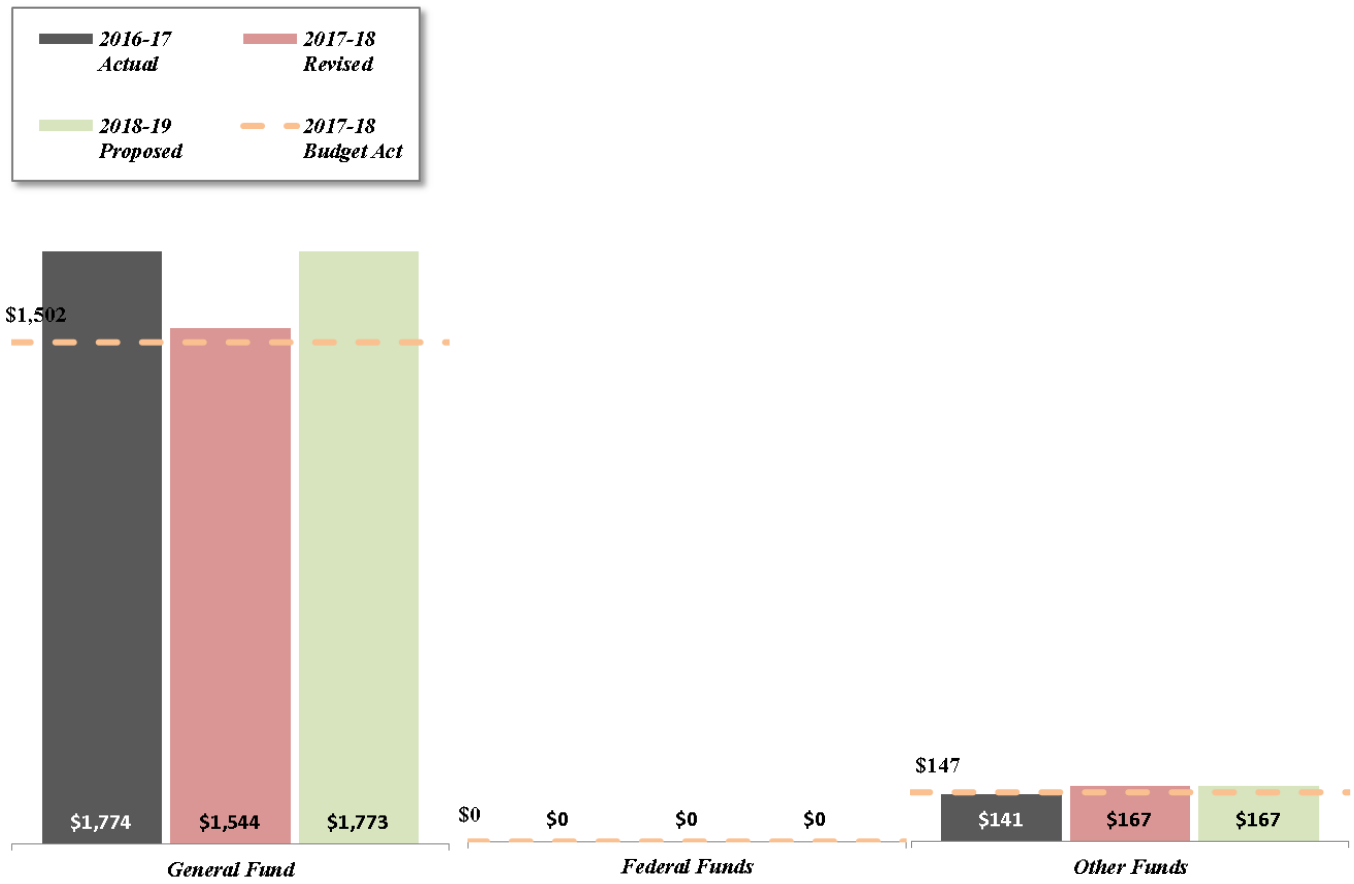
5. Does DSH or the Administration generally expect these community mental health diversion programs for individuals at risk of justice involvement to have the additional benefit of diverting individuals from incarceration in county jails or state prisons, as well as reducing felony IST referrals to State Hospitals?

6. DSH provides hospital-based and jail-based treatment and restoration of competency for individuals referred from counties as IST. What expertise does DSH possess that will allow it to effectively identify best practices for community-based diversion programs at the county level?

4440 DEPARTMENT OF STATE HOSPITALS

Issue 1: Overview

Department of State Hospitals – *Three-Year Funding Summary*
(dollars in millions)



Department of State Hospitals - *Department Funding Summary*			
Fund Source	***2017-18 Budget Act***	***2017-18 Revised***	***2018-19 Proposed***
General Fund	$1,501,897,000	$1,544,175,000	$1,772,657,000
Federal Funds	$0	$0	$0
Other Funds	$147,165,000	$167,295,000	$167,295,000
Total Department Funding:	**$1,649,062,000**	**$1,711,470,000**	**$1,939,952,000**
Total Authorized Positions:	**8569.6**	**9809.5**	**10344.1**
Other Funds Detail:			
CA State Lottery Education Fund (0814)	*$21,000*	*$32,000*	*$32,000*
Reimbursements (0995)	*$147,144,000*	*$167,263,000*	*$167,263,000*

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

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

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

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

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

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

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

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

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

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

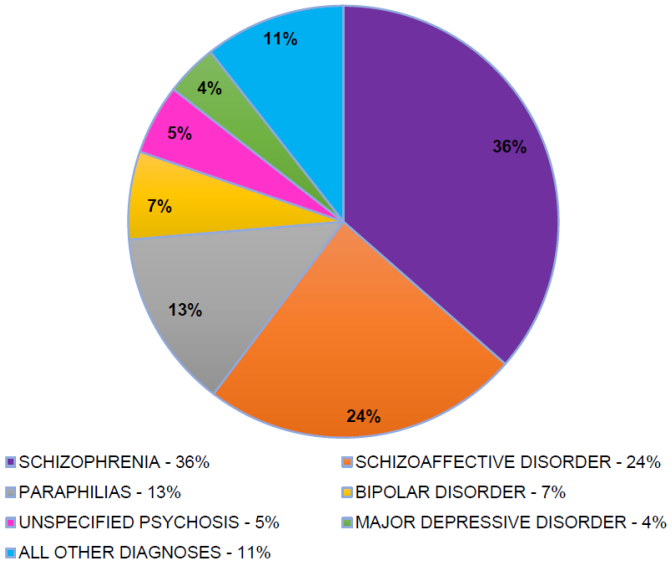


Figure 2: State Hospital Population By Major Diagnosis, as of July 1, 2017
Source: *Report on Measures of Patient Outcomes, Department of State Hospitals, January 2018*

The five state hospitals operated by DSH are:

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

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

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

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

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

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

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

1. Please provide a brief overview of the State Hospital system, including major inpatient categories, treatment programs, and significant organizational changes.

Issue 2: Unified Hospital Communications Public Address System – Phase 2

Budget Issue. DSH requests two positions and General Fund expenditure authority of $359,000 in 2018-19, $4.6 million in 2019-20, $7.7 million in 2020-21, and $3.7 million in 2021-22 and annually thereafter. If approved, these positions and resources would allow DSH to support an increase in maintenance costs for Phase 1, and implementation of Phase 2, of its Unified Hospital Communications Public Address System Project.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$359,000	$4,629,000
Total Funding Request:	**$359,000**	**$4,629,000**
Total Positions Requested:**	**2.0**	

* Additional fiscal year resources requested: 2020-21: $7,725,000; 2021-22: $3,721,000; 2022-23 (ongoing): $3,651,000
** Positions are ongoing after 2019-20.

Background. The 2015 Budget Act approved resources to fund Phase 1 of the implementation of a new public address system for the State Hospitals. The new Unified Hospital Communications Public Address (UHCPA) System is intended to improve communication and dissemination of information quickly and intelligibly throughout each hospital campus. According to DSH, once it is implemented, the UHCPA system will allow for two-way communications between public speakers in key areas and dispatch, allow for targeted announcements to specific hospital areas to prevent disruption in non-affected areas, provide clear and intelligible announcements, and allow message prioritization to prevent concurrent message delivery.

Phase 1 of implementation provided for the installation of the PA systems and associated local area networks (LAN) at Coalinga and Patton State Hospitals. Network-based PA systems can be integrated with a hospital's emergency system through a single interface, which can then broadcast appropriate warnings over the speakers on every floor in the event of an emergency or natural disaster. The UHCPA systems also provide complementary alert capability to the Personal Duress Alarm Systems (PDAS) implemented in recent years to provide alerts to nearby hospital police and other staff regarding incidents of physical aggression. According to DSH, the PDAS cannot inform staff when a response to an alert is no longer necessary. The UHCPA system can provide situational details to staff to respond appropriately to incidents of aggression and other emergencies.

Phase 2 of the UHCPA system project would provide for the installation of the system at Metropolitan, Atascadero, and Napa State Hospitals. DSH requests two Senior Information Systems Analysts, to be shared among the three hospital locations, to provide support for management of vendor contracts and performance, and to assist in integrating the new systems related to the PA system at the three hospitals. Implementation of Phase 2 would begin in October 2018 and proceed in three waves, concluding in January 2024. The DSH request includes contract resources of $1.7 million in 2019-20, $5.3 million in 2020-21, and $1.3 million in 2021-22 and annually thereafter for maintenance and operations of the system, as well as non-capital asset equipment purchases of $2.6 million in 2019-20, $2.1 million in 2020-21 and 2021-22, and $2 million in 2022-23 and annually thereafter.

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

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

1. Please provide a brief overview of this proposal.

Issue 3: Ongoing Costs for Personal Duress Alarm System

Budget Issue. DSH requests ongoing General Fund expenditure authority of $2.7 million. If approved, these resources would allow DSH to support ongoing maintenance and service for its Personal Duress Alarm System Project.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$2,700,000	$2,700,000
Total Funding Request:	**$2,700,000**	**$2,700,000**

* Resources are ongoing after 2019-20.

Background. The 2013 Budget Act approved resources to implement a Personal Duress Alarm System (PDAS) within the State Hospital system. PDAS units are used to alert hospital police and other nearby employees when a duress incident occurs. The system was approved in response to significant numbers of violent incidents within State Hospitals. According to 2013 data, patients committed 2,586 physically aggressive acts against staff and 3,344 physically aggressive acts against other patients.

According to DSH, when the PDAS project was initially approved and funded, the budget did not include sufficient funding to cover upgrades to new models or versions of equipment necessary for ongoing maintenance of the system. Vendors frequently introduce new models and versions of equipment and phase-out support of older models and versions. DSH requests General Fund resources of $2.7 million annually to refresh hardware components of the PDAS system as they reach the end of their useful life and are no longer supported by the manufacturer. According to the manufacturer, the refresh periods for the major PDAS components are as follows:

Replacement Item	Replacement Unit Cost	Refresh Cycle in Years
Personal Duress Alarm		
Ekahau tag	106.92	2
Ekahau charger	10.80	5
Access Point - Indoor	638.60	4
Access Point - Outdoor	3,087.14	4
Catalyst and Core Switches		
Cisco core switches	82,770.66	5
Cisco Catalyst 32 Port MDF switches	43,235.53	5
Cisco Catalyst 24 Port MDF switches	27,378.32	5
Cisco Catalyst 16 Port MDF swithces	20,778.44	5
Cisco Catalyst 3750/3850 IDF - 24 Port	6,872.69	5
Cisco Catalyst 3750/3850 IDF - 48 Port	11,071.73	5
Cisco Catalyst 4xxx IDF switches	25,646.22	5
Cisco Controllers and Servers		
Cisco Wireless LAN Controller	128,875.54	6
Cisco Nexus UCS	53,462.38	6
Cisco UCS server	40,550.03	6
EMC VNX Storage Area Network	69,784.20	6

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

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

1. Please provide a brief overview of this proposal.

Issue 4: Information Security Program Expansion

Budget Issue. DSH requests two positions and General Fund expenditure authority of $3.1 million in 2018-19 and $1.7 million in 2019-20 and annually thereafter. If approved, these positions and resources would allow DSH to provide adequate staffing to protect information assets and remediate findings identified in a recent security assessment by the California Military Department.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$3,080,000	$1,678,000
Total Funding Request:	**$3,080,000**	**$1,678,000**
Total Positions Requested*:	**2.0**	

* Positions and resources are ongoing after 2019-20.

Background. AB 670 (Irwin), Chapter 518, Statutes of 2015, authorizes the California Department of Technology (CDT) to conduct independent security assessments of state departments and agencies, requiring no fewer than 35 assessments be conducted annually. AB 670 requires CDT to prioritize for assessment state departments or agencies that are at higher risk due to handling of personally identifiable information or health information protected by law, handling of confidential financial data, or levels of compliance with certain information security and management practices. Independent security assessments are conducted by the Cyber Network Defense (CND) Team at the California Military Department.

Because DSH systems contain confidential and sensitive information, including Social Security Numbers and protected health information, DSH underwent a CND security assessment in October 2017. In January 2018, DSH also initiated a security review pursuant to the requirements of State Administrative Manual Section 5300 and HIPAA Security Rules. Both of these assessments identified similar findings:

1. Existing asset tracking practices do not include a comprehensive inventory of all information system components, nor permit full life cycle management of information assets.
2. Continuous monitoring of systems and alerting on security incidents has not been possible due to lack of personnel in security operations positions.
3. Detection of rogue devices connected to the DSH network is not possible using existing tools and personnel.
4. Insufficient funds exist for training of staff on modern, industry-standard secure coding techniques.
5. Scanning of systems for vulnerabilities is completed by security staff, but system hardening and remediation of vulnerabilities is difficult or impossible with existing tools.

DSH Requests Resources to Remediate Findings of the Security Assessment. In order to remediate the findings of the CND and internal security assessments, DSH requests two permanent positions and General Fund expenditure authority of $3.1 million in 2018-19 and $1.7 million in 2019-20 and annually thereafter. Specifically, DSH requests:

1. **One Systems Software Specialist II** to lead technical staff managing and maintaining the system which inventories all assets and tracks them through their lifecyle.

2. **One Systems Software Specialist II** to serve as lead technical staff managing and maintaining the system which monitors the threats to the Department's information technology resources from external and internal sources.
3. **Security System Solutions** including inventory and asset management, security information and event management, patching solutions for non-Microsoft applications, secure code review solutions and training, and on-premise rogue device detection paired with mobile and cloud security solutions.

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

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

1. Please provide a brief overview of this proposal.

Issue 5: Electronic Health Records Planning

Budget Issue. DSH requests four positions and General Fund expenditure authority of $1.3 million in 2018-19 and $713,000 in 2019-20. If approved, these positions and resources would allow DSH to complete Stages 3 and 4 of the Project Approval Lifecycle process for implementation of an integrated electronic health record for State Hospital inpatients.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20**
0001 – General Fund	$1,267,000	$713,000
Total Funding Request:	**$1,267,000**	**$713,000**
Total Positions Requested*:	**4.0**	

* Positions are ongoing after 2019-20.

Background. DSH manages the nation's largest inpatient forensic mental health hospital system. The five State Hospitals managed by DSH employ nearly 11,000 staff and served 13,403 patients with an average daily census of 7,087 in 2016-17. The department's jail-based competency programs served a total of 729 patients with a capacity of 178 and its conditional release program (CONREP) maintains an average daily census of approximately 636.

According to DSH, the size of the State Hospital system and its affiliated programs result in complex problems maintaining continuity of patient care and the accurate flow of information and patient data within and among hospitals and external care providers. Intra-hospital patient transfers occur frequently to accommodate changes in levels of care, commitment codes, safety, proximity to family and social supports, and other individualized needs. DSH reports it uses approximately 27 separate systems related to admissions, registration, pharmacy, billing, and primary medical care functions.

DSH also reports that it is out of compliance with the federal Health Information Technology for Economic and Clinical Health (HITECH) Act, which provides assistance and support for organizations to become meaningful users of electronic health records (EHR). DSH also reports it is out of compliance with federal and state recommendations that it adopt an inventory system to safeguard pharmaceutical drugs. As a result, DSH is seeking to implement an EHR system, and is collaborating with Cerner, a supplier of Health Information Technology solutions, as one possible alternative solution.

DSH seeks to replace certain key functions currently managed by other systems with implementation of an EHR system. Specifically, DSH seeks to replace admissions registration, pharmacy services, billing, and certain primary care business functions currently managed through other processes or through no process at all. DSH is seeking to achieve improvement in the following metrics:

1. Admission Registration
    a. Decrease the number of returning DSH patients incorrectly matched with previous records.
    b. Assign 100 percent of patients a single patient identifier across all electronic systems.
2. Pharmacy Services
    a. Provide access to active medication list for patients (Goal: 80 percent of patients within the first 90 days).

   b. Provide data exchange between pharmacy and billing systems, which does not currently exist.
3. Billing
   a. Reduce the number of Medicare claims returned with errors to less than 25 percent.
   b. Provide accurate patient cost of care accounts to reduce reconciliation time and labor.
   c. Eliminate instances of double billing.
4. Primary Care
   a. Provide exchange of data between primary care and other systems, which does not currently exist.
   b. Provide functionality to complete 100 percent of documents electronically.

DSH intends its proposed EHR system to meet confidentiality, security, and privacy requirements for protected health information (PHI) and personally identifiable information (PII) and other state and federal requirements. DSH also indicates it intends the EHR to be interoperable with external EHR systems to allow for continuity of care and data exchange for State Hospital patients discharged into the community.

Resources Requested to Complete Project Approval Lifecycle. DSH has begun the Project Approval Lifecycle process required by the California Department of Technology. The Stage 1 Business Analysis is complete and DSH is finalizing its Stage 2 Alternatives Analysis. According to DSH, the Stage 2 Alternatives Analysis is evaluating lower cost options to implement an EHR system, as its initial special project report indicates the cost is over $386 million.

DSH requests the following positions and resources to complete Stages 3 and 4 of the Project Approval Lifecycle:

1. **One Data Processing Manager IV** to serve as project manager to track and manage all EHR project readiness and governance efforts.
2. **One Data Processing Manager II** to serve as contract manager to coordinate among control agencies, DSH legal EHR experts, and project planning team members to ensure the solicitation development, selection, and award is properly planned and executed.
3. **One Health Program Specialist I** to implement organizational readiness activities to ensure the billing functions are integrated effectively with the clinical goals of the project.
4. **One Attorney III** to serve as a legal expert to ensure all HIPAA, privacy, and contractual considerations and requirements are addressed.
5. **Contract Resources** of $500,000 one-time to hire EHR implementation consultants. These consultants will focus on organizational readiness, provide guidance based on market research and contract preparation, and serve as subject matter experts, soliciting and incorporating input from DSH clinicians.

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

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

1. Please provide a brief overview of this proposal.

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 19, 2018
9:30 a.m., or Upon Adjournment of Floor Session
Room 4203, State Capitol

Consultants: Theresa Pena and 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.

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 $268.9 million (no General Fund) for CSD for 2018-19. Below is a summary of the Governor's proposed funding for 2017-18 and 2018-19:

Funding for Dept. of Community Services and Development - 4700	
Funding Source	**FFY 2017**
Low Income Home Energy Assistance Program	$170.8
Community Services Block Grant	$62.9
Dept. of Energy Weatherization Assistance Program	$6.2
Greenhouse Gas Reduction Fund [1/]	$18.0

Funding for Dept. of Community Services and Development - 4700	
Funding Source	**FFY 2018** [2/]
Low Income Home Energy Assistance Program	$159.2
Community Services Block Grant	$30.1
Dept. of Energy Weatherization Assistance Program	-
Greenhouse Gas Reduction Fund [3/]	-

Dollars in Millions

Footnote 1: $18 million in LIWP Funding for the 2017-18 State Fiscal Year
Footnote 2: 2018 Funding was just passed 4/23/18. CSD doesn't have official amounts. Funding received to date.
Footnote 3: GGRF reflects funding for the 2018-19 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. There is still much uncertainty about whether Congress will adopt this budget.

LIWP Update. Last year, there was some concern expressed about CSD's new Regional Administrator approach for LIWP by various stakeholders; in particular, it was pointed out that contractors located in the geographic region to which they were applying were not given proper consideration. In response, the Legislature directed CSD to prioritize existing ties to local communities and give preference to organizations with demonstrated performance outcomes in future procurements. CSD was also required to provide quarterly briefings on LIWP to legislative staff. The department published its first report to the Legislature in March 2018.

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

Questions.

1. Please provide an update on current funding levels and any new or significant developments.

2. Please provide a brief update on LIWP.

Issue 2: Budget Change Proposal: Low-Income Weatherization Program Reappropriation

Governor's Proposal. The Administration requests reappropriation of any unexpected balances of 2015-16 local assistance appropriations received from the Greenhouse Gas Reduction Fund (GGRF) to be available for encumbrance until the end of 2018-19, and available for liquidation until the end of 2018-2019. 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.

Launch of the LIWP 2015-16 Single-Family program was delayed following protests to the competitive bid process identifying Regional Administrator awardees. Due to this delay, contracts were not finalized until June 2017. When factoring in ramp-up activities such as the renegotiation of project implementation plans, implementation of outreach strategies, and seasonal factors during winter months that limit project completions, liquidation of all the funds by the end of 2017-18 seems unrealistic. If the reappropriation authority is not granted, CSD anticipates reverting a total of $57 million in GGRF.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

0530 – HEALTH AND HUMAN SERVICES AGENCY, OFFICE OF SYSTEMS INTEGRATION
4260 – DEPARTMENT OF HEALTH CARE SERVICES
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 of human services projects for the Department of Health Care Services (DHCS) and 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) in July 2016. The existing prime vendor contract ended on March 31, 2018, and OSI is conducting a competitive procurement to award a new prime vendor contract for M&O.

Child Welfare Services-California Automated Response and Engagement System (CWS-CARES). The CWS-CARES 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-CARES Project

to replace the current Child Welfare Services/Case Management System (CWS/CMS). The CWS-CARES Project will use an Agile procurement and design/development approach, where a 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 completed in 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 welfare-to-work (WTW) exemptions and sanctions. WDTIP is the interface system within the existing county SAWS consortia.

Medi-Cal Eligibility Data System (MEDS) Modernization. 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, Every Woman Counts, the Child Health and Disability Prevention Program, the Breast and Cervical Cancer Treatment Program, the Family Planning Access Care and Treatment Program, 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. OSI is currently leading a multi-departmental planning effort to modernize MEDS to more efficiently meet the eligibility needs of the state's health and human services programs, as well as comply with state and federal requirements.

Electronic Women, Infants, and Children (eWIC) Management Information Project (MIS). The Women, Infants, and Children (WIC) program is a federally-funded nutrition education and supplemental food program established in 1972. California's WIC Program is administered by the Department of Public Health, which contracts with 83 local agencies in 58 counties to provide WIC services at 637 sites and serves approximately 1.1 million participants each month. The federal Healthy, Hunger-Free Kids Act of 2010 requires all states to migrate from a WIC paper-based food benefits delivery system to an EBT system by 2020. DPH indicates the current WIC MIS is outdated and not EBT-compliant and received both federal and state approvals to begin the procurement to solicit bids and contract for the services of a design, development, and implementation of a systems integrator. DPH has contracted with OSI to leverage California's EBT Services Contract to automate the issuance of WIC food benefits via the California EBT system.

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

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

Budget Issue. CHHSA's Office of Systems Integration (OSI), DHCS, and DSS request seven positions (four positions for OSI, three positions for DSS) and expenditure authority of $7.9 million ($787,000 General Fund, $6.6 million federal funds, and $426,000 reimbursements) in 2018-19. If approved, these resources would continue the multi-departmental 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 (CHHSA-OSI)		
Fund Source	**2018-19**	**2019-20**
9745 – CHHS Automation Fund	$7,350,000	$-
Total Funding Request:	**$7,350,000**	**$-**
Total Requested Positions:	**4.0**	**0.0**

Program Funding Request Summary (DHCS)		
Fund Source	**2018-19**	**2019-20**
0001 – General Fund	$740,000	$-
0890 – Federal Trust Fund	$6,664,000	$-
Total Funding Request:	**$7,404,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Program Funding Request Summary (DSS)		
Fund Source	**2018-19**	**2019-20**
0001 – General Fund	$47,000	$-
0995 – Reimbursements	$426,000	$-
Total Funding Request:	**$473,000**	**$-**
Total Requested Positions:	**3.0**	**0.0**

Background. DHCS serves as the single state agency responsible for the administration of Medi-Cal, California's state Medicaid program. Medi-Cal provides medical, dental, mental health, substance use disorder services, and long-term care to more than 13 million low-income Californians. Eligibility for Medi-Cal is determined by local county welfare and public health agencies. Since 1983, DHCS has used the current MEDS system for a variety of eligibility and reporting functions for the Medi-Cal program. Specifically, MEDS captures beneficiary information from the three county Statewide Automated Welfare System (SAWS) consortia (LEADER, Consortium IV and CalWORKs Information Network), state and federal partners, and Covered California.

In addition to its role maintaining eligibility information for Medi-Cal, MEDS serves as the "system of record" to determine eligibility for many of the state's health and human services programs. DHCS utilizes MEDS data for determinations regarding its Every Woman Counts, Child Health and Disability Prevention, Breast and Cervical Cancer Treatment, and Family Planning Access Care and Treatment programs. The Department of Social Services (DSS) leverages MEDS data for eligibility determinations and administration of CalWORKs, CalFresh, Cash Aid Program for Immigrants, In-Home Supportive Services, and Refugee Cash Assistance. Local governments also use MEDS data, specifically for the

County Medical Services Program and the County Welfare and Tribal Temporary Assistance for Needy Families. Access to MEDS is provided to more than 35,000 end users and DHCS must ensure that the system and its end users protect confidential beneficiary information in accordance with state and federal security and privacy requirements.

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

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

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

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

2014-15

- Procured Project Management Support consultant services
- Performed initial business rules extraction
- Purchased and installed business rules extraction software
- Procured Business, Information, and Technology Enterprise Architects consulting services
- On-boarded 16 new state staff

- Obtained approval of Planning Advanced Planning Document Update (PAPDU) for federal year 2015 funding participation

2015-16

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

2016-17

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

2017-18

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

The 2017 Budget Act extended 16 positions for a two-year period for project activities related to the requirements of completing Stages 3 and 4 of the PAL process. OSI, DHCS, and DSS report the 2017-18 activities focused primarily on the first planned conversion of existing MEDS data, which consists of three Health Insurance System (HIS) data files currently maintained using outdated Virtual Storage Access Method (VSAM) technology. The HIS data component currently stores information about other health coverage, ensuring Medi-Cal is the payer of last resort. Utilizing this approach and focusing on the HIS data component will provide the opportunity to pilot the proposed use of modern Identity Access Management (IdAM), Application Programming Interface (API), and Master Data Management (MDM) principles, methods, and tools as part of the modernization solution. According to OSI, DHCS, and DSS, the pilot will be able to determine the effectiveness of proceeding with these modernization methods and tools for other components of the MEDS database and system environment, while avoiding negative impacts to current functioning of the MEDS system during the conversion.

OSI, DHCS, and DSS request seven positions and expenditure authority of $7.9 million ($787,000 General Fund, $6.6 million federal funds, and $426,000 reimbursements) in 2018-19. If approved, the positions and resources would be allocated as follows:

OSI Core Project Team Support Staff

- **One Executive Assistant** would support the OSI Deputy Director and MEDS Modernization Project Director with administrative tasks, such as scheduling, preparing agendas, minute taking, document printing and distribution.
- **One Management Services Technician** would provide project support services and would provide dedicated administrative and clerical support to the entire project staff.

OSI Direct Administrative Services Legal and IT Staff

- **0.5 Attorney III** position would support increased workload related to procurements and changes in planning documents. This request would augment an existing 0.5 Attorney III position, resulting in combined workload for one full-time Attorney III.
- **0.5 Staff Information Security Analyst** would serve as CHHSA Information Security Officer (ISO) and provide interagency support and oversight for compliance with project security requirements.
- **One Associate Information Systems Analyst** would provide IT support for project staff and contractors for desktops, networks, and maintenance.

DSS MEDS Modernization Project Team Members

- **One Staff Services Manager I (Specialist)** would serve as the DSS program subject matter expert, representing the programmatic needs of all DSS programs and divisions during the planning and implementation process, and making recommendations to executive management for future policy action and process implementation.
- **One Systems Software Specialist III (Technical)** would participate in the technical aspects of the MEDS Modernization project, including all DD&I modules activities, and provide technical expertise in DSS use of and need for MEDS access.
- **One Systems Software Specialist II (Technical)** would participate in the technical aspects of the MEDS Modernization project, including technical design, data conversion, and cleanup strategies and efforts.

Hardware and Software Services

- **$1.2 million** for the purchase of cloud-based hardware and software services, including hardware cloud fees, a testing software suite, modeling tool software, agile project management software, and office equipment.

Operating Expenses and Equipment

- **$1 million** for operating expenses and equipment, including general expenses, printing, communications, travel, and training, for both direct staff and contractors.

Contract Services

- **$81,000 for Program Management Support Services** to provide assistance with overall project planning, project management, scheduling, transition planning and strategies.
- **$1.2 million for Technical Support Services** to provide technical consulting, data clean up and conversion, and stakeholder and change management.
- **$3.2 million for Software Customization Services** to configure and customize software, provide testing services consultants to assist in the development, maintenance, and implementation of the project's test plans.

- **$352,000 for Project Oversight Services** for CDT to provide independent project oversight functions, including Independent Verification and Validation (IV&V) consultants to verify and validate that project and contractor products adhere to industry standards and meet other requirements and specifications.

The following is a detailed description, provided by OSI, DHCS, and DSS, of the total allocation of ongoing positions and resources approved in the 2017 Budget Act and the new requested positions and resources contained in this budget request:

BUDGET	FY 2017-18 Budget	FY 2018-19 Proposed Budget	BCP Request
OSI Costs			
Personnel Services	$1,806,000	$2,313,000	$507,000
OE&E	$179,000	$1,679,000	$1,500,000
Consultant Services	$2,915,000	$7,092,000	$4,177,000
Facilities	$597,000	$597,000	$-
Hardware/Software	$-	$1,166,000	$1,166,000
OSI MEDS Project Total	**$5,497,000**	**$12,847,000**	**$7,350,000**
CDSS Costs			
Personnel Services	$-	$371,000	$371,000
OE&E	$-	$102,000	$102,000
CDSS MEDS Project Total	**$-**	**$473,000**	**$473,000**
DHCS Costs			
Personnel Services	$292,000	$321,000	$29,000
OE&E	$640,000	$65,000	($575,000)
Consultant Services	$224,000	$224,000	$-
SME	$-	$600,000	$600,000
Transfer to CDSS	[$224,000]	[$426,000]	[$426,000]
Transfer to OSI	[$5,497,000]	[$12,847,000]	[$7,350,000]
DHCS MEDS Project Total	**$1,156,000**	**$1,210,000**	**$54,000**
Total Project Budget	**$6,653,000**	**$14,530,000**	**$7,877,000**
TOTAL DHCS REQUEST			**$7,404,000**

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

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

1. Please provide a brief overview of this proposal.

Issue 3: Budget Change Proposal: HIPAA Compliance and Technical Assistance

Budget Issue. CHHSA (CalOHII) requests one position and reimbursement expenditure authority of $128,000 annually. If approved, these resources would allow CalOHII to continue its oversight of statewide HIPAA compliance activities.

Program Funding Request Summary (CHHSA)		
Fund Source	**2018-19**	**2019-20***
0995 – Reimbursements	$128,000	$128,000
Total Funding Request:	**$128,000**	**$128,000**
Total Requested Positions:	**1.0**	**1.0**

*Positions and resources ongoing after 2019-20.

Background. The California Office of Health Information Integrity (CalOHII) within CHHSA provides statewide guidance, planning, and technical assistance to state departments and agencies for compliance with the Health Insurance Portability and Accountability Act (HIPAA). HIPAA, implemented in 1996, was intended to allow for portability and continuity of an individual's health care coverage by imposing significant administrative simplification and standardization requirements on health care entities, and strict security standards for protected health information. CalOHII was established in 2001 with the following responsibilities and authority:

- Provide statewide leadership, coordination, policy formulation, direction, and oversight responsibilities for HIPAA implementation by impacted state departments.
- Establish policy, provide direction to state entities, monitor progress, and report on HIPAA implementation efforts.
- Determine which provisions of state law concerning personal health information are preempted by HIPAA for state agencies.

Covered Entities, Business Associates, and Impacted State Departments. HIPAA administrative simplification and security rules apply to certain individuals or organizations known as covered entities or business associates. According to the U.S. Department of Health and Human Services (HHS), covered entities include the following:

1. Health care providers including physicians, clinics, psychologists, dentists, chiropractors, nursing homes, and pharmacies that transmit HIPAA-protected information in an electronic format.
2. Health plans including commercial health care service plans, health insurers, group health plans, and public health care programs, such as Medicare, Medicaid, and military or veteran's health care programs.
3. Health care clearinghouses that process nonstandard information they receive from another entity into a standard electronic format or data content, or vice versa.

According to HHS, a business associate is a person or entity that performs certain functions or activities that involve the use or disclosure of protected health information on behalf of, or provides services to, a covered entity. Business associate functions and activities include: claims processing or administration; data analysis, processing or administration; utilization review; quality assurance; billing; benefit management; practice management; and repricing. Business associate services may include: legal;

actuarial; accounting; consulting; data aggregation; management; administrative; accreditation; and financial. Examples of business associates are: third party administrators that assist a health plan with claims processing, accounting firms whose services to a health care provider involve access to protected health information, attorneys whose legal services to a health plan involve access to protected health information, consultants that perform utilization reviews for a hospital, health care clearinghouses that translates a claim from a non-standard format into a standard transaction on behalf of a health care provider and forwards the processed transaction to a payer, independent medical transcriptionists that provide transcription services to a physician, pharmacy benefits managers that manage a health plan's pharmacist network.

CalOHII is responsible for conducting periodic reviews of state departments, agencies, and other organizations that are considered covered entities or business associates with administrative and security responsibilities under HIPAA. CalOHII also evaluates whether state entities are impacted in other ways by state or federal laws and regulations related to HIPAA or generally to the privacy and security of protected health information. CalOHII completed its most recent statewide HIPAA assessment in 2017 and determined the state's covered entities, business associates, and impacted entities are as follows:

Covered Entities and Business Associates	Impacted State Entities
CA Correctional Health Care Services	Board of Behavioral Sciences
Dept. of Aging	Board of Chiropractic Examiners
Dept. of Corrections and Rehabilitation	Board of Pharmacy
Dept. of Developmental Services	Board of Pilot Commissioners for the Bays
Dept. of Forestry and Fire Protection	Board of Podiatric Medicine
Dept. of General Services	Board of Psychology
Dept. of Health Care Services	Board of Registered Nursing
Dept. of Public Health	Board of Vocational Nursing and Psychiatric Technician Examiners
Dept. of Social Services	
Dept. of State Hospitals	Bureau of Medical Cannabis Regulation
Dept. of Technology	CA Acupuncture Board
Dept. of Veterans Affairs	CA Board of Accountancy
Emergency Medical Services Authority	CA Committee on Employment of People with Disabilities
Office of Systems Integration	
Public Employees' Retirement System	CA Highway Patrol (CHP)
State Controller's Office	CA State Athletic Commission
	CA Student Aid Commission
	Council on Mentally Ill Offenders
	Covered CA
	Dental Board of CA
	Dental Hygiene Committee of CA
	Department of Consumer Affairs
	Department of Industrial Relations
	Department of Insurance
	Department of Managed Health Care
	Department of Motor Vehicles
	Department of Parks and Recreation
	Department of Pesticide Regulation

	Department of Rehabilitation Employment Development Department Health and Human Services Agency Medical Board of CA Mental Health Services Oversight & Accountability Commission Naturopathic Medicine Committee Office of Health Information Integrity (CalOHII) Office of Law Enforcement Support Office of Statewide Health Planning and Development Office of the Inspector General Office of the Patient Advocate Office of the State Public Defender Osteopathic Medical Board Physical Therapy Board of CA Respiratory Care Board Speech-Language Pathology & Audiology and Hearing Aid Dispensers Board State Board of Optometry State Personnel Board State Teachers' Retirement System Victim Compensation Board

CalOHII Significantly Restructured After Zero-Base Review. The 2016 Budget Act significantly restructured CalOHII, reducing its program staff by 11.5 positions and its annual budget by approximately $1.5 million. After a zero-base review of the CalOHII budget and program needs, CHHSA determined only four positions (three permanent and one limited-term) were needed to continue to focus on monitoring of departments' HIPAA compliance and periodic updates to statewide HIPAA policy.

CalOHII requests one Staff Services Manager I (SSM I) position and reimbursement expenditure authority of $128,000 annually. According to CalOHII, the SSM I position, which was the position approved on a limited-term basis during its 2016 restructuring, will continue to perform administrative functions, manage federal and state legislative analyses, conduct statewide HIPAA entity assessments, update the State Health Information Policy Manual, and update CalOHII HIPAA compliance tools.

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

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

1. Please provide a brief overview of this proposal.

Issue 4: Budget Change Proposal: Rightsizing Office of Law Enforcement Support

Budget Issue. CHHSA's Office of Law Enforcement Support (OLES) requests one new position, reclassification of nine existing positions, and General Fund expenditure authority of $686,000 in 2018-19 and $621,000 annually thereafter. If approved, these resources would allow OLES to recruit appropriate staff to provide monitoring and oversight of investigations conducted by the Department of State Hospitals (DSH) and Department of Developmental Services (DDS).

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$686,000	$621,000
Total Funding Request:	**$686,000**	**$621,000**
Total Requested Positions:**	**1.0**	**1.0**

* Positions and resources ongoing after 2019-20.

** The position request includes reclassifications of nine existing positions to classifications with higher total compensation.

Background. In July 2013, the California State Auditor released Report 2012-107: "*Developmental Centers - Poor‑Quality Investigations, Outdated Policies, Leadership and Staffing Problems, and Untimely Licensing Reviews Put Residents at Risk*". In the report, auditors reviewed 48 investigations conducted by the Office of Protective Services (OPS) at DDS, which is responsible for the department's response to alleged abuse of individuals with developmental disabilities residing in one of the state's developmental centers. Auditors discovered OPS often did not collect written declarations from witnesses and suspects, take photographs of crime scenes or victims, and did not always attempt to interview alleged victims, particularly those who were said to be nonverbal.

In response to concerns raised by the audit and additional concerns regarding investigations at DSH, the Office of Law Enforcement Support (OLES) was established in CHHSA in 2014 to provide monitoring and oversight of peace officers serving at DSH and DDS. The Budget Act of 2014 provided six permanent positions and directed OLES to develop training protocols, policies, and procedures for peace officers operating at DSH and DDS, as well as to develop recommendations to further improve the quality and stability of law enforcement and investigative functions at both departments. These activities were consistent with the establishment of OLES as a Peace Officer Standards and Training (POST) agency, which sets minimum selection and training standards for California law enforcement officers.

Law Enforcement Improvement Plan Recommendations and OLES Expansion. In March 2015, OLES released its recommendations in a report titled "*Office of Law Enforcement Support – Plan to Improve Law Enforcement in California's State Hospitals and Developmental Centers*". OLES placed several law enforcement administrators from outside agencies at DSH and DDS to evaluate law enforcement practices and identify critical deficiencies. Based on these administrators' observations, OLES required updated policies for investigators and staff, implemented systems changes to track staff and management adherence to the updated policies, and indicated it would continue to monitor the two departments to ensure accountability and a permanent change in cultural behavior. The report also recommended the following changes to the Professional Standards Section within OLES:

- Establish a Special Investigations Unit to monitor critical incidents, such as those involving sexual assault or other major assaults, and assist with complex investigations involving employee misconduct at state hospitals and developmental centers.
- Establish an Investigations Analysis Unit to provide quality control and analyses of administrative cases to evaluate policy and procedures and ensure proper re-training is provided, where applicable.
- Hire Vertical Advocates, employment advocacy and prosecution team attorneys assigned to a regional location, to advise OLES staff on the scope and thoroughness needed for each investigation and discuss investigation findings and disciplinary decisions with facility executive directors and department executives.
- Conduct independent, comprehensive staffing studies of law enforcement duties and needs at DSH and DDS to analyze how law enforcement staff is deployed and determine proper staffing levels and appropriate law enforcement duties.

The OLES report was followed by a budget request for 15 positions and General Fund expenditure authority of $2 million to implement the report's recommendations. The 15 positions included eight Investigator I positions (four in the Special Investigations Unit and four in the Investigations Analysis Unit) and one Supervising Special Investigator II to manage these new units in the section. Investigators and Supervising Special Investigators are expected to complete training programs and be certified by the state's Commission on Peace Officer Standards and Training (POST).

OLES requests one Attorney IV position, reclassification of seven Investigator I and two Supervising Investigator II positions, and General Fund expenditure authority of $686,000 in 2018-19 and $621,000 annually thereafter. The Attorney IV position would manage legal workload for the office's Central Region, which was previously being met with contracted experts from the Office of the Inspector General. The seven Investigator I positions would be reclassified as Special Agents and the two Supervising Investigator II positions would be reclassified as Senior Special Agents. According to OLES, these reclassifications are necessary for the following reasons:

- The Investigator classification series requires POST certification.
- OLES is not a POST organization and POST personnel cannot advance credentials while employed by OLES, creating difficulties in recruiting and retaining highly qualified candidates.
- The Special Agent series is a non-POST classification and is typical of internal affairs organizations in other state departments, which is more consistent with the new organizational structure and mission of OLES.
- The Special Agent series is exempt and is specific to investigations of employee misconduct, which will allow agents the autonomy and legal authority to investigate any other classification, including those in Bargaining Unit 7 covering the Investigator classification.

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

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

1. Please provide a brief overview of this proposal.

Issue 5: Spring Finance Letter: eWIC MIS Project Expenditure Increase

Spring Finance Letter. CHHSA (OSI) is requesting expenditure authority from the California Health and Human Services (CHHS) Automation Fund of $4.8 million in 2018-19, $9.1 million in 2019-20, and $6.2 million in 2020-21. If approved, these resources would allow OSI to continue implementation of the Electronic Women, Infants, and Children Management Information System (eWIC MIS), an electronic benefits transfer (EBT) system for the participants in California's WIC program.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
9745 – CHHS Automation Fund**	$4,808,000	$9,133,000
Total Funding Request:	**$4,808,000**	**$9,133,000**

* Additional fiscal year resources requested: 2020-21: $6,219,000

** The CHHS Automation Fund receives transfers from the Federal Trust Fund for this project.

Background. The United States Department of Agriculture's Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is a federally-funded nutrition education and supplemental food program established in 1972. DPH administers the WIC Program in California, contracting with 83 local agencies in 58 counties to provide WIC services at 637 sites, serving approximately 1.1 million participants each month.

The federal Healthy, Hunger-Free Kids Act of 2010 requires all states to migrate from a WIC paper-based food benefits delivery system to an EBT system by 2020. DPH indicates the current WIC MIS is outdated and not EBT-compliant and received both federal and state approvals to begin the procurement to solicit bids and contract for the services of a design, development, and implementation of a systems integrator. DPH also contracted with OSI to leverage California's EBT Services Contract to automate the issuance of WIC food benefits via the California EBT system.

OSI is requesting expenditure authority from the CHHS Automation Fund of $4.8 million in 2018-19, $9.1 million in 2019-20, and $6.2 million in 2020-21. According to OSI, this additional funding, which is provided by transfers of federal funds to the CHHS Automation Fund for this project, would align to the budgeted project contract costs to continue implementation of the eWIC MIS. The contract activities are as follows:

- **Consultant Support** – These resources would fund a Master Project Scheduler at the project site to develop and maintain the project schedule, advise management, track and measure project progress, and forecast potential schedule risks and issues.
- **Systems Integrator (SI)** – These resources would fund integration activities including configuration, system transfer, training, testing, implementation, and support. According to OSI, these costs are higher than originally estimated due to the large caseload of California's WIC participants, the large number of end users and the short time-frame for completion of a pilot and statewide implementation of EBT functionality by the federal deadline of 2020.
- **Organizational Change Management (OCM)** – These resources would fund contract staff to create, implement, and manage a comprehensive plan to successfully implement the new eWIC MIS and ensure users adopt the new processes.

- **Cost Per Case Month (CPCM)** – These resources would fund the transactional cost for the EBT service provider to issue WIC benefits. The provider bills for these services on a monthly basis based on the number of WIC cases.
- **Information Technology Project Oversight and Consulting (IPOC)** – These resources would fund consultants to review and provide feedback on project approval requests and project planning documents, provide project status reports, escalate project risks and issues, and assist customers in developing appropriate risk and issue mitigation strategies.

OSI has provided the following detail regarding the differences in funding for the project's current consulting budget and the additional costs contained within this budget request:

	2018-19	2019-20	2020-21	Total
Consulting Budget (*Current*)	$4,507,000	$3,754,000	$2,368,000	$10,629,000
Consulting Contracts (*Proposed*)				
Master Project Scheduler	$185,000	$185,000	$139,000	$508,000
MIS System Integrator	$8,298,000	$9,681,000	$8,364,000	$26,343,000
OCM	$719,000	$707,000	$-	$1,426,000
Cost per Case Month	$-	$2,202,000	$-	$2,202,000
Dept. of Technology (Oversight)	$113,000	$112,000	$84,000	$310,000
TOTAL DIFFERENCE (BCP REQUEST)	**$4,808,000**	**$9,134,000**	**$6,219,000**	**$20,160,000**

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

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

1. Please provide a brief overview of this proposal.

Issue 6: Overview: Child Welfare Services – California Automated Response and Engagement System (CWS-CARES) Update

Budget issue. The Governor's budget includes $176.5 million total funds ($88.3 million General Fund) for the CWS-CARES Project in the current year and $102.6 million total funds ($51.3 million General Fund).

2017-18 CWS-CARES Budget/Expenditure Report Summary

OSI Spending Authority Budget Item	2017-18 Budget	Actual Expenditures	Projected Expenditures
Personnel Services	11,883,786	3,352,975	6,006,865
Other OE&E	2,588,822	784,985	1,950,278
Data Center Services	650,000	172,989	467,678
Facilities	1,421,345	778,958	642,387
Contract Services	65,751,791	15,913,425	21,920,852
Hardware & Software	4,116,197	1,400,384	2,715,813
Enterprise Services	4,191,896	509,118	3,682,778
OSI Spending Authority Total	**90,603,837**	**22,912,834**	**37,386,651**

CDSS Local Assistance Budget Item	2017-18 Budget	Actual Expenditures	Projected Expenditures
Contract Services	2,284,820	291,399	439,715
Other OE&E	15,234,312	-	2,072,801
County Participation Costs	68,338,542	656,905	2,000,000
CDSS Local Assistance Total	**85,857,674**	**948,304**	**4,512,516**

CDSS State Operations Budget Item	2017-18 Budget	Actual Expenditures	Projected Expenditures
Personnel Services	1,930,359	955,993	974,366
Facilities	568,000	31,236	536,764
Other OE&E	224,497	16,114	208,383
CDSS State Operations Total	**2,722,856**	**1,003,343**	**1,719,513**
CWS-NS Project Total	**179,184,367**	**24,864,481**	**43,618,680**

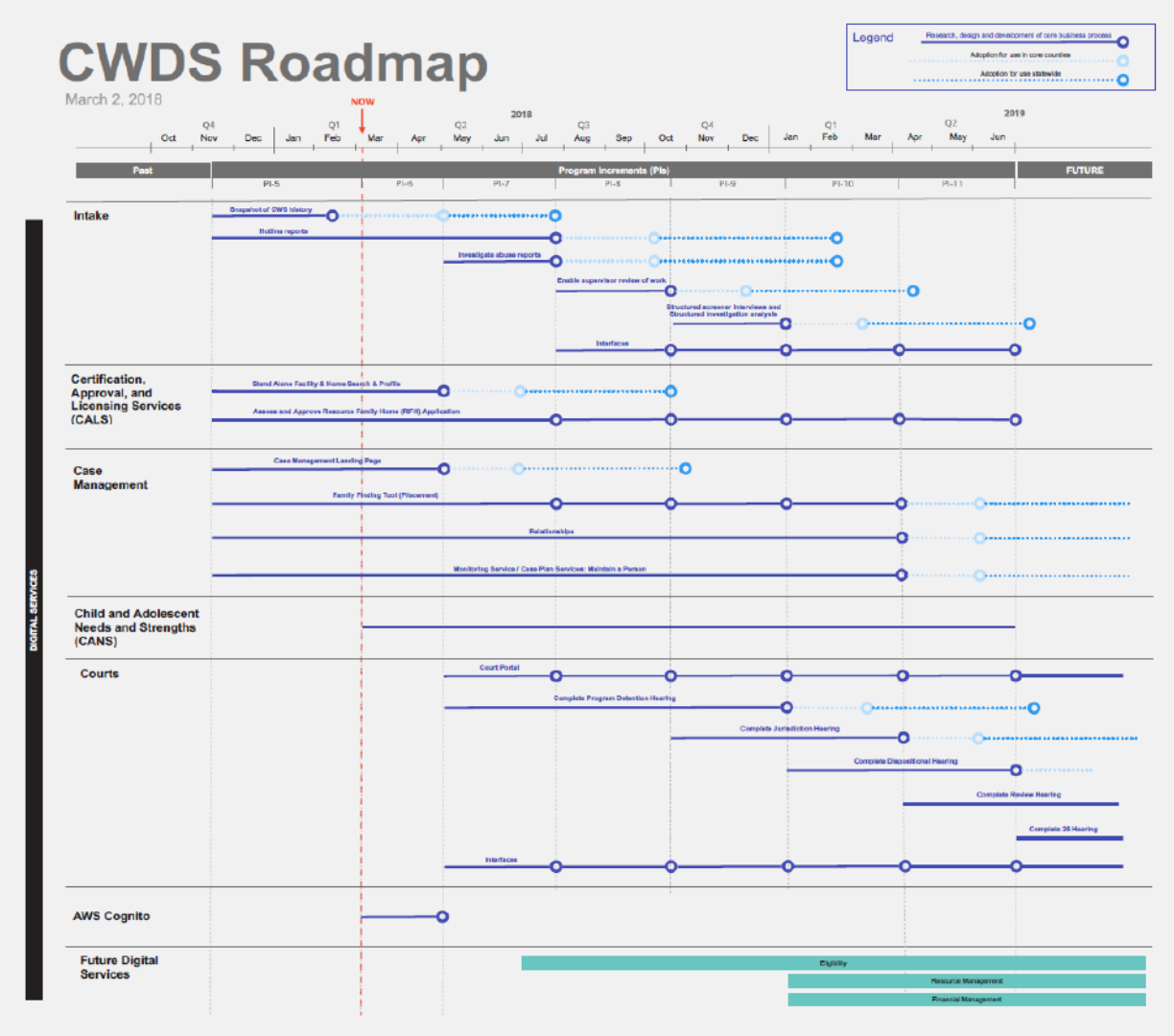
Background. Child Welfare Services/Case Management System (CWS/CMS) was fully implemented and transitioned to its operational phase in 1998. DSS has overall responsibility for the system, including providing project and program direction to OSI. OSI provides information technology expertise and is responsible 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-CARES Project (formerly 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-CARES 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-CARES 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 new digital services are also being designed around the principles of human/user centered design and free/open source software (FOSS).

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-CARES system because of its reduced maintenance and operations costs.

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) created a bridge between the legacy system and the new system, and establishes a foundation for future work across the entire platform. R1 was successfully launched in March of 2017. In February 2018, Release 2 (R2), an at-a-glance view of key elements of case history known as the Snapshot, was launched. Release 3 (R3) will occur in May of 2018 and add additional search criteria for Snapshot, and several new case management elements, and certification, approval, and licensing services.

CWDS, in partnership with the Department of Technology, continue to work together on a refresh of the Agile Development Pre-Qualified Vendor Pool (ADPQ). Currently, the vendor pool has expanded to include 24 vendors.

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 continuing to adapt to the Agile approach, and what you have learned about the Agile process in the past year.

Issue 7: Oversight: SAWS Single System

Budget Issue. The budget includes approximately $314 million ($114 million General Fund) for Local Assistance costs in SAWS in 2017-18 and $307 million ($113 million General Fund) in 2018-19.

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.

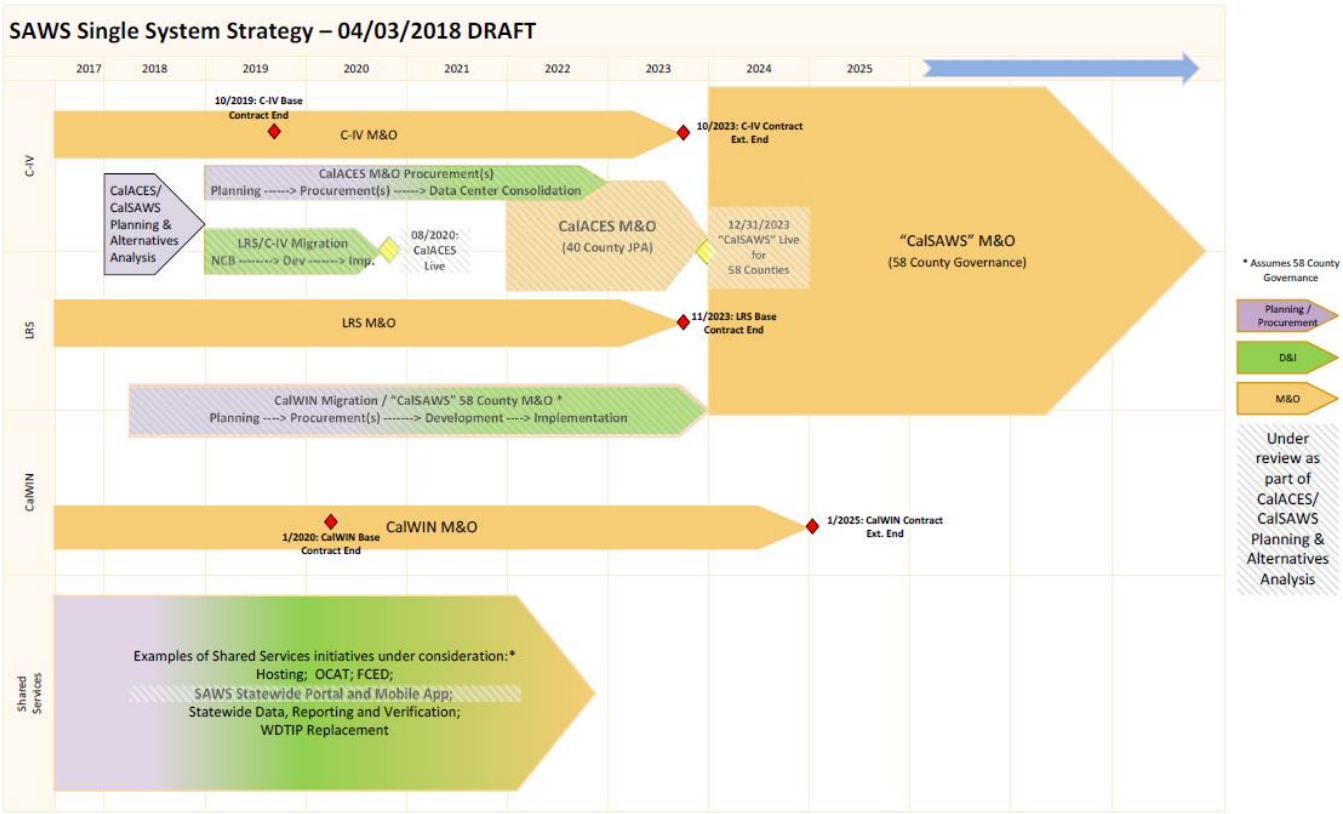
C-IV Migration into LRS. In September 2015, Los Angeles County began to rollout LRS, their new eligibility determination system. As of November 2016, the LRS Project has successfully completed countywide implementation for the Department of Public Social Services and the Department of Children and Family 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. Both the LRS and C-IV projects negotiated the CalACES migration contract and the CalACES 40 county Joint Powers Authority (JPA) in September 2017. Migration design, development and implementation activities began in January 2018. CalACES is scheduled to go-live in all 40 counties by April 2020 and to complete by August 2020.

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 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, CalWIN and CalACES must undergo a requirements and gap analysis to identify functionality that will be needed in CalSAWS, development of a database consolidation must occur, and finally, the procurement of design, development and implementation services is needed. To ensure alignment of technical architecture and policy implementation, development of a 58-county collaborative change management process will begin during 2017-18, and the SAWS single system strategy still be implemented through procurements within a new county-based governance structure with oversight by state and federal partners.

In January 2018, FNS and CMS approved an Advance Planning Document which extended planning activities through December 2018, for the CalACES migration and expanded those planning activities to include CalWIN. Federal partners have indicated support for California's phased approach to move to a single SAWS, but have requested a more in depth, comprehensive planning process, using independent consultants, be completed prior to beginning the CalACES migration activities.

Below is a timeline for implementing the SAWS single system:



Staff Comment and Recommendation. No action required. Item included for oversight and discussion purposes.

Questions.

1. Please discuss the current status of the SAWS system, and activities for shifting to a single system.

5180 DEPARTMENT OF SOCIAL SERVICES – DISASTER SERVICES BUREAU

Issue 1: Budget Change Proposal: Resources for Disaster Preparedness

Governor's Proposal. The Administration requests $428,000 General Fund in 2017-18 and $397,000 General Fund ongoing for three permanent positions (one Staff Services Manager I and two Associate Governmental Program Analysts) to support catastrophic planning and strengthen California's mass care and shelter capabilities.

Background. DSS has been assigned by the California Governor's Office of Emergency Services (Cal OES) in the State Emergency Plan as the lead for mass care and shelter in California. DSS's mass care and shelter responsibilities include: developing, maintaining, and exercising plans and procedures to support local government; facilitating the development, implementation, and maintenance of the Emergency Function Six Mass Care and Shelter Annex; recruiting, training, and deploying the Volunteer Emergency Services Team, and members of the state employee workforce; coordinating state resources in support of local government and the Red Cross for mass care and shelter responsibilities; administering the Emergency Food Assistance Program, the CalFresh or Disaster Supplemental Nutritional Assistance Program to meet temporary nutritional needs following a disaster; and providing language translation services when requested by the State Operations Center.

In the last five years, over 500 evacuation shelters have been operated across California in response to emergency incidents, including seven Presidentially-declared disasters within just the last three years. Recent disasters such as the Oroville Auxiliary Spillway Incident and the 2017 wildfires have expanded the workload for the department and highlighted the need for DSS to increase its capacity.

The requested resources will allow the Disaster Services Bureau to bifurcate into two units: the Field Operations Support Unit and the Program and Project Support Unit. Currently, the Bureau and all of its activities are supported by 10 permanent positions.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please briefly summarize the proposal.

5180 DEPARTMENT OF SOCIAL SERVICES – STATE HEARINGS DIVISION

Issue 2: Overview: State Hearings Division (SHD)

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 maximum 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) and federal Medicaid Managed Care rule changes affecting MediCal Scope of Benefit cases. The overall SHD total has increased from 88,214 hearing requests and 18,240 decisions in 2012-13 to 91,938 hearing requests and 25,943 written decisions by the end of FY 2016-17. Growth of hearing requests requiring hearings and written decisions has increased an average of 22 percent over the past three fiscal years, and exceeds the current resource capacity to timely process cases and avoid monetary penalties for late decisions.

As a result of the allocation of permanent general jurisdiction resources in 2012-13 and ACA resources in 2014-15, the SHD achieved a significant drop in penalties from $4.4 million in 2012-13 to $188,135 for FY 2015-16. However, due to the overall 22 percent increase in hearings requiring written decisions, penalties nearly doubled to $387,722 for FY 2016-17. The penalty rate per day of a late decision is currently $60.00 for Medi-Cal, $10.00 for CalWORKs, $7.50 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	66	4	$55.00
CalWORKs	90	153	63	$1,539.00
IHSS	90	149	53	$3,845.00
Medi-Cal	90	152	59	$4,316.00

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	$35,400	$4,300	$179,885	$168,137	$387,722

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 began testing these best practices in Yolo and San Diego in May 2017.

Staff Comment and Recommendation. No action needed. This is an informational item only.

Questions.

1. Please provide a brief program update and discuss caseload growth and potential growth in penalties.

Issue 3: Budget Change Proposal: Appeals Case Management System Implementation

Governor's Proposal. The Administration requests $188,000 General Fund ($493,000 Total Funds) for one permanent Staff Services Manager I, two Associate Governmental Program Analysts, and one Senior Information Systems Analyst to provide continued support for the development and implementation of the Appeals Case Management System (ACMS).

Background. The 2014 Budget Act approved four limited-term positions for the ACMS project. Project development for the ACMS began in August of 2017, with project implementation to begin in August of 2018 and maintenance and operations to begin in September 2018. However, the four positions expired in December 2017. The department considers the approval of these existing staff resources on an ongoing basis as necessary to complete the development and implementation of ACMS.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please briefly summarize the proposal.

Issue 4: Budget Change Proposal: Federal Medicaid Managed Care Rule Hearings and Increased Appeals Workload

Governor's Proposal. The Administration requests $1.2 million General Fund ($3.2 million Total Funds) in 2017-18 and $1.1 million General Fund ($3.1 million Total Funds) ongoing for 10 Administrative Law Judge II's and six Administrative Law Judge I's to process the increased workload associated with the implementation of the federal Medicaid Managed Care Final Rule and the increase in existing workload due primarily to the ongoing impact of the implementation of the Affordable Care Act (ACA).

Background. Under the federal Centers for Medicare and Medicaid Services (CMS) Final Rule, managed care plans that contract with the Department of Health Care Services (DHCS) will now be the first level of appeal for managed care case before asking for a state hearing. This rule change requires SHD to now review all of the managed care appeals for jurisdiction and conduct hearings and write decisions in all expedited appeals within three business days (under prior rules it was under 10 days).

The department points out that lack of adequate SHD staffing to address and implement the federal rule changes will result in delays in complying with timeliness requirements, which could increase penalties.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please briefly summarize the proposal.

5180 DEPARTMENT OF SOCIAL SERVICES - CALWORKS

Issue 5: Overview: CalWORKs

Governor's Proposal. The revised 2017-18 budget includes $5.0 billion in federal, state and local funds for the program, and estimates an average monthly caseload of 425,855 (a decline 5.6 percent from the previous estimate). The 2018-19 budget includes $4.8 billion in federal, state, and local funds for the program, and estimates an average monthly caseload of 400,777 families. Aside from a Home Visiting Initiative, which will be discussed later in this agenda, 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 2017-18.

CalWORKs Funding Sources

(Dollars in Millions)

	2017–18 Revised	2018–19 Proposed	Change From 2017–18 Amount	Change From 2017–18 Percent
Federal TANF block grant funds	$2,127	$1,938	–$189	–9%
State General Fund	455	552	97	21
Realignment and other county funds[a]	2,420	2,328	–92	–4
Totals	**$5,002**	**$4,819**	**–$183**	**–4%**

[a]Primarily various realignment funds, but also includes county share of grant payments, about $60 million.

TANF = Temporary Assistance for Needy Families.

(http://www.lao.ca.gov/Publications/Report/3757#CalWORKs)

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 2017-18 and FY 2018-19 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, $310.4 million will be available in 2017-18 and $388.0 million will be available in 2018-19.

Single Allocation. Another important source of state funding is the Single Allocation. 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. Counties have long been concerned 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. Last year, the Governor's Budget proposed to cut the Single Allocation by almost $250 million, which the Legislature partially restored by $108 million. The Legislature also directed the department and counties to work together to develop a new methodology.

The Governor's budget provides approximately $1.7 billion in funding the Single Allocation in 2018-19. This reflects an increase to the eligibility component of $187 million, inclusive of last year's legislative augmentation. The department and counties continue to have conversations about a new Single Allocation methodology and how that might impact the proposed funding in 2018-19, which counties are still concerned is not enough when considering the funding of other components in the Single Allocation and could have a negative impact.

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 around 500,000 families. During the recent recession the caseload grew, peaking at 585,000, but this was not anywhere close to the levels of the early 1990s. The caseload has declined each year since 2010-11. Over that time, the number of CalWORKs families has fallen by nearly 30 percent (about 160,000 families) to around 425,000 families in 2017-18. This is primarily due to the strong economy, and the decline is projected to continue for at least the next year.

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

[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.

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 reset 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 in 2015, which resulted in a penalty of $93 million, and in 2016, which resulted in a penalty of $8.8 million. The department disputed both penalties; the 2015 penalty was preliminarily reduced to $65.8 million in May 2017, with further action pending, and a resolution on the dispute for 2016 is currently pending. Overall, current penalty exposure is estimated to be $40.2 million.

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 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 two or more children under age six, 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 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.

CalWORKs Oversight and Accountability Review (Cal-OAR). SB 89 (Budget and Fiscal Review Committee), Chapter 24, Statutes of 2017, established a framework for a new performance measurement system for CalWORKs, to be known Cal-OAR. Under Cal-OAR, data on various performance indicators will be collected and published, and counties will regularly undergo self-assessment and develop system improvement plans with targets for the performance indicators. A workgroup convened by DSS in the fall of 2017 kicked off the initial phase of the project. A work plan is currently being developed, and the final process will be established by July 2019.

Statewide Fingerprint Imaging System (SFIS) Repeal. As part of the 2017 Budget, the Governor and Legislature agreed to discontinue the use of SFIS, or fingerprinting, for CalWORKs, which has long been a goal of advocates that would prefer a process parallel with the CalFresh program. In CalFresh, the fingerprinting requirement was repealed back in 2011. CalFresh verifies identity though the county file clearance process, which utilizes a number of existing state and federal databases.

As part of the repeal, it was agreed that a stakeholder process would be convened to consider possible automated, non-biometric identity verification methods that might take the place of SFIS. DSS was

required to consider how any new methods of identity verification would impact applicant or recipient experiences and make application and eligibility practices more efficient. DSS issued a report in the fall of 2017 which recommended an option that included the use of "Knowledge Based Authentification" (KBA) to verify identity for applicants applying remotely. However, in mid-March 2018, the Administration withdrew its KBA option and instead has indicated that it wishes to pursue an approach, through an All-County Letter (ACL), that would require a CalWORKs applicant applying remotely to come into the office to verify identify before issuing benefits. The proposed ACL has not yet been provided to legislative staff or other stakeholders.

The ability to apply remotely was enabled through SB 947 (Pan), Chapter 798, Statutes of 2016, which allows for a county to allow applicants for CalWORKs and CalFresh to apply remotely and opt out of the requirement for an in-office visit, also called the "face to face interview." Specifically, SB 947 authorizes the county human services agency to conduct this personal interview telephonically or through electronic means.

Application Hub. The Administration has recently begun to explore the concept of an Application Hub. The Hub is a new topic for the Legislature, but has been underway within the Administration as a planning effort for over a year. DSS states that it is exploring electronic options to streamline and modernize the processes for obtaining required verifications for CalFresh and CalWORKs eligibility. DSS has awarded a contract to Social Interest Solutions (SIS) to assist in analyzing the current environment of eligibility verifications for CalWORKs and CalFresh, engage stakeholders, perform an alternative analysis of electronic verification systems being used in California and other states, and outline recommendations for moving forward in the short and long term.

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. Two preliminary reports were published in 2015 and 2016, and the second report found that while SB 1041 was beneficial to clients, implementation remained difficult and complex, particularly related to understanding the 24-month time clock. These findings held true in the third year report, published in February 2018.

Summary of Major CalWORKs Changes
2009-2017

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
- ➢ Decrease earned income disregard form $225 to $112

2012-13

- ➢ Create 24-mo. flexible participation period with stricter federal requirements after 24 mo.

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

2017-18

- ➢ Cal-OAR established
- ➢ SFIS repeal

Policy considerations. The Legislature may wish to examine the following issues related to CalWORKs programs:

- Grant levels. The state made a number of cuts to CalWORKs during and after the Great Recession, including reducing grant levels and eliminating the annual state cost-of-living adjustment (COLA). Recent years' budgets have incrementally increased CalWORKs grant levels, but this has not been adequate to restore cuts made in prior years.

  If grant levels had been adjusted for inflation each year beginning in 2007-08, the maximum grant in 2018-19 would be $983, which is $269 higher than the current value of $714, and the purchasing power of the maximum grant will be 27 percent lower than in 2007-08. The CalWORKs grant will equal just 41.2 percent of the federal poverty line, leaving it below the deep-poverty line for the eleventh straight calendar year.

- Impact of the 24-month clock. With fewer than 200 clients that have exhausted the 24-month clock since implementation and have subsequently been removed from aid, there are no tangible associated 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 740 average monthly cases will be removed from aid in 2017-18

- Streamlining Eligibility and Verification. With the repeal of SFIS, conversations about the Hub, and the ongoing Cal-OAR efforts, it seems that there is an opportunity to reexamine the eligibility and verification processes in CalWORKs to make things less cumbersome for both workers and recipients. Staff suggests that these conversations take place in the context of the Hub as it continues to develop.

Staff Comment and Recommendation. Hold open. Staff recommends that caseload-related funding decisions be made after the May Revision.

Questions.

1. Please provide a brief update on the CalWORKs program, including funding sources, average grant amounts, recent legislative and policy changes, and caseload trends.

2. Please discuss ongoing conversations with county partners regarding the Single Allocation.

3. 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.

4. Please provide an update on the CalOAR process.

5. Please discuss the Administration's new approach to SFIS replacement as related to remote access.

6. Please discuss the Application Hub endeavor and next steps.

Issue 6: 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 2017-18 and 2018-19 is as follows:

Funding	FY 17-18	FY 18-19
Expanded Subsidized Employment (ESE)	$134 million Total Funds	$134 million Total Funds
Online CalWORKs Appraisal Tool (OCAT)	$15.1 million Total Funds	$19.6 million Total Funds
Family Stabilization (FS)	$46.9 million Total Funds	$46.9 million Total Funds

*Total Funds includes a mix of TANF and General Fund

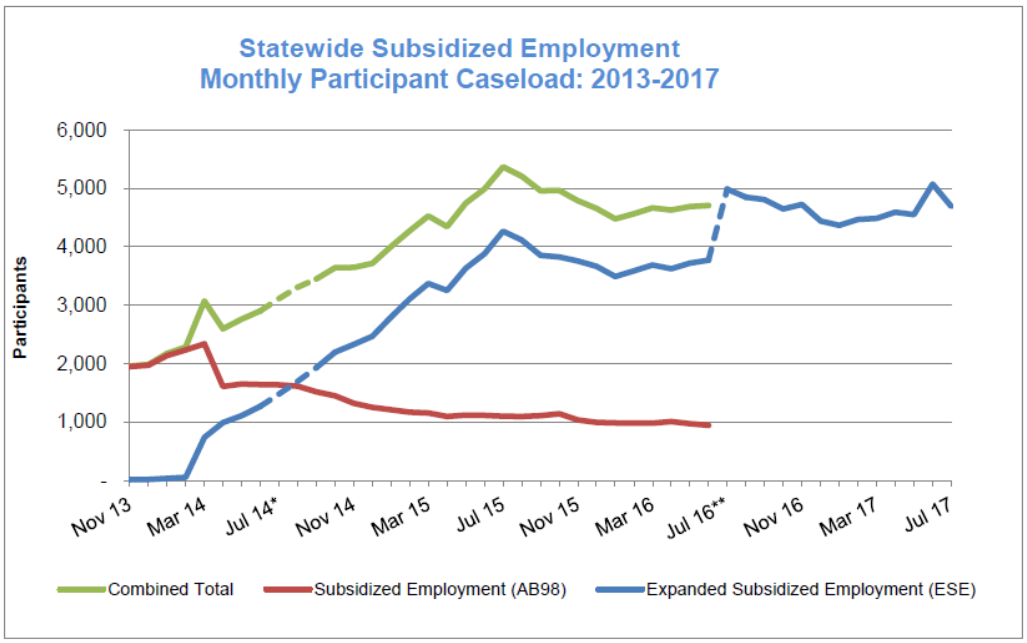
Expanded Subsidized Employment. Under subsidized employment, counties form partnerships with employers, non-profits, and public agencies to match recipients with jobs. Wages are fully or partially subsidized for six months to a year. While in an ESE placement, the CalWORKs recipient obtains specific 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. Proposed funding for this program in 2018-19 is $134 million.

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.

As of December 2017, 52 counties are participating in the program. 2015-16 saw the participation of 8,265 new participants, and increased to 10,120 in 2016-17.

The following figure shows an upward trend for subsidized employment activities.

Figure 6A. Subsidized Employment Caseload: 2013-2017



Data Source: Participant data is based on monthly county transmissions.

Notes:
*July – September 2014 data includes estimations to account for ESE data not reported from Los Angeles County for that period.
**AB98 program was discontinued and participants were consolidated into ESE reporting effective July 2016.

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. OCAT has been implemented in all 58 counties.

Between July 1, 2016, and June 30, 2017, 90,266 OCAT appraisals had been completed with recommendations for supportive services:

- 29,540 recommendations for mental health services.
- 19,821 recommendations related to domestic abuse.
- 5,908 recommendations related to substance abuse.
- 66,819 clients indicated they were not working at the time of appraisal.
- 11,582 clients were enrolled in education or training programs at the time of appraisal.

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.

The department is working towards integrating OCAT into SAWS. A collaborative team involving CalACES, CalWIN, CWDA, DSS, and OSI is meeting regularly on the rebuild planning and procurement effort. The OCAT rebuild procurement will be supported by San Bernardino County, and the contract held by the CalACES JPA, on behalf of all counties. This will require a legal agreement between CalACES and the eighteen CalWIN counties. An MOU to accomplish this, and support other shared services, is currently being developed. The department anticipates the RFP will be released by fall 2018, and will be reaching out to vendors, including those on the state's Agile Prequalified Vendor Pool, to advertise the procurement.

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.

Table 6A. CalWORKs Family Stabilization Status Report: FY 2016-17

CalWORKs Family Stabilization (FS) Status Report[1] Fiscal Year 2016-17 (July 2016 vs. June 2017 comparison)		
July 2016	June 2017	Participation
2,783	**3,901**	**Open FS cases.**
1,511	2,234	FS cases active in FS only.
342	273	FS cases that transitioned to a WTW plan.
930	1,394	FS cases that participated concurrently in WTW activities.
739	**795**	**FS cases that received good cause.**
		Services
2,454	**3,490**	**Total adults who received services.**
1,321	**1,633**	**Total children who received services.**
610	670	Domestic Abuse
1,561	1,895	Mental Health
397	383	Substance Abuse
1,609	2,964	Other[2]
		Housing Support/Services
815	**1,058**	**Total Homeless services provided per FS case.**
4,992	**6,970**	**Total FS services provided.[3]**

Notes:
[1]Data retrieved from the FSP 14. Cases and individuals captured based on the monthly totals from July 2016 and June 2017. Service totals are not an unduplicated count.
[2] Examples of additional types of Other FS services provided by individual counties.
[3] Total services provided includes services provided to individuals and FS cases.

2,891 cases were open in June 2017. 8,623 individuals received domestic abuse services, mental health services, substance abuse services, or other services in June 2017, and 939 cases received homeless support or services in June 2017.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an update on implementation of early engagement strategies.

2. Please discuss the automation of OCAT, and an update on initial data that OCAT has provided.

Issue 7: Oversight: Homeless Assistance and Housing Support

Budget Issue. The Budget Act of 2017 appropriates approximately $47 million ($16 million General Fund) for the Housing Support Program (HSP) in 2017-18 and 2018-19, and approximately $38 million ($11.5 million General Fund) for the Homeless Assistance Program (HAP) in 2017-18 and 2018-19.

Background. The 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. 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. Examples of services provided are landlord outreach and engagement, housing search and placement, housing barrier assessment, legal services and credit repair. Below is a table showing the numbers of families approved for HSP and the number of families that obtained permanent housing over the last several years.

Table 10B. Application Approvals and Families Housed: FY 2014-15 through FY 2016-17

	Families Approved	Families Housed
FY 2014-15	5,545	2,031
FY 2015-16	6,543	2,649
FY 2016-17	8,656	3,684
Total	**20,744**	**8,364**

Data Source: HSP 14

The HAP provides temporary shelter payments ($65 per day for a family of four or fewer, with an additional $15 for each extra family member, not to exceed $125 per day) for up to 16 consecutive calendar days while a household is looking for permanent housing, and helps households secure or retain a permanent residence by providing payment to cover the security deposit and last month's rent or two months of arrearages for those facing eviction. Both types of assistance are available once every 12 months, with exceptions for domestic violence or physical or mental illness, or a natural catastrophe beyond the family's control. Below is a table showing the number of families helped and net shelter expenditures in 2016-17.

Table 10A. Application Approvals and Shelter Expenditures: FY 2016-17

Type of Homeless Assistance	Number of Families Approved	FY 16-17 Net Shelter Expenditures
Temporary	46,073	$36,810,778
Permanent	4,445	$6,512,650
TOTAL	**50,518**	**$43,323,428**

Data Source: CA 237 HA

Staff Comment and Recommendation. No action required, informational item only.

Questions.

1. Please provide a brief update on homeless assistance and housing support programs.

Issue 8: Trailer Bill Language: CalWORKs Home Visiting Initiative

Budget Issue. The Administration proposes to implement a Home Visiting Initiative in the CalWORKs program. This program would engage a pregnant or first-time parent enrolled in the CalWORKs program or caretaker relative for a child only case, under 25 years old, that has a child less than 24 months of age. Participation in the program is voluntary and would not affect a family's application for aid or eligibility for any other CalWORKs benefits, supports, or services. Participation would be limited to 24 months.

The Governor's budget includes $157.5 million over a period of three years; $26.7 million is included in the 2018-19 budget, with implementation beginning January 1, 2019. The first-year cost in 2018-19 includes $19.6 million for conducting home visitations, $4.5 million for child care, $2.2 million for employment services, and $0.4 million for county administration. The annual cost for 2019-20 and 2020-21 is $52.5 million, with an additional $26.7 million for the first half of 2021-22, and is reflected in a TANF set-aside of $131.7 million. Funds would be allocated to applicant counties whose voluntary evidence-based home visiting programs meet the requirements of the statute.

Counties who opt in to the program will be asked to demonstrate that they have the capacity to provide targeted, coordinate, and evidence-based in-home services, and the ability to leverage resources that lead to positive outcomes for at-risk CalWORKs recipients. The goals of the initiative include: 1) improving family engagement practices; 2) reducing the incidence of reports of child maltreatment such as abuse and neglect; 3) supporting the healthy development of young children; 4) reducing children's need for remedial education; and 5) providing families with barrier removal and work readiness activities that will support families to reach self-sufficiency. During 2020-21, the program will be evaluated to determine if it should be continued beyond December 31, 2021.

Background. Home visiting is a voluntary, evidence-based program model that is intended to connect parents with resources to improve their parenting skills and maintain a safe and nurturing environment for their children. A number of counties have varies home visiting programs currently, although not limited to the population that the Administration's proposal focuses on. The Early Head Start Home-Based Option, Healthy Families America, Nurse-Family Partnership, and Parents as Teachers, have all been around for over a decade and are backed by research that points to home visiting as a whole effectively supporting healthy child development, increasing children's school readiness, enhancing parenting skills, and improving family economic self-sufficiency.

Staff Comment and Recommendation. While home visiting is not a new idea and appears to offer a host of benefits to families involved, it has not yet been targeted to the CalWORKs population as the Home Visiting Initiative intends. Given the sensitivities of this particular population, it is critical to consider whether any other specific additional criteria should be set at the state level about which models can be considered, and to decide if any specific data collection requirements should be included in statute to ensure that there are no negative consequences for families. Additionally, the Legislature should consider the related advocate proposals to expand the Administration's proposal and decide if any of the suggested elements would be helpful to include in a final proposal.

Questions.

1. Please summarize the proposal.

2. Why are first-time parents under 25 targeted in this proposal? What benefits in particular to this CalWORKs population can Home Visiting offer?

3. How will county workers be trained in both cultural competency and in linking recipients to other services and supports?

4. In the past, there has been some concern about the involvement of Child Protective Services in home visiting programs. Can you respond to these concerns?

5. Can you describe how the referral process for Home Visiting will work, since the program is voluntary?

Issue 9: Proposals for Investment

The subcommittee has received the following advocate requests related to the CalWORKs program:

1. End Childhood Deep Poverty

Budget Issue. Western Center on Law and Poverty (WCLP) and a large coalition of poverty advocates request support to end childhood deep poverty. Advocates point out that at an average of $556 for a family of three, which is 33 percent of the federal poverty level (FPL), CalWORKs grants are too low to support the healthy growth and development of the state's poorest children. Research has shown that when children live in deep poverty (defined as below 50 percent of FPL, they endure hardships that negatively impact their capacity to learn, develop, and thrive. Ultimately, deep poverty damages a child's chance to escape poverty and fuels an intergenerational cycle of poverty.

Background. This request is also reflected in SB 982 (Mitchell).

Staff Comment and Recommendation. Hold open. Budget staff will continue to work with stakeholders to refine the budget proposal and develop a cost estimate.

2. Adopt Governor's CalWORKs Home Visiting Initiative Proposal and Invest Additional Funds to Expand Services to Additional Families.

Budget Issue. Children Now, WCLP, CWDA, and others request the adoption of the Governor's CalWORKs Home Visiting Initiative and propose an additional $50 million per year to expand services to additional families. Currently the Governor's proposal is limited to pregnant women and families with children under two years of age who are CalWORKs recipients, when their child is their first born and when the parents are younger than 25 years of age. Advocates would like to see families in which parents are older than 25 or in which there is a child under the age of two included, even if that child has older siblings.

Other components of the request include continuous enrollment for eligible parents and caregivers versus the limited window in the Governor's proposal, the addition of a one-time allowance of $500 per participant for the purpose of assisting families with one-time costs such as cribs, car seats, and child-proofing supplies for the home, and building in time for counties to ramp up their programs.

Background. The 2018-19 Governor's budget includes a proposal to establish a voluntary, evidence-based early home visiting program to first-time, young pregnant women and parents in the CalWORKs program, and includes $23 million General Fund for these purposes.

Staff Comment and Recommendation. Hold open.

3. Support and Strengthen CalWORKs Home Visiting Initiative.

Budget Issue. The Child Abuse Prevention Center and the California Family Resource Association request the adoption of the Governor's CalWORKs Home Visiting Initiative with the addition of a broader array of families whose parents may be older than 25 and who may have more than one child, and trailer bill language encouraging all home visitation models utilized by counties to integrate home visitation families into community resources like family resource centers upon completion of home visitation services.

Staff Comment and Recommendation. Hold open.

4. WTW Self-Initiated Program (SIP) Student Study Time

Budget Issue. The WCLP and Coalition of California Welfare Rights Organizations (CCWRO) request that statute be clarified that all students can count their study time hours towards their work requirement.

Staff Comment and Recommendation. Hold open

5. Restore 60-Month Clock

Budget Issue. The WCLP and CCWRO request that the CalWORKs time limit be restored to the full 60 months. The time limit was reduced to 48 months in 2012-13. In particular, recipients in education programs are being steered towards programs that are 48 months or less.

Staff Comment and Recommendation. Hold open.

6. Restore Cut to the Single Allocation

Budget Issue. CWDA requests that $56.5 million that is proposed to be cut from the Single Allocation in 2018-19 be restored. While the Administration has provided a $187 million increase for 2018-19 to the Eligibility component of the Single Allocation, CWDA points out that this is offset by funding reductions to the Employment Services and Child Care components. The $56.5 million reduction would be on top of the $140 million reduction to the Single Allocation in the current year and another $156 million reduction taken the prior year, forcing counties to further reduce staff and services.

Background. The Single Allocation of CalWORKs funding provided to counties has historically fluctuated with caseload, although it funds both fixed and flexible work. Last year, the Single Allocation was facing a large reduction due to caseload decline. To mitigate these impacts, the Legislature restored a portion of the reduction and directed DSS to work with CWDA to develop a new budgeting methodology. While progress has been made on the new methodology in terms of the Eligibility component, there is still further to go in figuring out the Employment Services component in particular.

Staff Comment and Recommendation. Hold open.

7. Provide Additional Funding for Indian Health Clinics (IHCs)

Budget Issue. The California Rural Indian Health Board, Inc. (CRIHB) requests an augmentation of $2.15 million General Fund for IHCs. CRIHB points out that funding to these clinics has been reduced while the system is now in need of increased support to address the opioid public health emergency, which is severe among California Indian reservations.

Background. IHCs are administered by DSS, and operate 35 clinics. Grants in the IHC program supplement efforts to treat substance use disorders by Indian health organizations that serve CalWORKs and Tribal TANF clients, and it is the only behavioral health program for American Indians/Alaska Natives.

Staff Comment and Recommendation. Hold open.

8. Education Support Payments for CalWORKs Youth

Budget Issue. The Los Angeles County Board of Supervisors requests $3.5 million to give youth in CalWORKs households (who are not in the Cal Learn program) a $500 education support payment upon high school completion.

Background. CalWORKs youth who are pregnant and parenting must participate in Cal Learn, which offers a $500 stipend upon graduation from high school, among other supportive services.

Staff Comment and Recommendation. Hold open.

Issue 10: Overview: CalFresh

Governor's Proposal. The Governor's budget includes $1.8 billion ($614.0 million General Fund) for CalFresh administration in 2018-19. The CalFresh caseload is projected to serve 1.87 million households in 2018-19. This is a 3.7 percent decrease from 2017-18 projections of 1.93 million households.

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.

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 2016-17, approximately $572 million in CalFresh food assistance was disbursed to around 4.2 million Californians. The current average monthly benefit per household is around $272 ($117 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 for 2018-19 includes $59.1 million General Fund for food benefits, with an expected average monthly caseload of around 18,900 households (with about 42,100 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 $3,404 per month for a family of three) and net incomes of no more than 100 percent of the federal poverty level ($1,702 per month for a family of three), after specified adjustments.

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 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.

[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.

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 outreach to seniors. California's senior population has historically been underserved by CalFresh. Seniors made up approximately eight percent of the caseload in 2016, despite the fact that individuals ages 65 and over make up 10 percent of the population in poverty in California. In October 2017, the Department implemented the "Elderly Simplified Application Project (ESAP)" which provides households with only elderly and/or disabled members with no earnings a three year-certification period; default to all electronic verification when possible; and no interview at recertification, unless requested. At the same time, the state also implemented the "Standard Medical Deduction (SMD) demonstration project" which allows households with at least one elderly or disabled member to claim a standard medical deduction (or actual expenses if above the standard) based on verified expenses of $35 or more. The SMD is anticipated to result in increased benefits for many seniors while reducing the administrative burden of verifying and claiming actual expenses. With the implementation of both the ESAP and SMD, the state has experienced a caseload increase among seniors, adding approximately 27,000 new senior CalFresh recipients in the last year.

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

[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

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.

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. While most of the state is still under the waiver, three counties will be implementing the ABAWD time limit on September 1, 2018. In the lead up to implementation, the department is working extensively with stakeholders, including counties and client advocates, and has identified three implementation goals (1) maximize food benefits for eligible people, (2) ensure accuracy and timeliness when making benefit determinations, and (3) minimize administrative impact on clients and counties. DSS has also taken steps to ensure counties and other stakeholders are well aware of and preparing for the upcoming policy change. For example, DSS hosted a seven-part ABAWD policy webinar series, has provided on-site training at county's request for program staff, including eligibility workers, and released the ABAWD Policy Handbook Version 1.0 in January of 2018. The Department has now shifted its focus to automation, operations and the release of the ABAWD Policy Handbook 2.0 which will include additional notices, forms and other implementation resources.

Disaster CalFresh. Over the last year, California has had to implement Disaster CalFresh in eleven counties in response to wildfires in both Northern and Southern California. An affected area must have received a Presidential Declaration with IA in order to request this. Disaster CalFresh provides temporary food assistance for households impacted by a natural or man-made disaster. The program provides temporary benefits to eligible disaster victims while also facilitating the issuance of supplemental CalFresh benefits for ongoing households. To be eligible, a household must have lived or worked in the identified disaster area at the time of the disaster, must have been affected by the disaster and must meet certain D-CalFresh eligibility criteria. In addition to operating Disaster CalFresh, the department also coordinated the issuance of automatic mass replacement benefits to households impacted by assumed food loss due to extensive power outages resulting from the disaster. In total, DSS aided in the issuance of $2.9 million in benefits for the Northern California wildfires and an additional $5.6 million in benefits for the Southern California wildfires.

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 11: Proposals for Investment

The subcommittee received the following CalFresh-related requests for investment:

1. Increase CalFresh Funding

Budget Issue. The California Hunger Action Coalition (CHAC) requests increased funding for CalFresh in the 2018-19 Budget by adding state general fund dollars to the benefit allotment.

Background. CHAC points out that while the maximum monthly allotment in 2017-18 is $192 for a single person and $640 for a family of four; nationally, only 41 percent of households receive the maximum allotment and 23 percent of households receive less than half of the maximum allotment.

Staff Comment and Recommendation. Hold open.

2. Additional funding for CalFood

Budget Issue. The California Association of Food Banks requests funding CalFood at $20.6 million General Fund in the 2018-19 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. The 2016-17 budget provided $2 million for CalFood and $18.6 million for the Drought Food Assistance Program (DFAP). The 2017-18 Budget funded CalFood at $8 million, while DFAP funding expired. The Governor proposes $8 million for CalFood in 2018-19.

Staff Comment and Recommendation. Hold open.

3. Funding for Food Bank Infrastructure

Budget Issue. The California Association of Food Banks requests $25 million in the 2018-19 budget for one-time food bank infrastructure improvements. Advocates state that food banks are in serious need of improving capacity. The requested dollars would go towards providing modern refrigerated transportation, cold storage, and other capital improvements. It has been nearly 20 years since the state has invested in food bank infrastructure.

Staff Comment and Recommendation. Hold open.

4. Support for CalFresh Supplemental Fruit and Vegetable EBT Pilot in 2018-19 Budget

Budget Issue. California Food Policy Advocates and the San Francisco Bay Area Planning and Urban Research Association requests $9 million General Fund for the CalFresh Fruit and Vegetable EBT Pilot to increase the purchase and consumption of California-grown fruits and vegetables that are financially out-of-reach for low-income residents. The proposed pilot will modify the CalFresh EBT system to allow CalFresh shoppers to receive a matching benefit upon eligible purchases of California-grown fruits and vegetables, and implement seven community-based pilots to evaluate the efficacy of the EBT

system. This approach has already been piloted and implemented in Massachusetts through the Healthy Incentives Program.

Staff Comment and Recommendation. Hold open.

5. Food for All - Protect, Strengthen and Modernize Immigrant Access to Food Assistance

Budget Issue. California Food Policy Advocates and the California Immigrant Policy Center request Statutory Reporting Language (SRL) in the 2018-19 Budget Bill to bring stakeholders together to develop timely, responsive and actionable plans with regard to immigrant Californians, and with the goal to protect, strengthen, and modernize CalFresh and other food assistance programs for California immigrants.

Staff Comment and Recommendation. Hold open.

6. SAWS stakeholder process and legislative oversight

Budget Issue. The WCLP, CCWRO, and the Alliance to Transform CalFresh requests that the 2018-19 Budget include statutory language to establish a SAWS stakeholder process that emphasizes client-centered design, planning and implementation, and provides for legislative oversight for process and outcome accountability. Advocates purport that this is necessary to ensure quick, consistent, and equitable access to CalFresh.

Staff Comment and Recommendation. Hold open.

5180 – DEPARTMENT OF SOCIAL SERVICES – IMMIGRATION BRANCH

Issue 12: Update: Immigration Services Programs

Background. The 2017 Budget Act includes a base of $30 million General Fund for the Immigration Services Funding (ISF), with an additional $15 million General Fund for the current and budget years for a total of $45 million General Fund in both 2017-18 and 2018-19. 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. Last year services were expanded to include a broader definition of legal services, providing grants to qualified organizations to provide legal training and technical assistance, and making services available to persons presently or formerly residing in California. There was also an additional $20 million allocated in 2017-18 as one-time funding for Deferred Action for Childhood Arrivals (DACA) legal services.

DSS has awarded contracts to qualified nonprofit organizations that will provide services under one or more of the following service categories: (1) Education and Outreach (E&O); (2) Legal Training and Technical Assistance (LTTA); and (3) Legal Services. DSS also made targeted investments to increase capacity in rural, underserved areas and for hard-to-reach populations.

Below are charts that shows what activities were funded and at what level for the last several years:

Table 3. ISF Funding Overview

Fiscal Year	ISF Program Year	ISF Appropriation	Organizations Funded	Allowable Legal Services
FY 2015-16	Jan 2016 – June 2017	$15 million	62	• Naturalization • Deferred Action for Childhood Arrivals (DACA) • Deferred Action for Parents of American Citizens and Residents (DAPA)
FY 2016-17	Jan – Dec 2017[4]	$30 million	80	• Naturalization • Deferred Action for Childhood Arrivals (DACA) • Other Immigration Remedies
FY 2017-18	Jan – Dec 2018 Jan 2018 – Dec 2019 (*removal only*)	$45 million	92	• Naturalization • Deferred Action for Childhood Arrivals (DACA) • Other Immigration Remedies • Removal Defense • Post-Conviction Relief • Capacity for Public Defenders • Services for Deported Veterans

Table 4. ISF Funding Allocation Overview						
Service Category	Awarded Funding by Service Category (FY 15-16)	% of Funding by Service Category (FY 15-16)	Awarded Funding by Service Category (FY 16-17)	% of Funding by Service Category (FY 16-17)	Awarded Funding by Service Category (FY 17-18)	% of Awarded Funding by Service Category (FY 17-18)
LTTA	$443,500	3%	$976,000	3%	$1,168,250	3%
E&O	$2,221,600	15%	$3,270,200	11%	$4,073,500	10%
DACA	$5,810,050	40%	$2,310,800	8%	TBD	TBD
DAPA	$1,562,250	11%	N/A	N/A	N/A	N/A
Naturalization	$4,422,600	31%	$10,798,000	38%	$9,348,150	22%
Other Immigration Remedies	N/A	N/A	$10,157,400	35%	$14,155,700	34%
Removal Defense	N/A	N/A	N/A	N/A	$12,528,700	30%
Capacity	N/A	N/A	$1,250,000	1%	$680,000	2%
Capacity for Public Defenders	N/A	N/A	N/A	N/A	$540,000	1%
Services for Deported Veterans	N/A	N/A	N/A	N/A	$500,000	1%
Post-Conviction Relief	N/A	N/A	N/A	N/A	$400,000	1%
Temporary Protected Status	N/A	N/A	N/A	N/A	$300,000	1%

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. 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.

DACA Funding. In September 2017, the federal administration announced the end of the DACA program and a four-week window to file renewal applications. In response, the California Legislature appropriated $20 million General Fund to assist individuals with DACA with legal services, education and outreach, legal training and technical assistance, and assistance with the filing fee to process the DACA renewal. DSS awarded funding to over 40 non-profit organizations with an existing ISF contract. The table below shows the status of services and the balance of funds as of March 6, 2018.

Table 2. DACA Legal Services and Funding		
Service Provided	Individuals Served	Funding Claimed
DACA Consultations	1,958	$195,800
DACA Renewals	4,723	$1,967,300
OIR Consultations	1,668	$166,800
OIR Cases	166	$332,000
USCIS Filing Fees	2,529	$1,251,855
LTTA	N/A	$165,650
E&O	27,459	$549,180
TOTAL		**$4,628,585**

Temporary Protected Status (TPS). The Department of Homeland Security has recently announced the end of TPS for immigrants from El Salvador, Haiti, and Nicaragua. TPS is a humanitarian program that grants nationals of specifically designated countries temporary lawful status in the United States, including permission to work.

California has the largest population of TPS holders in the United States, with most nationals coming from El Salvador (49,100) and Honduras (5,900). Services funded by the ISF program, including consultations, other immigration remedies, education and outreach, legal training and technical assistance, and removal defense, are all available to serve the TPS holder population. DSS is actively consulting with TPS legal services providers to coordinate efforts.

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.

Unaccompanied Undocumented Minors (UUM). DSS annually 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:

Table 1. UUM Clients Served to Date by FY					
Fiscal Year	**2014-15**	**2015-16**	**2016-17**	**2017-18**	**Total**
Clients Served	725	580[3]	580	580	**2,456**
Clients Completed (Adjudicated)	315	118	23	0	**456**
Case Outcome					
Asylum	228	111	20	0	**359**
T-Visa	2	0	0	0	**2**
U-Visa	2	0	0	0	**2**
SIJS	81	7	1	0	**89**
Other (Citizenship)	2	0	0	0	**2**

DSS has awarded $11.6 million in funding through June 30, 2018 to non-profit legal services providers to provide legal services to 2,465 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 provide an update on funding levels and activities.

2. Please provide an update on the API Capacity Project.

3. Please provide an update on UUM.

Issue 13: Proposals for Investment

The subcommittee received the following immigration-related requests for investment:

1. Increasing Legal Defense Capacity in the Central Valley

Budget Issue. The Center at the Sierra Health Foundation, on behalf of the Fresno County Legal Defense Fund, request $4.5 million General Fund to fund immediate deportation defense and capacity building for local accredited organizations through partnerships with reputable private attorneys, a Rural Justice Fellows Project, a College Graduate Fellow Pipeline to Law School Project, and a Central Valley Immigration Career Assistance Program. Advocates point out that the combination of a large immigrant population, the scant availability of quality legal services, high levels of poverty, and the expansive geography of the Valley create a serious justice gap for immigrants in the region.

Staff Comment and Recommendation. Hold open.

5180 – DEPARTMENT OF SOCIAL SERVICES – MISCELLANEOUS

Issue 14: Proposals for Investment

The subcommittee received the following request for investment:

1. Provide two non-profits with funding for a civic engagement initiative

Budget Issue. The Martin Luther King Jr. Freedom Center and the Dolores Huerta Foundation request funding of $2 million General Fund ongoing for a Youth and Family Civic Engagement Initiative. The Initiative aims to reach 200 middle and high school students (50 each from Fresno, Kern, Contra Costa, and Alameda counties).

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

April 19, 2018
9:30 a.m., or Upon Adjournment of Floor Session
Room 4203, State Capitol

Consultants: Theresa Pena and Scott Ogus

OUTCOMES

Item	Department	Action
4700	**Community Services and Development**	
Issue 1	Program Update	Informational
Issue 2	BCP: LIWP Reappropriation	Hold Open
0530	**Health and Human Services Agency, Office of Systems Integration**	
4260	**Department of Health Care Services**	
5180	**Department of Social Services**	
Issue 1	Overview: Office of Systems Integration and Automation Projects	Informational
Issue 2	BCP: Medi-Cal Eligibility Data System (MEDS) Modernization	Hold Open
Issue 3	BCP: HIPAA Compliance and Technical Assistance	Hold Open
Issue 4	BCP: Rightsizing Office of Law Enforcement Support	Hold Open
Issue 5	SFL: eWIC MIS Project Expenditure Increase	Hold Open
Issue 6	Update: Child Welfare Services – New System	Hold Open
Issue 7	Update: SAWS Single System	Hold Open
5180	**Department of Social Services – Disaster Services Bureau**	
Issue 1	BCP: Resources for Disaster Preparedness	Hold Open
5180	**Department of Social Services – State Hearings Division**	
Issue 2	Overview: State Hearings Division	Informational
Issue 3	BCP: Appeals Case Management System	Hold Open
Issue 4	BCP: Medicaid Managed Care Final Rule Hearings and Increased Workload	Hold Open

5180	**Department of Social Services – CalWORKs**	
Issue 5	Overview: CalWORKs	Hold Open
Issue 6	Oversight: Early Engagement Strategies	Hold Open
Issue 7	Oversight: Homeless Assistance and Housing Support	Informational
Issue 8	TBL: Home Visiting Initiative	Hold Open
Issue 9	Proposals for Investment	Hold Open
5180	**Department of Social Services – CalFresh**	
Issue 10	Overview: CalFresh	Hold Open
Issue 11	Proposals for Investment	Hold Open
5180	**Department of Social Services – Immigration Branch**	
Issue 12	Update: Immigration Services Programs	Hold Open
Issue 13	Proposals for Investment	Hold Open
5180	**Department of Social Services – Miscellaneous**	
Issue 14	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, April 26, 2018
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.

4440 DEPARTMENT OF STATE HOSPITALS

Issue 1: 2018-19 Program Updates

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

The five state hospitals operated by DSH are:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

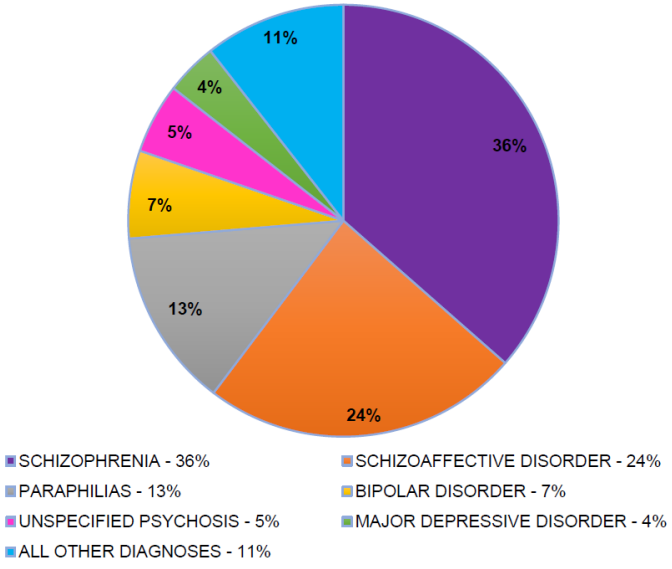


Figure 2: State Hospital Population By Major Diagnosis, as of July 1, 2017
Source: *Report on Measures of Patient Outcomes, Department of State Hospitals, January 2018*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of each of the program updates referenced in this item.

Issue 2: Coalinga: New Activity Courtyard Reappropriation

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 3: Metropolitan: Consolidation of Police Operations

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

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

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

The 2017 Budget Act approved General Fund expenditure authority of $1.3 million for preliminary planning for construction of a new building to consolidate DPS, OSI, and EDC and meet regulatory requirements as an Essential Services Building.

DSH requests General Fund expenditure authority of $1.5 million in 2018-19 for design and working drawings for continuation of the project. According to DSH, preliminary plans are expected to be approved in July 2018, the project is expected to proceed to bid in August 2019, the contract is expected to be awarded in December 2019, and the expected date for project completion is December 2021. The total expected cost for the project is $21 million, of which $18.2 million will be requested in future budget requests.

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

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

1. Please provide a brief overview of this proposal.

Issue 4: Metropolitan: CTE Fire Alarm System Upgrade Reappropriation

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 5: Patton: Fire Alarm System Upgrade

Capital Outlay Budget Issue. DSH requests General Fund expenditure authority of $9.4 million in 2018-19. If approved, these resources would allow DSH to remove and replace deficient SimplexGrinnell Fire Alarm Control Panels and associated components in four patient-occupied buildings at Patton State Hospital.

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

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

The 2015 Budget Act authorized General Fund expenditure authority of $731,000 for preliminary plans and the 2016 Budget Act authorized General Fund expenditure authority of $554,000 for working drawings.

DSH requests General Fund expenditure authority of $9.4 million in 2018-19 to continue to the construction phase of the fire alarm replacement project at Patton. Preliminary plans were approved in May 2017, the project is expected to proceed to bid in October 2018, to have the contract awarded in January 2019, and to be completed in December 2020.

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

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

1. Please provide a brief overview of this proposal.

Issue 6: Patton: Construct New Main Kitchen - Reappropriation

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

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

4260 DEPARTMENT OF HEALTH CARE SERVICES

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

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

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

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

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

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

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

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

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

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

Figure 2

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

(In Billions)

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

Figure 3

Medi-Cal Calculation Under Proposition 55 With Optional Deposit

(In Billions)

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

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

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

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

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

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

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

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

Questions. The subcommittee has requested Finance to respond to the following questions:

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

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

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

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

Issue 2: Denti-Cal - Overview

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Issue 3: Medi-Cal Optional Benefits

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Proposition 56 Expenditures
(Dollars in Millions)

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

1/ Annual amount specified in statute.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Proposition 56-Related Proposals

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

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

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

General Fund Investments

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

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

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

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

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

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

Issue 5: California 1115 Waiver - Medi-Cal 2020

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

* New program beginning July 1, 2017

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MCQMD also requests funding for three external evaluation contracts:

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

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

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

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

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

Issue 6: Hospital Quality Assurance Fee Program

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Office of Legal Services
  One Attorney

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

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

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

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

* Positions and resources ongoing after 2019-20.

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

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

Issue 10: Clinics/Community Treatment Facilities Supplemental Payments

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 11: Ombudsman Customer Relations Management System

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

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

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 12: HIPAA Privacy Rule Compliance

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

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 13: California Technical Assistance Program (CTAP) Extension

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 14: Medi-Cal Program Integrity Data Analytics

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

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

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

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 15: Health Care Reform Financial Reporting

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 16: Orange County Office Consolidation

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

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

* Resources ongoing after 2019-20.

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 17: Family Health Estimate Overview

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

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

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

The programs included in the Family Health Estimate are:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Issue 18: Additional Proposals for Investment

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

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

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

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

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

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

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

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

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Birth Certificate Processing Increase for Real ID Compliance

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 2: Center for Healthcare Quality

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Workforce Shortage Waiver Requirements

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

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

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

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

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

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

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

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

Patient Acuity Waiver Requirements

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

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

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

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

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

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

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

* Positions and resources ongoing after 2019-20.

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

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

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

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

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

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

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

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

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

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

Professional Certification Branch

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 5: Use of Federal Standards for State Regulation

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 6: AIDS Drug Assistance Program (ADAP)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Issue 7: AIDS Drug Assistance Program: Eligiblity and Enrollment

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

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

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

** Positions and resources ongoing after 2018-19.

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

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

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

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

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

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

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

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

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

One Public Health Medical Administrator I
One Research Scientist Supervisor I

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

Research Scientist Supervisor I

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

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

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

Administration (One Position)
One AGPA

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

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

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

1. Please provide a brief overview of this proposal.

Issue 8: Richmond Lab: Viral Rickettsial Disease Lab Upgrade

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

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 9: Baby BIG Infant Botulism Treatment and Prevention

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

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

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

Provisional Language. DPH requests the following provisional language:

Item 4265-001-0272

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

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

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

1. Please provide a brief overview of this proposal.

Issue 10: Emergency Response: Public Health Crisis Response Grant

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

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

Provisional Language. DPH requests the following provisional language:

Item 4265-001-0890

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

Item 4265-111-0890

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

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

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

1. Please provide a brief overview of this proposal.

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 3, 2018
9:30 a.m., or Upon Adjournment of Session
Room 4203, State Capitol
Part A

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: Budget Change Proposal: Low-Income Weatherization Program (LIWP) Reappropriation

The Administration requests reappropriation of any unexpected balances of 2015-16 local assistance appropriations received from the Greenhouse Gas Reduction Fund (GGRF) to be available for encumbrance until the end of 2018-19, and available for liquidation until the end of 2018-19. The proposal includes budget bill language.

Launch of the LIWP 2015-16 Single-Family program was delayed following protests to the competitive bid process identifying Regional Administrator awardees. Due to this delay, contracts were not finalized until June 2017. When factoring in ramp-up activities such as the renegotiation of project implementation plans, implementation of outreach strategies, and seasonal factors during winter months that limit project completions, liquidation of all the funds by the end of 2017-18 seems unrealistic. If the reappropriation authority is not granted, CSD anticipates reverting a total of $57 million in GGRF.

Staff Comment and Recommendation. Approve. This subcommittee heard and discussed this item during its April 19, 2018 hearing. No concerns have been raised.

5180 DEPARTMENT OF SOCIAL SERVICES – CHILD WELFARE SERVICES

Issue 1: Budget Change Proposal: Case Reviews Oversight Assistance

The Administration requests $1.1 million ($247,000 General Fund) in 2018-19 and $1.0 million ($231,000 General Fund) ongoing for eight Associate Governmental Program Analysts (AGPAs) and one Staff Services Manager I to allow for the department to provide increased coordination with and technical assistance to the counties to develop or improve mental and physical health services for vulnerable children ages zero to five, and to conduct required qualitative case reviews for rural child welfare and probation agencies who have been unable to conduct their own reviews.

The department notes that these new resources will allow the department to provide increased technical assistance to counties in an effort to reduce the percentage of children ages zero to five who are in foster care longer than 24 months from the current 40 percent to the federal standard of 30.3 percent, reduce the infant mortality rate, and conduct the necessary qualitative case reviews for rural counties, and ultimately bring the state into compliance with federal standards and avoid potential penalties.

Staff Comment and Recommendation. Approve. This subcommittee heard and discussed this item during its April 12, 2018 hearing. No concerns have been raised.

Issue 2: Budget Change Proposal: Psychotropic Medication Oversight in Foster Care

The Administration requests $1.4 million ($375,000 General Fund) split over two years to continue meeting statutory mandates of SB 484 (Beall), Statutes of 2015, Chapter 540. This is the equivalent of six positions.

SB 484 mandated additional review and increased standards regarding psychotropic medication usage in group homes, which created new data collection and notification requirements for the Community Care Licensing Division in DSS, and required that DSS annually develop a methodology for quantifying psychotropic medication usage to identify facility outliers. The bill also required DSS to publish a statewide summary of the information gathered during these inspections in order to review and evaluate the use of psychotropic medications among youth in group home care.

The department originally identified 206 facilities and redirected 22 Licensing Program Analysts (LPAs) for these purposes. However, over time, the department found that the time it took to complete these inspections was 7.2 hours per facility, which is 2.5 times the average time it takes to complete a group home inspection.

Staff Comment and Recommendation. Approve. This subcommittee heard and discussed this item during its April 12, 2018 hearing. No concerns have been raised.

5180 DEPARTMENT OF SOCIAL SERVICES – DISASTER SERVICES BUREAU

Issue 3: Budget Change Proposal: Resources for Disaster Preparedness

The Administration requests $428,000 General Fund in 2017-18 and $397,000 General Fund ongoing for three permanent positions (one Staff Services Manager I and two Associate Governmental Program Analysts) to support catastrophic planning and strengthen California's mass care and shelter capabilities.

DSS has been assigned by the California Governor's Office of Emergency Services (Cal OES) in the State Emergency Plan as the lead for mass care and shelter in California. In the last five years, over 500 evacuation shelters have been operated across California in response to emergency incidents, including seven Presidentially-declared disasters within just the last three years. Recent disasters such as the Oroville Auxiliary Spillway Incident and the 2017 wildfires have expanded the workload for the department and highlighted the need for DSS to increase its capacity.

Staff Comment and Recommendation. Approve. This subcommittee heard and discussed this item during its April 19, 2018 hearing. No concerns have been raised.

5180 DEPARTMENT OF SOCIAL SERVICES – STATE HEARINGS DIVISION (SHD)

Issue 4: Budget Change Proposal: Appeals Case Management System

The Administration requests $188,000 General Fund ($493,000 Total Funds) for one permanent Staff Services Manager I, two Associate Governmental Program Analysts, and one Senior Information Systems Analyst to provide continued support for the development and implementation of the Appeals Case Management System (ACMS).

The 2014 Budget Act approved four limited-term positions for the ACMS project. Project development for the ACMS began in August of 2017, with project implementation to begin in August of 2018 and maintenance and operations to begin in September 2018. However, the four positions expired in December 2017. The department considers the approval of these existing staff resources on an ongoing basis as necessary to complete the development and implementation of ACMS.

Staff Comment and Recommendation. Approve. This subcommittee heard and discussed this item during its April 19, 2018 hearing. No concerns have been raised.

Issue 5: Budget Change Proposal: Medicaid Managed Care Final Rule Hearings and Increased Workload

The Administration requests $1.2 million General Fund ($3.2 million Total Funds) in 2017-18 and $1.1 million General Fund ($3.1 million Total Funds) ongoing for 10 Administrative Law Judge II's and six Administrative Law Judge I's to process the increased workload associated with the implementation of the federal Medicaid Managed Care Final Rule and the increase in existing workload due primarily to the ongoing impact of the implementation of the Affordable Care Act.

Under the federal Centers for Medicare and Medicaid Services Final Rule, managed care plans that contract with the Department of Health Care Services will now be the first level of appeal for managed care case before asking for a state hearing. This rule change requires SHD to now review all of the managed care appeals for jurisdiction and conduct hearings and write decisions in all expedited appeals within three business days (under prior rules it was under 10 days).

The department points out that lack of adequate SHD staffing to address and implement the federal rule changes will result in delays in complying with timeliness requirements, which could increase penalties.

Staff Comment and Recommendation. Approve. This subcommittee heard and discussed this item during its April 19, 2108 hearing. No concerns have been raised.

ISSUES FOR DISCUSSION

4170 DEPARTMENT OF AGING (CDA)

Issue 1: Spring Finance Letter: Increased Resources for SNAP-Ed Program

Governor's Proposal. The Administration requests to increase state operations reimbursement authority by $200,000 and three positions, and local assistance reimbursement authority by $1.28 million (all federal funds), for the Supplemental Nutrition Assistance Program – Education (SNAP-Ed). The positions requested are one Health Program Specialist and the conversion of two existing Associate Governmental Program Analysts into permanent positions.

These funds will be used to administer and evaluate the department's SNAP-Ed service delivery model and increase base funding to the local Area Agencies on Aging (AAAs) that participate in the program.

Background. The Department of Social Services (DSS) receives SNAP-Ed funding from the United States Department of Agriculture/Food and Nutrition Services (USDA/FNS). SNAP-Ed grants are available to support statewide nutrition education programs for low-income individuals who are eligible or receiving benefits from the SNAP program (CalFresh in California). DSS partners with the Department of Public Health and the University of California Davis to provide SNAP-Ed to California's overall eligible population. DSS entered into an interagency agreement with CDA to provide SNAP-Ed services statewide specifically targeting older adults. CDA, through the AAAs, has been conducting SNAP-Ed outreach and educational programs focused on health promotion and obesity prevention, and increasing awareness and enrollment in CalFresh. Older Californians have a very low CalFresh participation rate.

Staff Comment and Recommendation. Approve. No concerns have been raised.

Questions.

1. Please provide an overview of the proposal.

4185 CALIFORNIA SENIOR LEGISLATURE (CSL)

Issue 1: Spring Finance Letter: Reappropriation of Unencumbered Balance

Governor's Proposal. The Administration requests the reappropriation of the unencumbered balance of General Fund appropriated to the CSL in the Budget Act of 2017. The CSL estimates that $300,000 of the $375,000 appropriated in 2017-18 will not be expended by the end of the fiscal year. CSL requests the reappropriated funds be available for encumbrance or expenditure until June 30, 2019.

The intent of the reappropriation is to provide the CSL more time to rebuild its revenue base through the Tax Check Off, which has been in decline since a name change and is currently undergoing rebranding efforts.

Background. The CSL, established in 1982, 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.

The CSL has been funded through voluntary contributions received with state income tax returns. 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.

Due to declining revenues stemming partly from a name change of the fund, the CSL was intermittently removed from the tax check off list over the past several years. In order to keep the CSL operational, the Legislature included a one-time $500,000 General Fund appropriation in the Budget Act of 2016. CSL spent $235,000 of this in the past year, and the remaining $265,000 were reappropriated and carried into 2017-18. Combined with the one-time 2017-18 General Fund appropriation of $375,000, CSL has approximately $640,000 to spend in the current year. Additionally, as of January 1, 2018, CSL has approximately $71,000 from the tax check off fund. CSL has estimated their current year expenditures to be $324,000.

Staff Comment and Recommendation. Approve. No concerns have been raised.

Questions.

1. Please provide an overview of the proposal.

2. Has the CSL had any further conversations with the Administration about a long-term funding source since the Three-Year Financing Plan came out this year?

5160 DEPARTMENT OF REHABILITATION (DOR)

Issue 1: Spring Finance Letter: CPUC Interagency Agreement

Governor's Proposal. The Administration requests an increase of $2 million in reimbursement authority for 2018-19 and 2019-20 to assist the California Public Utilities Commission (CPUC) in administering the Deaf and Disabled Telecommunications Program (DDTP). The CPUC will reimburse DOR's costs.

The $2 million will allow the DDTP to purchase speech generating devices (SGDs), and the DOR will administer part of the program by evaluating candidates, individuals with speech disabilities, and disseminating the devices to those who need SGDs.

Background. The CPUC is responsible for the DDTP, which offers relay service and assistive telecommunications equipment to California residents who are certified as having a hearing, speech, mobility, vision, or cognitive disability through the California Relay Service and the California Telephone Access Program. The DDTP is funded via a surcharge assessed on revenues collected from end-users for all intrastate communication services in California.

As a result of AB 136 (Beall), Chapter 404, Statutes of 2011, the CPUC engaged in a public forum discussion with stakeholders to expand the DDTP to include SGDs. The CPUC collaborated with the State Assistive Technology Contractor, California Foundation for Independent Living Centers, to undertake a small voice options pilot in 2016-17 to provide alternative equipment for those speech-disabled persons who cannot or would rather not receive the services of a Speech Language Pathologist and would rather choose a telecommunications assistive device for themselves. The need for additional information and resources to extend this pilot into a permanent statewide program is now necessary, and CPUC has identified a partnership with the DOR as key in ensuring that individuals with speech disabilities receive the necessary equipment. This collaboration with CPUC leverages resources and is consistent with DOR's role as the designated state unit for the provision of Assistive Technology services authorized by the federal Assistive Technology Act.

Staff Comment and Recommendation. Approve. No concerns have been raised.

Questions.

1. Please provide an overview of the proposal.

Issue 2: Spring Finance Letter: Disability Access Business Engagement

Governor's Proposal. The Administration requests $400,000 in reimbursement authority and three permanent positions for ongoing workload associated with two interagency agreements, the California State Lottery (CSL) and the California Workforce Association (CWA) and providing technical assistance to state entities to convert their websites and documents into an accessible format. The positions requested are two Associate Governmental Program Analysts (AGPAs) and one Training Officer. This request has no General Fund impact.

Background. DOR has been designated as the lead state agency in California's efforts to implement the Americans with Disabilities Act (ADA) in state government. The DOR established the Disability Access Services section to serve as subject matter experts and a resource that provides public information, consultation, training and technical assistance to state and local government, consumers, employers and businesses to increase access, independence and employment. The DOR is also required to assist in making places and information as available to Californians with disabilities as to Californians without disabilities, and is mandated under the Workforce Innovation and Opportunity Act (WIOA) to collaborate with local workforce systems to ensure competitive integrated employment for individuals with disabilities.

Currently, the number of requests for technical assistance, policy consultation, training, and education has increased and cannot be accommodated within DOR's resources at this time. There are 154 state departments and agencies who are potential customers of DOR for their services.

Additionally, the newly approved contract between DOR and the CWA will require delivery of 50 training classes with up to 1,500 attendees across the state, and combined with other activities resulting from DOR's increased involvement with local workforce development boards, will represent a 75 percent increase in workload for DOR.

DOR is also responsible for supporting the CSL Retailer Access Program by aiding the CSL with physical inspections for accessibility of five percent of 23,000 CSL facilities. DOR has had to redirect current staff to complete these inspections, but this has resulted in a six month backlog of quality assurance reviews.

Staff Comment and Recommendation. Approve. No concerns have been raised.

Questions.

1. Please provide an overview of the proposal.

Issue 3: Spring Finance Letter: Vending Stand Fund Authority Increase

Governor's Proposal. The Administration requests an increase of $1 million Vending Stand Fund (VSF) beginning 2018-19 for the Business Enterprises Program (BEP), which supports blind food vendors operating in government facilities.

The funds will provide DOR with the capacity to fund the increase cost of the necessary services and resources to approximately 90 BEP blind vendors. This request has no General Fund impact.

Background. DOR administers the BEP program under the Vocational Rehabilitation Services program. Federal law requires federal entities to give priority to blind individuals operating vending facilities on federal property, and California law requires the state to provide employment opportunity to vendors who are blind through establishing a priority for providing food service on state property. DOR is designated by the U.S. Department of Education as the State Licensing Agency to administer this priority through the BEP on both federal and state property. Eligible individuals who are blind must successfully complete the Vendor Training Program. Currently, there are 89 licensed BEP vendors operating 101 vending facilities.

Vendors operating a BEP facility pay a set-aside fee into the Vending Stand Fund, in addition to paying their liability insurance and workers' compensation fees. The set-aside fee is capped at six percent of gross sales; vendors can choose to pay the six percent or use the BEP set-aside fee schedule approved by the federal oversight agency, the Rehabilitation Services Administration. Set-aside fees are not collected from vendors when the net proceeds fall below a set exemption amount, which is adjusted annually. The BEP develops a yearly budget based on the projected revenues and expenses of the VSF. For over the last five years, the VSF has taken in more set-aside fees than required for BEP expenditures, and as a result the current balance is over $5 million and anticipated to continue to grow.

From 2007-08 to 2012-13, the VSF expenditure authority was $3.4 million. At the time, DOR found this to be more than adequate and in 2013-14 the Budget Act reduced VSF expenditure authority by $1 million. Over time, the result has been that the $1 million reduction has negatively impacted DOR's ability to fully cover BEP expenditures, especially as allocable expenditures such as equipment purchase, health and dental premiums, and worker's compensation has increased.

Staff Comment and Recommendation. Approve. No concerns have been raised.

Questions.

1. Please provide an overview of the proposal.

5180 DEPARTMENT OF SOCIAL SERVICES – IN-HOME SUPPORTIVE SERVICES

Issue 1: Spring Finance Letter: IHSS Collective Bargaining and State Administration

Governor's Proposal. The Administration requests an increase of $288,000 and reimbursements to be increased by $277,000 on a two-year limited-term basis to address a temporary increase in workload for the Department of Social Services (DSS) associated with recent statutory changes to the In-Home Supportive Services (IHSS) program related to collective bargaining for IHSS provider wages and benefits and county maintenance-of-effort (MOE) provisions.

The workload consists of technical assistance to counties and collective bargaining representatives, and review of county-negotiated collective bargaining proposals for compliance with state law. The requested resources will also support the increased administrative workload associated with the revised county IHSS MOE funding structure. Positions funded by these resources include one Staff Services Manager and three Research Analyst II's.

Background. SB 90 (Committee on Budget and Fiscal Review), Chapter 25, Statutes of 2017, and AB 110 (Committee on Budget), Chapter 8, Statutes of 2018, have both increased the workload of the Fiscal Forecasting and Policy Branch's Children and Adult Program Estimates Bureau (CAPEB) within DSS.

Through this legislation, an IHSS collective bargaining mediation and fact-finding process through the Public Employment Relations Board (PERB) was established, if a county and the collective bargaining representatives for IHSS providers fail to reach agreement by January 1, 2018. This process sunsets on January 1, 2020. The requested resources will address questions raised by counties and collective bargaining representatives during this period. The changes under both of these bills have also increased the CAPEB workload associated with providing technical assistance and review of county-negotiated collective bargaining proposals, as DSS anticipates the workload to provide a fiscal analysis on a collective bargaining proposal will significantly increase because all 58 counties can submit various wage and benefit increase scenarios.

The department states that this new workload is significant and current resources are not able to absorb the increases.

Staff Comment and Recommendation. Approve. No concerns have been raised.

Questions.

1. Please provide an overview of the proposal.

4170 DEPARTMENT OF AGING
5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: Miscellaneous Proposals for Investment

The subcommittee has received the following proposals for investment:

1. CalWORKs Sponsored Noncitizen Eligibility

Budget Issue. The Alameda County Board of Supervisors requests the expansion of CalWORKs program eligibility for sponsored noncitizens, aligning these provisions with CalFresh. In cases when a sponsor is suddenly unable to support the sponsored noncitizen, the sponsored noncitizen is determined to be indigent, which allows for an agency to certify the noncitizen's case. In CalFresh, these determinations are renewable annually without restriction; but in CalWORKs, there is no provision for renewal.

Staff Comment and Recommendation. Hold open.

2. Additional funding for the Deaf Access Program

Budget Issue. The California Coalition of Agencies Serving the Deaf & Hard of Hearing, Inc. request an increase of $4.1 million for the Deaf Access Program (DAP) in 2018-19, which would translate to the DAP being funded at $8.8 million for 2018-19 and beyond. $3 million of this funding is for serving "linguistically isolated" populations, which requires trilingual interpreters fluent in Spanish and other languages, while $1.1 million would offset past reductions and fill service gaps.

Background. The DAP provides equal access to state and local services and programs, as mandated by law, to all 58 counties. The program, currently funded at $4.7 million, has experienced reduced funding in 2008-09.

Staff Comment and Recommendation. Hold open.

3. Dignity at Home Fall Prevention Program

Budget Issue. This request asks for $2.5 million General Fund for the California Department of Aging to fund a program to help seniors and others at risk of falling make home modifications and take steps to reduce the risk of falls in homes. An average home modification costs $700.

Background. This request is also reflected in SB 1026 (Jackson).

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 3, 2018
9:30 a.m., or Upon Adjournment of Session
Room 4203, State Capitol
Part A

Consultant: Theresa Pena

OUTCOMES

ISSUES RECOMMENDED FOR VOTE-ONLY

Item	Department	Action
4700	**Department of Community Services and Development**	
Issue 1	BCP: Low-Income Weatherization Program Reappropriation	Approve (3-0)
5180	**Department of Social Services – Child Welfare Services**	
Issue 1	BCP: Case Reviews Oversight Assistance	Approve (3-0)
Issue 2	BCP: Psychotropic Medication Oversight in Foster Care	Approve (3-0)
5180	**Department of Social Services – Disaster Services Bureau**	
Issue 3	BCP: Resources for Disaster Preparedness	Approve (3-0)
5180	**Department of Social Services – State Hearings Division**	
Issue 4	BCP: Appeals Case Management System	Approve (3-0)
Issue 5	BCP: Medicaid Managed Care Final Rule Hearings and Increased Workload	Approve (3-0)

ISSUES FOR DISCUSSION

Item	Department	Action
4170	**Department of Aging**	
Issue 1	SFL: Increased Resources for SNAP-Ed Program	Approve (3-0)
4185	**California Senior Legislature**	
Issue 1	SFL: Reappropriation of Unencumbered Balance	Approve (3-0)
5160	**Department of Rehabilitation**	
Issue 1	SFL: CPUC Interagency Agreement	Approve (3-0)
Issue 2	SFL: Disability Access Business Engagement	Approve (3-0)
Issue 3	SFL: Vending Stand Fund Authority Increase	Approve (3-0)
5180	**Department of Social Services – In-Home Supportive Services**	
Issue 1	SFL: IHSS Collective Bargaining and State Administration	Approve (3-0)
4170	**Department of Aging**	
5180	**Department of Social Services**	
Issue 1	Miscellaneous 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, May 3, 2018
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203
PART B

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.

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: Mental Health Loan Assumption Program Administrative Resources

Spring Finance Letter. OSHPD requests expenditure authority of $215,000 from the Mental Health Services Fund in 2018-19 and 2019-20. If approved, these resources would support administrative activities to close out all grants awarded through the Mental Health Loan Assumption Program and ensure compliance with program requirements.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20**
3085 – Mental Health Services Fund	$215,000	$215,000
Total Funding Request:	**$215,000**	**$215,000**

Background. OSHPD administers the Health Professions Education Foundation (HPEF), a 501(c)(3) non-profit public benefit corporation established in 1987 through legislation. The HPEF offers scholarships and loan repayments for students and graduates willing to practice in underserved areas. HPEF administers the Mental Health Loan Assumption Program (MHLAP), a loan forgiveness program to help retain qualified mental health professionals working within the public mental health system.

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 for community services and supports, prevention and early intervention, innovative programs, workforce education and training (WET), and capital facilities and technological needs. For WET programs, Proposition 63 allocated $210 million to counties and $234.5 million to the state over a ten year period beginning in 2008. WET program funds must be expended by June 30, 2018.

MHLAP receives funding from the WET component of Proposition 63. According to OSHPD, $10 million is allocated annually to loan assumption awards for MHLAP recipients. An award recipient may receive up to $10,000 to repay educational loans in exchange for a 12 month service obligation in a hard to fill or retain position within a public mental health system. Each county determines which professions are eligible for awards in that county. Some of the professions that receive MHLAP funding are psychologists, psychiatrists, postdoctoral psychological assistants or trainees, marriage and family therapists, clinical social workers, clinical counselors, clinical counselor interns, and psychiatric mental health nurse practitioners.

According to OSHPD, the WET program budget does not include any administrative resources beyond the expiration of the WET program funding on June 30, 2018. OSHPD reports it reassessed the administrative workload necessary to manage close out activities for the 1,200 MHLAP grant agreements and open grants issued in prior years. OSHPD requests expenditure authority of $215,000 from the Mental Health Services Fund, **equivalent to two Associate Governmental Program**

Analysts, for two years for program management, processing of payments upon recipients' completion of the required service obligation, and permitting recipients to successfully complete the term of service.

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

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

1. Please provide a brief overview of this proposal.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Proposals for Investment

Stakeholder Proposals. Various stakeholder organizations have submitted the following proposals for investment in Medi-Cal.

Pediatric Primary Care Reimbursement Rate Increase. The American Academy of Pediatrics requests General Fund resources to increase pediatric primary care reimbursement rates to 100 percent of Medicare, consistent with the primary care rate increase authorized for two years under the federal Affordable Care Act.

Whole Genome Sequencing Pilot Project. Illumina, a leading developer, manufacturer, and marketer of life science tools, requests General Fund expenditure authority of $2 million for a clinical pilot project to demonstrate the diagnostic and financial value of clinical whole genome sequencing (cWGS) for the Medi-Cal program. The pilot would test 100 Medi-Cal neonatal and other pediatric patients with undiagnosed diseases that have remain undiagnosed, or had multiple diagnoses over an extended period of time. According to Illumina, the project is intended to demonstrate the value of cWGS as a first line diagnostic test compared to current standards of newborn and pediatric healthcare diagnostic tests.

Restoration of Provider Rate Reduction for Non-Emergency Medical Transportation. The California Medical Transportation Association (CMTA) requests $7.2 million ($3.6 million General Fund and $3.6 million federal funds) to restore the 10 percent provider rate reductions for non-emergency medical transportation (NEMT) imposed pursuant to AB 97 (Committee on Budget), Chapter 3, Statutes of 2011. According to CMTA, seriously ill and chronically disabled Medi-Cal patients are unable to obtain NEMT due to low payment rates and inappropriate transportation broker decisions. Medi-Cal fee-for-service rates do not cover NEMT provider trips costs for trips beyond short distances. Recognizing the inadequacy of fee-for-service NEMT rates, managed care plans pay higher NEMT rates to ensure adequate access. Most NEMT users are dialysis patients dependent on NEMT to access life-sustaining dialysis treatment. Failure to receive timely dialysis care causes complications that require extremely expensive emergency care, hospitalization, or death.

Healthy Start Initiative. United Ways of California and a coalition of several children and other advocacy organizations request conforming actions in the Department of Health Care Services budget to re-establish the Healthy Start Initiative. The Healthy Start Initiative provides comprehensive, school-community integrated services and activities to improve the health and wellness of children, youth, and families including: health, dental, and vision care; mental health and substance use disorder counseling; family support and parenting education; academic support; health education; safety education and violence prevention; youth development; employment preparation; and more. According to United Ways of California, evaluation of the program showed the physical, mental, and emotional health of students and their families were measurably enhanced, and the child's academic success improved greatly.

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

Questions. The subcommittee has requested advocates to present these proposals for investment.

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Proposals for Investment

MHSOAC Proposals. The MHSOAC has proposed the following investments.

Reappropriation of Unexpended Mental Health Triage Funding. MHSOAC requests reappropriation of expenditure authority from the Mental Health Services Fund of $29.4 million ($2.5 million from 2013-14, $8.8 million from 2014-15, $992,408 from 2015-16, and $17.1 million from 2016-17). These funds were originally appropriated under the Investment in Mental Health Wellness Act for triage personnel to provide intensive case management and linkage to services for individuals with mental health disorders at various points of access. The original appropriation was $54 million ($32 million Mental Health Services Fund and $22 million federal funds) for 600 triage personnel. According to MHSOAC, counties experienced challenges hiring triage personnel and were unable to spend all of their allotted funds during the term of their grants. These unspent funds, once reappropriated and available for encumbrance and expenditure through 2020-21, would allow MHSOAC to award more grants to counties during the next grant cycle.

Allocation of Triage Funding. MHSOAC requests trailer bill language to allocate at least one half of funds allocated for triage personnel for programs targeted at children and youth 18 years of age and under.

Stakeholder Contracts To Reduce Criminal Justice Involvement of Mental Health Consumers. MHSOAC requests expenditure authority of $670,000 from the Mental Health Services Fund annually to fund stakeholder advocacy contracts to reduce the involvement of mental health consumers in the criminal justice system. 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. MHSOAC awards a total of $4.7 million contracted funds annually.

According to MHSOAC, for too many Californians becoming involved with law enforcement remains the primary avenue to accessing mental health care. As part of a broader strategy to address this challenge, MHSOAC requests expenditure authority of $670,000 from the Mental Health Services Fund state administration account for stakeholder advocacy contracts to reduce the number of mental health consumers who become involved in the criminal justice system.

Children's Mental Health Innovation Incubator. MHSOAC requests expenditure authority of $5 million from the Mental Health Services Fund in 2018-19 to create a Children's Innovation Incubator to support program implementation, provide technical assistance and training and ensure counties are fully leveraging funds to improve outcomes for children within California's mental health system. According to MHSOAC, the incubator will assist MHSOAC and counties in improving the effectiveness of innovative approaches for children's mental health services and provide California the opportunity to develop and test new, unproven mental health models with the potential to become tomorrow's best practices. The $5 million investment would cover start-up and partially cover operations for three years.

AB 114 Technical Cleanup for Treatment of Innovation Funds. The California Behavioral Health Directors Association (CBHDA) requests trailer bill language to clarify the treatment of innovation funds subject to reversion prior to July 1, 2017, pursuant to the provisions of AB 114 (Committee on Budget), Chapter 38, Statutes of 2017. According to CBHDA, the provisions of AB114 are unclear whether counties are required to spend these innovation funds before July 1, 2020, particularly when the timeframe for expending innovation funds is based upon when a county's proposal has been approved by the MHSOAC. CBHDA requests a minor, technical amendment to Welfare and Institutions Code Section 5892.1 (c) to clarify that each county with unspent innovation funds subject to reversion that are deemed reverted and reallocated by AB 114 prepare and receive approval from the MHSOAC before July 1, 2020.

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

Questions. The subcommittee has requested MHSOAC and CBHDA to present these proposals for investment.

4800 CALIFORNIA HEALTH BENEFIT EXCHANGE (COVERED CALIFORNIA)

Issue 1: Insurance Affordability Proposals

Background. The federal Patient Protection and Affordable Care Act (ACA) implemented significant improvements to health care coverage offered in the individual health insurance market. Beginning in September 2010, ACA individual market reforms:

1. Eliminated lifetime limits on coverage.
2. Prohibited post-claims underwriting and rescission of policies.
3. Required health plans to offer coverage to dependent children up to age 26.
4. Eliminated pre-existing condition exclusions for children.
5. Eliminated copays and other cost sharing provisions for 45 preventive services.
6. Required health plans to spend at least 85 percent of premium dollars on health expenditures or provide rebates to customers (effective January 2012).

According to federal data, by 2013 more than eight million Californians received access to no-cost preventive services and 1.4 million residents with private insurance coverage received $65.7 million in insurance company rebates.

Beginning in January 2014, the ACA implemented additional market reforms and required establishment of health benefit exchanges, which provide federally subsidized health care coverage to individuals between 138 and 400 percent of the federal poverty level (FPL). California established its own health benefit exchange, Covered California, funded by assessments on health plan premiums. Covered California offers several options for individual health care coverage negotiated for cost and quality with health plans. Enrollment occurs during an annual open enrollment period that begins November 1 and ends January 31. The ACA requires all health insurance products, with some exceptions, to cover certain essential health benefits to be considered minimum essential coverage. These benefits include:

- Ambulatory patient services.
- Prescription drugs.
- Emergency services.
- Rehabilitative and habilitative services and devices.
- Hospitalization.
- Laboratory services.
- Maternity and newborn care.
- Preventive and wellness services and chronic disease management.
- Mental health and substance use disorder services, including behavioral health treatment.
- Pediatric services, including oral and vision care.

Metal Tiers for Health Insurance Products in Covered California. Consumers purchasing coverage in the Covered California health benefit exchange may choose from different "metal tiers" that determine the level of coverage and cost-sharing amounts provided by the product. According to Covered California, the metal tiers provide coverage as follows:

- **Bronze:** On average, Bronze health plans pay 60 percent of medical expenses, and consumers pay 40 percent.
- **Silver:** On average, Silver health plans pay 70 percent of medical expenses, and consumers pay 30 percent. Certain income-eligible individuals may qualify for an Enhanced Silver plan, which provides coverage with lower cost-sharing. Individuals in these savings categories get the benefits of a Gold or Platinum plan for the price of a Silver plan. The three categories of Enhanced Silver plans pay 94 percent, 87 percent or 73 percent of medical expenses.
- **Gold:** On average, Gold health plans pay 80 percent of medical expenses, and consumers pay 20 percent.
- **Platinum:** On average, Platinum health plans pay 90 percent of medical expenses, and consumers pay 10 percent.

Figure 1. Metal Tiers of Coverage in Covered California Health Benefit Exchange
Source: *Covered California website: "Coverage Levels/Metal Tiers" https://www.coveredca.com/individuals-and-families/getting-covered/coverage-basics/coverage-levels/*

Advance Premium Tax Credit Subsidies. The ACA subsidizes health care coverage purchased in health benefit exchanges, such as Covered California, for individuals between 138 and 400 percent of the FPL. The subsidies are provided in the form of advance premium tax credits (APTC), which reduce the amount of premium paid by income-eligible consumers purchasing coverage on the exchange. The amount of the APTC is linked to the cost of the second-lowest cost Silver plan in a consumer's coverage region. The APTC is meant to ensure that consumers are required to spend no more than two percent to 9.6 percent of their income for Silver plan premiums. Consumers may use the APTC subsidy amount to purchase other metal tiers of coverage that may be less expensive (e.g. Bronze) or more expensive (e.g. Gold or Platinum). According to Covered California, as of March 2018 nearly 1.3 million individuals covered by exchange products received an average of $452 per month in APTC subsidies. Nearly 167,000 individuals receive exchange-based coverage, but are not eligible for APTC subsidies.

Individual Mandate and Cost-Sharing Reductions. In addition to individual market reforms and new coverage options, the ACA eliminated pre-existing condition exclusions for adults beginning in 2014, and imposed a requirement that individuals enroll in health plans that offer minimum essential coverage or pay a penalty, known as the individual mandate. The individual mandate was designed to stabilize premiums by encouraging healthy individuals to enroll in health coverage and reduce the overall acuity of health insurance risk pools. Because health plans cannot deny coverage based on a pre-existing condition, in the absence of a mandate individuals may delay enrolling in coverage until they are diagnosed with a high-cost health condition, resulting in higher overall plan expenditures which lead to higher premiums. The ACA also limited the amount of cost-sharing that could be required of plan

beneficiaries under 250 percent of the FPL. These cost-sharing reductions result in savings to beneficiaries on deductibles, copayments, coinsurance, and maximum out-of-pocket costs. Until recently, the federal government provided cost-sharing reduction subsidies to health plans to help mitigate the costs of limiting cost-sharing amounts for these beneficiaries. These subsidies were designed to maintain those cost-sharing limits while reducing higher premium costs that would otherwise be required.

Elimination of Cost Sharing Reduction Subsidies and Repeal of Individual Mandate. In October 2017, the federal Administration eliminated cost-sharing reduction subsidies that prevent premium growth due to ACA requirements that limit cost-sharing for health plan beneficiaries under 250 percent of the FPL. According to Covered California, the loss of these subsidies will result in an annual reduction of approximately $750 million of federal funds available to reduce premiums. According to the Kaiser Family Foundation, health plans imposed cost-sharing reduction surcharges ranging from seven to 38 percent on premiums for 2018. In addition, the recently enacted federal tax proposal included the repeal of the individual mandate for purchase of health care coverage. The repeal takes effect beginning in 2019. According to Covered California, the increased premiums in 2019 resulting from elimination of the cost-sharing reduction subsidies and the individual mandate could range between 16 and 30 percent.

Stakeholder Proposals to Improve Health Insurance Affordability. Health Access California and the Care4AllCA Coalition have proposed three specific state investments to improve health insurance affordability and mitigate the negative impacts of recent federal actions. The combined General Fund impact of these proposals would likely be in the low billions of dollars.

Improve Premium Subsidies for Individuals Under 400 Percent of the FPL. The Care4AllCA Coalition proposes to increase premium subsidies for individuals purchasing health insurance in the Covered California health benefit exchange to reduce the costs of obtaining coverage. According to the Coalition, the improved affordability achieved by this proposal will result in between 140,000 and 150,000 newly insured individuals and lower premiums for approximately 1.2 million Covered California enrollees. The proposed premium changes for various income levels are summarized below:

Percent of FPL	Income Range (Single)	Premium as Percent of Income (Current)	Premium as Percent of Income (Proposed)	Approx. Monthly Premium Change
Under 138	Less than $16,800	2.0	0	$0, instead of $47
139-149	$16,800-$18,200	3.4-4.0	0.08-0.95	$15 instead of $61
150-199	$18,200-$24,300	4.0-6.3	0.95-5.0	$101 instead of $127
200-249	$24,300-$30,400	6.3-8.1	5.0-6.6	$167 instead of $204
250-299	$30,400-$36,400	8.2-9.6	6.6-8.2	$248 instead of $288
300-400	$36,400-$48,600	9.6	8.2	$332 instead of $384

Reduce Copays and Deductibles for Individuals Between 200 and 400 Percent of the FPL. The Care4AllCA Coalition proposes to improve cost-sharing requirements, including copays and deductibles, for individuals between 200 and 400 percent of the FPL purchasing coverage in the exchange. According to the Coalition, individuals in this income range get little or no help paying for

copays or deductibles, with one third purchasing Bronze coverage with a $6,300 deductible. This proposal, detailed below, would improve cost-sharing affordability for 500,000 Covered California enrollees.

Cost-sharing improvements	**Current Benefit Design**			**Proposed**
200-300% FPL ($24,300-$36,400 for individual)	**Bronze**	**Silver (200-250%)**	**Silver (250-300%)**	**200-300% FPL**
Avg. % costs paid by insurer	60%	73%	70%	87%
Primary care visit	$75	$30	$35	$10
Specialist visit	$105	$75		$25
Generic drugs	$15 after drug deductible is met			$5 or less
Emergency room	$350	$350		$100
Hospital facility fee	20% coinsurance			15%
Individual medical deductible	$6,300	$2,200	$2,500	$650
Individual pharmacy deductible	$500	$130		$50
Individual out-of-pocket maximum	$7,000	$5,850	$7,000	$2,450
Cost sharing improvements	**Current Benefit Design**			**Proposed**
300-400% FPL ($36,400-$48,600 for individual)	**Bronze**	**Silver**		**300-400% FPL**
Avg. % costs paid by insurer	60%	70%		80%
Primary care visit	$75	$35		$25
Specialist visit	$105			$55
Generic drugs	$15 after drug deductible is met			$15 or less
Emergency room	$350			$325
Hospital facility fee	20% coinsurance			$600/day up to 5 days
Individual medical deductible	$6,300	$2,500		N/A
Individual pharmacy deductible	$500	$130		N/A
Individual out-of-pocket maximum	$7,000	$7,000		$6,000

Limit Premiums to Eight Percent of Income for Individuals Above 400 Percent of the FPL. The Care4AllCA Coalition proposes to limit premiums to no more than eight percent of income for

individuals over 400 percent of the FPL. The limits would be based on the cost of Bronze coverage. According to the Coalition, some individuals in this income range pay more than 20 percent of their income for bronze coverage, which comes with a $6,300 deductible. An individual over age 50 making more than $50,000 could spend between $4,000 and $9,000 on premiums, depending on geographic region, and as much as $6,300 on care. For married couples, premiums could range from $3,600 to $6,400 for a couple aged 24, or $13,700 to $18,600 for a couple aged 62, depending on geography, with both couples subject to a $6,300 deductible for Bronze coverage. The Coalition reports this approach would primarily benefit those with incomes between 400 and 600 percent of the FPL, decrease the number of uninsured by 100,000, and improve affordability for an additional 350,000 individuals.

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

Questions. The subcommittee has requested advocates to present these proposals.

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 10, 2018
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultants: Scott Ogus, Renita Polk, Theresa Pena

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VOTE ONLY

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

Issue 1: HIPAA Compliance and Technical Assistance

Budget Issue. CHHSA (CalOHII) requests one position and reimbursement expenditure authority of $128,000 annually. If approved, these resources would allow CalOHII to continue its oversight of statewide HIPAA compliance activities.

Program Funding Request Summary (CHHSA)		
Fund Source	**2018-19**	**2019-20***
0995 – Reimbursements	$128,000	$128,000
Total Funding Request:	**$128,000**	**$128,000**
Total Requested Positions:	**1.0**	**1.0**

*Positions and resources ongoing after 2019-20.

This issue was heard during the subcommittee's April 19th hearing.

Subcommittee Staff Comment and Recommendation—Approve. CalOHII provides statewide guidance, planning, and technical assistance to 62 state departments and agencies for compliance with HIPAA. The limited-term position approved during the most recent zero-base review of CalOHII is performing HIPAA compliance and leadership workload that has only grown larger. Approving permanent extension of this position will allow that workload to continue.

Issue 2: eWIC MIS Project Expenditure Increase

Spring Finance Letter. CHHSA (OSI) is requesting expenditure authority from the California Health and Human Services (CHHS) Automation Fund of $4.8 million in 2018-19, $9.1 million in 2019-20, and $6.2 million in 2020-21. If approved, these resources would allow OSI to continue implementation of the Electronic Women, Infants, and Children Management Information System (eWIC MIS), an electronic benefits transfer (EBT) system for the participants in California's WIC program.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
9745 – CHHS Automation Fund**	$4,808,000	$9,133,000
Total Funding Request:	**$4,808,000**	**$9,133,000**

* Additional fiscal year resources requested: 2020-21: $6,219,000

** The CHHS Automation Fund receives transfers from the Federal Trust Fund for this project.

This issue was heard during the subcommittee's April 19th hearing.

Subcommittee Staff Comment and Recommendation—Approve. Federal law requires the state to migrate WIC paper-based food benefits to an EBT system by 2020. Approval of these resources, funded by federal fund transfers to OSI, will allow the project to achieve the EBT transition by the deadline.

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: Prescription Drug Cost Transparency Implementation Plan (SB 17)

Budget Issue. OSHPD requests three positions and expenditure authority from the California Health Data and Planning Fund of $500,000 in 2018-19, $850,000 in 2019-20, and $800,000 in 2020-21 and annually thereafter. Beginning in 2019-20, OSHPD also requests an additional 2.5 positions for a total of 5.5 permanent positions. If approved, these positions and resources would allow OSHPD to implement prescription drug price transparency initiatives required by SB 17 (Hernandez), Chapter 603, Statutes of 2017. Pursuant to SB 17, the resources requested from the California Health Data and Planning Fund are funded by revenue transfers from the Managed Care Fund, administered by the Department of Managed Health Care, and the Insurance Fund, administered by the California Department of Insurance.

Program Funding Request Summary			
Fund Source	**2018-19**	**2019-20**	**2020-21***
0143 – CA Health Data and Planning Fund	$500,000	$850,000	800,000
Total Funding Request:	**$500,000**	**$850,000**	**$800,000**
Total Requested Positions:	**3.0**	**5.5**	**5.5**

* Positions and Resources ongoing after 2020-21.

Revenue Transfers to CA Health Data and Planning Fund (0143)			
Fund Source	**2018-19**	**2019-20**	**2020-21***
0217 – Insurance Fund	$35,000	$60,000	$56,000
0933 – Managed Care Fund	$465,000	$790,000	$744,000
Total Funding Request:	**$500,000**	**$850,000**	**$800,000**

* Revenue Transfers ongoing after 2020-21.

This issue was heard during the subcommittee's March 22nd hearing.

Subcommittee Staff Comment and Recommendation—Approve. SB 17 requires OSHPD to receive notifications from drug manufacturers regarding prescription drug price increases, or new drugs exceeding a certain threshold. In addition, OSHPD is required to quarterly report pricing transparency information received from drug manufacturers on its website. Approval of these positions and resources will allow OSHPD to implement these prescription drug price transparency initiatives.

4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 1: Federal Mental Health Parity Compliance Review Resources Extension

Budget Issue. DMHC requests permanent extension of expiring, limited-term expenditure authority from the Managed Care Fund of $529,000 in 2018-19 and annually thereafter. If approved, these resources will allow DMHC to continue to review health care service plan filings for compliance with

the mental health parity requirements of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0933 – Managed Care Fund	$529,000	$529,000
Total Funding Request:	**$529,000**	**$529,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2019-20.

This issue was heard during the subcommittee's March 22nd hearing.

Subcommittee Staff Comment and Recommendation—Approve. DMHC is required to conduct reviews of health care service plans for compliance with the mental health and substance use parity requirements of MHPAEA. To complete these reviews, DMHC requires clinical expertise that cannot be provided by positions within the civil service classifications. Approval of these ongoing contract resources will provide DMHC with the clinical expertise necessary to make determinations regarding health plan compliance with mental health and substance use parity.

Issue 2: Prescription Drug Cost Transparency (SB 17)

Budget Issue. DMHC requests one position and expenditure authority from the Managed Care Fund of $307,000 in 2018-19 and $281,000 in 2019-20 and annually thereafter. If approved, these resources would allow DMHC to compile health plan information on prescription drug costs pursuant to SB 17 (Hernandez), Chapter 603, Statutes of 2017.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0933 – Managed Care Fund	$307,000	$281,000
Total Funding Request:	**$307,000**	**$281,000**
Total Requested Positions:	**1.0**	**1.0**

* Position and Resources ongoing after 2019-20.

This issue was heard during the subcommittee's March 22nd hearing.

Subcommittee Staff Comment and Recommendation—Approve. SB 17 requires DMHC to publish information received from health care service plans regarding expenditures on high cost prescription drugs and these expenditures' effects on plan premiums. Approval of this position and resources will allow DMHC to perform these required functions that will lead to additional transparency regarding expenditures on prescription drugs.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Expanded Lead Testing for California Children (AB 1316)

Budget Issue. DPH requests two positions and expenditure authority from the Childhood Lead Poisoning Prevention Fund of $276,000 in 2018-19 and annually thereafter. If approved, these resources would allow DPH to develop regulations and perform additional blood lead testing and analysis under an expanded standard of care required by AB 1316 (Quirk), Chapter 507, Statutes of 2017.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0080 – Childhood Lead Poisoning Prevention Fund	$276,000	$276,000
Total Funding Request:	**$276,000**	**$276,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and Resources ongoing after 2019-20.

This issue was heard during the subcommittee's March 22nd hearing.

Subcommittee Staff Comment and Recommendation—Approve. AB 1316 requires the Childhood Lead Poisoning Prevention (CLPP) Program to adopt regulations by July 2019 establishing an expanded standard of care to determine if a child is at risk for lead poisoning. Approval of these positions and resources will allow CLPP to implement these expanded monitoring and testing requirements to protect additional children from the adverse effects of lead poisoning.

Issue 2: Infant and Early Childhood Home Visiting Program

Budget Issue. DPH requests permanent extension of 27 expiring, limited-term positions and federal fund expenditure authority of $903,000 in 2018-19 and $21.8 million in 2019-20. Of the 27 positions, 11 would be renewed in January 2019, and 16 would be renewed in July 2019. If approved, these resources would allow DPH to continue operation of the California Home Visiting Program (CHVP).

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0890 – Federal Trust Fund		
State Operations	$903,000	$4,000,000
Local Assistance	$-	$17,800,000
Total Funding Request:	**$903,000**	**$21,800,000**
Total Requested Positions:	**11.0**	**27.0**

* Positions and Resources ongoing after 2019-20.

This issue was heard during the subcommittee's March 22nd hearing.

Subcommittee Staff Comment and Recommendation—Approve. The CHVP is a federally funded program that provides voluntary, evidence-based home visiting services to at-risk pregnant and newly

parenting families. Permanent extension of these expiring, limited-term positions and resources will allow DPH to continue administering this program.

Issue 3: New Genetic Disorders (SB 1095) and Second Tier Testing

Budget Issue. DPH requests 18 positions and expenditure authority from the Genetic Disease Testing Fund of $2.7 million. If approved, these resources would allow DPH to comply with expanded testing requirements pursuant to SB 1095 (Pan), Chapter 363, Statutes of 2016, including new screening for Mucopolysaccharidosis type I (MPS-I), Pompe disease, and any future additions to the Recommended Uniform Screening Panel (RUSP).

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0203 – Genetic Disease Testing Fund		
State Operations:	$2,690,000	$2,690,000
Local Assistance**:	[($460,000)]	[($460,000)]
Total Funding Request:	**$2,690,000**	**$2,690,000**
Total Requested Positions:	**18.0**	**18.0**

* Positions and Resources ongoing after 2019-20.

** Local Assistance reductions are non-add and are reflected in the GDSP Local Assistance Estimate.

This issue was heard during the subcommittee's March 22nd hearing.

Subcommittee Staff Comment and Recommendation—Approve. SB 1095 requires the Genetic Disease Screening Program to expand testing requirements for newborns to include MPS-I, Pompe disease and any future additions to the federal RUSP. In addition, the use of second tier testing to confirm positive test results will help prevent false positives for genetic disorders. Approval of these positions and resources will allow the program to implement the required expansion of genetic testing and improve the accuracy of existing testing.

Issue 4: Birth Certificate Processing Increase for Real ID Compliance

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

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

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

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—Approve. The Real ID Act prohibits federal agencies from accepting identification that does not comply with enhanced security requirements for air travel and other official purposes as of October 2020. Real ID-compliant identification requires documentation of legal presence in the United States, primarily in the form of a birth certificate. Approval of these limited-term resources and budget bill authority will allow DPH to manage the expected increase in requests for birth certificates as a result of these new identification requirements.

Issue 5: AIDS Drug Assistance Program: Eligiblity and Enrollment

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

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

* Resources in 2017-18 fund two administratively established positions.
** Positions and resources ongoing after 2018-19.

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—Approve. After ADAP terminated its enrollment benefits manager contract due to breach of contract and serious security and confidentiality issues, DPH began the process of implementing an in-house solution to enrolling and renewing ADAP clients. Approval of these positions and resources will allow DPH to complete the process of implementing the new ADAP enrollment and renewal system and programmatic infrastructure.

Issue 6: Baby BIG Infant Botulism Treatment and Prevention

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

Provisional Language. DPH requests the following provisional language:

Item 4265-001-0272

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

sooner than whatever lesser time the Chairperson of the Joint Legislative Budget Committee, or his or her designee, may determine.

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—Approve. DPH is the only producer of BabyBIG in the world and this treatment for infant botulism is difficult to schedule. Approval of the provisional language in this spring finance letter will provide DPH with the financial flexibility to fund early delivery of the next lot of BabyBIG.

Issue 7: Emergency Response: Public Health Crisis Response Grant

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

Provisional Language. DPH requests the following provisional language:

Item 4265-001-0890

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

Item 4265-111-0890

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

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—Approve. DPH has received approval from CDC to be placed on an "Approved-But-Unfunded" list of grantees for public health emergency funding. This list stipulates recipients have certified they can submit an amended budget to CDC within 14 days and complete hiring and execute contracts within 30 days. Approval of the provisional language in this spring finance letter will provide DPH with the financial flexibility to augment its federal fund expenditure authority if CDC makes funds available for a public health emergency.

ISSUES FOR DISCUSSION

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Oversight – Black Infant Health Program

Background. The Black Infant Health Program, administered by the California Department of Public Health (CDPH), provides empowerment-focused group support services and case management to improve the health and social conditions for African-American women and their families. Created in 1989 to address a disproportionately high infant mortality rate for black infants, the program seeks to address the complex factors related to infant mortality and preterm births for the population at greatest risk. Black Infant Health providers offer participants health education, social support, individualized case management, home visitation and referrals to other services.

Black Infant Health Model. Originally, the Black Infant Health Program focused primarily on prenatal care and one-on-one case management to address infant mortality. However, a 2006 assessment by the Center on Social Disparities in Health at the University of California, San Francisco, indicated this approach was insufficient, prompting the state and the Center to work towards a new, evidence-based model. The new model, while still providing prenatal care and case management services, emphasizes social support, stress management, and empowerment. In particular, research demonstrated that women who participate in group sessions, rather than the previously standard one-on-one care settings, experience significantly reduced risk of pre-term births, better psychosocial outcomes, more prenatal care knowledge, and feel more prepared for labor and delivery.[1] Local Black Infant Health Programs provide 10 pre-natal and 10 post-partum group sessions exploring the following topics: 1) Cultural Heritage as a Source of Pride; 2) Healthy Pregnancy, Labor & Delivery; 3) Nurturing Ourselves & Our Babies; 4) Prenatal, Postnatal & Newborn Care; 5) Stress Management; 6) Healthy Relationships; and 7) Celebrating Our Families. Case management services link participants with needed community and health-related services, such as health insurance application assistance and family planning counseling.

Black Infant Health Program Budget History. Since its inception, the Black Infant Health Program has been funded by a combination of state General Fund and federal Title V Maternal and Child Health Service Block Grant funding. The Title V block grant, administered by the Health Resources and Services Administration, provides states with funds for programs to improve the health of mothers and children based on a statewide needs assessment. The state General Fund is appropriated by the Legislature through the state budget process.

In response to a significant General Fund deficit resulting from the 2007 recession, the 2009 Budget Act eliminated the $3.9 million General Fund appropriation for the Black Infant Health Program. Local programs still received funds allocated from the federal Title V block grant, but overall funding for these programs was reduced significantly. The 2014 Budget Act authorized the addition of $4 million of ongoing General Fund for the program, restoring the recession-era reductions.

[1] Ickovics J. Group prenatal care and perinatal outcomes. Obstetrics & Gynecology 2007;110(2 Pt 1): 330-339.

The Black Infant Health Program's grant allocations for 2017-18 were as follows:

2017-18 Allocations for Black Infant Health Program		
County/City	**General Fund**	**Federal Fund (Title V)**
Alameda	$295,797	$308,786
City of Long Beach	$248,467	$259,379
Contra Costa	$248,467	$259,379
Fresno	$248,467	$259,379
Kern	$248,467	$259,379
Los Angeles	$462,983	$483,316
Riverside	$295,794	$308,785
Sacramento	$373,645	$390,054
San Bernardino	$373,645	$390,054
San Diego	$295,794	$308,785
San Francisco	$205,770	$214,807
San Joaquin	$248,467	$259,379
Santa Clara	$205,770	$214,807
Solano	$248,467	$259,379
TOTAL	**$4,000,000**	**$4,175,668**

Trends in African American Infant Mortality in California. According to data from the Centers for Disease Control (CDC), the infant mortality rate per 1,000 live births for African Americans in California declined from 13.29 to 8.87 between 1995 and 2015. While the state has made progress since 1995, this rate was still more than twice the rate in 2015 for white (4.24), Hispanic (4.40), and Asian/Pacific Islander (3.50)[2] Californians. In addition, there is some evidence that progress in reducing African American infant mortality has stalled in recent years.[3]

According to the CDC, the leading causes of black infant mortality include complications related to pre-term birth, low birth weight, congenital birth defects, Sudden Infant Death Syndrome (SIDS), and accidents. Complications related to pre-term birth and low birth weight are the most significant causes of black infant mortality, accounting for 60 to 75 percent of all deaths. In addition to being a significant cause of infant mortality, pre-term birth can lead to significant long-term intellectual and developmental

[2] United States Department of Health and Human Services (US DHHS), Centers of Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics (DVS). Linked Birth / Infant Death Records 2007-2015, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, on CDC WONDER On-line Database. Accessed at http://wonder.cdc.gov/lbd-current.html on Mar 2, 2018.

[3] Corinne A. Riddell, PhD; Sam Harper, PhD., Jay S. Kaufman, PhD. Trends in Differences in US Mortality Rates Between Black and White Infants. JAMA Pediatr. 2017;171(9):911-913

disabilities including autism and behavioral problems, as well as chronic medical problems, such as asthma, diabetes, and cancer. Interventions that reduce pre-term birth rates would be likely to lead to reduced infant mortality, as well as significant reductions in neonatal intensive care stays and utilization of medical and mental health services for the treatment of developmental disabilities and other prematurity-associated chronic medical conditions.

Interventions to Reduce Risk Factors for Black Infant Mortality. While the social support, stress management, and empowerment model of the Black Infant Health Program is an evidence-based intervention that reduces black infant mortality, the rate of black infant mortality has remained twice that of any other group. Other interventions that have shown promise generally include a team-based approach to care that couples social interventions with medical interventions. The Centering Pregnancy model is a group-based intervention that follows the recommended schedule of 10 prenatal visits, with each visit 90 minutes to two hours long. According to Centering Healthcare, which developed the model, pregnant women engage in their own care by taking their own weight and blood pressure and recording their own health data with private time with their provider for belly check. DPH indicates that the group-based intervention in the Black Infant Health Program is partially derived from the Centering Pregnancy model.

In addition to these models, a pilot program in Sacramento County demonstrated significant reductions in pre-term birth and low birth weight among its participants compared to rates of these conditions in the county and nationally. The program, affiliated with a federally qualified health center, provided a team-based approach that included an extensive evaluation of each African American pregnant woman, personalized case management, an educational program, and wraparound care provided by home visitors and various medical personnel. The program identified 56 risk factors for pre-term birth and each patient was evaluated by a physician for these social and medical factors. Between June 2014 and April 2016, 454 African American women participated in the program. The combined medical plan and home visiting approach reduced the pre-term birth rate from 16.8 percent for African Americans in Sacramento County to 2.9 percent for participants in the program. The rate of low birth rates was similarly reduced from 13.8 percent in Sacramento County to 4.3 percent for program participants.

Stakeholder Panel. In addition to DPH, the subcommittee has invited the following panelists to discuss potential improvements to state and local efforts to reduce risk factors of black infant mortality:

- **Deborah Allen, ScD --** Deputy Director Health Promotion, L.A. Co. Dept. of Public Health
- **Mashariki K. Kudumu, MPH** – Maternal/Child Health Dir, March of Dimes, Greater LA
- **Philippa Barron** – Alameda Co. Reg. Mgr of Medical Operations, La Clínica de La Raza
- **Chet P. Hewitt –** CEO/President, The Center at Sierra Health Foundation
- **Marie Young** – Taylor-Young African American Infant Death Prev. Program, Sacramento
- **Jo Taylor, MD** – Taylor-Young African American Infant Death Prev. Program, Sacramento

Stakeholder Proposal - California Perinatal Equity Initiative. The Los Angeles County Department of Public Health requests General Fund expenditure authority of $15 million for DPH to fund three interventions that have demonstrated potential to reduce California's black-white gap in infant mortality and improve maternal and infant health generally. The three interventions expand on but do not duplicate existing state and federally funded home visiting programs and the community-based Black Infant Health program. Each would fill a critical gap in programming to avert adverse birth outcomes in

California. Each also offers the opportunity to enhance resources in high risk communities. The three interventions are as follows:

1. Centering Pregnancy - Centering Pregnancy is the only structural approach to pregnancy care shown to reduce the rate of preterm birth, the leading correlate of infant death, among black women in the U.S. Centering is a group model of care that integrates woman-to-woman support with health education and clinical pregnancy care at ninety-minute to two hours sessions for 10-12 women together. It has been implemented in over 500 practices in 46 states across the U.S., among women in all demographic groups and at varying levels of pregnancy risk. Three factors thought to contribute to the effectiveness of Centering are: 1) addressing social isolation and disempowerment of consumers by bringing women together during prenatal care; 2) improving women's understanding of factors that affect infant health by providing time for participants to raise questions that don't get addressed in a 10 or 15 minute prenatal visit; 3) improving quality of care by letting providers get to know patients and identify and address risk factors that might otherwise be missed.
2. One Key Question (OKQ) - One Key Question (OKQ) promotes healthy pregnancy among women who wish to become pregnant, while averting unintended pregnancy among women who wish to avoid or delay childbearing. It calls on physicians to screen women for pregnancy intent by asking, "Do you want to become pregnant in the next year?" at every well-woman or chronic disease management visit. Public health researchers compare OKQ to screening for chronic disease, noting that unintended pregnancy, affecting approximately 50% of U.S. women during their reproductive years, can be seen as the most common adverse health outcome facing U.S. women.
3. Fatherhood Initiatives - Research indicates that "father involvement is related to positive child health outcomes in infants, such as improved weight gain in preterm infants and improved breastfeeding rates." These findings may reflect the value of a second nurturer for the developing child and the indirect benefit the child derives from reduced maternal stress when there is a second caregiver present. Unfortunately, while there is a patchwork of fatherhood programs across California there is no coordinated statewide effort to promote and support engagement of dads in pregnancy and childbearing. The proposal calls for a program operating at the state and local levels aimed at expanding and coordinating the opportunities for father engagement.

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

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

1. DPH: Please provide a brief overview of the Black Infant Health Program.

2. DPH: Please describe the social support model adopted in 2006 for the program.

3. DPH: Please describe the extent to which local Black Infant Health Programs coordinate social interventions with prenatal care and other medical interventions.

4. Panelists: Please describe your and/or your organization's current interactions with the Black Infant Health Program

5. Panelists: In what other types of interventions have you and/or your organizations participated or observed that attempt to reduce black infant mortality?

6. Panelists: What improvements could the state make to its approach to reducing black infant mortality, particularly in reducing the leading causes of infant mortality, such as pre-term birth or low birth weight?

Issue 2: Oversight – Statewide Infectious Disease Response

Background. The Division of Communicable Disease Control (DCDC) within DPH works to promptly identify, prevent and control infectious diseases that pose a threat to public health, including emerging and re-emerging infectious diseases, vaccine-preventable agents, bacterial toxins, bioterrorism, and pandemics. DCDC coordinates with local health departments, health care providers, and local public laboratories to perform these functions. The division's Infectious Disease Branch provides consultation and assistance to local public health, environmental health, and vector control agencies in the control and prevention of communicable diseases and outbreaks; collection, coordination, and analyses of surveillance data of over 50 infectious diseases; investigations of local, regional, statewide, or multistate outbreaks; information on infectious diseases to the DPH, local health jurisdictions, the medical community, and the public through emails, press releases, postings of pamphlets and fact sheets on the department's website, and publications in medical journals; and recommendations, guidelines, policies, and regulations on communicable disease prevention and control. DPH also oversees and coordinates with local, state, and federal public health laboratories. State public health laboratories confirm the presence of disease, respond to emergencies, detect outbreaks, and provide situational awareness.

DPH also maintains the California Reportable Disease Information Exchange (CalREDIE), a secure system for electronic disease reporting and surveillance. Specified diseases and conditions are mandated by state law and regulation to be reported by healthcare providers and laboratories to the public health authorities. CalREDIE improves the efficiency of surveillance activities and the early detection of public health events through the collection of complete and timely surveillance information on a state wide basis. Local health departments and DPH have access to disease and laboratory reports in near real-time for disease surveillance, public health investigation, and case management activities. The CalREDIE system is widely utilized by local health departments and healthcare providers in California and over 350 laboratories electronically submit reportable lab results through the CalREDIE Electronic Laboratory Reporting (ELR).

Recent Outbreak of Hepatitis A. In November 2016, an outbreak of Hepatitis A began in San Diego County and subsequently spread to Santa Cruz, Los Angeles, and Monterey counties. According to DPH, the majority of people infected with hepatitis A virus in this outbreak were people experiencing homelessness and/or using illicit drugs in settings of limited sanitation. During the outbreak, DPH helped to support the local health department response in the following ways: 1) coordinating and supporting hepatitis A outbreak response efforts across California; 2) monitoring the outbreak and providing epidemiologic support to the response by enhancing monitoring of cases, testing specimens to identify the outbreak strain, and providing staff and technical expertise, including developing and disseminating disease control, clinical, and vaccine prioritization guidance; 3) buying, distributing, and monitoring about 123,000 hepatitis A vaccine doses to local health departments during this outbreak; and 4) communicating accurate information about the outbreak, control measures, and level of risk of hepatitis A infection for different populations with partners, the media, and the public.

According to DPH, after review of the availability of Hepatitis A vaccine, the Governor issued a declaration of a state of emergency to secure and purchase additional vaccine. The Administration provided an augmentation from emergency appropriation authority provided in the state budget to account for the purchase of the additional vaccine. Following intensive efforts by local health departments and their clinical and community partners, including vaccination campaigns targeting the

at-risk population, education, obtaining and managing vaccine, and many other interventions, the number of reported outbreak-associated cases has substantially decreased in California.

Infectious Disease Response Panel. In addition to DPH, the subcommittee has requested the following panelists to discuss the state's response to emerging infectious diseases at the state and local level:

- **Arnold Leff, MD, REHS –** Health Officer, Santa Cruz County
- **Joel Buettner** – General Manager, Placer Mosquito and Vector Control District

Stakeholder Proposal – Mosquito Surveillance. The Mosquito and Vector Control Association of California requests General Fund expenditure authority of $2 million in 2018-19 for the California Vector-borne Disease Surveillance (CalSurv) system, as well as grants for vector research specific to California's unique ecosystems. According to the Association, mosquito surveillance is crucial for tracking, eliminating, and preventing the spread of mosquitos and the diseases they carry. Due to effective mosquito surveillance, efforts to limit the spread of West Nile were successful. However, mosquitos adapt quickly by becoming resistant to pesticides, alter their feeding and biting patterns, and infest geographic regions they have never before been detected.

Through competitive academic research grants, some federal assistance, and an agreement between the University of California (UC), Davis, mosquito abatement agencies, and DPH, UC Davis has been able to keep CalSurv functioning. However, the research grants and federal funding through the DPH have not been consistent and are not guaranteed. There is also concern that federal funding will no longer be available, given the current federal Administration. Additionally, this funding tends to have a more international focus leaving a gap for research that could benefit California's unique and diverse climate.

Stakeholder Proposal – Valley Fever Research. The Valley Fever Institute at Kern Medical requests General Fund expenditure authority of $3 million in 2018-19 for a research grant to fund Valley Fever treatment research and outreach. According to the Valley Fever Institute, there is no cure or vaccine for Valley Fever and studies show that early intervention ensures the best management of the disease. The most severe cases of Valley Fever stem from delayed diagnosis. The Centers for Disease Control and Prevention report Valley Fever infection rates rose twelve-fold nationwide between 1995 and 2009, and researchers estimate the fungus infects 150,000 people each year who either escape detection of the disease or suffer serious ailments without knowing the cause of their illness. The Valley Fever Institute at Kern Medical is ideally suited to be the premiere center for laboratory research, as it has the largest population of patients with Valley Fever, receives patients from around the world, has infectious disease experts dedicated to the study of Valley Fever, and is the site of clinical research trials on the effectiveness of early treatment with medication.

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

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

1. DPH: Please provide a brief overview of the state's monitoring, planning, and response to outbreaks of infectious disease.

2. DPH/Panelists: How do DPH and local health departments coordinate to monitor infectious disease outbreaks, and implement appropriate responses?

3. DPH/Panelists: What were the various roles of the state and local health departments in responding to the recent Hepatitis A outbreak? What type of planning for specific disease outbreaks occurs before the outbreak and how do DPH and local health departments adapt these plans in real-time in response to the details of an outbreak?

4. DPH/Panelists: How do the state and local health departments prepare for flu season? What planning occurs beforehand for a particularly virulent or widespread flu outbreak and how do the state and local health departments deploy resources to respond?

5. Panelists: How do DPH and the state generally support your organization in its mission to protect the public from infectious disease? Are there any areas for improvement of this support?

6. DPH/ (Vector Control) Panelist: How does DPH engage with local vector control districts to monitor the incidence of vector-borne disease such as West Nile and Zika?

7. DPH/Panelists: How does DPH respond to detection of cases of West Nile or Zika? What is the local vector control or local health department's responsibility?

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

Issue 1: Proposals for Investment

The subcommittee has received the following proposals for investment:

Issue 1A. Restoration of Social Recreation and Camp Services

Budget Issue. The Association of Regional Center Agencies (ARCA), Disability Rights California (DRC), Disability Voices United (DVU), and the ARC/United Cerebral Palsy (UCP) California Collaboration all request that social recreation and camp services be restored.

Background. In 2009, budget trailer bill language was enacted to address a $42 billion budget deficit and restore California's fiscal balance. Part of that solution was the temporary suspension of social recreation activities and camping services. These reductions were intended to be temporary pending the development and implementation of the Individual Choice Model (ICM). The ICM was to be an alternative service delivery model that provided an individual budget, and choice and flexibility for clients. Ultimately, that model was never implemented. However, the department is on track to begin implementation of the Self Determination Program in the near future, which seems to be similar to the ICM.

ARCA emphasizes that, "…these services had the added benefit of offering families a break while respecting cultural preferences for home-based family care, a particularly positive impact on diverse communities."

According to the ARC/UCP California Collaboration, "Social recreation and camping services increase community integration, improve socialization skills and have been of particular benefit to ethnically diverse communities."

Disability Rights California states, "The most important steps we can take is to ensure that consumers from ethnic and language distinct communities have access to culturally and linguistically competent services that they need." Restoring these services can help advance that goal.

Disability Voices United, "These services have been used at higher rates by underserved Latino, African-American, and Asian families in the past, and restoring funding would help reduce racial disparities."

DDS estimates the cost to restore social recreation and camping services for 2018-19, effective July 1, 2018, to be $22.2 million ($14 million General Fund) in 2018-19. This is based on the estimated full-year impact of $39.4 million, adjusted for ramp up of services. Ramp up will occur as regional centers review and update Individual Program Plans (IPPs) to identify the need for and authorize social recreation services, and to identify and develop providers to offer these services. The 2019-20 estimated costs are $35.4 million ($22.3 million General Fund). This amount is also based on the estimated full-year impact of $39.4 million, adjusted for continuing ramp up.

During the 2017-18 budget process the Assembly voted to restore these services, while the Senate voted to lift the cap on respite services. In the final budget negotiations, the Legislature approved the elimination of a cap on respite services.

Staff Recommendation. Hold open.

Issue 1B. Bridge Funding for Service Providers

Budget Issue. ARCA and the ARC/UCP California Collaboration have submitted written comments supporting a legislative proposal requesting $25 million (General Fund) be provided to service providers to help meet increasing labor and other operations costs.

Background. Supporters state, "These funds will help address cost pressures arising from extraordinary cost-of-living increases in California's major population centers." Due to rate freezes dating back to 2003, service providers cannot negotiate, nor can regional centers offer, a rate that reflects the actual operating costs.

There are two ways the department may increase an existing service provider's rate –a health and safety waiver or an unanticipated rate adjustment. State law authorizes the department to approve exemptions to rate freezes when necessary to protect the health and safety of a specific consumer.[4] 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. 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.

Rate adjustments drawing from requested funds would be implemented by building on existing rate adjustment mechanisms. Existing mechanisms could be used and expanded to include funding for increased mandated labor costs as well as increased transportation and lease expenses.

In 2017, the department received $3 million General Fund 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 requested funds are intended as bridge funding, pending the finalization of the rate study.

Staff Recommendation. Hold open.

[4] Welfare and Institutions Code sections 4648.4(b), 4681.6, 4684.55, 4689.8, 4691.9 and 4691.9.

Issue 1C. Integrated Community Living Fund

Budget Issue. The Lanterman Coalition requests the creation of the Integrated Community Living (ICL) Fund within DDS, which would award available funds to finance capital costs for the development of new housing units for regional center clients.

Background. According to the Lanterman Coalition, average rent in sixteen counties exceeds the SSI/SSP grant of $911 (effective January 1, 2018). Approximately 86% of regional center clients rely solely on SSI/SSP for their income. This proposal requests that revenue from certain closing developmental centers be used to fund housing costs for regional center clients. Proponents state that, "This is an opportunity to use one-time General Fund dollars to jumpstart housing developments, and ongoing revenues from the disposition of developmental center properties to sustainably fund affordable housing development in the future."

By 2021, DDS must close all of its remaining developmental centers, and transition remaining residents into the community. The ICL Fund would serve as a repository if/when revenue is generated from new uses of the General Treatment Area at Porterville and Fairview DC. The Lanterman Coalition proposes that the ICL Fund be administered through an interagency agreement between DDS and the California Department of Housing and Community Development, and would award available funds to finance capital costs for the development of new housing units for regional center clients. Funds would be awarded using minimum criteria and would be distributed to maximize access to low-income housing tax credit projects for the target population, as well as to incentivize the development of creative permanent supportive housing projects to meet the needs of persons living with intellectual and developmental disabilities.

Earlier this year the LAO released a report entitled, "Sequestering Savings from the Closure of Developmental Centers." This report discussed potential savings in terms of net operational savings and increased revenues from the sale or repurposing of DC properties. In the report, the LAO details that the unique characteristics of each property could affect market value, and sale and/or leasing potential. Currently, the value of the properties is unknown and local preferences could affect property value and interest among private entities to purchase the properties. The report also states that earmarking revenue for the closure of developmental centers limits flexibility of future Legislatures.

Staff Recommendation. Hold open.

Issue 1D. Best Buddies

Budget Issue. The Best Buddies organization requests $1.6 million to support and expand delivery of its social inclusion, integrated employment, and leadership development services to people with intellectual and developmental disabilities (IDD).

Background. Best Buddies states that it is "the only organization using peer-to-peer relationships between people with and without IDD to break down the barriers that inhibit opportunities for meaningful interactions between the populations." Best Buddies received $1.6 million General Fund in the 2017-18 budget to provide these services.

According to Best Buddies, the $1.6 million in current year funding is helping them support nearly 6,200 participants through 137 school-based chapters statewide, exceeding the project's output goal of 120 total schools served. 27 of these chapters launched in Fall 2017 and Spring 2018. This funding serves 110 adults with IDD already placed in competitive, integrated employment, and it will facilitate 34 new job placements in California. These funds will also provide public speaking training to 30 unduplicated participants with IDD through the Best Buddies Ambassador Program.

If $1.6 million were provided in the 2018-19 budget Best Buddies would be able to serve a minimum of 8,000 students with and without IDD through 137 existing school-based chapters, launch a minimum of 20 new chapters in elementary, middle, high school, and college chapters; recruit and train a minimum of 780 student leaders with and without IDD; provide opportunities for the development of critical social skills in at least 3,000 individuals with IDD through frequent contact with typical peers; execute 624 inclusive social and recreational group activities that engage school-based participants; provide a minimum of 122 individuals with IDD continued support and access to competitive, integrated employment; expand employment services to include a class of nine new interns at the Fresno Project SEARCH site, 12 new job placements in Northern California, 10 new job placements in Los Angeles, five new job placements in Long Beach, and intake a class of eight new interns in the Harbor City Project SEARCH 2018-2019 class.

Staff Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: Proposal for Investment – State Appropriation for Holocaust Survivors

Budget Issue. This proposal requests $3.6 million General Fund one-time to the Department of Social Services for a Holocaust Survivor's Assistance Program that would establish a grant program to help these individuals avoid institutionalization by providing services such as home care, culturally appropriate case management, home-delivered meals, transportation, and emergency financial assistance.

Staff Comment and Recommendation. Hold open.

0000 VARIOUS DEPARTMENTS

Issue 1: Additional Proposals for Investment

California Sickle Cell Action Plan Proposal. A coalition of organizations, including the Sickle Cell Disease Foundation (SCDF), the Center for Inherited Blood Disorders (CIBD), and the Pacific Sickle Cell Regional Collaborative (PSCRC) request General Fund expenditure authority of $15 million over five years to support infrastructure to expand an existing model of advance practice medical homes for adults with sickle cell disease (SCD) into five California locales with the largest numbers of affected adults. The goals of this expansion would be: 1) improve access to quality, coordinated, and comprehensive health care services for adults with SCD by developing five new sickle cell outpatient advance practice specialty medical homes, using a hub and spoke model; 2) enhance whole person care services for individuals and families with SCD by developing five new sickle cell Community Based Organization (CBO) spoke agencies. Spoke CBOs will collaborate with the local SCD medical homes providing case management, follow-up and educational services that address the social and behavioral health needs of the target population; 3) enhance stakeholder relationships within the sickle cell and broader blood disorders communities and population health systems by building partnerships with hospitals and health systems to sustain the model, chiefly with Managed Medi-Cal Health Plans; 4) design sustainability by building the hematology workforce via tele-mentoring opportunities statewide.

Lead Certification Application Processing. The California State Council of Laborers requests expenditure authority of $75,000 to fund staff in the Childhood Lead Poisoning Prevention Program to accelerate processing of applications for certification for providing lead construction services. The Laborers are requesting an increase in their certification fee of between $10 and $12 to fund this request. According to the Laborers, the current application processing timeline is 120 days. With additional staff funded by this request, the processing time would be reduced to no more than 60 days.

Hospital Detoxification Services in Drug Medi-Cal Organized Delivery System (DMC-ODS). The California Association of Alcohol and Drug Program Executives (CAADPE) requests General Fund expenditure authority of $25 million to expand funding for hospital detoxification services benefits under the Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver for free standing acute psychiatric and chemical dependency hospitals, as outlined in the 1115 waiver terms and conditions. According to CAADPE, the state's 1115 waiver terms and conditions waived the IMD exclusion for residential and hospital detoxification services as an allowable and reimbursable benefit. For detoxification it permits the use of Free Standing Acute Psychiatric and Chemical Dependency Hospitals. The Department of Health Care Services (DHCS) has issued a bulletin clarifying only state general acute hospitals or psychiatric hospitals within general acute hospitals can claim reimbursement directly through the Medi-Cal fee for service system. All other detox services, free standing acute psychiatric and chemical dependency facilities are to seek funding for detoxification services through their county DMC-ODS. However, counties and stakeholders assert that the DMC-ODS waiver did not fund hospital detoxification services through DMC-ODS as the state did for the expansion of residential service. Since these free-standing facilities are not eligible for state reimbursement, this badly needed hospital level of care is essentially nonexistent creating a true barrier to care.

Extension and Clarification of Medical Interpreters Pilot. The American Federation of State, County, and Municipal Employees (AFSCME) requests budget bill language and trailer bill language to

extend the timeline of the project and clarify the intent of the Legislature in the implementation of the pilot projects approved by AB 635 (Atkins), Chapter 600, Statutes of 2016.

Medical Outliers Proposal. Children's Hospital Los Angeles (CHLA) requests General Fund expenditure authority of $17 million to account for significant financial losses related to a change in Medi-Cal reimbursement for medical outliers. A medical outlier is a patient that requires additional care outside of what is covered by the diagnosis related group (DRG) reimbursement model due to the complexity of their condition. Last year, DHCS reduced reimbursement rates for patients with complex conditions, who achieve outlier patient status.

Suicide Hotlines. Didi Hirsch Mental Health Services requests expenditure authority of $4.8 million from the Mental Health Services Fund to fund California's 11 suicide prevention lifeline (Lifeline) network members and transfer oversight for the program to the Mental Health Services Oversight and Accountability Commission. According to Didi Hirsch, the National Suicide Prevention Lifeline is a network of 165 suicide crisis lines in the U.S. that must be accredited and adhere to specific standards and best practices. The federal government supports Lifeline's infrastructure, which includes a telecommunications system that links callers to the closest line and rolls calls over to a back-up line if the closest line is busy or has lost power. However, states are expected to fund direct services. The federal government provides individual lines with nominal stipends up to $1,500 per year. The Lifeline network also is able to link callers to services provided by larger crisis lines that would be far too costly for every Lifeline member to provide, such as 24/7 bilingual Spanish counselors and a Disaster Distress Helpline. Similarly, California's network of Lifeline members ensure 24/7 coverage for counties without a Lifeline crisis center. Many take calls outside their home counties, and the largest of the State's Lifeline centers answers calls from all 58 counties.

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

Questions. The subcommittee has requested advocates to present these proposals for investment.

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 10, 2018
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultants: Scott Ogus, Renita Polk, Theresa Pena

OUTCOMES

ISSUES RECOMMENDED FOR VOTE-ONLY

Item	Department	Action
0530	**CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY**	
Issue 1:	HIPAA Compliance and Technical Assistance	Approve (3-0)
Issue 2:	eWIC MIS Project Expenditure Increase	Approve (3-0)
4140	**OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT**	
Issue 1:	Prescription Drug Cost Transparency Implementation Plan (SB 17)	Approve (2-1)
4150	**DEPARTMENT OF MANAGED HEALTH CARE**	
Issue 1:	Federal Mental Health Parity Compliance Review Resources Extension	Approve (3-0)
Issue 2:	Prescription Drug Cost Transparency (SB 17)	Approve (2-1)
4265	**DEPARTMENT OF PUBLIC HEALTH**	
Issue 1:	Expanded Lead Testing for California Children (AB 1316)	Approve (3-0)
Issue 2:	Infant and Early Childhood Home Visiting Program	Approve (3-0)
Issue 3:	New Genetic Disorders (SB 1095) and Second Tier Testing	Approve (3-0)
Issue 4:	Birth Certificate Processing Increase for Real ID Compliance	Approve (3-0)
Issue 5:	AIDS Drug Assistance Program: Eligiblity and Enrollment	Approve (3-0)
Issue 6:	Baby BIG Infant Botulism Treatment and Prevention	Approve (3-0)
Issue 7:	Emergency Response: Public Health Crisis Response Grant	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

Tuesday, May 15, 2018
1:30 p.m.
State Capitol - Room 2040

PART A

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
5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: Medi-Cal Eligibility Data Systems (MEDS) Modernization

DOF Issue#: 0530-001-BCP-2018-GB
4260-014-BCP-2018-GB
5180-020-BCP-2018-GB

Budget Issue. CHHSA's Office of Systems Integration (OSI), DHCS, and DSS request seven positions (four positions for OSI, three positions for DSS) and expenditure authority of $7.9 million ($787,000 General Fund, $6.6 million federal funds, and $426,000 reimbursements) in 2018-19. If approved, these resources would continue the multi-departmental 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 (CHHSA-OSI)		
Fund Source	**2018-19**	**2019-20**
9745 – CHHS Automation Fund	$7,350,000	$-
Total Funding Request:	**$7,350,000**	**$-**
Total Requested Positions:	**4.0**	**0.0**

Program Funding Request Summary (DHCS)		
Fund Source	**2018-19**	**2019-20**
0001 – General Fund	$740,000	$-
0890 – Federal Trust Fund	$6,664,000	$-
Total Funding Request:	**$7,404,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Program Funding Request Summary (DSS)		
Fund Source	**2018-19**	**2019-20**
0001 – General Fund	$47,000	$-
0995 – Reimbursements	$426,000	$-
Total Funding Request:	**$473,000**	**$-**
Total Requested Positions:	**3.0**	**0.0**

This issue was heard during the subcommittee's April 19th 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 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, DHCS, and DSS to effectively upgrade this vital eligibility system for the state's health and human services programs.

Issue 2: Rightsizing Office of Law Enforcement Support

DOF Issue#: 0530-005-BCP-2018-GB

Budget Issue. CHHSA's Office of Law Enforcement Support (OLES) requests one new position, reclassification of nine existing positions, and General Fund expenditure authority of $686,000 in 2018-19 and $621,000 annually thereafter. If approved, these resources would allow OLES to recruit appropriate staff to provide monitoring and oversight of investigations conducted by the Department of State Hospitals (DSH) and Department of Developmental Services (DDS).

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$686,000	$621,000
Total Funding Request:	**$686,000**	**$621,000**
Total Requested Positions:**	**1.0**	**1.0**

* Positions and resources ongoing after 2019-20.

** The position request includes reclassifications of nine existing positions to classifications with higher total compensation.

This issue was heard during the subcommittee's April 19th hearing.

Subcommittee Staff Comment and Recommendation—Approve. The role of OLES as an internal affairs operation, rather than a Peace Officer Standards and Training (POST) organization, as well as the difficulties OLES has experienced in recruiting and retaining qualified Investigators, suggests reclassification of these Investigator positions to Special Agents is necessary and appropriate for long-term stability of the program.

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

Issue 1: Increased Information Technology Security Resources

DOF Issue#: 4120-001-BCP-2018-GB

Budget Issue. EMSA requests one permanent position and $356,000 General Fund in 2018-19 and $189,000 General Fund in 2019-20 and annually thereafter. If approved, these resources would allow EMSA to provide adequate staffing levels to strengthen the department's information technology (IT) infrastructure and compliance with state IT policy and regulatory requirements.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$356,000	$189,000
Total Funding Request:	**$356,000**	**$189,000**
Total Requested Positions:	**1.0**	**1.0**

* Positions and Resources are ongoing after 2019-20.

This issue was heard during the subcommittee's March 22nd hearing.

Subcommittee Staff Comment and Recommendation—Approve. An independent security assessment conducted by the Cyber Network Team at the California Military Department identified several deficiencies in EMSA's performance of its IT infrastructure and security responsibilities. These resources are necessary to correct those deficiencies and upgrade necessary IT infrastructure.

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: Mental Health Loan Assumption Program Administrative Resources

DOF Issue#: 4140-300-BCP-2018-A1

Spring Finance Letter. OSHPD requests expenditure authority of $215,000 from the Mental Health Services Fund in 2018-19 and 2019-20. If approved, these resources would support administrative activities to close out all grants awarded through the Mental Health Loan Assumption Program and ensure compliance with program requirements.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20**
3085 – Mental Health Services Fund	$215,000	$215,000
Total Funding Request:	**$215,000**	**$215,000**

This issue was heard during the subcommittee's May 3rd hearing.

Subcommittee Staff Comment and Recommendation—Approve. The ten year Mental Health Services Act Workforce Education and Training (WET) funding allocation will expire at the end of the 2017-18 fiscal year. In addition, OSHPD only has funded staff in its Health Professions Education Foundation to manage the Mental Health Loan Assumption Program (MHLAP) until that time. These resources will allow OSHPD to close out existing awards under the MHLAP as the program funding comes to an end.

4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 1: Consumer Outreach and Assistance Program Extension

DOF Issue#: None – Legislative Proposal

Consumer Outreach and Assistance Program. Section 1368.05 of the Health and Safety Code requires DMHC to contract with community-based organizations to assist consumers in navigating private and public health care coverage. Since 2012, DMHC has contracted with the Health Consumer Alliance (HCA) through the Consumer Outreach and Assistance Program (COAP) to advocate for health care consumers confronting barriers to eligibility, coverage, or obtaining services by providing free legal assistance. HCA is a statewide collaborative of consumer assistance programs operated by community-based legal services organizations, including: Bay Area Legal Aid, California Rural Legal Assistance, Central California Legal Services, Greater Bakersfield Legal Assistance, Legal Aid Society of Orange County, Legal Aid Society of San Diego, Legal Aid Society of San Mateo, Legal Services of Northern California, Neighborhood Legal Services of Los Angeles County, the National Health Law Program, and the Western Center on Law and Poverty.

According to HCA, COAP has been funded by $2.5 million from the Managed Care Fund since 2014. The program receives an explicit allocation through provisional budget language of $660,000, but HCA reports DMHC provides additional funding through redirection of other allocations within its overall appropriation from the Managed Care Fund. HCA requests an explicit allocation of $2.6 million from the Managed Care Fund, which includes continued funding of the program at its current level and a cost-of-living adjustment of $100,000.

This issue was heard during the subcommittee's March 22nd hearing.

Subcommittee Staff Comment and Recommendation—Approve and Adopt Placeholder Budget Bill Language to fund the program at $2.5 million from the Managed Care Fund. The COAP provides essential services to consumers to assist them in navigating the increasing complexities of both private and public health care coverage.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Federal Managed Care Regulations Implementation

DOF Issue#: 4260-005-BCP-2018-GB

Budget Issue. DHCS requests ongoing extension of nine expiring, limited-term positions and expenditure authority of $3.1 million ($1.5 million General Fund, $1.5 million federal funds). If approved, these resources would allow DHCS to continue efforts to implement the federal Medicaid managed care regulations. Included in the resource request is $1.3 million ($650,000 General Fund and $650,000 federal funds) for the department's contract with an External Quality Review Organization to perform quarterly access assessments.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$1,547,000	$1,547,000
0890 – Federal Trust Fund	$1,547,000	$1,547,000
Total Funding Request:	**$3,094,000**	**$3,094,000**
Total Requested Positions:	**9.0**	**9.0**

* Positions and Resources ongoing after 2019-20.

This issue was heard during the subcommittee's March 22nd hearing.

Subcommittee Staff Comment and Recommendation—Approve. The federal Medicaid managed care regulations, as well as recently enacted state legislation codifying and expanding these regulations, requires ongoing resources to monitor compliance and perform quality review evaluations. Extension of these expiring, limited-term resources will allow DHCS to continue these activities.

Issue 2: Discontinuation of 340B Drug Reimbursement

DOF Issue#: TBL: RN 1802014

Trailer Bill Language. DHCS requests trailer bill language to restrict the scope of the use of the 340B Program within the Medi-Cal program to comply with existing federal requirements. According to DHCS, these restrictions would help protect program integrity, prevent unnecessary overpayments, result in additional drug rebate savings, as well as serve to mitigate the amount of time and resources expended to resolve drug rebate disputes related to 340B claims.

This issue was heard during the subcommittee's March 22nd hearing.

Subcommittee Staff Comment and Recommendation—Deny. While it is clear that a mechanism should be found to avoid inappropriate duplicate prescription drug rebates, eliminating 340B drugs from the Medi-Cal program would have a significant negative impact on essential safety net providers, putting access to care for beneficiaries at risk. The subcommittee encourages the Administration to continue to work with stakeholders to find a solution to the duplicate rebates problem that mitigates or eliminates these negative impacts.

Issue 3: Drug Medi-Cal and Specialty Mental Health: FQHCs and RHCs (SB 323)

DOF Issue#: 4260-013-BCP-2018-GB

Budget Issue. DHCS requests five positions and expenditure authority of $891,000 ($446,000 General Fund and $445,000 federal funds) in 2018-19, and $3 million ($1.5 million General Fund and $1.5 million federal funds) in 2019-20, $3.2 million ($1.6 million General Fund and $1.6 million federal funds) in 2020-21, $1.2 million ($581,000 General Fund and $580,000 federal funds) in 2021-22, and $595,000 ($298,000 General Fund and $297,000 federal funds) in 2022-23 and annually thereafter. If approved, these resources would allow DHCS to provide oversight, implement system changes, and audit reimbursement rate changes for federally qualified health centers and rural health clinics to provide specialty mental health or Drug Medi-Cal services to eligible beneficiaries pursuant to SB 323 (Mitchell), Chapter 540, Statutes of 2017.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$446,000	$1,509,000
0890 – Federal Trust Fund	$445,000	$1,509,000
Total Funding Request:	**$891,000**	**$3,018,000**
Total Positions Requested:**	**5.0**	**5.0**

* Additional fiscal year resources requested: 2020-21: $3,233,000; 2021-22: $1,161,000; 2022-23 (ongoing): $595,000
** Limited-term expenditure authority equivalent to: 2018-20: 2.0 positions; 2019-21: 16.0 positions; 2020-22: 3.0 positions

This issue was heard during the subcommittee's April 12th hearing.

Subcommittee Staff Comment and Recommendation—Approve. Federally qualified health centers and rural health clinics seeking separate reimbursement for Drug Medi-Cal or specialty mental health services are required to apply for a change in scope of service to remove those services from the clinic's daily rate. These resources will allow DHCS to manage the auditing associated with the expected increase in change in scope of service requests.

Issue 4: Health Care Reform Financial Reporting

DOF Issue#: 4260-001-BCP-2018-GB

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

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

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

This issue was heard during the subcommittee's March 30th hearing.

Subcommittee Staff Comment and Recommendation—Approve. Implementation of the federal Affordable Care Act has resulted in additional complexity of financial reporting for federal matching funds. These resources will allow DHCS to manage this new workload.

Issue 5: Orange County Office Consolidation

DOF Issue#: 4260-002-BCP-2018-GB

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

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

* Resources ongoing after 2019-20.

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—Approve. The existing Santa Ana State Building is not an appropriate placement for DHCS staff given its level of disrepair. As the alternative Orange location is not large enough to house the Santa Ana staff, relocation to a new, larger building elsewhere in Orange County is an appropriate response to this issue.

Issue 6: HIPAA Privacy Rule Compliance

DOF Issue#: 4260-006-BCP-2018-GB

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

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

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

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—Approve. HIPAA related security incidents have continued to rise, with a concomitant rise in workload for DHCS staff to meet required reporting and notification requirements. These positions and resources will allow DHCS to manage these requirements.

Issue 7: California Technical Assistance Program (CTAP) Extension

DOF Issue#: 4260-007-BCP-2018-GB

Budget Issue. DHCS requests a two-year, no-cost extension and reappropriation of any remaining funding from the 2014 Budget Act allocation of $3.8 million from the Major Risk Medical Insurance

Fund for the California Technical Assistance Program (CTAP). If approved, the reappropriation of funding will allow DHCS to continue to implement and administer CTAP, which provides assistance to providers to adopt the use of electronic health records.

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—Approve. Delays in federal regulatory changes have hampered the ability of CTAP to utilize all of its expenditure authority. This no-cost extension will give the program the opportunity to assist additional providers to adopt electronic health records.

Issue 8: California 1115 Waiver - Medi-Cal 2020

DOF Issue#: 4260-008-BCP-2018-GB

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

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

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—Approve. The terms of California's 1115 Waiver require certain compliance activities and evaluation of programs by external entities. These resources will allow DHCS to comply with these requirements.

Issue 9: Graduate Medical Education (GME) Program Oversight and Monitoring

DOF Issue#: 4260-012-BCP-2018-GB

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

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

* Positions and resources ongoing after 2019-20.
** DPH GME Fund receives county intergovernmental transfer funds for the non-federal share of program costs.

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—Approve. While federal approval of the new GME program is pending, this program has the potential to offer significant resources to support development of the state's health care workforce. Approval of these resources will allow DHCS to administer this potentially significant program once federal approval is obtained.

Issue 10: Hospital Quality Assurance Fee Program

DOF Issue#: 4260-013-BCP-2018-GB
TBL: RN 1806970

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

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

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

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—Approve and Adopt Placeholder Trailer Bill Language. In 2016, voters approved permanent extension of the Hospital Quality Assurance Fee.

Because the fee was previously approved for a limited duration, limited-term resources were necessary. Due to the permanent extension of the fee, permanent extension of these resources is appropriate. In addition, the complexities of the transition to directed payments from the existing intergovernmental transfer program for supplemental hospital reimbursement warrant additional limited-term resources to manage the associated workload.

Issue 11: Federally Qualified Health Center Audits (AB 1863)

DOF Issue#: 4260-015-BCP-2018-GB

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

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

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—Approve. Federally qualified health centers and rural health clinics seeking reimbursement for a separate visit for marriage and family therapists are required to apply for a change in scope of service to remove those services from the clinic's daily rate. These resources will allow DHCS to manage the auditing associated with the expected increase in change in scope of service requests.

Issue 12: Clinics/Community Treatment Facilities Supplemental Payments

DOF Issue#: TBL: RN 1803402

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

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—Approve. After CMS approval of necessary cost reporting and evaluation of eligibility requirements for participation in the AB 959 supplemental

payment program, very few providers were eligible. As a result, approval of this trailer bill language proposal is necessary to repeal the program, as the program is not sustainable with such a small pool of participating providers.

Issue 13: Ombudsman Customer Relations Management System

DOF Issue#: 4260-303-BCP-2018-A1

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

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

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

This issue was heard during the subcommittee's April 26th hearing.

Subcommitee Staff Comment and Recommendation—Approve. Transferring the Office of the Ombudsman's CRM to a cloud-based software solution will allow DHCS to reduce its call wait time and collect demographic information from beneficiaries as required by the 2017 Budget Act.

Issue 14: Medi-Cal Program Integrity Data Analytics

DOF Issue#: 4260-303-BCP-2018-A1

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

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

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

This issue was heard during the subcommittee's April 26th hearing.

Subcommitee Staff Comment and Recommendation—Approve and Adopt Placeholder Budget Bill Language. DHCS' recent experience validating Drug Medi-Cal providers demonstrated the value of data analytics. Approval of these resources and budget bill language will improve DHCS' ability to detect inappropriate payments in the Medi-Cal system.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Alzheimer's Disease Program Grant Awards

DOF Issue#: 4265-009-BCP-2018-GB

Budget Issue. DPH requests expenditure authority of $3.2 million ($3.1 million General Fund and $104,000 CA Alzheimer's Disease and Related Disorders Research Fund) in 2018-19 and $3 million ($3.1 million General Fund and a reduction of $138,000 CA Alzheimer's Disease and Related Disorders Research Fund) in 2019-20 and annually thereafter. If approved, these resources would allow DPH to fund research related to the study of Alzheimer's disease and related disorders.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$3,115,000	$3,115,000
0823 – CA Alzheimer's Disease & Related Disorders Fund	$104,000**	($138,000)
Total Funding Request:	**$3,219,000**	**$2,997,000**

* Resources ongoing after 2019-20.

** Consists of a reduction of $138,000 State Operations offset by an increase in $242,000 for Local Assistance grants

This issue was heard during the subcommittee's March 22nd hearing.

Subcommittee Staff Comment and Recommendation—Approve. While the inappropriate over-award of grant funding resulted in additional costs to the program, the program has implemented an additional layer of review to prevent future issues. In addition, the Administration's proposed increase in General Fund resources for Alzheimer's research is a welcome augmentation to the resources of this vital research program.

Issue 2: Public Beaches: Inspection for Contaminants (SB 1395)

DOF Issue#: 4265-002-BCP-2018-GB

Budget Issue. DPH requests General Fund expenditure authority of $354,000 in 2018-19, $242,000 in 2019-20, $370,000 in 2020-21, and $125,000 in 2021-22 and 2022-23. If approved, these resources would allow DPH to finalize development of guidelines approving the use of new rapid test methods to replace current conventional culture methods for determining closures of public beaches, pursuant to the

provisions of SB 1395 (Block), Chapter 928, Statutes of 2014. Staff funded by these resources would be redirected from other divisions within DPH.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$354,000	$242,000
Total Funding Request:	**$354,000**	**$242,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional fiscal year resources requested: 2020-21: $370,000; 2021-22 and 2022-23: $125,000.

This issue was heard during the subcommittee's March 22nd hearing.

Subcommitee Staff Comment and Recommendation—Approve. Expansion of the use of rapid-testing for beach contamination will allow for shorter periods of potential exposure for Californians. These resources will ultimately allow local health departments to shorten the period between suspicion of contamination, confirmation, and closure to prevent public exposure to contaminants.

Issue 3: Richmond Lab: Viral Rickettsial Disease Lab Upgrade

DOF Issue#: 4265-001-COBCP-2018-GB

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

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

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

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—Approve. The federal Centers for Disease Control and the National Institute of Health recently updated requirements to qualify as a Bio-Safety Level-3 laboratory. These resources will allow DPH to build a new laboratory space that complies with these new requirements and will allow DPH to continue to process and analyze samples containing potentially dangerous viruses.

4440 DEPARTMENT OF STATE HOSPITALS

Issue 1: Unified Hospital Communications Public Address System – Phase 2

DOF Issue#: 4440-001-BCP-2018-GB

Budget Issue. DSH requests two positions and General Fund expenditure authority of $359,000 in 2018-19, $4.6 million in 2019-20, $7.7 million in 2020-21, and $3.7 million in 2021-22 and annually thereafter. If approved, these positions and resources would allow DSH to support an increase in maintenance costs for Phase 1, and implementation of Phase 2, of its Unified Hospital Communications Public Address System Project.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$359,000	$4,629,000
Total Funding Request:	**$359,000**	**$4,629,000**
Total Positions Requested:**	**2.0**	

* Additional fiscal year resources requested: 2020-21: $7,725,000; 2021-22: $3,721,000; 2022-23 (ongoing): $3,651,000
** Positions are ongoing after 2019-20.

This issue was heard during the subcommittee's April 12th hearing.

Subcommittee Staff Comment and Recommendation—Approve. The 2015 Budget Act approved resources to fund implementation of a new public address system for the state hospitals to improve communication and dissemination of information. These resources will allow DSH to continue implementation of this project.

Issue 2: Ongoing Costs for Personal Duress Alarm System

DOF Issue#: 4440-002-BCP-2018-GB

Budget Issue. DSH requests ongoing General Fund expenditure authority of $2.7 million. If approved, these resources would allow DSH to support ongoing maintenance and service for its Personal Duress Alarm System Project.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$2,700,000	$2,700,000
Total Funding Request:	**$2,700,000**	**$2,700,000**

* Resources are ongoing after 2019-20.

This issue was heard in the subcommittee's April 12th hearing.

Subcommittee Staff Comment and Recommendation—Approve. The 2013 Budget Act approved resources to implement a Personal Duress Alarm System within the state hospital system to alert hospital police and other nearby employees when a duress incident occurs. However, the initial funding did not account for the need to upgrade equipment at the end of its usable life. These resources will allow DSH to upgrade the equipment necessary for a functioning Personal Duress Alarm System.

Issue 3: Information Security Program Expansion

DOF Issue#: 4440-003-BCP-2017-GB

Budget Issue. DSH requests two positions and General Fund expenditure authority of $3.1 million in 2018-19 and $1.7 million in 2019-20 and annually thereafter. If approved, these positions and resources would allow DSH to provide adequate staffing to protect information assets and remediate findings identified in a recent security assessment by the California Military Department.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$3,080,000	$1,678,000
Total Funding Request:	**$3,080,000**	**$1,678,000**
Total Positions Requested*:	**2.0**	

* Positions and resources are ongoing after 2019-20.

This issue was heard in the subcommittee's April 12th hearing.

Subcommittee Staff Comment and Recommendation—Approve. An independent security assessment conducted by the Cyber Network Team at the California Military Department identified several deficiencies in DSH's performance of its IT infrastructure and security responsibilities. These resources are necessary to correct those deficiencies and upgrade necessary IT infrastructure.

Issue 4: Electronic Health Records Planning

DOF Issue#: 4440-005-BCP-2018-GB

Budget Issue. DSH requests four positions and General Fund expenditure authority of $1.3 million in 2018-19 and $713,000 in 2019-20. If approved, these positions and resources would allow DSH to complete Stages 3 and 4 of the Project Approval Lifecycle process for implementation of an integrated electronic health record for State Hospital inpatients.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20**
0001 – General Fund	$1,267,000	$713,000
Total Funding Request:	**$1,267,000**	**$713,000**
Total Positions Requested*:	**4.0**	

* Positions are ongoing after 2019-20.

This issue was heard in the subcommittee's April 12th hearing.

Subcommittee Staff Comment and Recommendation—Approve. DSH has responsibilities to protect personally identifiable information and protected health information for its patients. Adoption of electronic health records will assist with these responsibilities, as well as provide opportunities for continuity of care for patients when they leave the state hospital system. Approval of these resources will allow DSH to continue its implementation of electronic health records for its patients.

Issue 5: Coalinga: New Activity Courtyard Reappropriation

DOF Issue#: 4440-004-COBCP-2018-GB

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

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

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

This issue was heard in the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—Approve. Coalinga State Hospital's courtyard is currently insufficient for the treatment and exercise needs of its current census of 1,293 patients. The 2015 Budget Act approved resources to construct a new courtyard. Approval of reappropriation of these resources will allow DSH to continue this construction project.

Issue 6: Metropolitan: Consolidation of Police Operations

DOF Issue#: 4440-001-COBCP-2018-GB

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

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

This issue was heard in the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—Approve. California regulations require certain buildings used for police activities to be Essential Services Buildings, capable of providing essential services to the public after a disaster and constructed to minimize fire hazards and to resist the forces generated by earthquakes, gravity, and winds. Approval of these resources will allow DSH to consolidate its police operations, currently in non-compliant buildings, into a single building that qualifies as an Essential Services Building.

Issue 7: Metropolitan: CTE Fire Alarm System Upgrade Reappropriation

DOF Issue#: 4440-003-COBCP-2018-GB

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

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

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

This issue was heard in the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—Approve. The 2017 Budget Act approved resources to upgrade the existing fire alarm systems at Metropolitan State Hospital. The Chronic Treatment East building was removed from fire alarm upgrade planning to keep the project on schedule. Approval of reappropriation of these resources will allow DSH to complete the fire alarm upgrade at this building.

Issue 8: Patton: Fire Alarm System Upgrade

DOF Issue#: 4440-002-COBCP-2018-GB

Capital Outlay Budget Issue. DSH requests General Fund expenditure authority of $9.4 million in 2018-19. If approved, these resources would allow DSH to remove and replace deficient SimplexGrinnell Fire Alarm Control Panels and associated components in four patient-occupied buildings at Patton State Hospital.

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

This issue was heard in the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—Approve. The 2015 Budget Act approved resources to upgrade the existing fire alarm systems at Patton State Hospital. Approval of these resources will allow DSH to proceed to the construction phase of this project.

Issue 9: Patton: Construct New Main Kitchen - Reappropriation

DOF Issue#: 4440-300-COBCP-2018-A1

Capital Outlay Spring Finance Letter. DSH requests reappropriation of $33.1 million from the Public Buildings Construction Fund originally approved in the 2008 Budget Act and reappropriated in the 2010

and 2012 Budget Acts. If approved, these resources would allow DSH to continue the construction phase for a new main kitchen at Patton State Hospital.

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

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

This issue was heard in the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—Approve. The 2006 Budget Act approved resources to construct a new 32,000 square foot main kitchen at Patton State Hospital to accommodate a modern cook and chill preparation system and all dietary support facilities. Approval of these resources will allow DSH to complete this project. The Legislative Analyst's Office and the Administration disagree on whether these funds are still available for reappropriation. The subcommittee intends to approve resources for this project, whether through reappropriation or a reversion and new appropriation of the reverted funds.

ISSUES FOR DISCUSSION

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: AIDS Drug Assistance Program (ADAP) – May Revision Estimate and Adjustments

DOF Issue#: 4265-007-ECP-2018-GB
4265-078-ECP-2018-GB
4265-400-ECP-2018-MR
4265-404-ECP-2018-MR

ADAP Local Assistance Estimate May Revision Update. The May 2018 ADAP Local Assistance Estimate reflects revised 2017-18 expenditures of $392 million, which is a decrease of $6.2 million or 1.5 percent compared to the Governor's January budget. According to DPH, this decrease is primarily due to reduced overall caseload. For 2018-19, DPH estimates ADAP expenditures of $432.1 million, a decrease of $2.3 million or 0.5 percent, compared to the Governor's January Budget, and an increase of $40.1 million or 10.2 percent, compared to the revised 2017-18 estimate. According to DPH, the increase over 2017-18 is primarily due to higher caseload, particularly in the medication-only category..

ADAP Local Assistance Funding 2017-18 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0890 – Federal Trust Fund	$111,400,000	$111,400,000
3080 – AIDS Drug Assistance Program Rebate Fund	$286,700,000	$280,500,000
Total ADAP Local Assistance Funding – All Funds	**$398,100,000**	**$392,000,000**

ADAP Local Assistance Funding 2018-19 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0890 – Federal Trust Fund	$132,400,000	$132,400,000
3080 – AIDS Drug Assistance Program Rebate Fund	$302,000,000	$299,600,000
Total ADAP Local Assistance Funding – All Funds	**$434,400,000**	**$432,100,000**

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

Caseload by Client Group	**2017-18**	**2018-19**
Medication-Only	12,652	12,938
Medi-Cal Share of Cost	162	162
Private Insurance	8,023	8,804
Medicare Part D	7,510	7,510
Pre-Exposure Prophylaxis (PrEP) Assistance Program	250	1,450

Expenditures by Client Group	2017-18	2018-19
Medication-Only	$315,706,847	$338,933,509
Medi-Cal Share of Cost	$1,000,515	$1,000,515
Private Insurance	$45,906,517	$61,117,792
Medicare Part D	$20,475,511	$22,879,604
PrEP Assistance Program	$863,193	$1,304,313

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

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

According to DPH, enrollment sites will receive $8 million for this work in 2017-18, pursuant to the terms of the 2017 Budget Act. However, in 2018-19, enrollment site expenditures are expected to decrease to $6.8 million under the new reimbursement methodology due to updated caseload projections which forecast lower enrollment.

ADAP Eligibility and Enrollment System. In the Governor's January budget, DPH requested resources to manage the workload of transitioning ADAP eligibility and enrollment services to the Office of AIDS after terminating its enrollment broker contract for failure to complete contract deliverables and due to a security breach. DPH requests additional expenditure authority from the ADAP Rebate Fund of $1.6 million in 2017-18 and $4.4 million 2018-19 to support program enhancements to the interim ADAP Enrollment System, contract amendments, and planning resources to assist with the Project Approval Lifecycle process for a long-term enrollment system.

May Revision Adjustment. As a result of the decrease in ADAP Local Assistance expenditures and the requested increase in ADAP Rebate Fund expenditure authority for eligibility and enrollment, DPH requests net increased expenditure authority of approximately $2 million from the ADAP Rebate Fund.

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 major changes to caseload and expenditure in the ADAP May Revision Estimate.

2. Please provide a brief overview of the increased resources requested for the ADAP Enrollment System.

Issue 2: Genetic Disease Screening Program – May Revision Estimate and Adjustments

DOF Issue#: 4265-079-ECP-2018-GB
4265-401-ECP-2018-MR
4265-435-BBA-2018-MR

May Revision Issue The May 2018 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of $132.1 million ($27.7 million state operations and $104.4 million local assistance) in 2017-18, and $133 million ($29.5 million state operations and $103.5 million local assistance) in 2018-19. These figures represent a decrease of $293,000 (all local assistance) in 2017-18 and an increase of $28,000 (all local assistance) in 2018-19, compared to the Governor's January budget. According to DPH, the decrease in 2017-18 is primarily due to reduced demographic projections of live births by the Department of Finance's Demographic Research Unit, while the increase in 2018-19 is primarily due to a slight increase of the actual caseload of prenatal and newborn tests.

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:	$27,650,000	$27,650,000	$-
Local Assistance:	$104,732,000	$104,439,000	($293,000)
Total GDSP Expenditures	**$132,382,000**	**$132,089,000**	**($293,000)**

Genetic Disease Screening Program Funding 2018-19 May Revision Comparison to January			
	2018-19	**2018-19**	**Jan-May**
Fund Source	***January Budget***	***May Revision***	***Change***
0203 – Genetic Disease Testing Fund			
State Operations:	$29,451,000	$29,451,000	$-
Local Assistance:	$103,473,000	$103,501,000	$28,000
Total GDSP Expenditures	**$132,924,000**	**$132,952,000**	**$28,000**

Newborn Screening Program (NBS) Caseload Estimate: The May Revision estimates NBS program caseload of 478,679 in 2017-18, a decrease of 1,928 or 0.4 percent, compared to the Governor's January budget. The May Revision estimates NBS program caseload of 478,419 in 2018-19, an increase of 98 or 0.02 percent, compared to the Governor's January budget, and a decrease of 260 or 0.05 percent compared to the revised 2017-18 estimate. These updated estimates are based on state projections of 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 342,532 in 2017-18, a decrease of 1,401 or 0.4 percent, compared to the Governor's January budget. The May Revision estimates PNS program caseload of 342,347 in 2018-19, an increase of 50 or 0.01

percent, compared to the Governor's January budget, and a decrease of 185 or 0.05 percent, compared to the revised 2017-18 estimate. These updated estimates are based on state projections of the number of live births. DPH assumes 71.4 percent of births will participate in the PNS program annually.

Birth Defects Surveillance Activities Funding Adjustment. In addition to the NBS and PNS programs, GDSP includes the California Birth Defects Monitoring Program (CBDMP). According to DPH, the CBDMP conducts birth defect surveillance throughout the state, maintains the birth defects monitoring program, tracks birth defects and trends, evaluates whether environmental hazards are associated with birth defects, investigates other possible causes of birth defects, develops birth defect prevention strategies, and conducts interview studies about birth defect causes. CBDMP surveillance is conducted in 10 counties: Fresno, Kern, Kings, Madera, Merced, Orange, San Diego, San Joaquin, Stanislaus, and Tulare.

DPH proposes to shift funding for the CBDMP from the California Birth Defects Monitoring Program Fund (Fund 3114) to the Genetic Disease Testing Fund (Fund 0203). This shift would result in a reduction in Fund 3114 of $1.8 million. According to DPH, Fund 3114 receives a revenue transfer of a portion of fees paid in the PNS program. The balance of PNS program fees are deposited in Fund 0203. Therefore, although expenditures are proposed to shift between these funds, the program will continue to be funded by the same original revenue stream.

May Revision Finance Letter Adjustments. Consistent with local assistance expenditure updates to GDSP at May Revision and the requested fund shift for CBDMP, DPH requests the following adjustment:

- 4265-001-3114 be decreased by $1.8 million
- 4265-111-0203 be increased by $28,000

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 the major changes to caseload and expenditure in the GDSP May Revision Estimate.

2. Please provide a brief overview of the proposal to shift funding for the California Birth Defects Monitoring Program to the Genetic Disease Testing Fund.

Issue 3: Women, Infants, and Children Program – May Revision Estimate

DOF Issue#: 4265-080-ECP-2018-GB
4265-402-ECP-2018-MR

May Revision Issue. The May 2018 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of $1.2 billion ($932.7 million federal funds and $232.7 million WIC manufacturer rebate funds) in 2017-18, a reduction of $30.5 million ($29.9 million federal funds and $615,000 WIC manufacturer rebate funds) compared to the Governor's January budget. The May 2018 WIC Program Estimate includes $1.1 billion ($906.8 million federal funds and $229.8 million WIC manufacturer rebate funds) in 2018-19, a reduction of $47.1 million ($46 million federal funds and $1.1 million WIC manufacturer rebate funds) compared to the Governor's January budget, and a decrease of $28.8 million ($25.8 million federal funds and $2.9 million WIC manufacturer rebate funds) compared to the revised 2017-18 estimate. The federal fund amounts include state operations costs of $63.5 million in 2017-18 and $63.7 million in 2018-19.

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:	$63,463,000	$63,463,000	$-
Local Assistance:	$899,152,000	$869,219,000	($29,933,000)
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$233,307,000	$232,692,000	($615,000)
Total WIC Expenditures	**$1,195,922,000**	**$1,165,374,000**	**($30,548,000)**

WIC Funding Summary 2018-19 May Revisoin Comparison to January Budget			
	2018-19	**2018-19**	**Jan-May**
Fund Source	***January Budget***	***May Revision***	***Change***
0890 – Federal Trust Fund			
State Operations:	$63,684,000	$63,684,000	$-
Local Assistance:	$889,131,000	$843,150,000	($45,981,000)
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$230,852,000	$229,772,000	($1,080,000)
Total WIC Expenditures	**$1,183,667,000**	**$1,136,606,000**	**($47,061,000)**

The May Revision assumes a monthly average of 1,062,623 WIC participants in 2017-18, a decrease of 12,485 or 1.2 percent compared to the Governor's January budget. The May Revision assumes a monthly average of 1,012,984 WIC participants in 2018-19, a decrease of 11,398 or 1.1 percent compared to the Governor's January budget, and a decrease of 49,639 or 4.7 compared to the revised 2017-18 caseload estimate.

Food Expenditures Estimate. The May Revision includes $801.1 million ($568.4 million federal funds and $232.7 million WIC manufacturer rebate funds) in 2017-18 for WIC program food expenditures, a decrease of $30.5 million ($29.9 million federal funds and $620,000 WIC manufacturer rebate funds) or 3.7 percent, compared to the Governor's January budget. The May Revision includes $772.1 million ($542.3 million federal funds and $229.8 million WIC manufacturer rebate funds) in 2018-19 for WIC program food expenditures, a decrease of $47.1 million ($46 million federal funds and $1.1 million WIC manufacturer rebate funds) or 5.8 percent compared to the Governor's January budget, and a decrease of $29 million ($26.1 million federal funds and $2.9 million WIC manufacturer rebate funds) or 3.6 percent compared to the revised 2017-18 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 2017-18 and 2018-19, which is unchanged from the level assumed in the Governor's January budget. Funding from the NSA grant is provided to the Office of Systems Integration to fund the establishment of a WIC management information system (MIS).

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 major changes to caseload and expenditure in the WIC May Revision Estimate.

Issue 4: Center for Health Care Quality – May Revision Estimate and Adjustments

DOF Issue#: 4265-403-ECP-2018-GB

May Revision Update. The May Revision estimate for the Center for Health Care Quality includes $272.5 million ($3.7 million General Fund, $100.3 million federal funds, and $168.5 million special funds and reimbursements) in 2017-18, unchanged compared to the Governor's January budget, and $280.4 million ($3.7 million General Fund, $102.1 million federal funds, and $174.7 million special funds and reimbursements) in 2018-19, an increase of $2.7 million (all special funds) compared to the Governor's January budget.

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	$100,327,000	$100,327,000
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	$10,161,000	$10,161,000
3098 – Licensing and Certification Program Fund	$152,809,000	$152,809,000
Total CHCQ Funding – All Funds	**$272,502,000**	**$272,502,000**

Center for Health Care Quality Funding 2018-19 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	$102,056,000	$102,056,000
0942 – Internal Departmental Quality Improvement Acct	$2,304,000	$2,598,000
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	$10,436,000	$10,436,000
3098 – Licensing and Certification Program Fund	$156,153,000	$158,526,000
Total CHCQ Funding – All Funds	**$277,766,000**	**$280,433,000**

Provisional Language – Certified Nurse Assistant Training Kickstarter Program. DPH requests provisional language be added to item 4265-115-0942 to allow the department the flexibility to increase expenditure authority up to $1.7 million if the federal Center for Medicare and Medicaid Services approves the Certified Nursing Assistant (CNA) Training Kickstarter Program. Funding would be provided to the Quality Care Health Foundation to contract with health employers for CNA training classes, and provide technical assistance to skilled nursing facilities to develop and obtain approval of their own CNA training program. Any augmentation would be authorized no sooner than 30 days after notification to the Joint Legislative Budget 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 the major changes to caseload and expenditure in the CHCQ May Revision Estimate.

2. Please provide a brief overview of the CNA Training Kickstarter Program proposed in the May Revision.

Issue 5: Proposition 99 Adjustments – Health Education and Unallocated Accounts

DOF Issue#: 4265-405-BBA-2018-MR

Proposition 99 Tobacco Tax Allocations. DPH requests the following technical corrections reflecting changes in Proposition 99 revenues and a shift between state operations and local assistance:

Health Education Account
- Item 4265-001-0231 be increased by $122,000
- Item 4265-111-0231 be increased by $1,00,000

Unallocated Account
- Item 4265-001-0236 be increased by $66,000

According to DPH, the Health Education Account adjustment would be provided to additional community-based organizations engaged in tobacco prevention activities. In addition, these funds would support additional state operations staff for oversight of these programs.

The Unallocated Account adjustment will fund additional state administrative activities.

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 these proposed technical changes.

Issue 6: Proposition 56 Authority and Technical Adjustments

DOF Issue#: 4265-420-BBA-2018-MR
4265-421-BBA-2018-MR
4265-422-BBA-2018-MR
4265-430-BBA-2018-MR

May Revision Issue. DPH requests the elimination of the following budget items for expenditure of revenues from Proposition 56 tobacco taxes. These budget items fund the state Oral Health Program, tobacco law enforcement activities, and tobacco prevention activities. If approved, this request would eliminate these items and expenditures would be transferred to non-Budget Act items consistent with the provisions of Proposition 56. Specifically, DPH requests the following items be eliminated and converted into non-Budget Act items:

State Dental Program Account
- 4265-001-3307
- 4265-111-3307

Tobacco Law Enforcement Account
- 4265-001-3318
- 4265-111-3318

Tobacco Prevention Control Account
- 4265-001-3322
- 4265-111-3322

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 these proposed technical changes.

4440 DEPARTMENT OF STATE HOSPITALS

Issue 1: 2018-19 Program Updates – May Revision Adjustments

DOF Issue#: 4440-009-ECP-2018-GB
4440-010-ECP-2018-GB
4440-220-ECP-2018-MR
4440-003-ECP-2018-GB
4440-240-ECP-2018-MR
4440-005-ECP-2018-GB
4440-290-ECP-2018-MR
4440-001-ECP-2018-GB
4440-300-ECP-2018-MR
4440-004-ECP-2018-GB
4440-310-ECP-2018-MR
4440-320-ECP-2018-MR
4440-330-ECP-2018-MR
4440-340-ECP-2018-MR
4440-008-ECP-2018-GB
4440-350-ECP-2018-MR
4440-360-ECP-2018-MR

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

The five state hospitals operated by DSH are:

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

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

- **Metropolitan State Hospital** – Located in Norwalk in Los Angeles County, Metropolitan is an "open" style campus within a security perimeter. Due to community concerns, a formal agreement with the City of Norwalk and the county sheriff prohibits Metropolitan from accepting patients charged with murder or a sex crime, or at high risk for escape. Metropolitan

primarily serves LPS, IST, MDO, and NGI patients and has a licensed bed capacity of 1,106 and an operational bed capacity of 826.

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

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

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

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

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

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

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

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

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

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

	2017-18	2018-19
Population by Hospital		
Atascadero	1,247	1,184
Coalinga	1,318	1,398
Metropolitan	807	903
Napa	1,269	1,269
Patton	1,509	1,484
Population Total	**6,150**	**6,238**
Population by Commitment Type		
Incomptent to Stand Trial (IST)	1,523	1,621
Not Guilty by Reason of Insanity (NGI)	1,407	1,401
Mentally Disordered Offender (MDO)	1,328	1,321
Sexually Violent Predator (SVP)	920	920
Lanterman-Petris-Short Civil Commitments (LPS)	628	631
Coleman Referrals	336	336
Dept. of Juvenile Justice (DJJ)	8	8
Jail-Based Competency Treatment (JBCT) Programs		
Riverside JBCT	25	25
San Bernardino JBCT	126	146
Sacramento JBCT (Male and Female)	44	44
San Diego JBCT	30	30
Sonoma JBCT	10	12
Kern Admission, Evaluation, and Stabilization (AES) Center	60	60
Mendocino JBCT	TBD	TBD
Stansislaus JBCT	12	12
Proposed Expansion of JBCT	--	27
Los Angeles County Program	--	150
Total JBCT Programs	**307**	**518**

Figure 1: State Hospital Population by Hospital, Commitment Type and JBCT Programs
Source: *2018-19 May Revision Estimates, Department of State Hospitals,May 2018*

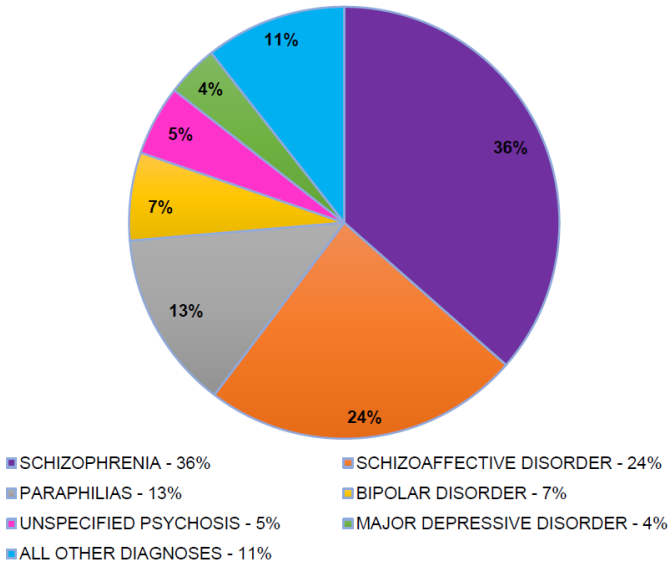

Figure 2: State Hospital Population By Major Diagnosis, as of July 1, 2017
Source: *Report on Measures of Patient Outcomes, Department of State Hospitals, January 2018*

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

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

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

In the May Revision, DSH requests additional General Fund expenditure authority of $610,000 in 2019-20, for a total authority of $1.6 million. DSH indicates it has identified one prospective provider in Northern California to establish a 26-bed STRP, which is larger than the 16 beds anticipated in the Governor's January budget. While the annual cost of operating the new 26-bed program is $1.6 million,

DSH is not requesting additional funding until 2019-20, based on the need for startup activities and modifications, and the timeline for activation of the additional capacity.

Program Update: Kern County Admission, Evaluation, and Stabilization Center. In the Governor's January budget, DSH reported a reduction in General Fund expenditures in 2017-18 of $1.7 million related to delays in negotiation and execution of a contact with Kern County to establish an Admission, Evaluation, and Stabilization (AES) Center at the Lerdo Pre-Trial Facility located in Bakersfield. The Kern AES Center is expected to receive and treat IST patients committed to State Hospitals directly from nearby catchment counties.

In the May Revision, DSH reports an additional reduction in General Fund expenditures in 2017-18 of $906,000, for a total expenditure reduction of $2.6 million. According to DSH, the Kern County Board of Supervisors approved the final contract for the AES Center in December 2017, with the 60 day startup period beginning in February 2018 with recruitment and training activities. The additional delay in recruitment and training has led to an admission date of April 23, 2018, which results in a total reduction in estimated General Fund expenditures in 2017-18 of $2.6 million, which is an increase of savings of $906,000 compared to the Governor's January budget.

Medicare Authority Increase. DSH pays Medicare premiums for third-party health coverage of Medicare beneficiaries who are patients at the state hospitals, pursuant to state law. The governing statute provides a continuous General Fund appropriation to DSH for this purpose.

In the May Revision, DSH reports additional General Fund expenditures of $600,000 for Medicare premium payments. According to DSH, the funding level has not changed in more than 16 years, although the Medicare-eligible population has increased. DSH indicates additional costs have been imposed by the implementation of Medicare Part D and regular cost-of-living adjustments by the federal government. As these expenditures are continuously appropriated, DSH indicates this program update is informational and does not require legislative action.

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

In the Governor's January budget, DSH requested authority to utilize $2.4 million of savings from construction delays for its ETP units at Atascadero State Hospital to fund the increased costs for these repair projects. If approved, these savings would allow DSH to complete all of these repairs by the end of 2019.

In the May Revision, DSH updated its project costs and timelines for the repair projects. These updates result in an additional request for expenditure authority of $1.9 million ($1.1 million General Fund and $834,000 reimbursements) in 2017-18, $1.2 million reimbursement expenditure authority in 2018-19, and $608,000 reimbursement expenditure authority in 2019-20.

According to DSH, the updated timeline of construction and expenditures on these repairs is as follows:

	DGS PROJECT 1 Three Historical Buildings	**DGS PROJECT 2** Buildings Outside the STA	**DSH PROJECT 3** Buildings Inside the STA
Design Completion	July 6, 2017	May 2018	N/A
Begin Construction	November 2, 2018	September 21, 2018	October 1, 2017
Complete Construction	July 5, 2019	September 21, 2019	December 31, 2019

Project	**2015-16**	**2016-17**	**2017-18**	**2018-19**	**2019-20**	**Grand Total**
1. Three Historical Buildings	$989,900	$0	$7,129,000	$0	$0	$8,118,900
2. Buildings Outside the STA	$0	$326,200	$3,675,000	$0	$0	$4,001,200
3. Buildings Inside the STA	$0	$0	$1,624,958	$1,216,958	$608,479	$3,450,395
Totals	**$989,900**	**$326,200**	**$12,428,958**	**$1,216,958**	**$608,479**	**$15,570,495**

Program Update: Metropolitan State Hospital Bed Expansion. In the Governor's January budget, DSH requested 346.1 positions and General Fund expenditure authority of $53.1 million in 2018-19 and 473.4 positions and General Fund expenditure authority of $69 million in 2019-20 and annually thereafter to activate newly secured units at Metropolitan State Hospital to provide increased capacity for the treatment of IST patients. The 2016 Budget Act included capital outlay construction funding to securely enclose existing patient buildings that currently house civilly committed patients under the Lanterman-Petris-Short (LPS) Act. Once secured, the LPS patients currently housed in these units will be transferred to non-secured buildings elsewhere on the Metropolitan campus and allow for additional secured capacity for the treatment of IST patients currently in county jails awaiting state hospital treatment.

In the May Revision, DSH updated its timeline and staff requests to reflect additional delays and a technical adjustment related to the civil service classification of the requested staff. As a result, DSH requests reduction of 10.1 positions and General Fund expenditure authority of $1 million in 2017-18, reduction of 183.3 positions and General Fund expenditure authority of $28.3 million in 2018-19, and a reduction of 131.2 positions and General Fund expenditure authority of $18.4 million in 2019-20. According to DSH, these reductions in staff and resources are the result of delayed inspections and additional modifications required by the State Fire Marshall, as well as delays in securing a contractor for the new secured fence.

This request previously activated and provided staff for approximately 236 forensic beds over the course of 2018-19 to treat IST patients. The May Revision update activates and provides staff for approximately 96 forensic beds in 2018-19 and 140 forensic beds in 2019-20.

Program Update: Jail-Based Competency Treatment Program Expansions. In the Governor's January budget, DSH requested General Fund expenditure authority of $516,000 in 2017-18, $8.1 million in 2018-19, and $8.3 million in 2019-20 and annually thereafter to activate jail-based competency treatment (JBCT) beds for the treatment of IST patients in county jails, pursuant to approval of program expansions in previous budget requests. DSH contracts with county jail facilities to provide

restoration of competency services in jails, treating IST patients with lower acuity and that are likely to be quickly restored to competency. This request nets savings from delayed implementation of existing JBCT contracts in Mendocino, Sacramento, and Stanislaus counties with additional costs for the activation of five JBCT beds in Riverside and 50 beds in San Bernardino.

In the Governor's January budget, DSH also requested $8 million in 2018-19 and $9.3 million in 2019-20 to activate new JBCT programs totaling 104 beds in five Northern California counties, one Southern California county, and one Central California county. Two of the Northern California counties would be small counties.

In the May Revision, DSH has revised its request for existing and new JBCT programs. For existing programs, DSH requests reduction of General Fund expenditure authority of $1.1 million in 2017-18 and $1.6 million in 2018-19, and an increase in General Fund expenditure authority of $305,000 in 2019-20. According to DSH, these reductions are based on delayed activation for JBCT programs in Mendocino and San Bernardino, offset in 2019-20 by an expansion of the JBCT program in Sonoma by two beds. Reflecting these May Revision adjustments, the total DSH request for existing JBCT programs is a General Fund expenditure authority decrease of $561,000 in 2017-18, and increased General Fund expenditure authority of $6.5 million in 2018-19 and $8.6 million in 2019-20.

For new programs, DSH requests reduction of General Fund expenditure authority of $4.9 million in 2018-19 and $2.3 million in 2019-20. According to DSH, these reductions are based on delayed contracts for activation of these programs and proposed replacement of a small Northern California county with a small Central California county for JBCT expansion. Reflecting these May Revision adjustments, the total DSH request for new JBCT programs is an increase in General Fund expenditure authority of $3.1 million in 2018-19 and $7 million in 2019-20.

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

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

for other services needed by the patient, discharge criteria, goals for an aftercare plan in a standard treatment environment upon discharge, and a plan for post-discharge follow up.

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

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

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

In the Governor's January budget, DSH also requested 23.2 positions and $2.8 million in 2018-19 and 65.7 positions and $8.4 million annually thereafter over the department's 2017 Budget Act authority for ETP unit construction. If approved, these resources would allow DSH to complete staffing and activation for the first two ETP units at Atascadero, as well as the planned activation of two additional ETP units, one at Atascadero and one at Patton State Hospital.

In the May Revision, DSH requests General Fund expenditure authority be increased by $70,000 in 2017-18, decreased by $7.4 million in 2018-19, and decreased by $50,000 in 2019-20. According to DSH, these changes are the result of delayed activation of the ETP units due to delays in receiving required approvals from the State Fire Marshall.

According to DSH, the updated timeline for construction for each of these units is as follows:

Units/Hospital	Construction Initiated	Construction Completed
DSH-Atascadero Unit 1	August 8, 2018	December 26, 2018
DSH-Atascadero Unit 2	December 26, 2018	April 17, 2019
DSH-Atascadero Unit 3	April 17, 2019	August 7, 2019
DSH-Patton Unit 1	April 12, 2019	September 6, 2019

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of each of the program updates referenced in this item.

Issue 2: Protected Health Information

DOF Issue#: 4440-001-BCP-2018-MR

May Revision Finance Letter. DSH requests eight three-year, limited-term positions and General Fund expenditure authority of $988,000 in 2018-19, 2019-20, and 2020-21. If approved, these positions and resources would allow DSH to implement new procedures for processing invoices and payments from external medical providers containing Protected Health Information and consolidate financial operations into a single unit.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$988,000	$988,000
Total Funding Request:	**$988,000**	**$988,000**
Total Positions Requested:**	**8.0**	

* Additional fiscal year resources requested: 2020-21: $988,000;
** Positions are limited-term and expire at the end of 2020-21.

Background. The Health Insurance Portability and Accountability Act (HIPAA), implemented in 1996, was intended to allow for portability and continuity of an individual's health care coverage by imposing significant administrative simplification and standardization requirements on health care entities, and strict security standards for protected health information (PHI). HIPAA administrative simplification and security rules apply to certain individuals or organizations known as covered entities or business associates. According to the U.S. Department of Health and Human Services (HHS), covered entities include the following:

1. Health care providers including physicians, clinics, psychologists, dentists, chiropractors, nursing homes, and pharmacies that transmit HIPAA-protected information in an electronic format.
2. Health plans including commercial health care service plans, health insurers, group health plans, and public health care programs, such as Medicare, Medicaid, and military or veteran's health care programs.
3. Health care clearinghouses that process nonstandard information they receive from another entity into a standard electronic format or data content, or vice versa.

DSH is a covered entity under HIPAA and is responsible for the security of protected health information for its patients. According to DSH, over 55,000 invoices are processed by the department annually and more than 65 percent contain PHI. DSH patients have unique and acute medical and clinical needs that oftentimes require visits to specific external providers. These medical providers' invoices in turn contain a combination of patient information such as the patient's name, patient identification number, diagnosis, medical service received, and date of service. In addition, DSH indicates processing these invoices is entirely paper-based.

DSH requests eight three-year, limited-term positions and General Fund expenditure authority of $988,000 in 2018-19, 2019-20, and 2020-21. **Five Accounting Officer Specialists** would manage the transition of the paper-based invoice process to a third party vendor or an electronic health record. DSH indicates it expects the interim process to drive additional accounting workload to transition invoices

into a PeopleSoft accounts payable module. In addition, **three Associate Accounting Analysts** would manage additional workload from implementing FI$Cal, the state's fiscal budgeting platform, particularly related to collapsing accounting from six separate business units for the headquarters and five hospitals into one single business unit.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 3: Los Angeles County Incompetent to Stand Trial Community Treatment

DOF Issue#: 4440-002-ECP-2018-GB
4440-230-ECP-2018-MR
4440-260-ECP-2018-MR

Background. In the Governor's January budget, DSH requested General Fund expenditure authority of $14.8 million to contract with Los Angeles County for 150 beds to treat IST patients in community settings, based on the county's experience in treating misdemeanor IST patients in similar settings. The contract, currently under negotiation to begin July 2018, would provide a coordinated continuum of mental health placements including five beds in a locked acute psychiatric hospital, 45 beds in a locked Institute for Mental Disease or mental health rehabilitation center, and 100 beds in residential facilities with clinical and supportive services. Los Angeles County has approximately 185 IST offenders awaiting state hospital placement. The contract would also include $2.5 million of funding for Los Angeles County staffing resources for 10-12 positions, including a clinical team of six to eight staff members, which would provide patient support by stabilizing patients on medications and preparing them for community placement, and a navigation team of two to three staff members to support connections to social services and other needs.

	Locked Inpatient	Locked IMD type IMD Type	Unlocked, secured, Clinically Enhanced Type
Proposed # of Beds	5	45	100
Facility Type	General Acute Care Hospital or Acute Psychiatric Hosptial -- likely Olive View Medical Center	Low acuity hospital, and/or Nursing facility; licenses as an Institute for Mental Disease facility or a Mental Health Rehabilitation Center	Residential site with clinical and supportive services on-site
Facility Bed Capacity	18 total beds with 5 set aside for this project	2 different facilities: 1st up to 15 beds in San Fernando Valley part of LA County; 2nd with up to 35 beds in southern LAC or San Diego County	3-5 sites across LA County with 20-40 beds each
Security	Locked unit	Locked facilities	Open, but gated and with staff and security cameras monitoring entrance/exit
Staffing	24/7 nursing and MD staff, full-time clinical SW and support staff	24/7 nursing staff, M-F and on call MD staff, full-time clinical SW and support staff	24/7 case management and security staff, full-time clinical social work and nursing staff; potentially nurse practitioner on call
Treatment	Stabilization of Acute Mental Health or Medical symptoms	Sub-acute stablization of patients who do not require acute care, but who are not clinically ready for outpatient care and restoration of competency treatment.	Outpatient treatment, maintenance of stabilization, on-site psychiatric care, medication support and monitoring, group and individual therapy and restoration of competency treatment.

Figure 1: Los Angeles County IST Restoration in Community Mental Health Treatment Placements
Source: *2018-19 Department of State Hospitals Governor's Budget Proposals and Estimate*

In the May Revision, DSH requests a reduction in one-time General Fund expenditure authority of $1.7 million in 2017-18 and an increase in ongoing General Fund expenditure authority of $750,000 in 2018-19. According to DSH, the 2017-18 reduction reflects a phase-in of community placements, one-time startup costs, additional clinical team members to work with the courts and to support an "off-ramp" for patients restored to competency before placement in the community or state hospitals. The 2018-19 increase is for additional staff for ongoing support of the "off-ramp" for competency restoration, including one psychiatrist, two social workers, and one support staff.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the proposed adjustments to this proposal.

Issue 4: Metropolitan State Hospital Central Utility Plant

DOF Issue#: 4440-270-ECP-2018-MR

May Revision Issue. DSH requests ongoing General Fund expenditure authority of $2.6 million. If approved, these resources would fund the operation and maintenance of the Central Utility Plant at Metropolitan State Hospital.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$2,580,000	$2,580,000
Total Funding Request:	**$2,580,000**	**$2,580,000**

* Resources ongoing after 2019-20.

Background. The 2017 Budget Act included provisional authority for the Department of Finance to approve up to $1.5 million for DSH to acquire and operate Metropolitan State Hospital's Central Utility Plant. According to DSH, Wheelabrator Norwalk Energy Company, Inc. (WNEC) owned and operated the plant under a 40 year contract. Upon expiration of the contract, DSH purchased the plant, with a transfer of ownership as of February 2018. Metropolitan has assumed responsibility for the operations and maintenance of the steam boilers, chillers, and associated machinery. These responsibilities have required DSH to hire six additional staff to manage the plant's operations.

DSH indicates the $1.5 million 2017-18 augmentation allowed for the purchase of the plant, equipment and repairs, staffing, training, and service agreements. The 2017-18 total cost was $1.8 million, exceeding the provisional augmentation by approximately $285,000. According to DSH, the full year costs of service agreements, staffing, and training is $2.6 million. DSH requests ongoing General Fund expenditure authority of $2.6 million to fund these operations and maintenance costs.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 5: Hepatitis C Treatment Expansion

DOF Issue#: 4440-370-ECP-2018-MR

May Revision Issue. DSH requests ongoing General Fund expenditure authority of $3.3 million. If approved, these resources would allow DSH to expand treatment eligibility for state hospital patients infected with Hepatitis C.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$3,300,000	$3,300,000
Total Funding Request:	**$3,300,000**	**$3,300,000**

* Resources ongoing after 2019-20.

Background. According to DSH, as of April 30, 2018, 907 state hospital patients are infected with Hepatitis C virus (HCV), a form of viral hepatitis that is transmitted via infected blood causing chronic liver disease. Unless successfully treated with medication, chronic HCV infection usually continues throughout the patient's life and causes other serious health problems, such as cirrhosis, liver cancer, liver failure, and the risk of end-stage renal disease.

New treatment options have changed the management of HCV, particularly in public health care systems. In 2015, in the context of a statewide assessment of treatment guidelines for individuals in publicly funded programs infected with HCV, DSH developed a set of guidelines for patient eligibility for the new treatments. According to DSH guidelines, to qualify for treatment, the patient would be expected to remain at the state hospital for the full treatment course and for the immediate post treatment follow up. Certain exclusion criteria would be used to screen the patients and ultimately determine whether the patient was a viable candidate including advanced HIV infection, anemia, pregnancy, and allergic reaction to the treatment medication. In addition, patients were generally only treated with liver fibrosis higher than stage 2, with other patients treated if there was a presence of a co-morbid condition.

DSH requests ongoing General Fund expenditure authority of $3.3 million. If approved, these resources would allow DSH to expand treatment eligibility for state hospital patients infected with HCV. In accordance with a statewide adjustment to eligibility criteria for HCV treatment occurring in the California Department of Corrections and Rehabilitation and the Department of Health Care Services, DSH proposes to update its treatment guidelines to offer treatment to all appropriate patients with chronic HCV regardless of the stage of liver fibrosis. These new guidelines are consistent with recent guidance provided by the American Association for the Study of Liver Disease.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

Issue 6: Miscellaneous Technical Adjustments

DOF Issue#: 4440-250-ECP-2018-MR

May Revision Issue. DSH requests technical adjustments to reduce reimbursement expenditure authority of $1 million in 2018-19 and $1.2 million in 2019-20. If approved, these adjustments would allow a one-time increase in reimbursement authority in 2018-19 from a local community college for DSH's Hospital Police Officer Academy program and remove unused reimbursement authority for implementation of the Health Insurance Portability and Accountability Act (HIPAA).

Background. Police officers hired by DSH receive approximately 15 weeks of training at the DSH Police Academy located in Atascadero, CA adjacent to Atascadero State Hospital. Housing and per diem is provided to all DSH Police Officers hired at one of the Hospitals at least 51 miles away from Atascadero, CA. The academy requirements include successful completion of 548 hours in multiple disciplines pertaining specifically to DSH Police Officer job specifications and with a passing standard of 76 percent or higher. The DSH Police Academy is endorsed by Allan Hancock Community College and participants receive college credit. Based on this relationship, DSH receives partial reimbursement from the college for the cost of the academy program of up to $72,000 per session with a maximum enrollment of 50 cadets. DSH indicates it will hold three academy sessions and will be able to collect reimbursements up to $216,000, exceeding its current reimbursement authority by $150,000.

DSH also is requesting the removal of unused reimbursement authority left over from when it was the Department of Mental Health (DMH). According to DSH, DMH received reimbursement from the Department of Health Care Services (DHCS) for HIPAA activities related to its oversight of the Mental Health Services Act (MHSA), which expanded mental health services statewide through a tax on incomes over $1 million. DMH was eliminated and its MHSA responsibilities transferred to DHCS, while the state hospitals responsibilities were transferred to the newly created DSH. DSH is requesting a reduction of reimbursement authority of $1.2 million, which is currently unused, as it no longer has responsibilities under MHSA.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the proposed adjustments in this proposal.

Issue 6: Competency Restoration Assessments

DOF Issue#: TBL (RN Pending)

May Revision Trailer Bill Language Proposal. DSH proposes trailer bill language to allow for an individual declared incompetent to stand trial to be assessed at any time to determine if the individual has regained competence and may be returned to the referring county for criminal proceedings.

Incompetent to Stand Trial Referrals. Under California law "[a] person cannot be tried or adjudged to punishment or have his or her probation, mandatory supervision, post-release community supervision, or parole revoked while that person is mentally incompetent." IST patients are referred to DSH under Section 1370 of the Penal Code if a court has determined they are unable to understand the nature of criminal proceedings or assist counsel in their defense. IST patients receive competency-based treatment and are returned to court once able to participate in court proceedings. If a defendant's attorney raises concerns about his or her competency to stand trial, the judge in the case may order a mental health evaluation by a psychiatrist or clinical psychologist. If the evaluation finds substantial evidence the defendant is incompetent, a competency hearing is scheduled with additional expert testimony and an opportunity for the defendant to respond to or refute the findings of the evaluation. If the court finds a defendant incompetent to stand trial, the local community health director determines whether the defendant is best treated in a local facility, an outpatient facility, or at a state hospital. Misdemeanants are typically treated in an outpatient setting or released, while felonies are typically referred for treatment at a state hospital. Maximum commitments are either three years or the maximum term of imprisonment for the most serious charge.

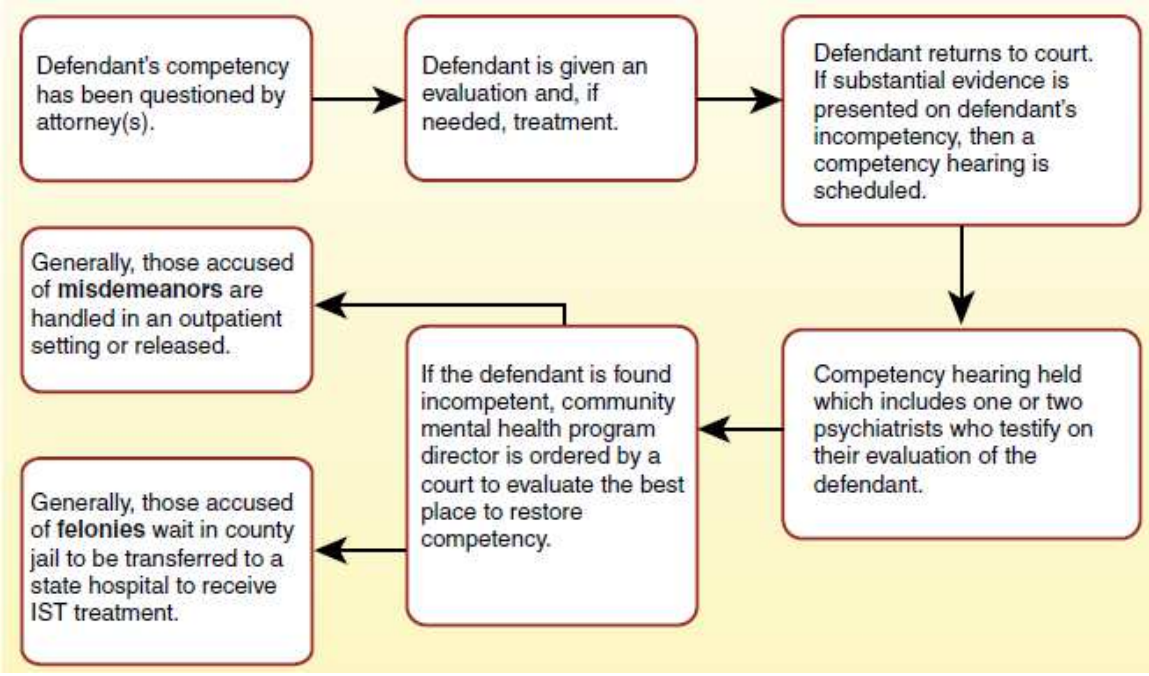

Figure 1: Incompetent to Stand Trial Commitment Process
Source: *"An Alternative Approach:Treating the Incompetent to Stand Trial", Legislative Analyst's Office, Jan 2012*

DSH proposes trailer bill language to allow an individual declared incompetent to stand trial pursuant Penal Code Section 1370 to be examined to determine whether the defendant has regained competence. If counsel for the individual, the district attorney, judge, jail medical, or mental health staff reports the individual appears to have regained competence, the court may appoint a psychiatrist, licensed psychologist, or any other expert to perform the examination. If, in the opinion of the expert, the individual has regained competence, the court would reinstate criminal proceedings.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the proposed trailer bill language.

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 15, 2018
1:30 pm or Upon Call of the Chair
Room 2040, 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: LIHEAP federal funds increase (Issue 400-MR)

May Revision. The Administration requests that Item 4700-101-0890 be increased by $33,683,000 to reflect a recent federal increase for the Low-Income Home Energy Assistance Program (LIHEAP) and the Community Services Block Grant (CSBG).

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 that Item 5175-101-0890 be decreased by $703,000 and Item 5175-101-8004 be increased by $703,000 to reflect revised forecasts of child support collections.

Staff Recommendation. Approve as requested. No concerns have been raised.

5180 DEPARTMENT OF SOCIAL SERVICES – CALWORKS

Issue 1: Increased AB 85 Savings (Issue 415-MR)

May Revision. The Administration requests that Item 5180-101-0001 be decreased by approximately $247.2 million to reflect an increase in AB 85 realignment funds available to offset General Fund costs in the CalWORKs program.

Staff Recommendation. Approve as requested. No concerns have been raised.

5180 DEPARTMENT OF SOCIAL SERVICES – CHILD WELFARE SERVICES

Issue 2: BBL: Children's Programs Reappropriation (Issue 421-MR)

May Revision. The Administration requests that Item 5180-492 be added for the purpose of reappropriating the unexpended balances from funds appropriated in the 2017 Budget Act for various child welfare services programs. The reappropriated funds would be available for encumbrance or expenditure until June 30, 2019.

Staff Comment and Recommendation. Approve as requested. No concerns have been raised.

5180 DEPARTMENT OF SOCIAL SERVICES – IN-HOME SUPPORTIVE SERVICES (IHSS)

Issue 3: BCP: In-Depth Monitoring of IHSS (Governor's Budget)

Governor's Budget. The Administration requests a total of six permanent positions (one Staff Services Manager I (SSM I) and five Associate Governmental Program Analysts (AGPAs) and $780,000 ($390,000 General Fund) in 2018-19 and $712,000 ($356,000 General Fund) annually thereafter to provide in-depth monitoring and technical assistance to help improve county administration of the IHSS program.

The department claims that due to limited resources, the QA Monitoring Unit is unable to provide in-depth monitoring and increased technical assistance to all counties. Additionally, they do not currently have the capacity to identify and address IHSS program cost trends, as the average number of hours paid per case has seen an increase of 21 percent between 2012-13 (86.3 hours) and 2015-16 (105.3 hours). DSS also points to an increased workload for QA staff due to the increased IHSS caseload and implementation of the Fair Labor Standards Act administrative changes and related overtime exemption procedures.

Staff Recommendation. Approve as requested. This subcommittee heard and discussed this item during its March 8, 2018 hearing. No concerns have been raised.

5180 DEPARTMENT OF SOCIAL SERVICES – COMMUNITY CARE LICENSING

Issue 4: BCP: Private Alternative Boarding Schools and Outdoor Programs Oversight (Governor's Budget)

Governor's Budget. The Administration requests 12.5 positions and $591,000 General Fund ongoing in order to implement SB 524 (Lara), Chapter 864, Statutes of 2016, which established Private Alternative Boarding Schools and Private Alternative Outdoor Programs as two new subcategories of Group Homes to be overseen by the department. Specifically, the positions requested are eight full-time Licensing Program Analysts (LPAs), one Licensing Program Manager (LPM), one and a half Office Assistant positions, and one Associate Governmental Program Analyst (AGPA). The Information Systems Division also requests $450,000 for contracts to make updates to the Licensing Information System.

The department estimates that there are 90 facilities (75 private alternative boarding schools and 15 private alternative outdoor programs.

Staff Recommendation. Approve as requested. This subcommittee heard and discussed this item during its March 8, 2018 hearing. No concerns have been raised.

5180 DEPARTMENT OF SOCIAL SERVICES – ADULT PROTECTIVE SERVICES

Issue 5: Home Safe Program (Issue 411-MR)

May Revision. The Administration requests $15 million General Fund one-time for a pilot of the new Home Safe Program within Adult Protective Services. The funding will be available to participating counties over a three-year period to provide housing-related supports to seniors experiencing homelessness or at risk of becoming homeless. Participating counties will provide a dollar-for-dollar match in local funds. This proposal requires trailer bill language. This request is part of a larger effort proposed by the Administration in the May Revision to address homelessness.

Staff Recommendation. This request was also heard as a proposal from the County Welfare Director's Association (CWDA) during this subcommittee's March 8, 2018 hearing. Approve funding as requested, and approve trailer bill language as placeholder, and direct department to work with CWDA regarding expanding the "homeless and at risk of homelessness" eligibility criteria in the following ways: (1) Those living in short-term housing arrangements, such as hotels, motels, and temporary stays with family members; (2) Those at imminent risk of receiving a termination notice; and (3) Those with a living situation that is at the root of their abuse or neglect issue, posing an imminent health and safety risk (e.g. those living with an abuser, or those living in unsanitary and harmful conditions).

ISSUES FOR DISCUSSION

0530 HEALTH AND HUMAN SERVICES AGENCY/OFFICE OF SYSTEMS INTEGRATION (OSI)
5180 DEPARTMENT OF SOCIAL SERVICES (DSS)

Issue 1: BCP: Electronic Visit Verification Multi-Departmental Planning Team (Issue 401-MR)

May Revision. In response to federal requirements that would require states to implement Electronic Visit Verification (EVV) systems for Medicaid-funded personal care and home health care services, including IHSS, the Administration had put forward an agency-wide proposal for limited-term resources to support planning of an EVV system across multiple programs. California has until January 2019 to comply for personal care services, and until January 2023 for home care services, or escalating penalties will be incurred.

The proposal requests $243,000 (122,000 General Fund) for the DSS on a two-year limited term basis to reflect funding equivalent of two positions to support planning activities, such as coordinating stakeholder meetings, developing policies and procedures, drafting county letters, and providing progress reports.

As federal rulemaking and guidance is not yet available, it has been difficult to proceed in developing an EVV system. Throughout 2018, California has planned an extensive stakeholder communication and collaboration process to inform the potential design and implementation of an EVV solution; however the state does not anticipate meeting the January 2019 deadline and plans to work with the Centers for Medicare and Medicaid Services (CMS) to request a good faith effort extension of time.

Stakeholders and advocates have expressed strong resistance to implementing EVV in California. They have noted because there are many unanswered questions regarding implementation, EVV could ultimately impose new, burdensome requirements for both providers and consumers. Stakeholders and advocates point out EVV reporting requirements could cause a disruption and/or reduction in services, put the consumer in danger, and require additional tasks that providers would not be compensated for. Additionally, consumers are troubled by the invasion of privacy this requirement may cause.

Staff Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – IN-HOME SUPPORTIVE SERVICES (IHSS)

Issue 1: BBL: Electronic Visit Verification (EVV) (Issue 408-MR)

May Revision. The Administration requests that Item 5180-111-0001 be amended to include provisional language to: (1) authorize increased expenditures to comply with federal EVV requirements for IHSS personal care services and Waiver Personal Care Services, and (2) allow the transfer of expenditure authority from Item 5180-111-0001 to Item 5180-001-0001 to fund any necessary state support expenditures, subject to Finance approval. The language specifies that any such increase shall be authorized no less than 10 calendar days following written notification to the Joint Legislative Budget Committee, or a lesser period if requested by the department and approved by the Joint Legislative Budget Committee.

Questions.

1. DSS: How does this proposed provisional language differ from the current process? Why is the Joint Legislative Budget Committee notification window shorter than the typical 30 days?

2. DSS: Does the department have a sense of magnitude when it comes to costs on just how much might the Legislature expect be authorized or transferred to the IHSS program for these purposes?

3. LAO: Please provide any comments, concerns, or recommendations you may have regarding this proposal.

Staff Recommendation. Hold open for discussion. Staff has concerns that this language is overly broad and does not include enough legislative oversight, nor does it include a maximum dollar amount. However, Staff understands the need to balance oversight with flexibility given that EVV is a time-sensitive federal mandate, and would like to continue to work with the Administration in refining the language at this time.

Issue 2: TBL: Electronic Visit Verification (EVV)

May Revision. The Administration requests trailer bill language that would authorize DSS to implement, interpret or make specific activities related to electronic visit verification requirements by means of all-county letters or similar instructions, without taking regulatory action.

Questions.

1. DSS: What is the purpose of this language? What additional flexibility does the department gain by not taking regulatory action, and what processes does this circumvent?

2. LAO: Please provide any comments, concerns, or recommendations you may have regarding this proposal.

Staff Recommendation. Hold open. Staff has concerns that this circumvents input from the Legislature and stakeholders. Stakeholders have raised concerns that the proposed language could undermine the collaborative approach promised by DSS on this sensitive issue, and given that DSS has publicly announced that it is not implementing EVV in IHSS until January 1, 2020, stakeholders believe there is time to ensure DSS works with stakeholders through the normal rulemaking process.

Issue 3: IHSS County Administration Adjustment (Issue 407-MR)

May Revision. The Administration requests an increase of approximately $24 million General Fund and reimbursements be increased by approximately $23 million to reflect revised workload assumptions for county and public authority administrative activities associated with the IHSS program. The workload assumptions and budgeting methodology will be reexamined as part of the 2020-21 Budget.

Questions.

1. DSS: Please provide an overview of the proposal.

2. LAO: Please provide any comments, concerns, or recommendations you may have regarding this proposal.

Staff Recommendation. Hold open. Stakeholders, while generally supportive of the augmentation, point out that cost assumptions used in constructing the augmentation may not have been based on the best available data, and that proposed new budget methodology for IHSS administration does not contain a mechanism to address future cost increases of the program.

5180 DEPARTMENT OF SOCIAL SERVICES – CHILD WELFARE SERVICES (CWS)

Issue 4: Continuum of Care Reform (CCR): Resource Family Approval Backlog (Issue 416-MR)

May Revision. The Administration requests an increase of $3,161,000 General Fund and an increase of $1,463,000 in Federal Funds to provide one-time funding to address the county backlog of Resource Family applications.

Questions.

1. DSS: What are you seeing in terms of county progress in reducing the backlog of families waiting for approval?

2. LAO: Please provide any comments, concerns, or recommendations you may have regarding this proposal.

Staff Comment and Recommendation. Hold open.

Issue 5: CCR: Level of Care Assessment Tool (Issue 418-MR)

May Revision. The Administration requests an increase of $2.5 million General Fund and an increase of $633,000 in Federal Funds to support an increased workload for county social workers and probation officers associated with implementation of the Level of Care (LOC) Protocol Assessment Tool developed for use with the Home-Based Family Care (HBFC) rate structure. This funding is contingent upon counties providing their Specialized Care Increment (SCI) plans to the department. Counties have until June 30, 2018 to update their SCI plans and indicate whether or not they will be continuing their SCI program.

CWDA still considers the workload for the LOC assessments as underfunded. They also point out that there is still no funding included in the budget for the new CANS assessment that social workers will also have to administer.

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? Is there a difference in the assumptions between how the department built their estimate and the counties are building their estimate?

3. DSS: Why did the Administration not include funding for counties to implement CANS?

Staff Comment and Recommendation. Hold open. Staff shares the concerns of stakeholders that some of the assessment work done by social workers for both the LOC and the CANS may be underfunded in the May Revision, and encourages the Administration and counties to discuss and come to agreement on assumptions and what a reasonable amount of funding for this would look like.

Issue 6: CCR: Revised Group Home Caseload Projections (Issue 419-MR)

May Revision. The Administration requests an increase of $39,740,000 General Fund and an increase of $7,472,000 in Federal Funds to reflect increased costs associated with revised group home caseload projections based on actual caseload movement, to which there is a slower than anticipated decline in congregate care caseload.

Questions.

1. DSS: Please provide an overview of the proposal.

2. DSS: Given that the amount of foster youth still in group homes is going slower than expected, and that group home extensions end in December 2018, does the department still expect to meet its target? Has the department considered any action to mitigate the potential scenario where group homes are no longer in operation but foster youth in them do not yet have a placement?

3. LAO: Please provide any comments, concerns, or recommendations you may have regarding this proposal.

Staff Comment and Recommendation. Hold open.

Issue 7: CCR: Specialized Care Increment Savings Adjustment (Issue 420-MR)

May Revision. The Administration requests an increase of $16,231,000 General Fund and an increase of $3,052,000 in Federal Funds to reflect a correction related to assumed county savings associated with Specialized Care Increments (SCIs) provided in addition to the basic foster care rate. The May Revision continues to assume that counties will reduce SCI payments to reflect the transition from age-based foster care rates to the new Home-Based Family Care rate structure.

Questions.

1. DSS: Please provide an overview of the proposal.

2. DSS: When do you assume that county savings related to SCIs will be realized?

3. LAO: Please provide any comments, concerns, or recommendations you may have regarding this proposal.

Staff Comment and Recommendation. Hold open.

Issue 8: TBL: Home-Based Family Rate Clarification

May Revision. The Administration proposes trailer bill language to clarify state statute regarding the non-applicability of the Home-Based Family Care (HBFC) rate structure for Adoption Assistance Program (AAP), Kin-GAP, and Non-Related Legal Guardian (NLRG) cases that went to permanency on or before December 31, 2016.

The Administration states that for NRLG cases established between May 1, 2011 to December 31, 2016, to continue receiving the age-based rates that existed at the time permanency was established because the costs for these cases are not included in the existing HBFC Level of Care (LOC) rates budget. The statute would further clarify that on or after January 1, 2017, NRLG cases where the guardianship is established in probate will qualify for the Basic Level Rate.

The Administration also states that language is needed to limit the Kin-Gap and AAP cases established between May 1, 2011 and December 31, 2016, to the age-based rates negotiated at the time of the agreement; therefore, these cases are not entitled to the HBFC LOC rates upon reassessment. The department notes that failure to implement this trailer bill language will result in an annual General Fund cost pressure in the tens of millions.

Questions.

1. DSS: Please provide an overview of the proposal.

Staff Comment and Recommendation. Hold open.

Issue 9: Proposal for Investment: TBL: Group Home Extension

CWDA proposes trailer bill language to authorize DSS to allow foster youth to be placed in eligible group homes that have not converted to a Short-Term Residential Therapeutic Program (STRTP) beyond the statutory deadline of December 31, 2018, to ensure that the state and counties can build enough capacity to successfully transition youth out of group homes. To be eligible for an extension, county child welfare must submit documentation to DSS describing the county's plan to transition all foster youth residing in group homes in a home-based placement or STRTP. The language would also require the county to describe barriers to these transitions and identify local and state-level solutions.

Questions.

1. CWDA: Please provide an overview of the proposal.

2. DSS: Please provide any comments, concerns, or recommendations you may have regarding this proposal.

Staff Comment and Recommendation. Hold open.

Issue 10: TBL: Proposal for Investment: Specialized Care Rate Savings and True-Up

CWDA proposes trailer bill language that would codify the true-up process for the state and county costs and savings associated with the CCR. Under the Constitutional terms of Proposition 30, the state is required to fund the net cost increases associated with mandated child welfare activities and costs enacted after 2011 Realignment was adopted. CWDA and the current Administration have worked together to develop a detailed calculation to reconcile state and county costs and savings on a monthly basis in the county cost claim, including those related to reduced SCIs, for CCR-related assistance costs. Reduced assistance costs due to the implementation of the CCR are then to be used to offset state General Fund investments for CCR administration, including but not limited to, CFTs, LOC protocol work, and the CANS assessment. Codification of the CCR true-up calculation will ensure that all relevant costs and savings are reflected on an ongoing basis and that counties that do experience net costs related to CCR will have those costs covered.

Questions.

1. CWDA: Please provide an overview of the proposal.

2. DSS: Please provide any comments, concerns, or recommendations you may have regarding this proposal.

Staff Comment and Recommendation. Hold open. Specific trailer bill language has not yet been provided and is forthcoming.

5180 DEPARTMENT OF SOCIAL SERVICES – CALWORKS

Issue 11: CalWORKs Single Allocation (Issue 406-MR)

May Revision. The Administration requests an increase of $55.8 million federal Temporary Assistance for Needy Families (TANF) block grant funds in 2018-19 to reflect the adoption of a revised budgeting methodology for county administration of the CalWORKs eligibility determination process.

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. This can be problematic when the program sees dramatic swings in caseload, as often happens in CalWORKs since it is so closely tied to the economy.

Last year, the Legislature directed the department and counties to work together to develop a new methodology. The Governor's budget provided approximately $1.7 billion in funding the Single Allocation in 2018-19. The May Revision increases the Single Allocation by $29 million. However, even with the May Revision augmentation to the Single Allocation and an agreement on the eligibility methodology, CWDA considers that an additional $28.7 million has been cut from the Employment Services component due to the ongoing caseload reduction, and would force counties to carry additional staffing vacancies to offset the funding shortfall.

Staff Comment and Recommendation. Hold open for further discussion.

Questions.

1. DSS: Please provide an overview of the proposal.

2. DSS: Can you describe the new methodology developed?

3. DSS: Please comment on advocate concerns referenced in this agenda. Are you working with advocates to address these concerns?

Issue 12: Tribal Title IV-E: Start-Up Administration Costs (Issue 414-MR)

May Revision. The Administration requests an increase of $87,000 to provide start-up funds for tribes with existing federal Title IV-E agreements and to assist tribes in establishing a Title IV-E child welfare program. Related, forthcoming trailer bill is also requested.

Staff Recommendation. Hold open.

Issue 13: CalWORKs Housing Support Program (Issue 405-MR)

May Revision. The Administration requests approximately $24 million General Fund in 2018-19 for the CalWORKs Housing Support Program, which assists CalWORKs families in obtaining and retaining permanent housing. The Administration also plans to invest an additional $24 million in 2019-20 to bring total program funding to $95 million. This request is part of a larger effort proposed by the Administration in the May Revision to address homelessness.

Staff Recommendation. Hold open. CWDA also requests that trailer bill language be included to allow the additional funding for the HSP program be able to be used to provide housing assistance to CalWORKs victims of the recent wildfires and other disasters.

Issue 14: Increase CalWORKs Homeless Assistance Program Payment Rate (Issue 413-MR) and TBL: CalWORKs Temporary Homeless Assistance Daily Rate Increase

May Revision. The Administration requests an increase of approximately $8.1 million General Fund to reflect a proposed increase to the daily payment rate from $65 to $85 for temporary shelter support in the CalWORKs Homeless Assistance Program, effective January 1, 2019. Related trailer bill language is also requested. This request is part of a larger effort proposed by the Administration in the May Revision to address homelessness.

Staff Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – DISASTER SERVICES BUREAU

Issue 15: Disaster Assistance

May Revision. The Administration requests an increase of $200,000 General Fund for the State Supplemental Grant Program to assist victims of the 2017 wildfires and the 2018 Southern California mudslides.

Questions.

1. DSS: Please provide an overview of the proposal.

2. LAO: Please provide any comments, concerns, or recommendations you may have regarding this proposal.

Staff Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – VARIOUS PROGRAMS

Issue 16: May Revision Caseload Adjustments (Issues 401-MR, 402-MR, 403-MR, and 404-MR)

May Revision. The May Revision proposes a net increase of $245,550,000 (increases of $178,908,000 reimbursements, $98,144,000 General Fund, $10,000 State Children's Trust Fund, and $2,000 Child Health and Safety Fund, partially offset by a decrease of $31,514,000 Federal Trust Fund) 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	($75,849,000) ($31,248,000) ($1,000)
Kinship Guardianship Assistance Payment	5180-101-0001	$5,739,000
Supplemental Security Income/ State Supplementary Payment (SSI/SSP)	5180-111-0001	($34,431,000)
In-Home Supportive Services (IHSS)	5180-111-0001 Reimbursements	$174,699,000 $164,878,000
Other Assistance Payments	5180-101-0001 5180-101-0890	($23,984,000) ($22,043,000)
County Administration and Automation Projects	5180-141-0001 5180-141-0890 Reimbursements	$24,416,000 $34,273,000 $13,201,000
Community Care Licensing	5180-151-0001 5180-151-0890	($21,000) $286,000
Special Programs	5180-151-0001	$4,000
Realigned Programs		
Adoption	5180-101-0890	$4,013,000
Foster Care	5180-101-0001 5180-101-0890 5180-141-0890	$26,154,000 $18,620,000 ($517,000)
Child Welfare Services (CWS)	5180-151-0001 5180-151-0803 5180-151-0890	$3,000,000 $10,000 $463,000

	5180-151-0279 Reimbursements	$2,000 $316,000
Title IV-E Waiver	5180-153-0001 5180-153-0890	($1,583,000) ($35,610,000)
Adult Protective Services	5180-151-0890 Reimbursements	$249,000 $514,000

The updated 2018-19 caseload estimates for the largest programs are summarized below:

Program[1]	**January estimate**	**May Revision**
CalWORKs	400,777	406,175
SSI/SSP	1,264,275	1,246,147
IHSS	545,180	544,444

LAO Comments. In response to the May Revision caseload adjustments,, the LAO makes the following comments:

- SSI/SSP caseload assumptions appear reasonable. The LAO also points out that the May Revision assumes a slightly higher federal SSI COLA, but this amount will not be final until fall.

- Administration's CalWORKs caseload estimates appear reasonable. However, the LAO acknowledges that it is possible that the actual caseload will be lower than both the Administration's and the LAO's estimates, given that the rapid caseload decline makes forecasting difficult. These savings in the CalWORKs program would not be identified until next January.

- IHSS estimates, including increases in caseload, hours per case, and cost per hour relative to January, appear reasonable, and are primarily driven by (1) higher hours per case; (2) higher provider costs per hour; and (3) more IHSS providers with a single recipient claiming overtime.

Questions.

1. DSS: Please provide an overview of the May Revision estimates for major programs.

2. LAO: Are the estimates reasonable?

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

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 15, 2018
1:30 pm or Upon Call of the Chair
Room 2040, 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	LIHEAP federal funds increase (Issue 400-MR)	3-0
5175	**Department of Child Support Services**	
Issue 1	May Revision Estimate (Issue 402-MR)	3-0
5180	**Department of Social Services – CalWORKs**	
Issue 1	Increased AB 85 Savings (Issue 415-MR)	3-0
5180	**Department of Social Services – Child Welfare Services**	
Issue 2	BBL: Children's Programs Reappropriation (Issue 421-MR)	3-0
5180	**Department of Social Services – IHSS**	
Issue 3	BCP: In-Depth Monitoring of IHSS (Governor's Budget)	3-0
5180	**Department of Social Services – Community Care Licensing**	
Issue 4	BCP: Private Alternative Boarding Schools and Outdoor Program Oversight and Policy Development (Governor's Budget)	2-1

5180	**Department of Social Services – Adult Protective Services**	
Issue 5	HomeSafe Program (Issue 411-MR)	3-0

ISSUES FOR DISCUSSION

0530	**Health and Human Services Agency/Office of Systems Integration**	
5180	**Department of Social Services**	
Issue 1	BCP: Electronic Visit Verification Multi-Departmental Planning Team (Issue 401-MR)	Hold open
5180	**Department of Social Services – IHSS**	
Issue 1	BBL: Electronic Visit Verification (Issue 408-MR)	Hold open
Issue 2	TBL: Electronic Visit Verification	Hold open
Issue 3	IHSS County Administration Adjustment (Issue 407-MR)	Hold open
5180	**Department of Social Services – Child Welfare Services**	
Issue 4	CCR: Resource Family Approval Backlog (Issue 416-MR)	Hold open
Issue 5	CCR: Level of Care Assessment Tool (Issue 418-MR)	Hold open
Issue 6	CCR: Revised Group Home Caseload Projections (Issue 419-MR)	Hold open
Issue 7	CCR: Specialized Care Increment Savings Adjustment (Issue 420-MR)	Hold open
Issue 8	TBL: Home-Based Family Rate Clarification	Hold open
Issue 9	Proposal for Investment: TBL: Group Home Extension	Hold open
Issue 10	Proposal for Investment: TBL: Specialized Care Rate Savings and True-Up	Hold open
5180	**Department of Social Services – CalWORKs**	
Issue 11	CalWORKs Single Allocation (Issue 406-MR)	Hold open
Issue 12	Tribal Title IV-E: Start-up Administration Costs (Issue 414-MR)	Hold open
Issue 13	CalWORKs Housing Support Program (Issue 405-MR)	Hold open
Issue 14	Increase CalWORKs Homeless Assistance Program Payment Rate (Issue 413-MR) and TBL: CalWORKs Temporary Homeless Assistance Daily Rate Increase	Hold open
5180	**Department of Social Services – Disaster Services Bureau**	
Issue 15	Disaster Assistance (Issue 412-MR)	Hold open
5180	**Department of Social Services – Various Programs**	
Issue 16	May Revision Caseload Adjustments (Issues 401-MR, 402-MR, 403-MR and 404-MR)	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 16, 2018
10:30 am or Upon Call of the Chair
Room 4203, State Capitol

PART A

Consultant: Theresa Pena

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 FOR DISCUSSION

5180 DEPARTMENT OF SOCIAL SERVICES – CHILD WELFARE SERVICES (CWS)

Issue 1: CCR: Caregiver Emergency Assistance Payments (Issue 417-MR) and TBL: Long-Term Funding Solution

May Revision. The Administration requests an increase of $13,363,000 federal Temporary Assistance for Needy Families (TANF) funds for counties to support up to six months of emergency assistance (EA) payments prior to resource family approval (RFA) beginning July 1, 2018, and up to three months of EA payments beginning July 1, 2019.

Earlier this year, it came to light that the RFA process was taking as long as six months – far beyond the goal of 90 days. Due to the fact that many families are going unpaid, the Legislature and the Administration included a short-term fix for families in an urgency bill, AB 110 (Committee on Budget), Chapter 8, Statutes of 2018. This provides at least 90 days of payments to be made to caregivers who already have a child placed in their homes on an emergency basis while RFA approval is pending. The fix is only in place through the end of June 2018.

The Administration intends to continue using EA TANF payments, similar to AB 110, for the purposes of paying families while they wait for RFA approval. This differs from the AB 110 approach, which also used Approved Relative Caregiver (ARC) funding for relative caregivers and non-related extended family members (NREFMs). This bill also includes a provision for a caregiver, who is currently receiving interim funding pursuant to AB 110, to continue such payments, for a period no longer than a combined total of six months, or until the RFA application is approved or denied, whichever is sooner.

Questions.

1. DSS: Please provide an overview of the proposal.
2. DSS: How does this proposed long-term solution differ from AB 110?
3. DSS: Please respond to stakeholder concerns raised in this agenda.
4. LAO: Please provide any comments, concerns, or recommendations you may have regarding this proposal.

Staff Comment and Recommendation. Hold open for further discussion. Counties raise concerns that the Administration is proposing to eliminate all of the state General Fund that is currently providing payments to relatives and NREFMs through the ARC program, resulting in a cost shift to counties and an unfunded mandate that triggers Proposition 30 concerns. Under the terms of Proposition 30, counties may choose not to perform this new requirement, making this solution optional and potentially leaving families at risk of not being paid when pending under the RFA process. Other advocates raise concerns that it is unclear what happens to a family if still not approved within the timelines outlined and the county can no longer access EA funds. As trailer bill language is still forthcoming, it is difficult to know whether some concerns raised by advocates and stakeholders will be addressed or not.

Issue 2: TBL: Federal Compliance: Indian Child Welfare Act Child Custody Proceedings

May Revision. The Administration proposes trailer bill language to align state law with the minimum standards of the Federal Indian Child Welfare Act's (ICWA) Final Rule, which, among other things, specifies a tribe's exclusive jurisdiction over child custody proceedings involving an Indian Child and clarifies notification requirements. The department notes that codification of the Final Rule is consistent with previous ICWA compliance efforts.

Questions.

1. DSS: Please provide an overview of the proposal.

2. LAO: Please provide any comments, concerns, or recommendations you may have regarding this proposal.

Staff Comment and Recommendation. Hold open.

Issue 3: TBL: Tribal/State Title IV-E Agreement Start-Up Allocation

May Revision. The Administration proposes trailer bill language to provide start-up funds, from existing allocations and funding, for tribes who have executed Tribal/State Title IV-E Agreements to provide child welfare service programs. The funding would be available for the first three years of implementation of their agreement.

Recently, a tribe expressed interest in implementing their Title IV-E Agreements to be used for start-up funds that will provide tribes with the ability to reasonably establish their child welfare programs in accordance with their agreement.

Questions.

1. DSS: Please provide an overview of the proposal.

2. LAO: Please provide any comments, concerns, or recommendations you may have regarding this proposal.

Staff Comment and 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

Wednesday, May 16, 2018
10:30 a.m.
State Capitol - Room 4203
PART B

Consultant: Scott Ogus

PUBLIC COMMENT

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4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Medi-Cal Local Assistance Estimate – May Revision Update

DOF Issue#: 4260-001-ECP-2018-GB (November 2017 – Medi-Cal Estimate)
4260-003-ECP-2018-GB (November 2017 – Medi-Cal Estimate)
4260-005-ECP-2018-GB (November 2017 – Children's Health Insurance Program)
4260-007-ECP-2018-GB (November 2017 – Full Adult Dental Restoration)
4260-008-ECP-2018-GB (November 2017 – ACA Optional Expansion)
4260-401-ECP-2018-MR (May 2018 – Medi-Cal Estimate)
4260-403-ECP-2018-MR (May 2018 – SMHS Federal Audit Repayment)
4260-411-ECP-2018-MR (May 2018 – Medi-Cal Unanticipated Costs)
4260-412-ECP-2018-MR (May 2018 – Medi-Cal Estimate)
4260-413-ECP-2018-MR (May 2018 – Reauthorization of CHIP)
4260-414-ECP-2018-MR (May 2018 – CMS Deferrals)

May Revision Issue. The May 2018 Medi-Cal Local Assistance Estimate includes $97.3 billion ($20.3 billion General Fund, $59.9 billion federal funds, and $17.1 billion special funds and reimbursements) for expenditures in 2017-18, and $103.9 billion ($22.9 billion General Fund, $67.2 billion federal funds, and $13.7 billion special funds and reimbursements) for expenditures in 2018-19. These figures represent an increase in estimated General Fund expenditures in the Medi-Cal program of $286.3 million in 2017-18 and $1.3 billion in 2018-19 compared to the Governor's January budget.

Caseload. In 2017-18, the May Revision assumes annual Medi-Cal caseload of 13.3 million, a decrease of 0.9 percent compared to assumptions in the Governor's January budget. In 2018-19, the May Revision assumes annual Medi-Cal caseload of 13.3 million, a decrease of 1.1 percent compared to assumptions in the Governor's January budget and a decrease of 0.1 percent compared to the revised caseload estimate for 2017-18. The decrease in estimated caseload is primarily due to lower projected enrollment for families on public assistance, medically needy families, and Medi-Cal expansion beneficiaries 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 increased by $1,346,759,000 and reimbursements be decreased by $36,503,000
- Item 4260-101-0232 be decreased by $2,245,000
- Item 4260-101-0233 be increased by $764,000
- Item 4260-101-0236 be increased by $1,687,000
- Item 4260-101-0890 be decreased by $880,267,000
- Item 4260-101-3305 be increased by $3,717,000
- Item 4260-102-0001 be decreased by $4,763,000
- Item 4260-102-0890 be increased by $25,377,000
- Item 4260-106-0890 be increased by $3,794,000
- Item 4260-117-0001 be increased by $40,000
- Item 4260-117-0890 be increased by $326,000

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	$18,866,694,000	$18,994,776,000	$128,082,000
Federal Funds	$60,011,965,000	$56,699,346,000	$(3,312,619,000)
Special Funds/Reimbursements	$16,284,778,000	$17,040,522,000	$755,744,000
Total Expenditures	**$95,163,437,000**	**$92,734,644,000**	**$(2,428,793,000)**
County Administration			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$1,030,976,000	$1,204,382,000	$173,406,000
Federal Funds	$3,384,520,000	$2,887,258,000	$(497,262,000)
Special Funds and Reimbursements	$11,994,000	$11,458,000	$(536,000)
Total Expenditures	**$4,427,490,000**	**$4,103,098,000**	**$(324,392,000)**
Fiscal Intermediary			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$160,741,000	$145,513,000	$(15,228,000)
Federal Funds	$288,451,000	$267,640,000	$(20,811,000)
Special Funds and Reimbursements	$-	$-	$-
Total Expenditures	**$449,192,000**	**$413,153,000**	**$(36,039,000)**
TOTAL MEDI-CAL EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$20,058,411,000	$20,344,671,000	$286,260,000
Federal Funds	$63,684,936,000	$59,854,244,000	$(3,830,692,000)
Special Funds and Reimbursements	$16,296,772,000	$17,051,980,000	$755,208,000
Total Expenditures	**$100,040,119,000**	**$97,250,895,000**	**$(2,789,224,000)**

Medi-Cal Local Assistance Funding Summary 2018-19 Comparison to January Budget			
Fiscal Year:	**2018-19**	**2018-19**	**Jan-May**
Benefits			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$20,388,693,000	$21,605,761,000	$1,217,068,000
Federal Funds	$63,651,192,000	$63,709,372,000	$58,180,000
Special Funds/Reimbursements	$12,767,374,000	$13,728,797,000	$961,423,000
Total Expenditures	**$96,807,259,000**	**$99,043,930,000**	**$2,236,671,000**
County Administration			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$1,083,553,000	$1,219,962,000	$136,409,000
Federal Funds	$3,280,762,000	$3,285,546,000	$4,784,000
Special Funds and Reimbursements	$4,960,000	$5,355,000	$395,000
Total Expenditures	**$4,369,275,000**	**$4,510,863,000**	**$141,588,000**
Fiscal Intermediary			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$116,846,000	$112,776,000	$(4,070,000)
Federal Funds	$211,277,000	$213,511,000	$2,234,000
Special Funds and Reimbursements	$-	$-	$-
Total Expenditures	**$328,123,000**	**$326,287,000**	**$(1,836,000)**
TOTAL MEDI-CAL EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$21,589,092,000	$22,938,499,000	$1,349,407,000
Federal Funds	$67,143,231,000	$67,208,429,000	$65,198,000
Special Funds and Reimbursements	$12,772,334,000	$13,734,152,000	$961,818,000
Total Expenditures	**$101,504,657,000**	**$103,881,080,000**	**$2,376,423,000**

Significant General Fund Changes. The May 2018 Medi-Cal Local Assistance Estimate includes the following significant General Fund changes:

Medi-Cal Unanticipated Costs: 2017-18 Deficiency — The May Revision estimates the Medi-Cal 2017-18 General Fund deficiency has increased by $286.3 million compared to the Governor's January budget, from $543.7 million to $829.9 million. According to the Administration, this significant net increase is primarily attributable to the following factors:

- Drug Rebates ($275.3 million increase) – Savings from federal drug rebates and rebates for drugs purchased in Medi-Cal managed care were revised lower due to a significantly higher

proportion of rebate claims from the Medi-Cal expansion population and the Children's Health Insurance Program (CHIP) population than estimated in the Governor's January budget. Claims for these populations receive a higher federal match, which results in more rebate funds being returned to the federal government than to the state.

- Managed Care Organization Taxes ($428.2 million increase) – Estimates of General Fund offsets from the enrollment tax on managed care plans were revised downward due to updated payment data. General Fund offsets from the previous tax on revenues of Medi-Cal managed care plans were also revised downward due to repayment of the tax paid by plans subject to recoupment of previously paid capitation payments for the Medi-Cal expansion population.
- Managed Care Financing ($177.6 million decrease) – Due to reduced caseload estimates, the costs for capitation payments to Medi-Cal managed care plans decreased.
- Hospital Quality Assurance Fee ($477.1 million decrease) – Due to the timing of federal approval of the revised hospital quality assurance fee, additional 2017-18 costs were offset.
- Federal CHIP Reauthorization ($243.5 million decrease) – Congress reauthorized CHIP at the enhanced 88 percent federal matching rate until September 2019, at 76.5 percent until September 2020, and at the traditional 65 percent thereafter. The Governor's January budget had assumed reauthorization of CHIP, but at the traditional 65 percent federal matching rate. As a result, additional matching funds offset more General Fund expenditures than were estimated in the Governor's January budget.
- Deferred Claims ($682.3 million increase) – The federal Centers for Medicare and Medicaid Services (CMS) reviews claims submitted by state Medicaid programs and may defer payment on claims requiring additional information or interpreted as not meeting all federal funding requirements. A recent federal change requires Medi-Cal to repay these deferred claims immediately pending adjudication. Because Medi-Cal is budgeted on a cash-basis, the fiscal impact of these deferrals occurs in the year in which the determination is made, while any recoupment based on favorable adjudication occurs in later years. According to DHCS, the cost of these deferrals is $682.3 million more than was estimated in the Governor's January budget.

Homeless and Mental Health Funding. The May Revision includes a one-time General Fund augmentation of $50 million to provide counties or local entities with targeted funding for multi-disciplinary teams to provide intensive outreach, treatment, and related services for homeless persons with mental illness.

Proposition 56 Supplemental Provider Payments — The May Revision continues supplemental payments for physicians, dentists, women's health services, intermediate care facilities for individuals with developmental disabilities, and HIV/AIDS Waiver services approved in the 2017 Budget Act, as well as a $163 million augmentation for physicians and $70 million augmentation for dental services included in the Governor's January budget. However, DHCS reports that claims for physicians are lower than expected, resulting in lower estimated expenditures of allocated Proposition 56 revenues. DHCS estimates total Proposition 56 expenditures of $252.2 million in 2017-18 and $602.2 million in 2018-19. For 2017-18, $293.8 million of the $546 million Proposition 56 funds appropriated in the 2017 Budget Act remains unspent. For 2018-19, $197.8 million of the $546 million Proposition 56 funds allocated pursuant to the 2017 Budget Act remains unspent which, along with the Administration's augmentation of $232.8 million, results in a total of $430.6 million of Proposition 56 funds unallocated in 2018-19. DHCS indicates it will continue to work with stakeholders and the

Legislature on a supplemental payment structure to be submitted to the federal government for approval by September 2018.

In addition to these supplemental payments, the May Revision continues the 50 percent base rate increase for home health services provided through fee-for-service and home- and community-based waivers. The May Revision assumes $56.7 million ($27.6 million Proposition 56 funds) for these services. In addition, the May Revision funds this rate increase for the California Children's Services (CCS) program with a General Fund allocation of $7.6 million.

The May Revision also includes $224.7 million of Proposition 56 funds for program growth over the 2016 Budget Act. This reflects an increase of $55.3 million over the Governor's January budget.

Reauthorization of the Children's Health Insurance Program — The May Revision includes additional General Fund offset of $898.1 million for both 2017-18 and 2018-19 for the reauthorization of the Children's Health Insurance Program (CHIP) and other program changes. The Governor's January budget assumed reauthorization, but at the traditional 65 percent federal matching rate. Congress approved a ten year extension for CHIP, which continues the enhanced federal funding of 88 percent through September 2019. The enhanced funding will incrementally decrease over time to the traditional 65 percent federal matching rate. The incremental decreases will begin October 2019. The ten-year extension also includes maintenance of eligibility requirements for children in both Medi-Cal and CHIP through September 2027.

Drug Medi-Cal Organized Delivery System Waiver – The May Revision includes a decrease in projected expenditures in the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver of $242.9 million ($61.5 million General Fund) in 2018-19. The DMC-ODS waiver was approved by CMS in August 2015 with the first services beginning in February 2017. Through the waiver, counties provide new and expanded substance use disorder services, in addition to existing DMC services. In 2017-18, 11 counties are estimated to begin providing ODS services, and 29 counties are expected to begin providing services in 2018-19. The DMC-ODS estimate reflects updated phase-in dates and county interim rates. Also included is a new projection for the costs of adding a buprenorphine-naloxone combination product for participating waiver counties.

Medi-Cal Specialty Mental Health Services Federal Audit Repayment – The May Revision includes $180.7 million General Fund expenditures for repayment of disallowed costs for Medi-Cal specialty mental health services. A recent audit by the U.S. Department of Health and Human Services, Office of Inspector General, is expected to be finalized and released in 2018-19. The audit will result in the disallowance of approximately $180.7 million in federal claims for Medi-Cal services provided by county mental health plans for specialty mental health services. These funds will initially be paid by the state's General Fund in 2018-19 with repayments from counties occurring over the next four years to prevent significant funds from being diverted from the mental health delivery system in a single year. DHCS reports it will work with county stakeholders and the Department of Finance to establish the county repayment plan.

Hepatitis C – The May Revision includes an increase of $70.4 million ($21.8 million General Fund) in 2018-19 to authorize treatment for all patients ages 13 and above with Hepatitis C, regardless of liver fibrosis stage or co-morbidity, except for patients with a life expectancy of less than 12 months. The Department of State Hospitals and California Department of Corrections and Rehabilitation will align

treatment guidelines for state hospital patients and prison inmates with the Medi-Cal guideline expansion for Hepatitis C.

The current DHCS Chronic Hepatitis C treatment policy limits treatment based on stage of disease and the co-occurrence of chronic conditions. Since the policy was released in 2015, national treatment guidelines now recommend treatment for patients with chronic hepatitis C regardless of stage or co-occurrence of conditions. Additionally, several lower cost hepatitis C drugs have been FDA-approved and have significantly lowered the treatment costs for hepatitis C. DHCS proposes to expand its current Chronic Hepatitis C Treatment Policy to allow treatment regardless of stage, to be in alignment with national guidelines and CMS guidance.

Health Care Services for Reentry Program – The Department of Health Care Services will establish an interagency agreement with the California Department of Corrections and Rehabilitation to provide health care services to reentry program participants starting July 1, 2018. This state-only funded program will serve approximately 1,100 participants and services will be provided through the department's contracting health plans. Program expenditures are expected to be $9.7 million in 2018-19.

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 significant caseload and expenditure changes in the May 2018 Medi-Cal Estimate.

2. Please provide a brief overview of the factors leading to the significant increase in the 2017-18 deficiency.

3. Please provide a brief overview of the federal audit that led to the significant federal disallowance and General Fund repayment. Please also describe the schedule and planning process for repayment of those funds by the counties.

4. Please provide a brief overview of the changes to federal guidance, as well as waiver requirements that led to the significant increase in costs related to repayment of federally deferred claims, as well as disallowed CHIP funds.

Issue 2: Family Health Estimate – May Revision Update

DOF Issue#: 4260-002-ECP-2018-GB (November 2017 Family Health Estimate)
4260-402-ECP-2018-MR (May 2018 Family Health Estimate)

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	$77,478,000	$76,420,000	$(1,058,000)
Special Funds/Reimbursements	$5,453,000	$5,453,000	$-
County Funds [non-add]	[$82,771,000]	[$82,057,000]	[$(714,000)]
Total CCS Expenditures	**482,931,000**	**$81,873,000**	**$(1,058,000)**
Child Health and Disability Prevention (CHDP)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$3,000	$3,000	$-
Total CHDP Expenditures	**$3,000**	**$3,000**	**$-**
Genetically Handicapped Persons Program (GHPP)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$98,718,000	$89,104,000	$(9,614,000)
Special Funds and Reimbursements	$18,435,000	$19,478,000	$1,043,000
Total GHPP Expenditures	**4117,153,000**	**$108,582,000**	**$(8,571,000)**
Every Woman Counts Program (EWC)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$6,000,000	$4,500,000	$(1,500,000)
Federal Funds	$4,509,000	$5,128,000	$619,000
Special Funds and Reimbursements	$22,427,000	$22,427,000	$-
Total EWC Expenditures	**$32,936,000**	**$32,055,000**	**$(881,000)**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$182,199,000	$170,027,000	$(12,172,000)
Federal Funds	$4,509,000	$5,128,000	$619,000
Special Funds and Reimbursements	$46,315,000	$47,358,000	$1,043,000
County Funds [non-add]	[$81,527,000]	[$82,057,000]	[$(714,000)]
Total Family Health Expenditures	**$233,023,000**	**$222,513,000**	**$(10,510,000)**

Family Health Local Assistance Funding Summary 2018-19 Comparison to January Budget			
Fiscal Year:	**2018-19**	**2018-19**	**Jan-May**
California Children's Services (CCS)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$83,372,000	$85,690,000	$2,318,000
Special Funds/Reimbursements	$5,453,000	$5,453,000	$-
County Funds [non-add]	[$88,128,000]	[$83,629,000]	[$(4,499,000)]
Total CCS Expenditures	**$88,825,000**	**$91,143,000**	**$2,318,000**
Child Health and Disability Prevention (CHDP)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$3,000	$3,000	$-
Total CHDP Expenditures	**$3,000**	**$3,000**	**$-**
Genetically Handicapped Persons Program (GHPP)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$118,327,000	$138,227,000	$19,900,000
Special Funds and Reimbursements	$14,523,000	$16,737,000	$2,214,000
Total GHPP Expenditures	**$132,850,000**	**$154,964,000**	**$22,114,000**
Every Woman Counts Program (EWC)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$8,962,000	$5,608,000	$(3,354,000)
Federal Funds	$4,509,000	$5,128,000	$619,000
Special Funds and Reimbursements	$22,504,000	$22,504,000	$-
Total EWC Expenditures	**$35,975,000**	**$33,240,000**	**$(2,735,000)**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$210,664,000	$229,528,000	$18,864,000
Federal Funds	$4,509,000	$5,128,000	$619,000
Special Funds and Reimbursements	$42,480,000	$44,694,000	$2,214,000
County Funds [non-add]	[$88,128,000]	[$83,629,000]	[$(4,499,000)]
Total Family Health Expenditures	**$257,653,000**	**$279,350,000**	**$21,697,000**

May Revision Issue. The May 2018 Family Health Local Assistance Estimate includes $222.5 million ($170 million General Fund, $5.1 million federal funds, and $47.4 million special funds and reimbursements) for expenditures in 2017-18, and $279.4 million ($229.5 million General Fund, $5.1 million federal funds, and $44.7 million special funds and reimbursements) for expenditures in 2018-19. These figures represent a decrease in estimated General Fund expenditures in Family Health programs of $12.2 million in 2017-18 and an increase in estimated General Fund expenditures of $18.9 million in 2018-19 compared to the Governor's January budget. These changes are primarily attributed to

increased costs in the Genetically Handicapped Persons Program (GHPP) due to retroactive payments for treatment expenditures resulting from delayed processing, offset by decreased costs in GHPP for base expenditures.

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 174,278 in 2017-18, a decrease of 1,044 or 0.6 percent, compared to the Governor's January budget. The May Revision estimates Medi-Cal CCS caseload of 177,299 in 2018-19, a decrease of 763 or 0.4 percent, compared to the Governor's January budget, and an increase of 3,453 or 1.7 percent, compared to the revised 2017-18 estimate.
  State-Only: The May Revision estimates state-only CCS caseload of 14,885 in 2017-18, a decrease of 736 or 4.7 percent, compared to the Governor's January budget. The May Revision estimates state-only CCS caseload of 14,819 in 2018-19, a decrease of 802 or 5.1 percent, compared to the Governor's January budget, and a decrease of 66 or 0.4 percent, compared to the revised 2017-18 estimate.
- **Child Health and Disability Prevention (CHDP) Caseload Estimate**
  The May Revision estimates state-only CHDP caseload of 19 in 2017-18, a decrease of 17 or 47.2 percent, compared to the Governor's January budget. The May Revision estimates state-only CHDP caseload of 22 in 2018-19, a decrease of 14 or 38.8 percent compared to the Governor's January budget, and an increase of 3 or 15.8 percent, compared to the revised 2017-18 estimate. According to DHCS, the significantly low caseload is 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 703 in 2017-18, an increase of 48 or 7.3 percent, compared to the Governor's January budget. The May Revision estimates state-only GHPP caseload of 721 in 2018-19, an increase of 62 or 9.4 percent, compared to the Governor's January budget, and an increase of 18 or 2.6 percent, compared to the revised 2017-18 estimate.
- **Every Woman Counts (EWC) Program Caseload Estimate**
  The May Revision estimates EWC caseload of 26,280 in 2017-18, a decrease of 720 or 2.7 percent compared to the Governor's January budget. The May Revision estimates EWC caseload of 26,420 in 2018-19, a decrease of 580 or 2.1 percent, compared to the Governor's January budget, and an increase of 140 or 0.5 percent, compared to the revised 2017-18 estimate.

May Revision Local Assistance Adjustments. The Administration requests the following adjustments to reflect caseload and miscellaneous adjustments:

- Item 4260-111-0001 be increased by $22,218,000 and reimbursements be increased by $43,000
- Item 4260-114-0001 be increased by $3,354,000
- Item 4260-114-0890 be increased by $619,000

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 the significant caseload and expenditure changes in the May 2018 Family Health Estimate.

Issue 3: Homeless Mentally Ill Outreach and Treatment

DOF Issue#: 4260-415-ECP-2018-MR

May Revision Issue and Budget Bill Language. DHCS requests one-time General Fund expenditure authority of $50 million. If approved, these resources would allow DHCS to provide counties with targeted funding for multi-disciplinary teams to support intensive outreach, treatment, and related services for homeless persons with mental illness. According to the Administration, counties would be encouraged to match these funds with local mental health funding and federal matching funds, where appropriate. The funded interventions are intended to result in earlier identification of mental health needs, prevention of criminal justice involvement, and improved coordination of care for this population at the local level.

In addition to the allocation of General Fund expenditure authority, DHCS seeks provisional budget bill language to govern implementation of the program. The provisional language includes the following components:

1. Would require DHCS to consult with the Department of Finance and the California State Association of Counties to determine allocation of funding.
2. Funding allocations would consider county incidence of homeless individuals with serious mental illnesses and county population.
3. Counties may submit requests within 90 days of enactment of the budget.
4. Counties may use the funding to leverage other fund sources.
5. The funds may not be used to supplant existing funds for these purposes.
6. Counties would be required to report to DHCS within 90 days after full expenditure of funding. The report would include disposition of funds, services provided and number of individuals receiving services.

The provisional language also allocates $150,000 to DHCS for administration of the program.

Interaction with Community Treatment Proposal at Department of State Hospitals. In the Governor's January budget, the Department of State Hospitals (DSH) requested $100 million to implement a grant program to counties to provide community-based treatment and diversion for individuals at risk of being deemed incompetent to stand trial (IST) and referred for state hospital placement. The DSH proposal is intended to establish local post-booking diversion programs to reduce the number of individuals referred as IST by promoting community treatment. According to DSH, nearly half of the individuals referred to state hospitals as IST are unsheltered homeless. It is likely that both the $50 million allocation for treatment of homeless persons with mental illness proposed by DHCS, as well as the community-based diversion program proposed by DSH, would target similar populations. It is unclear the extent to which DHCS and DSH have discussed coordinating funding and program details if both programs are approved.

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. If both this proposal and the DSH proposal are approved, does DHCS or the Administration plan to coordinate with DSH to ensure resources and programming for both departments' programs are complementary, rather than duplicative?

Issue 4: Mental Health Services Fiscal Oversight and Behavioral Health Data Modernization

DOF Issue#: 4260-402-BCP-2018-MR

May Revision Issue. DHCS requests 21 positions and expenditure authority of $6.7 million ($2.8 million General Fund, $3.2 million federal funds, and $725,000 Mental Health Services Fund) in 2018-19, an additional seven positions and expenditure authority of $6.5 million ($2.7 million General Fund, $2.7 million federal funds, and $1.1 million Mental Health Services Fund) in 2019-20, $5.5 million ($2.2 million General Fund, $2.2 million federal funds, and $1 million Mental Health Services Fund) in 2020-21, and $4 million ($1.5 million General Fund, $1.5 million federal funds, and $1 million Mental Health Services Fund) annually thereafter. If approved, these resources would allow DHCS to strengthen fiscal oversight of the Mental Health Services Act, the Medi-Cal Mental Health Managed Care Program, and planning for a comprehensive Behavioral Health Data Modernization Project.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$2,781,000	$2,700,000
0890 – Federal Trust Fund	$3,219,000	$2,698,000
3085 – Mental Health Services Fund	$725,000	$1,062,000
Total Funding Request:	**$6,725,000**	**$6,460,000**
Total Positions Requested:**	**21.0**	**28.0**

* Additional fiscal year resources requested: 2020-21: $5,477,000; 2021-22 (ongoing): $4,045,000
** Positions ongoing after 2019-20.

Background. DHCS is responsible for administering California's community mental health system through three primary programs: 1) the Bronzan-McCorquodale Act (1991 Realignment), 2) the Mental Health Services Act (MHSA), and 3) the Medi-Cal Mental Health Managed Care program. DHCS contracts with 57 county mental health departments to provide community mental health services through the Bronzan-McCorquodale Act and the MHSA and contracts with 56 county mental health departments to provide specialty mental health services through the Medi-Cal Mental Health Managed Care program.

Mental Health Services Act Responsibilities. DHCS is responsible for fiscal oversight activities of MHSA-funded programs. The department collects annual revenue and expenditure reports from county mental health programs, calculates unspent amounts subject to reversion after three years pursuant to the MHSA, withholds funds from counties or imposes corrective action plans for non-compliance with MHSA requirements, and performs various accounting and reporting responsibilities. The 2017 Budget Act included specific requirements for DHCS regarding managing the reversion process for MHSA funds, which had not been performed for several years. In addition, a recent state audit found significant deficiencies in the department's oversight of the program.

Medi-Cal Mental Health Managed Care Program. DHCS is also responsible for fiscal oversight activities of the Medi-Cal Mental Health Managed Care program. County claims are submitted through an electronic claims processing system called Short-Doyle/Medi-Cal (SD/MC) for processing by DHCS to receive federal matching funds. DHCS is responsible for maintaining the claiming system and ensuring accurate and appropriate payments. According to DHCS, it does not have sufficient staff to

maintain and update the SD/MC claiming system for this monitoring purpose. In addition, a recent federal audit identified more than $180 million of inappropriate claims for federal reimbursement that is being repaid by the state's General Fund, with county reimbursement over four years.

Comprehensive Behavioral Health Data Systems Modernization. DHCS reports it collects data for its mental health and substance use programs on multiple data systems, but that the 12 legacy data systems for behavioral health transferred from the Departments of Mental Health and Alcohol and Drug Programs make data collection, reporting, and analysis extremely labor intensive. As a result, DHCS has begun the Project Approval Lifecycle planning process, pursuant to California Department of Technology (CDT) requirements, to implement a Comprehensive Behavioral Health Data Systems Modernization Project. According to DHCS, the project will allow improved information updates and tracking, allow improved evaluation of effectiveness of behavioral health treatment, allow improved monitoring of compliance, and improve data quality enforcement. DHCS reports the Stage 1 Business Analysis was approved by CDT in October 2016. These resources would allow DHCS to continue to develop its Stage 2 Alternatives Analysis.

DHCS requests 21 positions and expenditure authority of $6.7 million ($2.8 million General Fund, $3.2 million federal funds, and $725,000 Mental Health Services Fund) in 2018-19, an additional seven positions and expenditure authority of $6.5 million ($2.7 million General Fund, $2.7 million federal funds, and $1.1 million Mental Health Services Fund) in 2019-20, $5.5 million ($2.2 million General Fund, $2.2 million federal funds, and $1 million Mental Health Services Fund) in 2020-21, and $4 million ($1.5 million General Fund, $1.5 million federal funds, and $1 million Mental Health Services Fund) annually thereafter. Specifically, these positions would be allocated as follows:

Audits and Investigations
Seven Health Program Auditor (HPA) III
20 HPA III – two-year, limited-term

These positions would audit a four year backlog of mental health plan cost reports, audit county MHSA revenue and expenditure reports, and verify audits are conducted for all mental health plan cost reports.

Mental Health Services Division
Two Associate Information Systems Analysts
One Accounting Technician
One Associate Accounting Analyst
Five Associate Governmental Program Analysts (AGPA)

These positions would address a backlog of technical updates to the SD/MC claiming system, review and validate mental health plan claim certifications, process appeals of denied claims, and process a four-year backlog of cost report interim settlements and address current workload to avoid future backlogs.

Enterprise Innovation and Technology Services
Two Staff Programmer Analysts
Two Senior Programmer Analysts
One Senior Information System Analyst

These positions would work with the Mental Health Services Division staff to address a backlog of technical updates to the SD/MC claiming system, support technical changes to the cost reporting process to verify timely submission of cost reports and prevent future backlogs.

Office of Administrative Hearings and Appeals
Two Health Program Audit Manager I
One Administrative Law Judge

These positions would manage ongoing SD/MC and MHSA appeals workload regarding disputes of cost reports and annual revenue and expenditure reports.

Office of Legal Services
Two Attorney III
One Senior Legal Analyst
One Legal Secretary

These positions would support other divisions during formal appeals hearings, provide the Mental Health Services Division with counsel advice during the audit processes, and provide administrative support.

In addition to the position requests, the department's request includes $1.7 million ($754,000 General Fund and $956,000 federal funds) for contractor services for the Comprehensive Behavioral Health Data Systems Modernization Project.

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 5: California Medicaid Management Information Legacy and Modernization Resources

DOF Issue#: 4260-406-BCP-2018-MR

Budget Issue. DHCS requests 17 positions and expenditure authority of $41.7 million ($9.7 million General Fund and $32 million federal funds) in 2018-19, an additional eight positions and expenditure authority of $23.9 million ($2.7 million General Fund and $21.1 million federal funds) in 2019-20, $11.5 million ($1.4 million General Fund and $10.1 million federal funds) in 2020-21, and $3 million ($582,000 General Fund and $2.4 million federal funds) annually thereafter. If approved, these resources would allow DHCS to further implement its modernization approach for the California Medicaid Management Information System (CA-MMIS).

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$9,675,000	$2,723,000
0890 – Federal Trust Fund	$32,040,000	$21,131,000
Total Funding Request:	**$41,715,000**	**$23,854,000**
Total Positions Requested:**	**17.0**	**25.0**

* Additional fiscal year resources requested: 2020-21: $11,540,000; 2021-22 (ongoing): $2,991,000
** Positions ongoing after 2019-20.

Background. DHCS contracts with a fiscal intermediary (FI) to maintain and operate CA-MMIS, which is utilized 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 for the state and delivers other services to program providers, beneficiaries, and federal and state users of the system. The department's CA-MMIS Division is responsible for oversight, management, monitoring, and administration of the single FI vendor responsible for providing information technology system maintenance and operations and business operations services, as well as the design, development and implementation of a new system to modernize CA-MMIS.

In October 2012, the FI contractor began design and development of a new CA-MMIS replacement system, "Health Enterprise" (HE). In October 2015, the FI 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 the FI signed a settlement agreement to terminate design and development of the replacement system and compensate DHCS for costs incurred under the FI contract. The FI contractor 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 maintenance and operations services and support. DHCS reports it intends to award two new vendors for maintenance and operations and business services after September 30, 2019.

According to DHCS, the CA-MMIS Division developed a new Modernization Approach to replace the legacy CA-MMIS system using a modular procurement approach coupled with agile design and development techniques to incrementally deliver new functionality to CA-MMIS across multiple fiscal years. This consists of iteratively implementing CA-MMIS business functionality in the form of "digital services" as they are developed. Each new digital service will replace CA-MMIS business functionality. The 2017 Budget Act approved positions and personal services consultants needed to continue this

project. This request is focused on implementation and replacements for federal draw and reporting, third party liability, and claims modernization.

DHCS requests 17 positions and expenditure authority of $41.7 million ($9.7 million General Fund and $32 million federal funds) in 2018-19, an additional eight positions and expenditure authority of $23.9 million ($2.7 million General Fund and $21.1 million federal funds) in 2019-20, $11.5 million ($1.4 million General Fund and $10.1 million federal funds) in 2020-21, and $3 million ($582,000 General Fund and $2.4 million federal funds) annually thereafter. Specifically, these positions and resources would be allocated within the CA-MMIS Division as follows:

Digital Service Teams (DSTs) Strategy
Two AGPAs
One Information Technology Manager I (ITM I)
Three Information Technology Specialist I (IT Spec I)
One Staff Services Manager III

These positions would form DSTs comprised of multi-disciplinary teams of state positions and personal services consultants to plan, design, and build fully functional modules. The DST for claims modernization would explore user and technical requirements for claims processing, research claims processing solutions, and plan for incremental implementation for all fee-for-service claim types.

Oversight to Ownership Strategy
Two ITM I
One Information Technology Manager II
One IT Spec I
Five Information Technology Specialist II
Two Information Technology Specialist II (two-year, limited-term)
One Information Technology Specialist III

These positions would build technical and business expertise for vendor management, contract management, performance management, risk management, quality management, procurement management, and integration management.

In addition to these positions and resources, this request includes $22.9 million ($7.4 million General Fund and $15.5 million federal funds) for one-time contractor costs for the two new vendors taking over the maintenance and operations and business services functions from the legacy FI. The takeover activities are scheduled to begin in October 2018 and conclude September 30, 2019, when the vendors will take over responsibility for these functions.

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 6: Medi-Cal General Fund Reappropriation and Loan Authority

DOF Issue#: Issue 405 – May Revision Finance Letter
TBL (RN Pending)

May Revision Issue and Trailer Bill Language Proposal. DHCS requests reappropriation of General Fund balances from the 2017-18 fiscal year, including any approved supplemental appropriations prior to June 30, 2018. If approved, the reappropriated funds would be comprised of any unspent General Fund expenditure authority appropriated to DHCS for the Medi-Cal program in items 4260-101-0001 and 4260-113-0001.

In addition to this request, DHCS proposes trailer bill language to increase its existing General Fund loan authority to continue funding health care services in Medi-Cal in the event of a deficiency. According to DHCS, the increased loan authority is necessary as the significant growth of the program has resulted in significantly larger deficiencies that can exceed the current $1 billion loan authority upon which the department relies to continue funding health care services when Medi-Cal costs exceed the department's appropriation authority. The department proposes to increase the loan authority from $1 billion to $2 billion.

Reappropriation Language. DHCS requests the following reappropriation language:

> 4260-491—Reappropriation, State Department of Health Care Services. Notwithstanding any other provision of law, upon order of the Department of Finance, the balances of the appropriations provided in the following citations are reappropriated for the same purposes provided for those appropriations as detailed in the preceding May Revision Medi-Cal estimate, and shall be available for expenditure until June 30, 2019.
>
> 0001—General Fund
>
> (1) Item 4260-101-0001, Budget Act of 2017 (Chs. 14, 22, and 54, Stats. 2017)
>
> (2) Item 4260-113-0001, Budget Act of 2017 (Chs. 14, 22, and 54, Stats. 2017)
>
> (3) Any Supplemental Appropriation Bills passed for this purpose prior to June 30, 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 these proposals.

Issue 7: Cost-Based Reimbursement Clinic Directed Payment Program

DOF Issue#: TBL (RN Pending)

May Revision Trailer Bill Language Proposal. DHCS proposes trailer bill language to establish a new Cost-Based Reimbursement Clinic (CBRC) directed payment program no sooner than July 1, 2019 to reimburse CBRCs that contract with managed care plans. The non-federal share of the program may be funded through voluntary intergovernmental transfers from public entities. The first 30 million dollars of non-federal share in each fiscal year, or a lesser amount as determined by the department, would be financed by other state funds appropriated to the department for this purpose.

Background. On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) issued a final rule that amended and expanded requirements pertaining to Medicaid managed care plans. The final rule introduced new requirements, practices, and procedures related to Medicaid capitation rate setting, including prohibiting states from directing provider reimbursement through managed care contracts except through one of the following allowable directed payment mechanisms:

- Value-based purchasing models for provider reimbursement, such as pay-for-performance arrangements, bundled payments, or other payment arrangements that recognize value or outcomes over volume of services
- Delivery system reform or performance improvement initiatives
- Minimum or maximum fee schedules, or uniform dollar or percentage increases, for network providers that provide designated services under the contract
- Through existing pass-through payments subject to a 10-year phase-down and annual "base amount" calculation beginning July 1, 2017

The department's proposed language would allow implementation of a cost-based fee-for-service methodology for reimbursement of CBRCs that are network providers of a Medi-Cal managed care plan. According to the Administration, this program would be allowable under the requirements of the new federal regulations.

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: Federal Substance Abuse and Mental Health Services Administration Grant Awards

DOF Issue#: Issues 402 and 413 – May Revision Finance Letter

May Revision Issues. DHCS requests increased federal fund authority due to receipt of two grant awards from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The first grant award is a supplemental award of the department's annual SAMHSA allocation for county mental health and substance use disorder services. The second grant is the revised amount awarded for the Regular Service Program Crisis Counseling Program, which provides counseling services to Californians affected by the recent wildfires.

May Revision Local Assistance Adjustments. Pursuant to these requests and consistent with the revised grant awards, the Administration requests the following adjustments:

Increase to Annual SAMHSA Grant

- Item 4260-115-0890 be increased by $15,675,000
- Item 4260-116-0890 be increased by $2,262,000

Regular Service Program Crisis Counseling Program Award

- Item 4260-115-0890 be increased by $5,400,000

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 these proposals.

Issue 9: Technical Adjustments – Reimbursements and Distributed Administration

DOF Issue#: 4260-411-BBA-2018-MR

May Revision Issue. DHCS requests technical adjustment of its administrative cost schedules. These schedules account for the department-wide costs of certain administrative activities provided to all department divisions and entities. This adjustment results in increasing Schedule (2) of item 4260-001-0001 by $1.5 million and reducing Schedule (3) of the same item by $1.5 million. This item is the main state operations appropriation for DHCS.

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 10: Lawsuits and Claims Payment Notification Provisional Requirements

DOF Issue#: 4260-414-BBA-2018-MR

May Revision Issue and Budget Bill Language Proposal. DHCS requests elimination of provisional language in item 4260-101-0001 that waives legislative notification for payment of attorney fees below $50,000. According to DHCS, this provision is no longer necessary as the department's current practice is to include estimated costs of all Medi-Cal lawsuits, judgments, settlements, and attorney fees in the semi-annual Medi-Cal Local Assistance Estimates. This information is currently provided in Base Policy Change 208 – Lawsuits/Claims, in the May 2018 Medi-Cal Local Assistance Estimate and reflects 2017-18 attorney fee payments of $22,400.

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 11: Intermediate Care Facility/Developmental Disabilities and Home Health Payments

DOF Issue#: Issue 415 – May Revision Finance Letter

May Revision Issue and Budget Bill Language Proposal. DHCS requests amendment of Provision 3 of item 4260-101-3305. If approved, the department's proposed amendments would extend supplemental payments to facilities providing continuous skilled nursing care to individuals with developmental disabilities pursuant to the department's continuous skilled nursing pilot. The amendments would also allow a rate increase for home health providers.

Background. Proposition 56, approved by voters in 2016, increased the excise tax rate on cigarettes by $2 per pack, with an equivalent increase on other tobacco products, including electronic cigarettes, to provide funding for various public health and tobacco-related law enforcement programs. After allocations for administration, auditing, and backfills of other revenue streams, Proposition 56 requires 82 percent of remaining funds be transferred to the Healthcare Treatment Fund to increase funding for existing healthcare programs and services by providing improved payments for all healthcare, treatment, and services in the Medi-Cal program. The 2017 Budget Act allocated Proposition 56 Medi-Cal funding for supplemental payments in the following categories:

- $325 million for physician services
- $140 million for dental services
- $50 million for women's health
- $27 million to unfreeze reimbursement rates to intermediate care facilities for individuals with developmental disabilities (ICF-DDs)
- $4 million to increase reimbursement to providers serving beneficiaries of the AIDS Waiver.

In addition, the Governor's January budget proposed to allocate Proposition 56 revenue to provide a 50 percent increase for home health services provided in fee-for-service or through a home- and community-based waiver.

DHCS requests amendment of the provisional authority for the ICF-DD allocation of Proposition 56 resources. These amendments would expand the definition of facilities that qualify for the supplemental payments, as well as allow the rate increase for home health services proposed by the Administration.

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.

0000 VARIOUS DEPARTMENTS

Issue 1: Proposal for Investment

DOF Issue#: None – Stakeholder Proposal

Stakeholder Proposal - "Jordan's Syndrome" PPP2R5D Research Grants. The UC Davis Institute of Regenerative Cures requests expenditure authority of $12 million for research related to a genetic mutation, PPP2R5D, which has recently been described as a cause of neurodevelopmental disorders including autism, intellectual disabilities, behavioral challenges, and seizures. According to the Institute of Regenerative Cures, the research grant would fund a clinical registry and biorepository, creation of transgenic mouse models with the most common mutations, various characterization and biochemical studies, identification of lead compounds, and mouse clinical trials. Once a compound is identified, the project would partner with a pharmaceutical company to begin formal human clinical trials. The process is expected to take six to ten years.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions. The subcommittee has requested advocates to present this proposal.

Senate Budget and Fiscal Review—Holly Mitchell, Chair

SUBCOMMITTEE NO. 3 Agenda

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

Wednesday, May 16, 2018
Upon Call of Chair
State Capitol - Room 4203

PART C

Consultant: Renita Polk

PROPOSED FOR VOTE ONLY

PROPOSED 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.

PROPOSED FOR VOTE ONLY

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

Issue 1: Centralize Statewide Activities for Developmental Services (BCP)

Proposal. The budget proposes shifting $2.1 million ($1.6 million General Fund) for 15.5 permanent positions from the State Operated Residential and Community Services Program (formerly the Developmental Centers program) to Headquarters.

Staff Comments and Recommendation – Approve as budgeted: This issue was discussed on March 15th and no issues have been raised.

Issue 2: Clinical Staff for Community Homes Oversight (BCP)

Proposal. The budget proposes $2 million ($1.4 million General Fund) for nine permanent positions to increase clinical staff and expertise within Headquarters to support development and ongoing monitoring of Adult Residential Facilities of Persons with Special Health Care Needs (ARFPSHNs), Enhanced Behavioral Supports Homes (EBSHs), and Community Crisis Homes (CCHs).

Staff Comments and Recommendation – Approve as budgeted: This issue was discussed on March 15th and no issues have been raised.

Issue 3: Internal Audit Unit (BCP)

Proposal. The budget proposes $295,000 ($178,000 General Fund) and two positions to begin start-up and planning activities to establish an internal audit unit that will evaluate fiscal and programmatic internal controls, identify areas for improved efficiencies, and provide recommendations for addressing internal deficiencies.

Staff Comments and Recommendation – Approve as budgeted: This issue was discussed on March 15th and no issues have been raised.

PROPOSED FOR DISCUSSION

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

Background. The Department of Developmental Services is responsible for administering the Lanterman Developmental Disabilities Services Act (Lanterman Act). The Lanterman Act provides for the coordination and provision of services and supports to enable people with developmental disabilities to lead more independent, productive, and integrated lives. The Early Start Program provides for the delivery of appropriate services to infants and toddlers at risk of having developmental disabilities. DDS carries out its responsibilities through 21 community-based, non-profit corporations known as regional centers, three state-operated developmental centers, and one state-operated community facility.

The number of individuals with developmental disabilities in the community served by regional centers (consumers) is expected to increase from 317,596 in the current year, to 332,738 in 2018-19. The number of individuals who will reside in state-operated residential facilities is estimated to be 323 on July 1, 2019.

The May Revision includes $7.3 billion total funds ($4.4 billion GF) for the Department in 2018-19; a net increase of $427.4 million ($305.9 million GF) over the updated 2017-18 budget.

FUNDING SUMMARY
(Dollars in Thousands)

	2017-18	2018-19	Difference	Percentage Change
BUDGET SUMMARY				
Community Services	$6,358,800	$6,879,880	$521,080	8.2%
Developmental Centers	483,369	384,549	-98,820	-20.4%
Headquarters Support	63,156	68,278	5,122	8.1%
TOTALS, ALL PROGRAMS	**$6,905,325**	**$7,332,707**	**$427,382**	**6.2%**
GENERAL FUND				
Community Services	$3,742,305	$4,103,311	$361,006	9.6%
Developmental Centers	358,135	299,150	-58,985	-16.5%
Headquarters Support	36,232	40,121	3,889	10.7%
GF TOTAL, ALL PROGRAMS	**$4,136,672**	**$4,442,582**	**$305,910**	**7.4%**

Issue 1: Developmental Centers – May Revision Adjustments

Current Year Adjustments: The May Revision reflects an ending DC population of 534 residents on June 30, 2018, which is a decrease of three residents as compared to the Governor's Budget. The May Revision proposes a decrease of $11.4 million ($8.5 million General Fund) for current year support. The following adjustments reflect this decrease:

- Operations Expenditures: $51,000 decrease ($29,000 GF decrease) in resident-driven Operations Expense and Equipment (OE&E) costs due to a net reduction of three residents.

- Salary Savings: $11.4 million decrease ($8.5 million GF decrease) in personal services, staff benefits, and OE&E expenditures resulting from estimated salary savings.

Budget Year Adjustments: The May Revision reflects an ending DC population of 323 residents on June 30, 2019, which is a decrease of 38 residents as compared to the Governor's Budget. For the budget year, the May Revision proposes an increase of $8.9 million ($7.2 million General Fund) over the January budget to reflect the following adjustments:

- Operations Expenditures: $9.1 million net increase ($7.6 million GF increase). This includes an increase of $6.5 million ($6.3 million GF increase) and 125.2 positions at the Sonoma DC to reflect a technical correction, and a $2.6 million increase ($1.4 million GF increase) for updated operations expenditures at the Fairview and Porterville DCs due to revised resident populations.

- Closure Activity Costs: $0.2 million decrease ($0.4 million GF decrease) to reflect updated closure activity costs at the Fairview, Porterville, and Sonoma DCs.

Deferred Maintenance: The May Revision proposes $60 million General Fund to address critical deferred maintenance issues at Porterville DC. This amount is included in Budget Act Control Section 6.10, which will be discussed in Budget and Fiscal Review Subcommittee No. 4.

Questions for DDS:

- Briefly present the May Revision proposal for developmental centers.

Staff Comments and Recommendation – Hold open.

Issue 2: Community Services Program – May Revision Adjustments

Current Year (2017-18) Adjustments: The May Revision projects the total community caseload at 317,596, reflecting a decrease of 241 consumers from the 2018 Governor's Budget. For the current year, the Governor's May Revision proposes an updated budget of $6.4 billion ($3.7 billion General Fund), a net decrease of $16.7 million ($44 million General Fund decrease) from the Governor's January budget. The decrease includes the following adjustments:

- Caseload and Utilization: $16.7 million net decrease ($43.9 million GF decrease) in regional center Operations (OPS) and Purchase of Services (POS) as follows:
    - OPS decrease of $2.1 million ($3.6 million GF decrease)
    - POS decrease of $14.6 million ($40.3 million GF decrease)

The net decrease in OPS reflects updated projections for regional center rent expenditures, a caseload-driven decrease in Federal Compliance, the cancellation of the Department's contract with University Enterprises, Inc. for assistance with forecasting projections, and a decrease in administration fees for Intermediate Care Facilities for the Developmentally Disabled (ICF-DD).

The decrease in POS reflects the net difference of adjustments for all POS budget categories based on updated prior year expenditures upon which current year expenses are projected. The decrease in GF reflects an estimated increase in Home and Community Based Services (HCBS) Waiver and 1915(i) State Plan Amendment reimbursements, resulting in an offset to the GF.

- DC Closure Community Placement Plan: $0 net impact ($0.1 million GF decrease) to reflect an estimated increase in federal reimbursements, resulting in an offset to the GF.

- BHT Transition – Consumers without an ASD Diagnosis: $0.2 million decrease ($0.2 million GF decrease) reflecting updated expenditures for consumers without an Autism Spectrum Disorder (ASD) diagnosis who receive services on a fee-for-services basis, as reimbursed by the Department of Health Care Services (DHCS).

- ICF-DD Supplemental Payment Program: $0.2 million increase ($0.2 million GF increase) to provide supplemental payments to ICF-DDs consistent with a corresponding Medi-Cal rate increase.

Budget Year (2018-19) Adjustments: The May Revision estimates the total community caseload at 332,738 consumers, reflecting a projected decrease of 286 consumers from the caseload estimated in the 2018 Governor's Budget. The department estimates total funding of $6.9 billion ($4.1 billion GF), reflecting a net increase of $21.6 million ($2.6 million GF decrease) over the Governor's Budget. The decrease in GF reflects an estimated increase in HCBS Waiver and 1915(i) State Plan Amendment reimbursements, resulting in an offset to the GF. This increase includes the following adjustments:

- Caseload and Utilization: $6.6 million decrease ($20.8 million GF decrease) in regional center OPS and POS as follows:
    - OPS decrease of $0.5 million ($2.2 million GF decrease)

- POS decrease of $6.1 million ($18.6 million GF decrease)

The net OPS decrease results from caseload-driven decreases in core staffing and Federal Compliance, a slight decrease in ICF-DD administration fees, and a net increase in projects.

The decrease in POS reflects the net difference of adjustments for all POS budget categories based on current year expenditure trends.

- BHT Transition – Consumers without an ASD Diagnosis: $0.9 million net increase ($0.9 million GF increase) in expenditures for consumers without an ASD diagnosis. The adjustment includes a $0.5 million decrease for consumers who receive services on a fee-for-services basis, and a $1.4 million increase reflecting a three month phased transition of Medi-Cal managed care consumers in Los Angeles, Orange, Riverside, and San Bernardino counties.

- DC Closure Community Placement Plan: $2.2 million increase ($0.6 million GF increase) to fund CPP placement activities for an increased number of individuals moving from a DC.

- ICF-DD Supplemental Payment program: $0.2 million increase ($0.2 million GF increase) representing the full year impact of the program consistent with a corresponding Medi-Cal rate increase.

- Home Health Rate Increase: $29.5 million increase ($17.1 million GF increase) to fund the 50% rate increase for Home Health Agency, Licensed Vocational Nurse, and Registered Nurse services consistent with a corresponding Medi-Cal rate adjustment. This is a conforming adjustment to align the developmental services rate with the Department of Health Care Services (DHCS) rate. Pursuant to existing regulations, the developmental services rates for home health services and intermediate care facilities are based on a rate scheduled established by DHCS.

- Uniform Holiday Schedule: $4.6 million decrease ($0.2 million GF decrease) to correct an error in the Governor's Budget. The correction results in additional estimated savings to implement the Uniform Holiday Schedule in accordance with W&I Code Section 4692.

- SB 3 Minimum Wage Increase: $0 net impact ($0.4 million GF decrease) reflecting an estimated increase in federal reimbursements which offset the GF.

Questions for DDS:

- Please briefly present the May Revision proposal for the Community Services Program.

Staff Comments and Recommendation – Hold open.

Issue 3: Headquarters – May Revision Adjustments

The May Revision proposes $68.3 million ($40.1 million GF) for Headquarters in 2018-19, which is a $0.7 million increase ($0.5 million GF increase) compared to the Governor's Budget. The increase results from the following two Budget Change Proposals (BCPs):

Electronic Visit Verification (EVV) BCP

Proposal. The May Revision proposes a $277,000 increase ($222,000 General Fund and $55,000 reimbursements) to support planning activities to comply with the federal EVV requirements related to Home and Community-Based Services programs. These resources would fund two, two-year limited term positions. This proposal is part of a larger Health and Human Services Agency proposal.

Background. Electronic visit verification (EVV) is a telephone and computer-based system that electronically verifies service visits occur. Pursuant to Subsection l of Section 1903 of the Social Security Act (42 U.S.C. 1396b), all states must implement EVV for Medicaid-funded personal care services by January 2019 and home health care services by January 2023.

Staff Comments and Recommendation – Hold open: This proposal is part of a larger agency wide proposal that the subcommittee will take action on once it hears all the May Revision proposals.

Person-Centered Planning Training Resources BCP

Proposal. The May Revision proposes a one-time augmentation of $404,000 ($310,000 General Fund) for the department to contract for resources to develop and implement training on person-centered practices.

Background. Federal regulations, referred to as the Home and Community-Based Services (HCBS) Final Rule, require that service plans for individuals in Medicaid funded HCBS programs be developed through a person-centered planning process. A person-centered planning process helps guide the selection of the most appropriate and effective services which can reduce the need for changes in services and the potential need for more restrictive services. The department receives more than $2 billion annually in Medicaid HCBS reimbursements under the existing 1915(c) HCBS waiver and the 1915(i) State Plan Amendment for HCBS. In addition, the upcoming Self Determination program will be funded as a 1915(c) waiver. All of these programs require compliance with person-centered service planning.

To effectively implement and monitor statewide compliance with person-centered planning requirements, the department must develop training resources for consumers, families, and regional centers that are consistent throughout the state.

Staff Comments and Recommendation – Hold open.

Senate Budget and Fiscal Review—Holly Mitchell, Chair

SUBCOMMITTEE NO. 3 Agenda

Senator Richard Pan, M.D., Chair
Senator Steven M. Glazer
Senator Scott Wilk

Thursday, May 17, 2018
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Part A

Consultant: Renita Polk

PROPOSED FOR VOTE-ONLY

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.

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

Issue 1: May Revision Adjustments

The subcommittee heard the following issues during its May 16, 2018 hearing.

Proposal. The May Revision includes $7.3 billion total funds ($4.4 billion General Fund) for the Department in 2018-19; a net increase of $427.4 million ($305.9 million General Fund) over the updated 2017-18 budget.

More specifically, the proposal includes:

- Developmental Centers Adjustments - The May Revision proposes a decrease of $11.4 million ($8.5 million General Fund) for current year support. For the budget year, the May Revision proposes an increase of $8.9 million ($7.2 million General Fund) over the January budget.

- Community Services Program Adjustments - The May Revision proposes a net decrease of $16.7 million ($44 million General Fund decrease) from the Governor's January budget. For the budget year, the May Revision proposes a net increase of $21.6 million ($2.6 million GF decrease) over the Governor's Budget.

- Headquarters Adjustments – The May Revision proposes no changes to the current year Headquarters budget. The May Revision proposes $68.3 million ($40.1 million General Fund) for Headquarters in 2018-19, which is a $0.7 million increase ($0.5 million General Fund increase) compared to the Governor's Budget.

Staff Comments and Recommendation. Approve May Revision, as adjusted by other subcommittee actions.

Issue 2: Acute Crisis Services TBL

The subcommittee heard the following issue during its March 15, 2018, hearing.

Proposal. The budget provides TBL to make a technical adjustment to comply with Assembly Bill (AB) 107, Chapter 18, Statutes of 2017, which was the 2017 Developmental Services omnibus trailer bill.

Staff Comment and Recommendation. After the March 15, 2018 an incorrect reference to an acute crisis home was inadvertently left in the language. This should have been changed to refer to a developmental center. Staff recommends approval of placeholder language that would incorporate this technical correction, along with the administration's proposed TBL.

Issue 3: Safety Net Facilities and Acute Crisis Services Related Proposals

The subcommittee heard the following issues during its March 15, 2018, hearing.

Proposal. During the previous hearing the subcommittee heard the following issues:

- Disability Rights California proposed to strengthen protections for individuals placed in IMDs, such as aligning admission and transition with developmental center acute crisis standards. Longstanding concern about the number of individuals who remain in IMDs for many years and the inadequacy of transition planning upon admission were raised during the hearing.

- Disability Rights California proposed to grant clients' rights advocates statutory rights to access records for individuals in facilities for which client rights advocates receive statutory notice upon admission. Current law authorizes regional center clients' rights advocates to receive notification when individuals are placed in certain restrictive settings, and to participate in planning for individuals in those settings unless the individual objects on his or her own behalf. Current law also authorizes clients' rights advocates to access the confidential information of consumers who reside in some, but not all, of these settings. It was proposed to amend statute to allow clients' rights advocates to access confidential records and information for individuals who are placed in settings for which there are also statutory provisions requiring notification of admission to the clients' rights advocate and ability of the clients' rights advocates to meaningfully participate in post-admission planning meetings.

- Disability Rights California proposed additional safety net funding, in the amount of $5.6 million. Concerns about community capacity and adequacy of services, particularly crisis services, as well as concerns with the delay in implementing the services outlined in the plan were presented.

Staff Comment and Recommendation. Staff recommends adopting placeholder language to do the following:

- Require regional centers to prepare reports on why community based services could not meet a consumer's needs within three days of their placement in an IMD, require the director of the department to review and consult with regional center on the report, require regional centers to include a transiton plan in the assessment required within 30 days of admission to an IMD, and require the director of the department to review and consult on the transition plan.

- Grant client rights advocates statutory rights to access records for individuals in facilities for which client rights advocates receive statutory notice upon admission.

In addition, staff recommends providing the department with an additional $5.6 million General Fund to develop additional safety net services and the adoption of placeholder language to direct how those funds will be spent.

Issue 4: Uniform Holiday Schedule

The subcommittee heard the following issue during its March 15, 2018, hearing.

Proposal. The January budget included a $5.6 million reduction ($2.9 million General Fund) to re-implement the 14-day uniform holiday schedule. The May Revision included an additional $4.6 milllion decrease ($0.2 million General Fund) to correct an error in the original January budget.

Staff Recommendation. Reject the Governor's proposal. Adopt placeholder trailer bill language to put this change into statute.

Issue 5: Restoration of Social Recreation and Camp Services

The subcommittee heard the following issue during its May 10, 2018, hearing.

Proposal. The Association of Regional Center Agencies, Disability Rights California, Disability Voices United, the ARC/United Cerebral Palsy California Collaboration, and many other stakeholders have requested that social recreation and camp services be restored.

DDS estimates the cost to restore social recreation and camping services for 2018-19, effective July 1, 2018, to be $22.3 million ($14 million General Fund) in 2018-19. This is based on the estimated full-year impact of $39.4 million, adjusted for ramp up of services. Ramp up will occur as regional centers review and update Individual Program Plans (IPPs) to identify the need for and authorize social recreation services, and to identify and develop providers to offer these services. The 2019-20 estimated costs are $35.4 million ($22.3 million General Fund). This amount is also based on the estimated full-year impact of $39.4 million, adjusted for continuing ramp up.

Staff Comment and Recommendation. Provide $14 million General Fund in 2018-19, $22.3 million General Fund in 2019-20, and $25.2 million General Fund ongoing to restore social recreation and camp services. Adopt placeholder trailer bill language to put this change into statute.

Senate Budget and Fiscal Review—Holly Mitchell, Chair

SUBCOMMITTEE NO. 3 Agenda

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

Thursday, May 17, 2018
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

OUTCOMES

Part A

Consultant: Renita Polk

PROPOSED FOR VOTE-ONLY

In addition, a motion was made and approved 3-0 to adopt placeholder language specifying that it is the intent of the Legislature that federal funds intended for the Self Determination program be distributed with a priority for the needs of self-determination participants.

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, 2018
Upon Call of the Chair
Room 4203, State Capitol

PART B

Consultant: Theresa Pena

ISSUES FOR VOTE ONLY

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ISSUES FOR VOTE ONLY

0530 HEALTH AND HUMAN SERVICES AGENCY/OFFICE OF SYSTEMS INTEGRATION (OSI)
4260 DEPARTMENT OF HEALTH CARE SERVICES (DHCS)
4300 DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS)
5180 DEPARTMENT OF SOCIAL SERVICES (DSS)

Issue 1: BCP: Electronic Visit Verification Multi-Departmental Planning Team (Issue 401-MR)

May Revision. In response to federal requirements that would require states to implement Electronic Visit Verification (EVV) systems for Medicaid-funded personal care and home health care services, including IHSS, the Administration has put forward an agency-wide proposal for limited-term resources to support planning of an EVV system across multiple programs. California has until January 2019 to comply for personal care services, and until January 2023 for home care services, or escalating penalties will be incurred. The resources requested are as follows:

- DSS: $243,000 ($122,000 General Fund) on a two-year limited term basis for two positions
- OSI: $143,000 in expenditure authority equivalent to one position, and a corresponding increase of $143,000 ($72,000 General Fund) for DSS
- DDS: $277,000 ($222,000 General Fund) on a two-year limited term basis for two positions
- DHCS: $286,000 ($143,000 General Fund) on a two-year limited term basis for two positions

Staff Recommendation. Approve as requested. This subcommittee heard and discussed this item during its May 15, 2018 and May 16, 2018 hearings.

5180 DEPARTMENT OF SOCIAL SERVICES – IN-HOME SUPPORTIVE SERVICES (IHSS)

Issue 2: BBL: Electronic Visit Verification (EVV) (Issue 408-MR)

May Revision. The Administration requests that Item 5180-111-0001 be amended to include provisional language to: (1) authorize increased expenditures to comply with federal EVV requirements for IHSS personal care services and Waiver Personal Care Services, and (2) allow the transfer of expenditure authority from Item 5180-111-0001 to Item 5180-001-0001 to fund any necessary state support expenditures, subject to Finance approval, and (3) to allow the department to implement EVV requirements by means of all-county letter in consultation with stakeholders without taking further regulatory action. The language specifies that any such increase shall be authorized no less than 30 calendar days following written notification to the Joint Legislative Budget Committee, or a lesser period if requested by the department and approved by the Joint Legislative Budget Committee.

Staff Recommendation. Approve provisional language as placeholder, striking language in (c) pertaining to implementing EVV requirements by all-county letter without taking regulatory action.

Issue 3: IHSS County Administration Adjustment (Issue 407-MR)

May Revision. The Administration requests an increase of approximately $24 million General Fund and reimbursements be increased by approximately $23 million to reflect revised workload assumptions for county and public authority administrative activities associated with the IHSS program. The workload assumptions and budgeting methodology will be reexamined as part of the 2020-21 Budget.

Staff Recommendation. Approve requested amount, increased by one thousand dollars, as placeholder; the Subcommittee directs the Department of Finance to work with county and labor partners in refining the amount needed to fully fund social workers.

5180 DEPARTMENT OF SOCIAL SERVICES – CHILD WELFARE SERVICES (CWS)

Issue 4: Continuum of Care Reform (CCR): Resource Family Approval Backlog (Issue 416-MR)

May Revision. The Administration requests an increase of $3,161,000 General Fund and an increase of $1,463,000 in Federal Funds to provide one-time funding to address the county backlog of Resource Family applications.

Staff Comment and Recommendation. Approve as requested. This subcommittee heard and discussed this item during its May 15, 2018 hearing.

Issue 5: CCR: Level of Care Assessment Tool (Issue 418-MR)

May Revision. The Administration requests an increase of $2.5 million General Fund and an increase of $633,000 in Federal Funds to support an increased workload for county social workers and probation officers associated with implementation of the Level of Care (LOC) Protocol Assessment Tool developed for use with the Home-Based Family Care (HBFC) rate structure. This funding is contingent upon counties providing their Specialized Care Increment (SCI) plans to the department. Counties have until June 30, 2018 to update their SCI plans and indicate whether or not they will be continuing their SCI program.

Staff Comment and Recommendation. Approve as requested. This subcommittee heard and discussed this item during its May 15, 2018 hearing.

Issue 6: CCR: Revised Group Home Caseload Projections (Issue 419-MR)

May Revision. The Administration requests an increase of $39,740,000 General Fund and an increase of $7,472,000 in Federal Funds to reflect increased costs associated with revised group home caseload projections based on actual caseload movement, to which there is a slower than anticipated decline in congregate care caseload.

Staff Comment and Recommendation. Approve as requested. This subcommittee heard and discussed this item during its May 15, 2018 hearing.

Issue 7: CCR: Specialized Care Increment Savings Adjustment (Issue 420-MR)

May Revision. The Administration requests an increase of $16,231,000 General Fund and an increase of $3,052,000 in Federal Funds to reflect a correction related to assumed county savings associated with Specialized Care Increments (SCIs) provided in addition to the basic foster care rate. The May Revision continues to assume that counties will reduce SCI payments to reflect the transition from age-based foster care rates to the new Home-Based Family Care rate structure.

Staff Comment and Recommendation. Approve as requested. This subcommittee heard and discussed this item during its May 15, 2018 hearing.

Issue 8: TBL: Home-Based Family Rate Clarification

May Revision. The Administration proposes trailer bill language to clarify state statute regarding the non-applicability of the Home-Based Family Care (HBFC) rate structure for Adoption Assistance Program (AAP), Kin-GAP, and Non-Related Legal Guardian (NLRG) cases that went to permanency on or before December 31, 2016.

The Administration states that for NRLG cases established between May 1, 2011 to December 31, 2016, to continue receiving the age-based rates that existed at the time permanency was established because the costs for these cases are not included in the existing HBFC Level of Care (LOC) rates budget. The statute would further clarify that on or after January 1, 2017, NRLG cases where the guardianship is established in probate will qualify for the Basic Level Rate.

The Administration also states that language is needed to limit the Kin-Gap and AAP cases established between May 1, 2011 and December 31, 2016, to the age-based rates negotiated at the time of the agreement; therefore, these cases are not entitled to the HBFC LOC rates upon reassessment. The department notes that failure to implement this trailer bill language will result in an annual General Fund cost pressure in the tens of millions.

Staff Comment and Recommendation. Approve trailer bill as placeholder. The Subcommittee directs the Department of Finance to address advocate concerns raised regarding clarity that that families would still be able to re-negotiate their AAP or KinGAP rate into the new rates system based on the needs of the child.

Issue 9: Proposal for Investment: TBL: Group Home Extension

CWDA proposes trailer bill language to authorize DSS to allow foster youth to be placed in eligible group homes that have not converted to a Short-Term Residential Therapeutic Program (STRTP) beyond the statutory deadline of December 31, 2018, to ensure that the state and counties can build enough capacity to successfully transition youth out of group homes. To be eligible for an extension, county child welfare must submit documentation to DSS describing the county's plan to transition all foster youth residing in group homes in a home-based placement or STRTP. The language would also require the county to describe barriers to these transitions and identify local and state-level solutions.

Staff Comment and Recommendation. Approve trailer bill language as placeholder. This subcommittee heard and discussed this item during its May 15, 2018 hearing.

Issue 10: TBL: Proposal for Investment: Specialized Care Rate Savings and True-Up

CWDA proposes trailer bill language that would codify the true-up process for the state and county costs and savings associated with the CCR. Under the Constitutional terms of Proposition 30, the state is required to fund the net cost increases associated with mandated child welfare activities and costs enacted after 2011 Realignment was adopted. CWDA and the current Administration have worked together to develop a detailed calculation to reconcile state and county costs and savings on a monthly basis in the county cost claim, including those related to reduced SCIs, for CCR-related assistance costs. Reduced assistance costs due to the implementation of the CCR are then to be used to offset state General Fund investments for CCR administration, including but not limited to, CFTs, LOC protocol work, and the CANS assessment. Codification of the CCR true-up calculation will ensure that all relevant costs and savings are reflected on an ongoing basis and that counties that do experience net costs related to CCR will have those costs covered.

Staff Comment and Recommendation. Approve trailer bill language as placeholder. This subcommittee heard and discussed this item during its May 15, 2018 hearing.

Issue 11: Tribal Title IV-E: Start-Up Administration Costs (Issue 414-MR)

May Revision. The Administration requests an increase of $87,000 to provide start-up funds for tribes with existing federal Title IV-E agreements and to assist tribes in establishing a Title IV-E child welfare program. Related, forthcoming trailer bill is also requested.

Staff Recommendation. Approve as requested. This subcommittee heard and discussed this item during its May 15, 2018 hearing.

Issue 12: TBL: Federal Compliance: Indian Child Welfare Act Child Custody Proceedings

May Revision. The Administration proposes trailer bill language to align state law with the minimum standards of the Federal Indian Child Welfare Act's (ICWA) Final Rule, which, among other things, specifies a tribe's exclusive jurisdiction over child custody proceedings involving an Indian Child and clarifies notification requirements. The department notes that codification of the Final Rule is consistent with previous ICWA compliance efforts.

Staff Comment and Recommendation. Approve trailer bill language as placeholder. This subcommittee heard and discussed this item during its May 16, 2018 hearing.

Issue 13: TBL: Tribal/State Title IV-E Agreement Start-Up Allocation

May Revision. The Administration proposes trailer bill language to provide start-up funds, from existing allocations and funding, for tribes who have executed Tribal/State Title IV-E Agreements to provide child welfare service programs. The funding would be available for the first three years of implementation of their agreement.

Recently, a tribe expressed interest in implementing their Title IV-E Agreements to be used for start-up funds that will provide tribes with the ability to reasonably establish their child welfare programs in accordance with their agreement.

Staff Comment and Recommendation. Approve trailer bill language as placeholder. This subcommittee heard and discussed this item during its May 15, 2018 hearing.

5180 DEPARTMENT OF SOCIAL SERVICES – CALWORKS

Issue 14: CalWORKs Single Allocation (Issue 406-MR)

May Revision. The Administration requests an increase of $55.8 million federal Temporary Assistance for Needy Families (TANF) block grant funds in 2018-19 to reflect the adoption of a revised budgeting methodology for county administration of the CalWORKs eligibility determination process.

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. This can be problematic when the program sees dramatic swings in caseload, as often happens in CalWORKs since it is so closely tied to the economy.

Last year, the Legislature directed the department and counties to work together to develop a new methodology. The Governor's budget provided approximately $1.7 billion in funding the Single Allocation in 2018-19. The May Revision increases the Single Allocation by $29 million. However, even with the May Revision augmentation to the Single Allocation and an agreement on the eligibility methodology, CWDA considers that an additional $28.7 million has been cut from the Employment Services component due to the ongoing caseload reduction, and would force counties to carry additional staffing vacancies to offset the funding shortfall.

Staff Comment and Recommendation. Approve increase in May Revision and augment with an additional $10 million General Fund for Employment Services in 2018-19.

Issue 15: Trailer Bill Language: CalWORKs Home Visiting Initiative

Budget Issue. The Administration proposes to implement a Home Visiting Initiative in the CalWORKs program. This program would engage a pregnant or first-time parent enrolled in the CalWORKs program or caretaker relative for a child only case, under 25 years old, that has a child less than 24 months of age. Participation in the program is voluntary and would not affect a family's application for aid or eligibility for any other CalWORKs benefits, supports, or services. Participation would be limited to 24 months.

The May Revision includes $158.5 million over three years, including $26.9 million in 2018-19 with implementation beginning January 1, 2019. The remaining $131.6 million in TANF money will be set aside in a Home Visiting Initiative Reserve to fund this program for a total of three years.

Staff Comment and Recommendation. Approve trailer bill language as placeholder, and corresponding dollars as placeholder. Trailer bill language should also: 1) Remove limits on age and the number of children for participants in the program; 2) Include language that would make implicit bias training a requirement for all home visitors; and 3) Include additional specifics on data collection points, including child welfare referrals; 4) Include an bi-annual gathering for counties and participating programs to share challenges and best practices; 5) Include language that indicates preference for county applicants that include co-location of home visitors at the welfare office; 6) Permit a five year longitudinal study of the children who participated in the program to assess their overall well-being.

Issue 16: CalWORKs Stage 1 Child Care

Conforming Action. The Senate Subcommittee No.1 on Education Finance took action on Tuesday, May 15, 2018 to increase the hourly rates for license-exempt child care providers to 70 percent of the hourly rate for Family Child Care Home licensed providers. The rate changes impacts the CalWORKs program. CalWORKs Stages 2 and 3 child care are administered by the Department of Education while Stage 1 is administered by the Department of Social Services.

State law requires that license-exempt child care providers be reimbursed at 70 percent of the Family Child Care Home ceiling. However, license-exempt providers providing part-time hourly child care services are typically reimbursed at 30 percent of this rate. The low reimbursement rate limits access to child care services for families that need flexible, part-time, hourly, license-exempt child care.

Staff Comment and Recommendation. Approve $20.5 million General Fund in 2018-19 for Stage 1 child care to conform to actions in Senate Subcommittee No.1 to increase the hourly rates for license-exempt child care providers.

5180 DEPARTMENT OF SOCIAL SERVICES – DISASTER SERVICES BUREAU

Issue 17: Disaster Assistance

May Revision. The Administration requests an increase of $200,000 General Fund for the State Supplemental Grant Program to assist victims of the 2017 wildfires and the 2018 Southern California mudslides.

Staff Comment and Recommendation. Approve as requested. This subcommittee heard and discussed this item during its May 15, 2018 hearing.

5180 DEPARTMENT OF SOCIAL SERVICES – SENATE PROPOSALS

Issue 18: Safety Net Reserve

Senate Proposal. The Senate proposes to create a Safety Net Reserve, create MediCal and CalWORKs subaccounts within the reserve, and deposit $1 billion into the CalWORKs subaccount. The Senate directs the Department of Finance to work with the Legislative Analyst's Office to determine a methodology to calculate how future caseload savings will be deposited into this subaccount and potentially other subaccounts for other safety net programs. The intent of the Safety Net Reserve is to build a specific reserve for these two programs, as they are often the most needed and heavily utilized during an economic downturn, yet often face severe cuts during tough times. The Safety Net Reserve will provide additional resources in a recession to mitigate this effect and avoid cutting these programs when they are needed most.

Staff Comment and Recommendation. Approve.

Issue 19: Honest Budget Adjustments in SSI/SSP and CalWORKs

Senate Proposal. The Senate proposes to include adjustments for inflation in the SSI/SSP and CalWORKs programs beginning January 1, 2019 and annually thereafter, using the California Necessities Index (CNI) as the inflation factor. Without inflation adjustments, these programs, which serve some of the most impoverished and vulnerable populations in California, are effectively cut every year, making it more and more difficult for recipients to keep up with rising costs of living. Using a 4.04 percent CNI in 2018-19, this proposal would allocate $55 million in SSI/SSP and $50 million for CalWORKs in 2018-19, and continue to use the CNI in calculations for the out years.

Staff Comment and Recommendation. Approve.

Issue 20: Ending Deep Poverty for CalWORKs Recipients

Senate Proposal. The Senate proposes to increase CalWORKs grants to keep children out of deep poverty, which is defined as below 50 percent of the Federal Poverty Level. Currently, CalWORKs grants are too low to support the healthy growth and development of the state's poorest children. Research has shown that when children live in deep poverty, they endure hardships that negatively impact their capacity to learn, develop, and thrive. Ultimately, deep poverty damages a child's chance to escape poverty and fuels an intergenerational cycle of poverty. This Senate action would ultimately raise the maximum aid payment from $714 to $1,046 for a family of three by 2021-22, as costs are phased in over several years. This action is estimated at $400 million in 2018-19, growing to $1.5 billion by 2021-22.

Staff Comment and Recommendation. Approve.

Issue 21: Ending the SSI Cash-Out

Senate Proposal. Currently, State policy provides SSI/SSP recipients an extra $10 payment in lieu of their being eligible to receive federal food benefits through California's CalFresh program. The Senate proposes to end the SSI Cash-Out, and allow all SSI recipients to apply for CalFresh benefits, and hold harmless those households that would see either a loss or reduction of benefits due to this policy change, either currently in the program or in the future.

Staff Comment and Recommendation. Approve a placeholder amount of $60 million in 2018-19 and $120 million ongoing for a hold harmless. Amounts approved in this action includes costs for the benefit for populations held harmless, outreach, administration, and automation.

0000 VARIOUS DEPARTMENTS – PROPOSALS FOR INVESTMENT

All Items in this section were heard in previous Subcommittee No.3 hearings this year.

Issue 22: Long-Term Care Ombudsman Augmentation

Budget Issue. The California LTC Ombudsman Association requests $7.3 million General Fund ongoing for the local LTC Ombudsman Programs. The breakdown of the requested funds is as follows: 1) $3.5 million to enable local programs to conduct quarterly unannounced visits to long term care facilities; 2) $420,000 to enable the program to focus on volunteer recruitment; 3) $1.1 million to enable programs to investigate and resolve additional complaints; and 4) $2.3 million to adjust the local annual program base to $100,000 (an additional $65,000 per program).

Staff Comment and Recommendation. Approve $2.3 million General Fund ongoing to adjust the local annual program base and approve corresponding trailer bill language as placeholder.

Issue 23: MSSP Rate Increase

Budget Issue. The MSSP Site Association (MSA) requests $4.6 million General Fund ongoing to provide a supplemental rate adjustment for MSSP sites. MSA points out that MediCal funding for MSSP has been flat and was reduced during recession years, while the cost of professional staff and operations has continued to increase. The requested funds would increase the per client rate to $5,356.

Staff Comment and Recommendation. Approve as requested.

Issue 24: Equitable Child Support Services Funding

Budget Issue. Various county representatives request an increase in child support services funding as follows: $17.9 million of General Fund in 2018-19; $28.4 million General Fund in 2019-20; $38.8 million General Fund in 2020-21; and $4.8 million additional General Fund in each of the three years. Requested trailer bill language also enshrines a new methodology based on a ratio based of cases per Full Time Equivalent (FTE) position to determine each Local Child Support Agency's (LCSA's) allocation. Requested trailer bill language also directs LCSAs and the Administration to work together over the 2018-2019 budget year to develop additional program improvements or improvements to the methodology.

Staff Comment and Recommendation. Approve as requested, and approve corresponding trailer bill language and budget bill language as placeholder.

Issue 25: Indian Health Clinics

Budget Issue. The California Rural Indian Health Board, Inc. (CRIHB) requests an augmentation of $2.15 million General Fund for Indian Health Clinics.

Staff Comment and Recommendation. Approve as requested.

Issue 26: Fruit and Vegetables EBT Pilot

Budget Issue. California Food Policy Advocates and the San Francisco Bay Area Planning and Urban Research Association requests $9 million General Fund one-time for the CalFresh Fruit and Vegetable EBT Pilot to increase the purchase and consumption of California-grown fruits and vegetables that are financially out-of-reach for low-income residents. The proposed pilot will modify the CalFresh EBT system to allow CalFresh shoppers to receive a matching benefit upon eligible purchases of California-grown fruits and vegetables, and implement seven community-based pilots to evaluate the efficacy of the EBT system.

Staff Comment and Recommendation. Approve as requested, and approve trailer bill language as placeholder.

Issue 27: Funding for Food Bank Infrastructure

Budget Issue. The California Association of Food Banks requests $25 million in the 2018-19 budget for one-time food bank infrastructure improvements. Advocates state that food banks are in serious need of improving capacity. The requested dollars would go towards providing modern refrigerated transportation, cold storage, and other capital improvements. It has been nearly 20 years since the state has invested in food bank infrastructure.

Staff Comment and Recommendation. Approve $5 million in 2018-19 for one-time food bank infrastructure improvements.

Issue 28: Additional Funding for Continuum of Care Reform (CCR)

Budget Issue. The California State Association of Counties (CSAC), County Welfare Directors Association of California (CWDA) and the Service Employees International Union of California (SEIU) request an additional $49.1 million General Fund in 2018-19 to address county workload associated with implementation of the CCR. This funding would be allocated as follows: 1) $9.5 million General Fund in one-time funding to clear the RFA backlog; 2) $7.3 million General Fund for new county workload associated with LOC assessments for 2018-19; 3) $38 million General Fund for new county workload to implement the CANS assessment tool.

Staff Comment and Recommendation. Approve $25 million General Fund for unfunded county workload requirements related to CCR implementation.

Issue 29: Continued Foster Parent Retention, Recruitment & Support (FPPRs) Funding

Budget Issue. The Alliance for Children's Rights, California Alliance of Caregivers, Children Now, and others request that FPPRs funding continue at its current level for 2018-19, as the Governor's budget proposes a decrease in funding next year. Stakeholders also propose trailer bill language that would add measures to (1) require counties to obtain resource family input into their spending plans, (2) refine the recruitment focus to support best practices and (3) enhance accountability through improved reporting.

Staff Comment and Recommendation. Approve an additional $21.6 million General Fund for FPPRs funding in 2018-19 and approve trailer bill language as placeholder.

Issue 30: Eliminating Barriers to Enter or Re-enter Extended Foster Care

Budget Issue. The Alliance for Children's Rights, California Coalition for Youth, Children's Law Center, and others request a modest increase to Extended Foster Care to ensure youth who are in need of services but were unable to enter or re-enter foster care are able to do so. This proposal is a result of recent issues raised by appellate courts. The changes are narrow and technical in nature. The LAO estimates that this proposal would cost between $800,000 General Fund to $1.7 million General Fund.

Staff Comment and Recommendation. Approve trailer bill as placeholder and $1 million General Fund to implement provisions of the trailer bill.

Issue 31: Waiver Personal Care Services (WPCS) Provider Parity

Budget Issue. The California Association of Public Authorities (CAPA), UDW and AFSCME Local 3930 and the SEIU request $2.8 million General Fund ongoing to establish an employer of record and provide health care benefits for approximately 700 WPCS providers in California. Currently, WPCS providers cannot receive health benefits because their hours are not covered by existing collective bargaining agreements.

Staff Comment and Recommendation. Approve funding as requested and approve trailer bill language as placeholder.

Issue 32: Streamlining IHSS Provider Enrollment

Budget Issue. The UDW and AFSCME Local 3930 and the SEIU request a $2.7 million ongoing to expedite the provider enrollment process at the county level. It can take several weeks or even months before a new IHSS provider is enrolled into the program and they are mailed their first timesheet. This delay impacts the ability of IHSS consumers to recruit and retain new workers.

Staff Comment and Recommendation. Approve funding as requested and approve trailer bill language as placeholder.

Issue 33: Provider Back Up System for IHSS

Budget Issue. The UDW and AFSCME Local 3930 and the SEIU request that the Administration develop a comprehensive provider back-up system, and trailer bill language that does the following: 1) Requires the Department of Social Services to convene a stakeholder workgroup no later than September 1, 2018; 2) Requires the work of the stakeholder workgroup be completed by June 30, 2019; and 3) Requires that each county have an operational provider backup system no later than when the state minimum wage reaches $13 an hour (currently in 2020).

Staff Comment and Recommendation. Approve trailer bill language as placeholder.

Issue 34: Stakeholder Participation in CalSAWS Development Process

Budget Issue. The WCLP, CCWRO, and the Alliance to Transform CalFresh and others requests that the 2018-19 Budget include statutory language to establish a SAWS stakeholder process that emphasizes client-centered design, planning and implementation, and provides for legislative oversight for process and outcome accountability.

Staff Comment and Recommendation. Approve trailer bill language as placeholder.

Issue 35: SRL: Food for All Stakeholder Process

Budget Issue. California Food Policy Advocates and the California Immigrant Policy Center request Statutory Reporting Language (SRL) in the 2018-19 Budget Bill to bring stakeholders together to develop timely, responsive and actionable plans with regard to immigrant Californians, and with the goal to protect, strengthen, and modernize CalFresh and other food assistance programs for California immigrants.

Staff Comment and Recommendation. Approve as requested.

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, 2018
Upon Call of the Chair
Room 4203, State Capitol

PART B

Consultant: Theresa Pena

OUTCOMES

ISSUES FOR VOTE ONLY

		Action
0530	**Health and Human Services Agency/Office of Systems Integration**	
4360	**Department of Health Care Services**	
4300	**Department of Developmental Services**	
5180	**Department of Social Services**	
Issue 1	BCP: Electronic Visit Verification Multi-Departmental Planning Team (Issue 401-MR)	3-0
5180	**Department of Social Services – IHSS**	
Issue 2	BBL: Electronic Visit Verification (Issue 408-MR)	3-0
Issue 3	IHSS County Administration Adjustment (Issue 407-MR)	3-0
5180	**Department of Social Services – Child Welfare Services**	
Issue 4	CCR: Resource Family Approval Backlog (Issue 416-MR)	3-0
Issue 5	CCR: Level of Care Assessment Tool (Issue 418-MR)	3-0
Issue 6	CCR: Revised Group Home Caseload Projections (Issue 419-MR)	3-0
Issue 7	CCR: Specialized Care Increment Savings Adjustment (Issue 420-MR)	3-0
Issue 8	TBL: Home-Based Family Rate Clarification	3-0
Issue 9	Proposal for Investment: TBL: Group Home Extension	3-0
Issue 10	Proposal for Investment: TBL: Specialized Care Rate Savings and True-Up	3-0
Issue 11	Tribal Title IV-E: Start-up Administration Costs (Issue 414-MR)	3-0
Issue 12	TBL: Federal Compliance: Indian Child Welfare Act Child Custody Proceedings	3-0
Issue 13	TBL: Tribal/State Title IV-E Agreement Start-Up Allocation	3-0

5180	**Department of Social Services – CalWORKs**	
Issue 14	CalWORKs Single Allocation (Issue 406-MR)	3-0
Issue 15	TBL: CalWORKs Home Visiting Initiative	3-0
Issue 16	CalWORKs Stage 1 Child Care	2-1
5180	**Department of Social Services – Disaster Services Bureau**	
Issue 17	Disaster Assistance (Issue 412-MR)	3-0
5180	**Department of Social Services – Senate Proposals**	
Issue 18	Safety Net Reserve	2-1
Issue 19	Honest Budgeting Adjustments	2-1
Issue 20	Ending Childhood Deep Poverty	2-0
Issue 21	Ending the SSI Cash Out	3-0
0000	**Various Departments – Proposals for Investment**	
Issue 22	Long-Term Care Ombudsman Funding	3-0
Issue 23	MSSP Rate Increase	3-0
Issue 24	Equitable Child Support Services Funding	3-0
Issue 25	Indian Health Clinics	3-0
Issue 26	Fruit and Vegetables EBT Pilot	3-0
Issue 27	Funding for Food Bank Infrastructure	3-0
Issue 28	Additional Funding for Continuum of Care Reform	3-0
Issue 29	Continued Foster Parent Retention, Recruitment & Support Funding	3-0
Issue 30	Eliminating Barriers to Enter or Re-enter Extended Foster Care	3-0
Issue 31	Waiver Personal Care Services Provider Parity	2-1
Issue 32	Streamlining IHSS Provider Enrollment	3-0
Issue 33	Provider Back Up System for IHSS	3-0
Issue 34	Stakeholder Participation in CalSAWS Development Process	3-0
Issue 35	SRL: Food for All Stakeholder Process	2-1

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 17, 2018
Upon Call of the Chair
State Capitol - Room 4203

PART C

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.

VOTE ONLY

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Medi-Cal Local Assistance Estimate – May Revision Update

DOF Issue#: 4260-001-ECP-2018-GB (November 2017 – Medi-Cal Estimate)
4260-003-ECP-2018-GB (November 2017 – Medi-Cal Estimate)
4260-005-ECP-2018-GB (November 2017 – Children's Health Insurance Program)
4260-007-ECP-2018-GB (November 2017 – Full Adult Dental Restoration)
4260-008-ECP-2018-GB (November 2017 – ACA Optional Expansion)
4260-401-ECP-2018-MR (May 2018 – Medi-Cal Estimate)
4260-403-ECP-2018-MR (May 2018 – SMHS Federal Audit Repayment)
4260-411-ECP-2018-MR (May 2018 – Medi-Cal Unanticipated Costs)
4260-412-ECP-2018-MR (May 2018 – Medi-Cal Estimate)
4260-413-ECP-2018-MR (May 2018 – Reauthorization of CHIP)
4260-414-ECP-2018-MR (May 2018 – CMS Deferrals)

May Revision Issue. The May 2018 Medi-Cal Local Assistance Estimate includes $97.3 billion ($20.3 billion General Fund, $59.9 billion federal funds, and $17.1 billion special funds and reimbursements) for expenditures in 2017-18, and $103.9 billion ($22.9 billion General Fund, $67.2 billion federal funds, and $13.7 billion special funds and reimbursements) for expenditures in 2018-19. These figures represent an increase in estimated General Fund expenditures in the Medi-Cal program of $286.3 million in 2017-18 and $1.3 billion in 2018-19 compared to the Governor's January budget.

Caseload. In 2017-18, the May Revision assumes annual Medi-Cal caseload of 13.3 million, a decrease of 0.9 percent compared to assumptions in the Governor's January budget. In 2018-19, the May Revision assumes annual Medi-Cal caseload of 13.3 million, a decrease of 1.1 percent compared to assumptions in the Governor's January budget and a decrease of 0.1 percent compared to the revised caseload estimate for 2017-18. The decrease in estimated caseload is primarily due to lower projected enrollment for families on public assistance, medically needy families, and Medi-Cal expansion beneficiaries 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 increased by $1,346,759,000 and reimbursements be decreased by $36,503,000
- Item 4260-101-0232 be decreased by $2,245,000
- Item 4260-101-0233 be increased by $764,000
- Item 4260-101-0236 be increased by $1,687,000
- Item 4260-101-0890 be decreased by $880,267,000
- Item 4260-101-3305 be increased by $3,717,000
- Item 4260-102-0001 be decreased by $4,763,000
- Item 4260-102-0890 be increased by $25,377,000
- Item 4260-106-0890 be increased by $3,794,000
- Item 4260-117-0001 be increased by $40,000

- Item 4260-117-0890 be increased by $326,000

This issue was heard during the subcommittee's March 22nd (November 2017 Estimate) and May 16th (May 2018 Estimate) hearing.

Subcommittee Staff Comment and Recommendation—Approve the balance of the technical adjustments to the Medi-Cal Local Assistance Estimate, as updated for the May Revision, with any changes necessary to conform to other actions that have been, or will be, taken.

Issue 2: Family Health Estimate – May Revision Update

DOF Issue#: 4260-002-ECP-2018-GB (November 2017 Family Health Estimate)
4260-402-ECP-2018-MR (May 2018 Family Health Estimate)

May Revision Issue. The May 2018 Family Health Local Assistance Estimate includes $222.5 million ($170 million General Fund, $5.1 million federal funds, and $47.4 million special funds and reimbursements) for expenditures in 2017-18, and $279.4 million ($229.5 million General Fund, $5.1 million federal funds, and $44.7 million special funds and reimbursements) for expenditures in 2018-19. These figures represent a decrease in estimated General Fund expenditures in Family Health programs of $12.2 million in 2017-18 and an increase in estimated General Fund expenditures of $18.9 million in 2018-19 compared to the Governor's January budget. These changes are primarily attributed to increased costs in the Genetically Handicapped Persons Program (GHPP) due to retroactive payments for treatment expenditures resulting from delayed processing, offset by decreased costs in GHPP for base expenditures.

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 174,278 in 2017-18, a decrease of 1,044 or 0.6 percent, compared to the Governor's January budget. The May Revision estimates Medi-Cal CCS caseload of 177,299 in 2018-19, a decrease of 763 or 0.4 percent, compared to the Governor's January budget, and an increase of 3,453 or 1.7 percent, compared to the revised 2017-18 estimate.
  State-Only: The May Revision estimates state-only CCS caseload of 14,885 in 2017-18, a decrease of 736 or 4.7 percent, compared to the Governor's January budget. The May Revision estimates state-only CCS caseload of 14,819 in 2018-19, a decrease of 802 or 5.1 percent, compared to the Governor's January budget, and a decrease of 66 or 0.4 percent, compared to the revised 2017-18 estimate.
- **Child Health and Disability Prevention (CHDP) Caseload Estimate**
  The May Revision estimates state-only CHDP caseload of 19 in 2017-18, a decrease of 17 or 47.2 percent, compared to the Governor's January budget. The May Revision estimates state-only CHDP caseload of 22 in 2018-19, a decrease of 14 or 38.8 percent compared to the Governor's January budget, and an increase of 3 or 15.8 percent, compared to the revised 2017-18 estimate. According to DHCS, the significantly low caseload is 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 703 in 2017-18, an increase of 48 or 7.3 percent, compared to the Governor's January budget. The May Revision estimates state-only GHPP caseload of 721 in 2018-19, an increase of 62 or 9.4 percent, compared to the Governor's January budget, and an increase of 18 or 2.6 percent, compared to the revised 2017-18 estimate.

- **Every Woman Counts (EWC) Program Caseload Estimate**
  The May Revision estimates EWC caseload of 26,280 in 2017-18, a decrease of 720 or 2.7 percent compared to the Governor's January budget. The May Revision estimates EWC caseload of 26,420 in 2018-19, a decrease of 580 or 2.1 percent, compared to the Governor's January budget, and an increase of 140 or 0.5 percent, compared to the revised 2017-18 estimate.

May Revision Local Assistance Adjustments. The Administration requests the following adjustments to reflect caseload and miscellaneous adjustments:

- Item 4260-111-0001 be increased by $22,218,000 and reimbursements be increased by $43,000
- Item 4260-114-0001 be increased by $3,354,000
- Item 4260-114-0890 be increased by $619,000

This issue was heard during the subcommittee's March 22nd (November 2017 Estimate) and May 16th (May 2018 Estimate) hearing.

Subcommittee Staff Comment and Recommendation—Approve the balance of the technical adjustments to the Family Health Local Assistance Estimate, as updated for the May Revision, with any changes necessary to conform to other actions that have been, or will be, taken.

Issue 3: Medi-Cal Unanticipated Costs, General Fund Reappropriation and Loan Authority

DOF Issue#: 4260-411-ECP-2018-MR
Issue 405 – May Revision Finance Letter
TBL (RN Pending)

Budget and May Revision Issue. In the Governor's January budget, the Administration estimated unanticipated increases in Medi-Cal program expenditures in 2017-18 would exceed its 2017 Budget Act appropriation, resulting in a current year General Fund deficiency of approximately $543.7 million. In the May Revision, the Administration estimated the 2017-18 General Fund deficiency has grown by $286.3 million to a total of $829.9 million.

May Revision Issue and Trailer Bill Language Proposal. DHCS requests reappropriation of General Fund balances from the 2017-18 fiscal year, including any approved supplemental appropriations prior to June 30, 2018. If approved, the reappropriated funds would be comprised of any unspent General Fund expenditure authority appropriated to DHCS for the Medi-Cal program in items 4260-101-0001 and 4260-113-0001.

In addition to this request, DHCS proposes trailer bill language to increase its existing General Fund loan authority to continue funding health care services in Medi-Cal in the event of a deficiency.

According to DHCS, the increased loan authority is necessary as the significant growth of the program has resulted in significantly larger deficiencies that can exceed the current $1 billion loan authority upon which the department relies to continue funding health care services when Medi-Cal costs exceed the department's appropriation authority. The department proposes to increase the loan authority from $1 billion to $2 billion.

Reappropriation Language. DHCS requests the following reappropriation language:

> 4260-491—Reappropriation, State Department of Health Care Services. Notwithstanding any other provision of law, upon order of the Department of Finance, the balances of the appropriations provided in the following citations are reappropriated for the same purposes provided for those appropriations as detailed in the preceding May Revision Medi-Cal estimate, and shall be available for expenditure until June 30, 2019.
>
> 0001—General Fund
>
> (1) Item 4260-101-0001, Budget Act of 2017 (Chs. 14, 22, and 54, Stats. 2017)
>
> (2) Item 4260-113-0001, Budget Act of 2017 (Chs. 14, 22, and 54, Stats. 2017)
>
> (3) Any Supplemental Appropriation Bills passed for this purpose prior to June 30, 2018.

This issue was heard during the subcommittee's March 22nd (November 2017 Estimate) and May 16th (May 2018 Estimate) hearing.

Subcommittee Staff Comment and Recommendation—It is recommended the subcommittee take the following actions:

1. **Approve and Adopt Placeholder Trailer Bill Language** to authorize the supplemental appropriation for the 2017-18 General Fund deficiency.

2. **Approve** the reappropriation language for 2017-18

3. **Adopt Modified Placeholder Trailer Bill Language** to adopt the Administration's proposed changes to DHCS' General Fund loan authority, as well as a requirement that the Department of Finance notify the Legislature within ten days of a transfer of loan proceeds to DHCS for this purpose. The notification shall include the amount of the transfer, the reasons for the transfer, and the fiscal assumptions used in calculating the transfer amount.

Issue 4: County Administration Estimate and Budget Proposals

DOF Issue#: None – Medi-Cal Local Assistance Estimate

Budget Issue. The Governor's January budget included $2 billion ($979 million General Fund and $979 million federal funds) in 2017-18 and $2 billion ($1 billion General Fund and $1 billion federal funds) for the base allocation to counties for eligibility determinations for Medi-Cal beneficiaries. The base allocations include $655.3 million ($327.7 million General Fund and $327.7 million federal funds) in 2017-18 and $673.7 million ($336.8 million General Fund and $336.8 million federal funds) in 2018-19 allocated for costs related to eligibility determinations for newly eligible beneficiaries under the federal Affordable Care Act (ACA). Beginning in 2018-19 the budget combines the base allocation with the allocation for ACA, which had previously been reflected separately in the Medi-Cal estimate. The combined base allocation for county administration in 2017-18 is unchanged from the amount included in the 2017 Budget Act. Included in these allocations was $54.8 million ($18.5 General Fund and $36.3 million federal funds) in 2018-19 for a cost-of-doing-business adjustment for county eligibility workload.

The May Revision includes $2 billion ($979 million General Fund and $979 million federal funds) for the base allocation to counties for eligibility determinations in 2017-18, unchanged compared to the Governor's January budget. In 2018-19, the May Revision includes $2 billion ($1 billion General Fund and $1 billion federal funds) for the base allocation, an increase of $1.8 million ($543,000 General Fund and $1.2 million federal funds) compared to the Governor's January budget. This increase is attributable to an increase in the California Price Index from 2.8 percent to 2.89 percent, resulting in a higher cost-of-doing-business adjustment. This adjustment is now $56.6 million ($19 million General Fund and $37.5 million federal funds).

This issue was heard during the subcommittee's March 22nd hearing.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended the subcommittee approve the county administration estimate, as updated at May Revision, as well as the proposed cost-of-doing-business adjustment.

Issue 5: Homeless Mentally Ill Outreach and Treatment

DOF Issue#: 4260-415-ECP-2018-MR

May Revision Issue and Budget Bill Language. DHCS requests one-time General Fund expenditure authority of $50 million. If approved, these resources would allow DHCS to provide counties with targeted funding for multi-disciplinary teams to support intensive outreach, treatment, and related services for homeless persons with mental illness. According to the Administration, counties would be encouraged to match these funds with local mental health funding and federal matching funds, where appropriate. The funded interventions are intended to result in earlier identification of mental health needs, prevention of criminal justice involvement, and improved coordination of care for this population at the local level.

This issue was heard during the subcommittee's May 16th hearing.

Subcommittee Staff Comment and Recommendation—Approve and Adopt Modified Placeholder Budget Bill Language that includes the Administration's requested appropriation and provisional authority, but allows cities operating a Whole Person Care pilot to be eligible for allocation of these funds, and includes the following additional requirements:

1. Prior to submitting requests for allocations, cities or counties must consult with representatives and interested stakeholders from the city or county's local mental health community, including, but not limited to, service providers, consumer organizations, and other appropriate interests, such as health care providers and law enforcement.
2. Cities or counties receiving allocations that are operating a Whole Person Care pilot shall use the funds in coordination with the administering entity of the pilot for the purpose of providing services, such as housing assistance, not otherwise funded through the pilot.

Issue 6: Mental Health Services Division Policy Implementation

DOF Issue#: 4260-009-BCP-2018-GB

Budget Issue. DHCS requests 10 positions and expenditure authority of $1.3 million ($665,000 General Fund and $664,000 federal funds) in 2018-19 and $1.3 million ($638,000 General Fund and $637,000 federal funds) in 2019-20 and annually thereafter. If approved, these resources would allow DHCS to provide additional monitoring, oversight and external review of county mental health programs and short-term residential therapeutic programs.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$665,000	$638,000
0890 – Federal Trust Fund	$664,000	$637,000
3085 – Mental Health Services Fund**	[$500,000]	[$500,000]
Total Funding Request:	**$1,329,000**	**$1,275,000**
Total Positions Requested:	**10.0**	**10.0**

* Positions and Resources are ongoing after 2019-20.

** Mental Health Services Fund resources are non-add, as resources, but not positions, were previously approved.

This issue was heard during the subcommittee's May 16th hearing.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended the subcommittee approve this request for positions and resources. DHCS has various fiscal oversight responsibilities for county mental health programs. These positions and resources will improve the department's oversight activities. The subcommittee will continue to monitor the department's progress in improving fiscal oversight, particularly with regard to revenue and expenditure reporting and other oversight of the Mental Health Services Act.

Issue 7: Mental Health Services Fiscal Oversight and Behavioral Health Data Modernization

DOF Issue#: 4260-402-BCP-2018-MR

May Revision Issue. DHCS requests 21 positions and expenditure authority of $6.7 million ($2.8 million General Fund, $3.2 million federal funds, and $725,000 Mental Health Services Fund) in 2018-19, an additional seven positions and expenditure authority of $6.5 million ($2.7 million General Fund, $2.7 million federal funds, and $1.1 million Mental Health Services Fund) in 2019-20, $5.5 million ($2.2 million General Fund, $2.2 million federal funds, and $1 million Mental Health Services Fund) in 2020-21, and $4 million ($1.5 million General Fund, $1.5 million federal funds, and $1 million Mental Health Services Fund) annually thereafter. Included in these resources are funding equivalent to 20 two-year, limited-term positions. If approved, these resources would allow DHCS to strengthen fiscal oversight of the Mental Health Services Act, the Medi-Cal Mental Health Managed Care Program, and planning for a comprehensive Behavioral Health Data Modernization Project.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$2,781,000	$2,700,000
0890 – Federal Trust Fund	$3,219,000	$2,698,000
3085 – Mental Health Services Fund	$725,000	$1,062,000
Total Funding Request:	**$6,725,000**	**$6,460,000**
Total Positions Requested:**	**21.0**	**28.0**

* Additional fiscal year resources requested: 2020-21: $5,477,000; 2021-22 (ongoing): $4,045,000
** Positions ongoing after 2019-20.

This issue was heard during the subcommittee's May 16th hearing.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended the subcommittee approve this request for positions and resources to further improve fiscal oversight of county mental health programs and modernize the department's behavioral health data systems.

Issue 8: California Medicaid Management Information Legacy and Modernization Resources

DOF Issue#: 4260-406-BCP-2018-MR

May Revision Issue and Budget Bill Language Proposal. DHCS requests 17 positions and expenditure authority of $41.7 million ($9.7 million General Fund and $32 million federal funds) in 2018-19, an additional eight positions and expenditure authority of $23.9 million ($2.7 million General Fund and $21.1 million federal funds) in 2019-20, $11.5 million ($1.4 million General Fund and $10.1 million federal funds) in 2020-21, and $3 million ($582,000 General Fund and $2.4 million federal funds) annually thereafter. If approved, these resources would allow DHCS to further implement its modernization approach for the California Medicaid Management Information System (CA-MMIS).

DHCS also requests provisional authority allowing the Department of Finance to augment this request by up to $5.3 million General Fund and up to $47.7 million federal funds after consultation with the Department of Technology. The approval would consider progress that incorporates lessons learned, or

completion of milestones related to CA-MMIS modernization modules in progress. The language also requires notification of the Legislature ten days prior to any augmentation.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$9,675,000	$2,723,000
0890 – Federal Trust Fund	$32,040,000	$21,131,000
Total Funding Request:	**$41,715,000**	**$23,854,000**
Total Positions Requested:**	**17.0**	**25.0**

* Additional fiscal year resources requested: 2020-21: $11,540,000; 2021-22 (ongoing): $2,991,000
** Positions ongoing after 2019-20.

This issue was heard during the subcommittee's May 16th hearing.

Subcommittee Staff Comment and Recommendation—Approve and Adopt Modified Placeholder Budget Bill Language that adopts the Administration's proposed provisional augmentation authority for the CA-MMIS project, but with a 30 day notification requirement, rather than 10 days.

Issue 9: Cost-Based Reimbursement Clinic Directed Payment Program

DOF Issue#: TBL (RN Pending)

May Revision Trailer Bill Language Proposal. DHCS proposes trailer bill language to establish a new Cost-Based Reimbursement Clinic (CBRC) directed payment program no sooner than July 1, 2019 to reimburse CBRCs that contract with managed care plans. The non-federal share of the program may be funded through voluntary intergovernmental transfers from public entities. The first $30 million of non-federal share in each fiscal year, or a lesser amount as determined by the department, would be financed by other state funds appropriated to the department for this purpose.

This issue was heard during the subcommittee's May 16th hearing.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language approving the Administration's proposed directed payment program for CBRCs.

Issue 10: Technical Adjustments-Federal Grant Awards, Reimbursements, and Dist. Admin.

DOF Issue#: Issues 402, 403, and 413 – May Revision Finance Letter
4260-411-BBA-2018-MR

May Revision Issues. DHCS requests increased federal fund authority due to receipt of two grant awards from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The first grant award is a supplemental award of the department's annual SAMHSA allocation for county mental health and substance use disorder services. The second grant is the revised amount awarded for the Regular Service Program Crisis Counseling Program, which provides counseling services to Californians affected by the recent wildfires.

May Revision Local Assistance Adjustments. Pursuant to these requests and consistent with the revised grant awards, the Administration requests the following adjustments:

Increase to Annual SAMHSA Grant

- Item 4260-115-0890 be increased by $15,675,000
- Item 4260-116-0890 be increased by $2,262,000

Regular Service Program Crisis Counseling Program Award

- Item 4260-115-0890 be increased by $5,400,000

DHCS also requests a reduction of excess reimbursement authority in the children's medical services program to reflect an accurate representation of actual expenditures. The department requests Item 4260-111-0001 be amended by decreasing reimbursements by $36,010,000.

DHCS also requests technical adjustment of its administrative cost schedules. These schedules account for the department-wide costs of certain administrative activities provided to all department divisions and entities. This adjustment results in increasing Schedule (2) of item 4260-001-0001 by $1.5 million and reducing Schedule (3) of the same item by $1.5 million. This item is the main state operations appropriation for DHCS.

These issues were heard during the subcommittee's May 16th hearing.

Subcommittee Staff Comment and Recommendation—Approve the Administration's requested technical adjustments to the DHCS budget.

Issue 11: Provisional Changes: Lawsuits/Claims Payment, ICF-DD and Home Health

DOF Issue#: 4260-414-BBA-2018-MR
Issue 415 – May Revision Finance Letter

May Revision Issues and Budget Bill Language Proposals. DHCS requests elimination of provisional language in item 4260-101-0001 that waives legislative notification for payment of attorney fees below $50,000. According to DHCS, this provision is no longer necessary as the department's current practice is to include estimated costs of all Medi-Cal lawsuits, judgments, settlements, and attorney fees in the semi-annual Medi-Cal Local Assistance Estimates. This information is currently provided in Base Policy Change 208 – Lawsuits/Claims, in the May 2018 Medi-Cal Local Assistance Estimate and reflects 2017-18 attorney fee payments of $22,400.

DHCS also requests amendment of Provision 3 of item 4260-101-3305. If approved, the department's proposed amendments would extend supplemental payments to facilities providing continuous skilled nursing care to individuals with developmental disabilities pursuant to the department's continuous skilled nursing pilot. The amendments would also allow a rate increase for home health providers.

These issues were heard during the subcommittee's May 16th hearing.

Subcommittee Staff Comment and Recommendation—Approve and Adopt Placeholder Budget Bill Language to adopt the Administration's requested provisional changes for lawsuits and claims payment notifications, extension of supplemental payments to additional facilities, and an increase for home health provider reimbursement.

Issue 12: Medi-Cal Eligibility Regardless of Immigration Status – Over Age 65

DOF Issue#: None – Legislative Proposal

Expansion of Medi-Cal Eligibility Regardless of Immigration Status. The California Immigrant Policy Center, Health Access California, and a coalition of 80 organizations request General Fund resources, likely in the low billions of dollars, to fund expansion of full-scope Medi-Cal services to otherwise eligible adults regardless of immigration status. According to the coalition, California's robust implementation of the Affordable Care Act (ACA) has brought the uninsured rate to a historic low of 6.8 percent. In 2015, California showed great leadership by investing in access to full-scope Medi-Cal for all income eligible children under the age of 19, regardless of immigration status, which has provided comprehensive care to over 200,000 undocumented children. Through these efforts, California now provides near-universal coverage for children. However, their parents and other undocumented adult Californians still face exclusions to health care access. Of the nearly three million uninsured Californians, 58 percent are undocumented adults who are locked out of health care access simply because of their immigration status. Any effort to achieve universal health coverage in California must include immigrant communities who shape our state and who call California home.

This issue was heard during the subcommittee's March 22nd hearing.

Subcommittee Staff Comment and Recommendation—It is recommended the subcommittee take the following actions:

1. **Augment** General Fund expenditure authority for the Medi-Cal program by $75 million in 2018-19 and $150 million annually thereafter.
2. **Adopt Placeholder Trailer Bill Language** to expand Medi-Cal eligibility to income-eligible individuals over age 65 regardless of immigration status, beginning on January 1, 2019.

Issue 13: Expand Aged and Disabled Eligibility to 138 Percent of FPL

DOF Issue#: None – Legislative Proposal

Aged and Disabled Program Eligibility. AB 2877 (Thomson), Chapter 93, Statutes of 2000, established the Aged and Disabled program, which extends full-scope Medi-Cal coverage to individuals with income under 100 percent of the federal poverty level (FPL) and who are over age 65 or are disabled. The statute also provided for an income disregard of $230 for an individual or $310 for a couple, raising the effective level of eligibility to those with income higher than 100 percent of the FPL, currently about 124 percent of the FPL. This income disregard has not been updated since the program was implemented. Prior to AB 2877, aged and disabled individuals could qualify for the Medically Needy program, which imposes a monthly share of cost, which must be paid prior to receiving Medi-Cal benefits. Today, aged and disabled individuals whose incomes exceed 100 percent of the FPL plus the

income disregard are still eligible under the Medically Needy program and must pay a monthly share of cost, which is the difference between eligible income and the Maintenance Need Income Level, a fixed dollar amount in statute intended to provide for food, rent and utilities. This level is $600 for an individual and $934 for a couple.

The Western Center on Law and Poverty (WCLP), Disability Rights California, Justice in Aging, and a coalition of 50 organizations request approximately $30 million General Fund annually 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. While the Administration reports it does not possess sufficient data to provide a specific estimate of the costs of this proposal, its fiscal analyses of previous versions of this proposal estimate ongoing General Fund costs in the tens of millions of dollars, consistent with the budget request from the coalition.

According to the coalition, when the aged and disabled program was established, the income standard was equivalent to 133 percent FPL, the same level as most other adults enrolled in Medi-Cal. However, the disregards lose real value every year, because they are specific dollar amounts rather than percentages of FPL. Today, these unchanged dollar amounts place the resulting income standard at 123 percent FPL. When a senior has even a small increase in their income that puts them over 123 percent FPL, they are forced into the Medi-Cal Medically Needy program with a high share of cost.

This issue was heard during the subcommittee's March 22nd hearing.

Subcommittee Staff Comment and Recommendation—It is recommended the subcommittee take the following actions:

1. **Augment** General Fund expenditure authority for the Medi-Cal program by $15 million in 2018-19 and $30 million annually thereafter.
2. **Adopt Placeholder Trailer Bill Language** to expand eligibility for Medi-Cal's aged and disabled program up to 138 percent of the FPL, beginning January 1, 2019.

Issue 14: Air Ambulance Rate Increase

DOF Issue#: None – Legislative Proposal

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

Fee, air ambulances are precluded from doing so by federal law, as they are licensed air carriers. Air ambulance providers will be devastated by the impending decrease in the EMATA rate. An increase to the rural Medicare rate will sustain services, preventing potential base closures or reductions in services.

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation— It is recommended the subcommittee take the following actions:

1. **Augment** General Fund expenditure authority for the Medi-Cal program by $9.9 million in 2018-19, $17.7 million in 2019-20, and $23.7 million annually thereafter.
2. **Adopt Placeholder Trailer Bill Language** to increase air ambulance rates to the rural Medicare fee schedule, beginning January 1, 2019.

Issue 15: Asthma Home Visiting Benefit

DOF Issue#: None – Legislative Proposal

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

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation— It is recommended the subcommittee take the following actions:

1. **Augment** General Fund expenditure authority for the Medi-Cal program by $1 million annually.
2. **Adopt Placeholder Trailer Bill Language** to establish an asthma home visiting benefit in the Medi-Cal program to provide access to medically necessary asthma education and home environmental trigger assessments for Medi-Cal beneficiaries with poorly controlled asthma.

Issue 16: Restoration of Optional Benefits

DOF Issue#: None – Legislative Proposal

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

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

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

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

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation— It is recommended the subcommittee take the following actions:

1. **Augment** General Fund expenditure authority for the Medi-Cal program by $16.6 million in 2018-19 and $41.4 million annually thereafter.
2. **Adopt Placeholder Trailer Bill Language** to restore the optional benefits subject to elimination during the recession, including audiology, incontinence creams/washes, optician/optical lab, podiatry, and speech therapy. According to this schedule, these benefits would be restored on January 1, 2019. The 2017 Budget Act restored optical benefits effective January 1, 2020. This action accelerates the optical benefit restoration by one year to January 1, 2019.

Issue 17: Remove BCCTP Treatment Limits

DOF Issue#: None – Legislative Proposal

Elimination of Treatment Limitations for State-Only BCCTP. Susan G. Komen for the Cure requests General Fund expenditure authority of $8.4 million and trailer bill language to eliminate treatment limitations in the Breast and Cervical Cancer Treatment Program (BCCTP). According to

Susan G. Komen for the Cure, the state-funded BCCTP's period of coverage is limited to 18 months for breast cancer and 24 months for cervical cancer. There are no similar treatment limitations for BCCTP coverage for Medi-Cal beneficiaries. This discrepancy causes gaps in service and leaves women that are stuck in the middle untreated, since women who qualify for state-only BCCTP may not qualify for BCCTP in Medi-Cal.

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation— It is recommended the subcommittee take the following actions:

1. **Augment** General Fund expenditure authority for the Medi-Cal program by $8.4 million in 2018-19, $10.5 million in 2019-20, $8.5 million in 2020-21, $7.6 million in 2021-22, and $6.9 million annually thereafter.
2. **Adopt Placeholder Trailer Bill Language** to eliminate breast and cervical cancer treatment limitations for state-only BCCTP beneficiaries.

Issue 18: Funding for Health Information Exchanges

DOF Issue#: None – Legislative Proposal

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

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation— It is recommended the subcommittee take the following actions:

1. **Augment** General Fund expenditure authority for the Medi-Cal program by $5 million in 2018-19.
2. **Adopt Placeholder Trailer Bill Language** to allow General Fund to be used for assisting health care providers with onboarding to health information exchanges in accordance with the State Medicaid Health Information Technology Plan.

Issue 19: SBIRT Expansion for Opioids and Other Drugs

DOF Issue#: None – Legislative Proposal

Screening, Brief Intervention, Referral, and Treatment (SBIRT) Expansion. The County Behavioral Health Directors Association requests $8.4 million ($2.6 million General Fund and $5.8 million federal funds) to expand the Medi-Cal benefit for alcohol misuse, screening and counseling to include screening for overuse of opioids and other illicit drugs such as heroine and methamphetamine. The program for screening, brief intervention, referral, and treatment (SBIRT) has traditionally focused on alcohol misuse and has been shown to reduce hazardous drinking across diverse populations when implemented according to established best practices. This request seeks to expand screening to detect use of opioids and other drugs as an important step to combatting the current crisis and save lives.

This issue was heard during the subcommittee's April 12th hearing.

Subcommittee Staff Comment and Recommendation— It is recommended the subcommittee take the following actions:

1. **Augment** General Fund expenditure authority for the Medi-Cal program by $2.6 million annually.
2. **Adopt Placeholder Trailer Bill Language** to expand SBIRT services in Medi-Cal to detect use of opioids and other drugs.

Issue 20: Substance Use Counselors in Emergency Departments

DOF Issue#: None – Legislative Proposal

Drug and Alcohol Counselors in Emergency Departments. The California chapter of the American College of Emergency Physicians (CalACEP) requests $20 million total funds to create a statewide pilot program that places a certified drug and alcohol counselor in each of the roughly 400 emergency departments (EDs) throughout California. Data would be gathered during the pilot to measure the efficacy of treatment and the cost savings to the Medi-Cal program and other payers.

According to CalACEP, a variety of studies have shown direct referrals to treatment have enrollment rates as high as 50 percent. In New Jersey, the newly established Opioid Overdose Recovery Program provides ED intervention for patients who experience an opioid overdose. In the first six months of implementation, over 80 percent of patients accepted bedside intervention, while 40 percent of those patients accepted recovery support services, and 45 percent accepted detox, substance use disorder treatment and/or recovery. Over 60 percent of the overdose patients were Medicaid beneficiaries.

The University of California, Davis Medical Center ED applied for a grant through the Office of the President over a year ago to employ a certified drug and alcohol counselor to provide interventions in their ED and has also shown impressive results. Over a 12 month period, the Medi-Cal patients who received a brief intervention and referral to treatment experienced a 60 percent decline in ED utilization.

This issue was heard during the subcommittee's April 12th hearing.

Subcommittee Staff Comment and Recommendation— It is recommended the subcommittee take the following actions:

1. **Augment** General Fund expenditure authority for the Medi-Cal program by $20 million annually.
2. **Adopt Placeholder Trailer Bill Language** to create a statewide pilot program that places a certified drug and alcohol counselor in each of the roughly 400 EDs throughout California.

Issue 21: LTSS Data in California Health Interview Survey (CHIS)

DOF Issue#: None – Legislative Proposal

Long-Term Services and Supports (LTSS) Data Collection in California Health Interview Survey. The California Collaborative for Long-Term Services and Supports (CCLTSS) requests General Fund expenditure authority of $3 million to address the need for data that assesses the use of and demand for long-term services and supports (LTSS) in California. Specifically, CCLTSS proposes to add LTSS screening questions and a 15 minute follow-on survey to the 2019-20 and 2023-24 cycles of the California Health Interview Survey (CHIS), conduct in-person, in-depth qualitative interviews with 100 Californians with LTSS needs in 2021, and support the continuation of a module of caregiver questions in CHIS during the 2023-24 cycle.

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation— It is recommended the subcommittee take the following actions:

1. **Augment** General Fund expenditure authority for the Medi-Cal program by $3 million in 2018-19.
2. **Adopt Placeholder Trailer Bill Language** to contract with the University of California, Los Angeles to incorporate questions on LTSS needs in the California Health Interview Survey (CHIS) in the 2019-20 and 2023-24 survey cycles.

Issue 22: Children's Data in California Health Interview Survey (CHIS)

DOF Issue#: None – Legislative Proposal

Children's Data Collection in California Health Interview Survey. The California Children's Health Coverage Coalition requests General Fund expenditure authority of $750,000 to implement a pilot expansion for the California Health Interview Survey (CHIS) to strengthen data collection efforts of California's children and youth. According to the Coalition, CHIS is experimenting with alternative modes of data collection, including a Spring 2018 test with an online survey. The use of an online response is expected to yield more child and teen interviews due to the fact that younger households tend to be more likely to respond online, whereas older persons tend to respond more by telephone. Due to funding limitations, the test will only be conducted in three California counties (Los Angeles, Tulare, and Santa Clara), and the online questionnaire will only be available in English, leaving speakers of other languages to respond by telephone. This proposal seeks to conduct a second test in the fall of 2018 that would: 1) explore methods to increase the data obtained for children age 0-11 by experimentally reversing the questionnaire sequence to ask questions first about the selected child followed by questions about the selected adult; 2) refine methods for obtaining interviews from adolescents age 12-17 through

additional enhancements to the text, email, and paper mail materials that request their participation; 3) conduct the test among a sample of households in all California counties to measure the impact of such a design change across the state and inform future decisions about the need for customized approaches in different parts of the state; and 4) add a Spanish version of the online CHIS questionnaire, which will increase the data we collect about teens and children in Spanish-speaking households.

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation— It is recommended the subcommittee take the following actions:

1. **Augment** General Fund expenditure authority for the Medi-Cal program by $750,000 in 2018-19.
2. **Adopt Placeholder Trailer Bill Language** to implement a pilot expansion for the California Health Interview Survey (CHIS) to strengthen data collection efforts of California's children and youth.

Issue 23: Federally Qualified Health Centers/Rural Health Clinics Same Day Visits

DOF Issue#: None – Legislative Proposal

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

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—It is recommended the subcommittee take the following actions:

1. **Augment** General Fund expenditure authority for the Medi-Cal program by $3 million in 2018-19 and $1.5 million annually thereafter.
2. **Adopt Placeholder Trailer Bill Language** to allow FQHCs and RHCs to be reimbursed separately for mental health services provided on the same day as medical services.

Issue 24: Dental Services Managed Care Integration Pilot in San Mateo County

DOF Issue#: None – Legislative Proposal

Dental Services Managed Care Integration Pilot in San Mateo County. Health Plan of San Mateo (HPSM) proposes a pilot project to integrate dental services into managed care in San Mateo County. HPSM, which is a county organized health system, would establish a network and provide reimbursement to providers of dental services to Medi-Cal beneficiaries in the county. HPSM would receive an enhanced, at-risk capitation payment to account for the additional dental services provided.

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation— It is recommended the subcommittee take the following actions:

1. **Adopt Placeholder Trailer Bill Language** to implement a pilot project to integrate Medi-Cal dental services into Medi-Cal managed care in San Mateo County.

Issue 25: Erroneous Payment Correction Recoupments for Physicians

DOF Issue#: None – Legislative Proposal

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

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation— It is recommended the subcommittee take the following actions:

1. **Adopt Placeholder Trailer Bill Language** to limit the length of time DHCS can recoup overpayments to physicians for state errors to one year and the percentage of the current payment that can be withheld to 20 percent until the total amount is recouped.

Issue 26: Collection of AANHPI Data in Eligibility Systems

DOF Issue#: None – Legislative Proposal

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

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation— It is recommended the subcommittee take the following actions:

1. **Augment** General Fund expenditure authority for the Medi-Cal program by $1.4 million annually.
2. **Adopt Placeholder Trailer Bill Language** to require DHCS to expand disaggregated demographic data collection of Asian-American, Native Hawaiian, and Pacific Islander (AANHPI) ethnicities for enrollees in Medi-Cal and other health programs through SAWS, CalHEERs, and MEDS.

Issue 27: Extension and Clarification of Medical Interpreters Pilot

DOF Issue#: None – Legislative Proposal

Extension and Clarification of Medical Interpreters Pilot. The American Federation of State, County, and Municipal Employees (AFSCME) requests budget bill language and trailer bill language to extend the timeline of the project and clarify the intent of the Legislature in the implementation of the pilot projects approved by AB 635 (Atkins), Chapter 600, Statutes of 2016.

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation— It is recommended the subcommittee take the following actions:

1. **Adopt Placeholder Trailer Bill Language** to extend the sunset date of the budget allocation for the AB 635 program by two years and clarify that the pilot project be conducted simultaneously with the study, with the pilot projects established no later than January 1, 2019.

Issue 28: Allocation of Proposition 56 Tobacco Tax Revenue

DOF Issue#: None – Legislative Proposal

Proposition 56 Supplemental Provider Payments. The May Revision continues supplemental payments for physicians, dentists, women's health services, intermediate care facilities for individuals with developmental disabilities, and HIV/AIDS Waiver services approved in the 2017 Budget Act, as well as a $163 million augmentation for physicians and $70 million augmentation for dental services included in the Governor's January budget. However, DHCS reports that claims for physicians are lower than expected, resulting in lower estimated expenditures of allocated Proposition 56 revenues. DHCS estimates total Proposition 56 expenditures of $252.2 million in 2017-18 and $602.2 million in 2018-19. For 2017-18, $293.8 million of the $546 million Proposition 56 funds appropriated in the 2017 Budget Act remains unspent. For 2018-19, $197.8 million of the $546 million Proposition 56 funds allocated pursuant to the 2017 Budget Act remains unspent which, along with the Administration's augmentation of $232.8 million, results in a total of $430.6 million of Proposition 56 funds unallocated in 2018-19. DHCS indicates it will continue to work with stakeholders and the Legislature on a supplemental payment structure to be submitted to the federal government for approval by September 2018.

This issue was heard during the subcommittee's May 16th hearing.

Subcommittee Staff Comment and Recommendation— It is recommended the subcommittee take the following actions:

1. **Augment** expenditure authority from the Healthcare Treatment Fund of $800 million, available for expenditure until the end of the 2019-20 fiscal year.
2. **Adopt Placeholder Budget Bill Language** that allocates the unspent Proposition 56 revenue as follows:
    a. $427 million unallocated in 2018-19 (Ongoing)
        i. $300 million for supplemental payments for pediatric primary care providers codes to be reimbursed at Medicare rates, consistent with the primary care rate increase provided pursuant to the federal Affordable Care Act.
        ii. $45 million for supplemental payments for pediatric specialty providers.
        iii. $30 million for supplemental payments to dental providers that treat children with special needs.
        iv. $40 million for supplemental payments for adult dental preventive treatment.
        v. $4 million for supplemental payments for pediatric day health centers.
        vi. $4 million for supplemental payments to pediatric subacute facilities.
        vii. $4 million for supplemental payments for breast pumps provided by Medi-Cal.
    b. $294 million unallocated in 2017-18 (One-time)
        i. $150 million for workforce development programs, including but not limited to, loan repayments, for physicians who agree to provide a significant portion of their services for Medi-Cal beneficiaries.
        ii. $144 million for a provider incentive payment program to cover fixed costs, provide supplemental reimbursements or other incentives to providers who serve Medi-Cal beneficiaries in rural or high poverty urban areas with a demonstrated shortage of access to providers.
    c. Direct DHCS to apply for federal approval for all supplemental payment programs for a two year period, with the funding provided by the two-year appropriation of the Healthcare Treatment Fund item.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: AIDS Drug Assistance Program (ADAP) – May Revision Estimate and Adjustments

DOF Issue#: 4265-007-ECP-2018-GB
4265-078-ECP-2018-GB
4265-400-ECP-2018-MR
4265-404-ECP-2018-MR

ADAP Local Assistance Estimate May Revision Update. The May 2018 ADAP Local Assistance Estimate reflects revised 2017-18 expenditures of $392 million, which is a decrease of $6.2 million or 1.5 percent compared to the Governor's January budget. According to DPH, this decrease is primarily due to reduced overall caseload. For 2018-19, DPH estimates ADAP expenditures of $432.1 million, a decrease of $2.3 million or 0.5 percent, compared to the Governor's January Budget, and an increase of $40.1 million or 10.2 percent, compared to the revised 2017-18 estimate. According to DPH, the increase over 2017-18 is primarily due to higher caseload, particularly in the medication-only category..

ADAP Local Assistance Funding 2017-18 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0890 – Federal Trust Fund	$111,400,000	$111,400,000
3080 – AIDS Drug Assistance Program Rebate Fund	$286,700,000	$280,500,000
Total ADAP Local Assistance Funding – All Funds	**$398,100,000**	**$392,000,000**

ADAP Local Assistance Funding 2018-19 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0890 – Federal Trust Fund	$132,400,000	$132,400,000
3080 – AIDS Drug Assistance Program Rebate Fund	$302,000,000	$299,600,000
Total ADAP Local Assistance Funding – All Funds	**$434,400,000**	**$432,100,000**

This issue was heard during the subcommittee's April 26th (November 2017) and May 16th (May 2018) hearings.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended the subcommittee approve the balance of the technical adjustments to the ADAP estimate, as updated for the May Revision, with any changes necessary to conform to other actions that have been, or will be, taken.

Issue 2: Genetic Disease Screening Program – May Revision Estimate and Adjustments

DOF Issue#: 4265-079-ECP-2018-GB
4265-401-ECP-2018-MR
4265-435-BBA-2018-MR

May Revision Issue The May 2018 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of $132.1 million ($27.7 million state operations and $104.4 million local assistance) in 2017-18, and $133 million ($29.5 million state operations and $103.5 million local assistance) in 2018-19. These figures represent a decrease of $293,000 (all local

assistance) in 2017-18 and an increase of $28,000 (all local assistance) in 2018-19, compared to the Governor's January budget. According to DPH, the decrease in 2017-18 is primarily due to reduced demographic projections of live births by the Department of Finance's Demographic Research Unit, while the increase in 2018-19 is primarily due to a slight increase of the actual caseload of prenatal and newborn tests.

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:	$27,650,000	$27,650,000	$-
Local Assistance:	$104,732,000	$104,439,000	($293,000)
Total GDSP Expenditures	**$132,382,000**	**$132,089,000**	**($293,000)**

Genetic Disease Screening Program Funding 2018-19 May Revision Comparison to January			
	2018-19	**2018-19**	**Jan-May**
Fund Source	***January Budget***	***May Revision***	***Change***
0203 – Genetic Disease Testing Fund			
State Operations:	$29,451,000	$29,451,000	$-
Local Assistance:	$103,473,000	$103,501,000	$28,000
Total GDSP Expenditures	**$132,924,000**	**$132,952,000**	**$28,000**

Newborn Screening Program (NBS) Caseload Estimate: The May Revision estimates NBS program caseload of 478,679 in 2017-18, a decrease of 1,928 or 0.4 percent, compared to the Governor's January budget. The May Revision estimates NBS program caseload of 478,419 in 2018-19, an increase of 98 or 0.02 percent, compared to the Governor's January budget, and a decrease of 260 or 0.05 percent compared to the revised 2017-18 estimate. These updated estimates are based on state projections of 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 Revision estimates PNS program caseload of 342,532 in 2017-18, a decrease of 1,401 or 0.4 percent, compared to the Governor's January budget. The May Revision estimates PNS program caseload of 342,347 in 2018-19, an increase of 50 or 0.01 percent, compared to the Governor's January budget, and a decrease of 185 or 0.05 percent, compared to the revised 2017-18 estimate. These updated estimates are based on state projections of the number of live births. DPH assumes 71.4 percent of births will participate in the PNS program annually.

May Revision Finance Letter Adjustments. Consistent with local assistance expenditure updates to GDSP at May Revision and the requested fund shift for CBDMP, DPH requests the following adjustment:

- 4265-001-3114 be decreased by $1.8 million
- 4265-111-0203 be increased by $28,000

This issue was heard during the subcommittee's March 22nd (November 2017) and May 16th (May 2018) hearings.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended the subcommittee approve the adjustments to the GDSP Local Assistance Estimate, as updated in the May Revision.

Issue 3: Women, Infants, and Children Program – May Revision Estimate

DOF Issue#: 4265-080-ECP-2018-GB
4265-402-ECP-2018-MR

May Revision Issue. The May 2018 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of $1.2 billion ($932.7 million federal funds and $232.7 million WIC manufacturer rebate funds) in 2017-18, a reduction of $30.5 million ($29.9 million federal funds and $615,000 WIC manufacturer rebate funds) compared to the Governor's January budget. The May 2018 WIC Program Estimate includes $1.1 billion ($906.8 million federal funds and $229.8 million WIC manufacturer rebate funds) in 2018-19, a reduction of $47.1 million ($46 million federal funds and $1.1 million WIC manufacturer rebate funds) compared to the Governor's January budget, and a decrease of $28.8 million ($25.8 million federal funds and $2.9 million WIC manufacturer rebate funds) compared to the revised 2017-18 estimate. The federal fund amounts include state operations costs of $63.5 million in 2017-18 and $63.7 million in 2018-19.

WIC Funding Summary 2017-18 May Revision Comparison to January Budget			
	2017-18	**2017-18**	**Jan-May**
Fund Source	***January Budget***	***May Revision***	***Change***
0890 – Federal Trust Fund			
State Operations:	$63,463,000	$63,463,000	$-
Local Assistance:	$899,152,000	$869,219,000	($29,933,000)
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$233,307,000	$232,692,000	($615,000)
Total WIC Expenditures	**$1,195,922,000**	**$1,165,374,000**	**($30,548,000)**

WIC Funding Summary 2018-19 May Revision Comparison to January Budget			
	2018-19	**2018-19**	**Jan-May**
Fund Source	***January Budget***	***May Revision***	***Change***
0890 – Federal Trust Fund			
State Operations:	$63,684,000	$63,684,000	$-
Local Assistance:	$889,131,000	$843,150,000	($45,981,000)
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$230,852,000	$229,772,000	($1,080,000)
Total WIC Expenditures	**$1,183,667,000**	**$1,136,606,000**	**($47,061,000)**

The May Revision assumes a monthly average of 1,062,623 WIC participants in 2017-18, a decrease of 12,485 or 1.2 percent compared to the Governor's January budget. The May Revision assumes a monthly average of 1,012,984 WIC participants in 2018-19, a decrease of 11,398 or 1.1 percent compared to the Governor's January budget, and a decrease of 49,639 or 4.7 compared to the revised 2017-18 caseload estimate.

Food Expenditures Estimate. The May Revision includes $801.1 million ($568.4 million federal funds and $232.7 million WIC manufacturer rebate funds) in 2017-18 for WIC program food expenditures, a decrease of $30.5 million ($29.9 million federal funds and $620,000 WIC manufacturer rebate funds) or 3.7 percent, compared to the Governor's January budget. The May Revision includes $772.1 million ($542.3 million federal funds and $229.8 million WIC manufacturer rebate funds) in 2018-19 for WIC program food expenditures, a decrease of $47.1 million ($46 million federal funds and $1.1 million WIC manufacturer rebate funds) or 5.8 percent compared to the Governor's January budget, and a decrease of $29 million ($26.1 million federal funds and $2.9 million WIC manufacturer rebate funds) or 3.6 percent compared to the revised 2017-18 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 2017-18 and 2018-19, which is unchanged from the level assumed in the Governor's January budget. Funding from the NSA grant is provided to the Office of Systems Integration to fund the establishment of a WIC management information system (MIS).

This issue was heard during the subcommittee's March 22nd (November 2017) and May 16th (May 2018) hearings.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended the subcommittee approve the adjustments to the WIC Local Assistance Estimate, as updated in the May Revision. The subcommittee will continue to monitor the ongoing decline in participation in the program and encourages the department to continue to evaluate strategies for increasing participation.

Issue 4: Center for Health Care Quality – May Revision Estimate and Adjustments

DOF Issue#: 4265-403-ECP-2018-GB

May Revision Update. The May Revision estimate for the Center for Health Care Quality includes $272.5 million ($3.7 million General Fund, $100.3 million federal funds, and $168.5 million special funds and reimbursements) in 2017-18, unchanged compared to the Governor's January budget, and $280.4 million ($3.7 million General Fund, $102.1 million federal funds, and $174.7 million special funds and reimbursements) in 2018-19, an increase of $2.7 million (all special funds) compared to the Governor's January budget.

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	$100,327,000	$100,327,000
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	$10,161,000	$10,161,000
3098 – Licensing and Certification Program Fund	$152,809,000	$152,809,000
Total CHCQ Funding – All Funds	**$272,502,000**	**$272,502,000**

Center for Health Care Quality Funding 2018-19 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	$102,056,000	$102,056,000
0942 – Internal Departmental Quality Improvement Acct	$2,304,000	$2,598,000
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	$10,436,000	$10,436,000
3098 – Licensing and Certification Program Fund	$156,153,000	$158,526,000
Total CHCQ Funding – All Funds	**$277,766,000**	**$280,433,000**

Provisional Language – Certified Nurse Assistant Training Kickstarter Program. DPH requests provisional language be added to item 4265-115-0942 to allow the department the flexibility to increase expenditure authority up to $1.7 million if the federal Center for Medicare and Medicaid Services approves the Certified Nursing Assistant (CNA) Training Kickstarter Program. Funding would be provided to the Quality Care Health Foundation to contract with health employers for CNA training classes, and provide technical assistance to skilled nursing facilities to develop and obtain approval of their own CNA training program. Any augmentation would be authorized no sooner than 30 days after notification to the Joint Legislative Budget Committee.

This issue was heard during the subcommittee's April 26th (November 2017) and May 16th (May 2018) hearings.

Subcommittee Staff Comment and Recommendation—It is recommended the subcommittee take the following actions:

1. **Approve** the balance of the technical adjustments to the CHCQ estimate, as updated for the May Revision, with any changes necessary to conform to other actions that have been, or will be, taken.
2. **Adopt Placeholder Budget Bill Language** to allow the department the flexibility to increase expenditure authority for the Certified Nurse Assistant Training Kickstarter Program.

Issue 5: L&C - Los Angeles County Contract Extension and Supplemental Fee Proposal

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

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

DPH is also requesting trailer bill language to assess a supplemental license fee on facilities located in LA County to offset additional costs necessary to regulate these entities in LA County. The proposed supplemental fee will prevent the need to increase license fees on health care facilities statewide to absorb these increasing contract costs. The supplemental fee would allow health care facilities in LA County to receive services comparable to other health care facilities statewide and ensure that facilities pay license fees that are more commensurate with their regulatory costs. According to DPH, the imposition of the supplemental fee is meant to allow regulatory activities in LA County to be fully funded by fee revenue paid by LA County facilities, rather than subsidized by fees paid in other parts of the state.

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—It is recommended the subcommittee take the following actions:

1. **Augment** the department's expenditure authority request by $2.7 million for a total of $4.6 million, consistent with the estimate of costs necessary to perform the required workload provided by Los Angeles County.
2. **Adopt Placeholder Trailer Bill Language** allowing DPH to assess the proposed supplemental license fee on facilities located in Los Angeles County.

Issue 6: Licensing & Certification - Health Care Licensing and Oversight

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

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

* Positions and resources ongoing after 2019-20.

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended the subcommittee approve this request for positions and resources. The subcommittee will continue to monitor the department's efforts to address the workforce needs for certified nurse assistants.

Issue 7: Use of Federal Standards for State Regulation

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

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language. It is recommended the subcommittee approve the department's proposed trailer bill language using federal certification standards for facility licensure.

Issue 8: Proposition 99 Adjustments – Health Education and Unallocated Accounts

DOF Issue#: 4265-405-BBA-2018-MR

Proposition 99 Tobacco Tax Allocations. DPH requests the following technical corrections reflecting changes in Proposition 99 revenues and a shift between state operations and local assistance:

Health Education Account
- Item 4265-001-0231 be increased by $122,000
- Item 4265-111-0231 be increased by $1,00,000

Unallocated Account
- Item 4265-001-0236 be increased by $66,000

According to DPH, the Health Education Account adjustment would be provided to additional community-based organizations engaged in tobacco prevention activities. In addition, these funds would support additional state operations staff for oversight of these programs.

The Unallocated Account adjustment will fund additional state administrative activities.

This issue was heard during the subcommittee's May 15th hearing.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended the subcommittee approve the department's proposed technical adjustments to Proposition 99 authority.

Issue 9: Proposition 56 Authority and Technical Adjustments

DOF Issue#: 4265-420-BBA-2018-MR
4265-421-BBA-2018-MR
4265-422-BBA-2018-MR
4265-430-BBA-2018-MR

May Revision Issue. DPH requests the elimination of the following budget items for expenditure of revenues from Proposition 56 tobacco taxes. These budget items fund the state Oral Health Program, tobacco law enforcement activities, and tobacco prevention activities. If approved, this request would eliminate these items and expenditures would be transferred to non-Budget Act items consistent with the provisions of Proposition 56. Specifically, DPH requests the following items be eliminated and converted into non-Budget Act items:

State Dental Program Account
- 4265-001-3307
- 4265-111-3307

Tobacco Law Enforcement Account
- 4265-001-3318
- 4265-111-3318

Tobacco Prevention Control Account
- 4265-001-3322
- 4265-111-3322

This issue was heard during the subcommittee's May 15th hearing.

Subcommittee Staff Comment and Recommendation—It is recommended the subcommittee take the following actions:

1. **Approve** transfer of items for the State Dental Program Account (4265-001-3307 and 4265-111-3307) and the Tobacco Prevention Control Account (4265-001-3322 and 4265-111-3322) to non-Budget Act items that are continuously appropriated.
2. **Adopt Placeholder Trailer Bill Language** directing DPH to allow local health departments that receive grants from the Proposition 56 allocations for the Oral Health Program and tobacco prevention to expend these funds within three fiscal years after the grant award.
3. **Reject** transfer of items for the Tobacco Law Enforcement Account (4265-001-3318 and 4265-111-3322).

Issue 10: Expansion of Black Infant Health Program

DOF Issue#: None – Legislative Proposal

Interventions to Reduce Risk Factors for Black Infant Mortality. While the social support, stress management, and empowerment model of the Black Infant Health Program is an evidence-based intervention that reduces black infant mortality, the rate of black infant mortality has remained twice that of any other group. Other interventions that have shown promise generally include a team-based approach to care that couples social interventions with medical interventions. The Centering Pregnancy model is a group-based intervention that follows the recommended schedule of 10 prenatal visits, with each visit 90 minutes to two hours long. According to Centering Healthcare, which developed the model, pregnant women engage in their own care by taking their own weight and blood pressure and recording their own health data with private time with their provider for belly check. DPH indicates that the group-based intervention in the Black Infant Health Program is partially derived from the Centering Pregnancy model.

In addition to these models, a pilot program in Sacramento County demonstrated significant reductions in pre-term birth and low birth weight among its participants compared to rates of these conditions in the county and nationally. The program, affiliated with a federally qualified health center, provided a team-based approach that included an extensive evaluation of each African American pregnant woman, personalized case management, an educational program, and wraparound care provided by home visitors and various medical personnel. The program identified 56 risk factors for pre-term birth and each patient was evaluated by a physician for these social and medical factors. Between June 2014 and April 2016, 454 African American women participated in the program. The combined medical plan and home visiting approach reduced the pre-term birth rate from 16.8 percent for African Americans in Sacramento County to 2.9 percent for participants in the program. The rate of low birth rates was similarly reduced from 13.8 percent in Sacramento County to 4.3 percent for program participants.

This issue was heard during the subcommittee's May 10th hearing.

Subcommittee Staff Comment and Recommendation—It is recommended the subcommittee take the following actions:

1. **Augment** the Black Infant Health Program's General Fund expenditure authority by $15 million annually.
2. **Adopt Placeholder Trailer Bill Language** to expand the Black Infant Health Program's scope to fund local programs that combine social interventions with medical interventions and other wrap-around services including, but not limited to, evaluation, personalized case management, educational programs, and wraparound care provided by home visitors and various medical personnel. These programs may utilize existing approaches, such as Centering Pregnancy, or other evidence-based approaches that have shown promise in reducing the incidence of black infant mortality, premature labor, and low birth weight.

Issue 11: Local Comprehensive HIV Prevention

DOF Issue#: None – Legislative Proposal

Comprehensive HIV Prevention Services Including PrEP and PEP. The HIV Alliance requests $10 million General Fund annually to provide grants to support comprehensive HIV prevention services including Pre-Exposure Prophylaxis (PrEP) and Post-Exposure Prophylaxis (PEP), including outreach and navigation, HIV testing for high risk populations, and related prevention services. Because the specific needs of local health jurisdictions vary widely, the Request for Proposals should allow applicants to identify the range of HIV prevention services needed in their individual communities with special attention given to applicants serving key populations in resource limited areas.

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation— It is recommended the subcommittee take the following actions:

1. **Augment** General Fund expenditure authority for the Office of AIDS by $10 million annually.
2. **Adopt Placeholder Trailer Bill Language** to establish a grant program to support comprehensive HIV prevention services including PrEP and PEP.

Issue 12: Modify and Expand PrEP Assistance Program

DOF Issue#: None – Legislative Proposal

Modify PrEP Assistance Program to Provide More Comprehensive Coverage for PrEP and PEP. The HIV Alliance proposes trailer bill language to modify the PrEP Assistance Program to expand coverage. Currently the program is limited to individuals 18 years old and above, does not provide financial assistance for post-exposure prophylaxis (PEP) and is not authorized to provide health insurance premium support. The program is also not authorized to cover the full cost of PrEP and PEP medications under any circumstances. These limitations prevent the program from providing adequate safety-net coverage for PrEP and PEP to those who qualify. The trailer bill language would make the following changes:

1. Change program eligibility to include all residents of California at least 12 years of age.
2. Authorize program to provide financial assistance for PEP.
3. Cover the full cost of PrEP and PEP medications for uninsured individuals under 18 years old.
4. Provide health insurance premium support.
5. Cover the full cost of PrEP and PEP, including medication and medical costs, for individuals unable to use their insurance for confidentiality or safety reasons.
6. Cover all PrEP- and PEP-related drug costs not covered by the individual's health insurance plan when manufacturer's copay assistance program imposes an undue burden.
7. Cover starter packs for PrEP and PEP.

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation— It is recommended the subcommittee take the following actions:

1. **Augment** ADAP Rebate Fund expenditure authority for ADAP program by $2 million annually to fund more comprehensive coverage for PrEP and PEP.
2. **Adopt Placeholder Trailer Bill Language** to make the following changes to the PrEP Assistance Program:
   a. Change program eligibility to include all residents of California at least 12 years of age.
   b. Authorize program to provide financial assistance for PEP.
   c. Cover the full cost of PrEP and PEP medications for uninsured individuals under 18 years old.
   d. Provide health insurance premium support.
   e. Cover the full cost of PrEP and PEP, including medication and medical costs, for individuals unable to use their insurance for confidentiality or safety reasons.
   f. Cover all PrEP- and PEP-related drug costs not covered by the individual's health insurance plan when manufacturer's copay assistance program imposes an undue burden.
   g. Cover starter packs for PrEP and PEP.

Issue 13: Demonstration Project for Persons Living with HIV/AIDS Over Age 50

DOF Issue#: None – Legislative Proposal

Health and Psychosocial Needs of Older Adults Living with HIV. The HIV Alliance requests $3 million General Fund over three years to establish demonstration projects that address the health and psychosocial needs of people living with HIV over the age of 50. The demonstration projects would serve both rural and urban jurisdictions as well as diverse groups of clients. The demonstration projects would include an evaluation component, a plan for disseminating lessons learned in order to strengthen ongoing programs, and would be evaluated based on multiple factors including need in the area, population served, competency of the entity applying, project design and evaluation design. CDPH OA would oversee the demonstration projects in consultation with the Department of Aging.

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation— It is recommended the subcommittee take the following actions:

1. **Augment** General Fund expenditure authority for the Office of AIDS by $3 million in 2018-19, available for expenditure for three years.
2. **Adopt Placeholder Trailer Bill Language** to establish a demonstration project that addresses the health and psychosocial needs of people living with HIV over the age of 50.

Issue 14: Demonstration Projects for Transgender Care Coordination

DOF Issue#: None – Legislative Proposal

Linkage to HIV Care and Prevention for Transgender Women. The HIV Alliance requests $2 million General Fund over three years to support demonstration projects that provide economic empowerment services for transgender women in coordination with linkage to HIV care and prevention services. These demonstration projects would include assessing client needs and potential barriers to

employment, client-centered career development trainings, referrals to inclusive and affirming employers and culturally competent referrals to HIV care and prevention services.

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation— It is recommended the subcommittee take the following actions:

1. **Augment** General Fund expenditure authority for the Office of AIDS by $2 million in 2018-19, available for expenditure for three years.
2. **Adopt Placeholder Trailer Bill Language** to establish a demonstration project to provide economic empowerment services for transgender women in coordination with linkage to HIV care and prevention services.

Issue 15: Substance Use Disorders Treatment Navigators at Harm Reduction Programs

DOF Issue#: None – Legislative Proposal

Substance Use Disorders Treatment Navigators at Harm Reduction Programs. The Drug Policy Alliance requests $11 million for the California Department of Public Health Office of AIDS (OA) for grants to harm reduction programs, including syringe access programs, to provide outreach to people who use drugs who are not in treatment and assist them with linkage to health care services. This outreach would increase the number of people who are able to benefit from medication assisted treatment such as methadone and buprenorphine and reduce the burden of opioid misuse, drug overdose deaths, hepatitis C and HIV in our communities by connecting individuals with substance use disorders to effective treatment and other services.

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation— It is recommended the subcommittee take the following actions:

1. **Augment** General Fund expenditure authority for the Office of AIDS by $11 million annually.
2. **Adopt Placeholder Trailer Bill Language** to establish a grant program to harm reduction programs, including syringe access programs, to provide outreach to people who use drugs who are not in treatment and assist them with linkage to health care services.

Issue 16: Systems of Care for Amyotrophic Lateral Sclerosis (ALS)

DOF Issue#: None – Legislative Proposal

Systems of Care for Amyotrophic Lateral Sclerosis (ALS). The ALS Association requests $3 million General Fund to help support the critical System of Care, both clinic- and community-based, for ALS patients and their caregivers. According to the ALS Association, ALS, often referred to as Lou Gehrig's disease, is a progressive and fatal neuro-degenerative disease. When motor neurons die, the ability of

the brain to initiate and control muscle movement is lost. The result is that people with ALS lose the ability to move, speak, swallow and breathe. The life expectancy of a person diagnosed with ALS is 2 to 5 years, and there is no effective treatment or cure. There are only two drugs approved by the FDA for ALS, neither are proven to extend life by more than 2 to 4 months. The only way to meaningfully extend the length and quality of life for people diagnosed with ALS is to provide them with access to the ALS Association's evidence-based model of care. This model of care involves the seamless integration of community and clinic based multidisciplinary services. This "wraparound" model of care is proven to help people diagnosed with ALS to live significantly longer and better than the only FDA approved drugs.

This issue was heard during the subcommittee's March 22nd hearing.

Subcommittee Staff Comment and Recommendation— It is recommended the subcommittee take the following actions:

1. **Augment** General Fund expenditure authority for DPH by $3 million annually.
2. **Adopt Placeholder Trailer Bill Language** to administer a grant to a qualified non-profit organization which specializes in ALS and is incorporated in the State of California to support the implementation of the System of Care wraparound model for Californians diagnosed with ALS.

Issue 17: Resources for California Safe Cosmetics Program

DOF Issue#: None – Legislative Proposal

Enforcement and Program Improvements for the California Safe Cosmetics Program. Breast Cancer Prevention Partners and a coalition of companies manufacturing safer cosmetics, public health and environmental health organizations request General Fund expenditure authority of up to $1.5 million to increase staffing and for enforcement and program improvement activities. The coalition also requests implementation of a $30 fee for each reportable product and penalty authority of $10,000 per company or $1,000 per product for failure to report covered products to the CSCP for inclusion in the database. The fee and penalty revenue would be used to reimburse the General Fund for the increased funding request.

According to the coalition, increased funding would provide the following:

- Increase staffing of the program to fulfill its statutory mandates and fully implement the law.
- Enable the program to address underreporting by manufacturers.
- Enable the program to address the industry abuse of "trade secret" designations which businesses have used to conceal hundreds of toxic chemicals from public view.
- Initiate investigations into the safety of ingredients and products.
- Refer investigations that find potential harm to Cal/OSHA to protect California's salon workers.
- Allow for increased awareness and use of the Safe Cosmetics Database and regular outreach to consumers and salon workers.
- Require companies to report to the state's database whether their products are intended for professional salon use or consumer use.
- Overhaul and modernize the SCP's outdated platform to address database malfunctioning.

This issue was heard during the subcommittee's March 22nd hearing.

Subcommittee Staff Comment and Recommendation— It is recommended the subcommittee take the following actions:

1. **Augment** General Fund expenditure authority for the California Safe Cosmetics Program by $1.5 million in 2018-19 and $500,000 annually thereafter to support one-time infrastructure upgrades and additional enforcement and outreach staff to ensure full implementation of program requirements by manufacturers of covered products.

Issue 18: Mosquito Surveillance Funding

DOF Issue#: None – Legislative Proposal

Mosquito Surveillance. The Mosquito and Vector Control Association of California requests General Fund expenditure authority of $500,000 annually for the California Vector-borne Disease Surveillance (CalSurv) system, as well as grants for vector research specific to California's unique ecosystems. According to the Association, mosquito surveillance is crucial for tracking, eliminating, and preventing the spread of mosquitos and the diseases they carry. Due to effective mosquito surveillance, efforts to limit the spread of West Nile were successful. However, mosquitos adapt quickly by becoming resistant to pesticides, alter their feeding and biting patterns, and infest geographic regions they have never before been detected.

This issue was heard during the subcommittee's May 10th hearing.

Subcommittee Staff Comment and Recommendation—Approve and Adopt Placeholder Budget Bill Language to augment DPH's General Fund expenditure authority by $500,000 annually to fund the CalSurv system.

Issue 19: Jordan's Syndrome PPP2R5D Research Grants

DOF Issue#: None – Legislative Proposal

Stakeholder Proposal - "Jordan's Syndrome" PPP2R5D Research Grants. The UC Davis Institute of Regenerative Cures requests expenditure authority of $12 million for research related to a genetic mutation, PPP2R5D, which has recently been described as a cause of neurodevelopmental disorders including autism, intellectual disabilities, behavioral challenges, and seizures. According to the Institute of Regenerative Cures, the research grant would fund a clinical registry and biorepository, creation of transgenic mouse models with the most common mutations, various characterization and biochemical studies, identification of lead compounds, and mouse clinical trials. Once a compound is identified, the project would partner with a pharmaceutical company to begin formal human clinical trials. The process is expected to take six to ten years.

This issue was heard during the subcommittee's May 16th hearing.

Subcommittee Staff Comment and Recommendation—Approve and Adopt Placeholder Trailer Bill Language to create a grant program for a collaborative research effort into diseases associated with variances in the Gene PPP2R5D. These funds will be used to provide various research functions, including, but not limited to, development of pluripotent stem cells into brain cell lines, development of mouse models, three-dimensional modeling of proteins, high throughput drug screening, gene editing applications and funding research agreements with other institutes of higher education children's hospitals to collaborate in providing those functions.

Issue 20: Valley Fever Funding

DOF Issue#: None – Legislative Proposal

Valley Fever Research. The Valley Fever Institute at Kern Medical requests General Fund expenditure authority of $3 million in 2018-19 for a research grant to fund Valley Fever treatment research and outreach. According to the Valley Fever Institute, there is no cure or vaccine for Valley Fever and studies show that early intervention ensures the best management of the disease. The most severe cases of Valley Fever stem from delayed diagnosis. The Centers for Disease Control and Prevention report Valley Fever infection rates rose twelve-fold nationwide between 1995 and 2009, and researchers estimate the fungus infects 150,000 people each year who either escape detection of the disease or suffer serious ailments without knowing the cause of their illness. The Valley Fever Institute at Kern Medical is ideally suited to be the premiere center for laboratory research, as it has the largest population of patients with Valley Fever, receives patients from around the world, has infectious disease experts dedicated to the study of Valley Fever, and is the site of clinical research trials on the effectiveness of early treatment with medication.

This issue was heard during the subcommittee's May 10th hearing.

Subcommittee Staff Comment and Recommendation—Approve and Adopt Placeholder Budget Bill Language to augment DPH's General Fund expenditure authority by $3 million as follows: 1) $2 million to the Valley Fever Institute at Kern Medical for capital expenses for research, awareness and education, and patient care; and 2) $1 million for a Valley Fever public awareness campaign.

Issue 21: Hepatitis C Prevention, Testing, Linkage, and Retention in Care

DOF Issue#: None – Legislative Proposal

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

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation— It is recommended the subcommittee take the following actions:

1. **Augment** General Fund expenditure authority for the DPH STD Control Branch by $6.6 million annually.
2. **Adopt Placeholder Trailer Bill Language** to expand the existing pilot for HCV prevention, testing, and linkage to, and retention in, care projects and capacity building support services to assist new programs.

Issue 22: Integrity of Inspections

DOF Issue#: None – Legislative Proposal

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

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language. It is recommended the subcommittee adopt placeholder trailer bill language mirroring Labor Code sections for Cal-OSHA to allow employees of entities inspected by DPH to have the right to discuss regulatory violations or patient safety concerns with an inspector privately during the course of an investigation or inspection by DPH.

Issue 23: Needle Exchange Program Sunset Extension

DOF Issue#: None – Legislative Proposal

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

This issue was heard during the subcommittee's April 26th hearing.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language. It is recommended the subcommittee adopt placeholder trailer bill language to eliminate the sunset date for needle exchange programs.

Issue 24: Lead Certification Application Processing

DOF Issue#: None – Legislative Proposal

Lead Certification Application Processing. The California State Council of Laborers requests expenditure authority of $75,000 to fund staff in DPH to accelerate processing of applications for certification for providing lead construction services. The Laborers are requesting an increase in their certification fee of between $10 and $12 to fund this request. According to the Laborers, the current application processing timeline is 120 days. With additional staff funded by this request, the processing time would be reduced to no more than 60 days.

This issue was heard during the subcommittee's May 10th hearing.

Subcommittee Staff Comment and Recommendation—It is recommended the subcommittee take the following actions:

1. **Augment** special fund expenditure authority in the Lead Certification Program by $75,000 annually
2. **Adopt Placeholder Budget Bill Language** to allow DPH to augment the lead certification fee by up to $12 to fund additional staff to improve certification processing time to no more than 60 days.

4440 DEPARTMENT OF STATE HOSPITALS

Issue 1: 2018-19 Program Updates – May Revision Adjustments

DOF Issue#: 4440-009-ECP-2018-GB
4440-010-ECP-2018-GB
4440-220-ECP-2018-MR
4440-003-ECP-2018-GB
4440-240-ECP-2018-MR
4440-005-ECP-2018-GB
4440-290-ECP-2018-MR
4440-001-ECP-2018-GB
4440-300-ECP-2018-MR
4440-004-ECP-2018-GB
4440-310-ECP-2018-MR
4440-320-ECP-2018-MR
4440-330-ECP-2018-MR
4440-340-ECP-2018-MR
4440-008-ECP-2018-GB
4440-350-ECP-2018-MR
4440-360-ECP-2018-MR

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

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

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

In the May Revision, DSH requests additional General Fund expenditure authority of $610,000 in 2019-20, for a total authority of $1.6 million. DSH indicates it has identified one prospective provider in Northern California to establish a 26-bed STRP, which is larger than the 16 beds anticipated in the Governor's January budget. While the annual cost of operating the new 26-bed program is $1.6 million, DSH is not requesting additional funding until 2019-20, based on the need for startup activities and modifications, and the timeline for activation of the additional capacity.

Program Update: Kern County Admission, Evaluation, and Stabilization Center. In the Governor's January budget, DSH reported a reduction in General Fund expenditures in 2017-18 of $1.7 million related to delays in negotiation and execution of a contact with Kern County to establish an Admission, Evaluation, and Stabilization (AES) Center at the Lerdo Pre-Trial Facility located in Bakersfield. The Kern AES Center is expected to receive and treat IST patients committed to State Hospitals directly from nearby catchment counties.

In the May Revision, DSH reports an additional reduction in General Fund expenditures in 2017-18 of $906,000, for a total expenditure reduction of $2.6 million. According to DSH, the Kern County Board of Supervisors approved the final contract for the AES Center in December 2017, with the 60 day startup period beginning in February 2018 with recruitment and training activities. The additional delay in recruitment and training has led to an admission date of April 23, 2018, which results in a total reduction in estimated General Fund expenditures in 2017-18 of $2.6 million, which is an increase of savings of $906,000 compared to the Governor's January budget.

Medicare Authority Increase. DSH pays Medicare premiums for third-party health coverage of Medicare beneficiaries who are patients at the state hospitals, pursuant to state law. The governing statute provides a continuous General Fund appropriation to DSH for this purpose.

In the May Revision, DSH reports additional General Fund expenditures of $600,000 for Medicare premium payments. According to DSH, the funding level has not changed in more than 16 years, although the Medicare-eligible population has increased. DSH indicates additional costs have been imposed by the implementation of Medicare Part D and regular cost-of-living adjustments by the federal government. As these expenditures are continuously appropriated, DSH indicates this program update is informational and does not require legislative action.

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

In the Governor's January budget, DSH requested authority to utilize $2.4 million of savings from construction delays for its ETP units at Atascadero State Hospital to fund the increased costs for these repair projects. If approved, these savings would allow DSH to complete all of these repairs by the end of 2019.

In the May Revision, DSH updated its project costs and timelines for the repair projects. These updates result in an additional request for expenditure authority of $1.9 million ($1.1 million General Fund and

$834,000 reimbursements) in 2017-18, $1.2 million reimbursement expenditure authority in 2018-19, and $608,000 reimbursement expenditure authority in 2019-20.

According to DSH, the updated timeline of construction and expenditures on these repairs is as follows:

	DGS PROJECT 1 Three Historical Buildings	**DGS PROJECT 2** Buildings Outside the STA	**DSH PROJECT 3** Buildings Inside the STA
Design Completion	July 6, 2017	May 2018	N/A
Begin Construction	November 2, 2018	September 21, 2018	October 1, 2017
Complete Construction	July 5, 2019	September 21, 2019	December 31, 2019

Project	**2015-16**	**2016-17**	**2017-18**	**2018-19**	**2019-20**	**Grand Total**
1. Three Historical Buildings	$989,900	$0	$7,129,000	$0	$0	$8,118,900
2. Buildings Outside the STA	$0	$326,200	$3,675,000	$0	$0	$4,001,200
3. Buildings Inside the STA	$0	$0	$1,624,958	$1,216,958	$608,479	$3,450,395
Totals	**$989,900**	**$326,200**	**$12,428,958**	**$1,216,958**	**$608,479**	**$15,570,495**

Program Update: Metropolitan State Hospital Bed Expansion. In the Governor's January budget, DSH requested 346.1 positions and General Fund expenditure authority of $53.1 million in 2018-19 and 473.4 positions and General Fund expenditure authority of $69 million in 2019-20 and annually thereafter to activate newly secured units at Metropolitan State Hospital to provide increased capacity for the treatment of IST patients. The 2016 Budget Act included capital outlay construction funding to securely enclose existing patient buildings that currently house civilly committed patients under the Lanterman-Petris-Short (LPS) Act. Once secured, the LPS patients currently housed in these units will be transferred to non-secured buildings elsewhere on the Metropolitan campus and allow for additional secured capacity for the treatment of IST patients currently in county jails awaiting state hospital treatment.

In the May Revision, DSH updated its timeline and staff requests to reflect additional delays and a technical adjustment related to the civil service classification of the requested staff. As a result, DSH requests reduction of 10.1 positions and General Fund expenditure authority of $1 million in 2017-18, reduction of 183.3 positions and General Fund expenditure authority of $28.3 million in 2018-19, and a reduction of 131.2 positions and General Fund expenditure authority of $18.4 million in 2019-20. According to DSH, these reductions in staff and resources are the result of delayed inspections and additional modifications required by the State Fire Marshall, as well as delays in securing a contractor for the new secured fence.

This request previously activated and provided staff for approximately 236 forensic beds over the course of 2018-19 to treat IST patients. The May Revision update activates and provides staff for approximately 96 forensic beds in 2018-19 and 140 forensic beds in 2019-20.

Program Update: Jail-Based Competency Treatment Program Expansions. In the Governor's January budget, DSH requested General Fund expenditure authority of $516,000 in 2017-18, $8.1 million in 2018-19, and $8.3 million in 2019-20 and annually thereafter to activate jail-based competency treatment (JBCT) beds for the treatment of IST patients in county jails, pursuant to approval of program expansions in previous budget requests. DSH contracts with county jail facilities to provide restoration of competency services in jails, treating IST patients with lower acuity and that are likely to be quickly restored to competency. This request nets savings from delayed implementation of existing JBCT contracts in Mendocino, Sacramento, and Stanislaus counties with additional costs for the activation of five JBCT beds in Riverside and 50 beds in San Bernardino.

In the Governor's January budget, DSH also requested $8 million in 2018-19 and $9.3 million in 2019-20 to activate new JBCT programs totaling 104 beds in five Northern California counties, one Southern California county, and one Central California county. Two of the Northern California counties would be small counties.

In the May Revision, DSH has revised its request for existing and new JBCT programs. For existing programs, DSH requests reduction of General Fund expenditure authority of $1.1 million in 2017-18 and $1.6 million in 2018-19, and an increase in General Fund expenditure authority of $305,000 in 2019-20. According to DSH, these reductions are based on delayed activation for JBCT programs in Mendocino and San Bernardino, offset in 2019-20 by an expansion of the JBCT program in Sonoma by two beds. Reflecting these May Revision adjustments, the total DSH request for existing JBCT programs is a General Fund expenditure authority decrease of $561,000 in 2017-18, and increased General Fund expenditure authority of $6.5 million in 2018-19 and $8.6 million in 2019-20.

For new programs, DSH requests reduction of General Fund expenditure authority of $4.9 million in 2018-19 and $2.3 million in 2019-20. According to DSH, these reductions are based on delayed contracts for activation of these programs and proposed replacement of a small Northern California county with a small Central California county for JBCT expansion. Reflecting these May Revision adjustments, the total DSH request for new JBCT programs is an increase in General Fund expenditure authority of $3.1 million in 2018-19 and $7 million in 2019-20.

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

Patients are evaluated for admission to an ETP based on requirements contained in AB 1340. A patient referred to an ETP by state hospital clinical staff is assessed by a dedicated forensic psychologist within three business days to make an initial determination regarding the appropriateness of the referral. If the referral is appropriate, the patient is further assessed by a panel comprised of a state hospital medical director, psychiatrist, and psychologist to certify admission to the ETP within seven days of the original referral. Upon admission, a forensic needs assessment team psychologist conducts a violence risk

assessment and develops a treatment plan in writing and, if possible, with the collaboration of the patient. The treatment plan, which must be reviewed and updated every ten days, must include information about the patient's mental health status and diagnoses, prescribed medications, goals of treatment, planned interventions and methods, documentation of success in meeting objectives, evaluation of the factors contributing to or detracting from the patient's progress, an activity plan, plans for other services needed by the patient, discharge criteria, goals for an aftercare plan in a standard treatment environment upon discharge, and a plan for post-discharge follow up.

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

The 2017 Budget Act authorized 44.7 positions and $8 million in 2017-18 and 115.1 positions and $15.2 million annually thereafter to activate the first two ETP units at Atascadero State Hospital. According to DSH, construction for the first unit was expected to begin in December 2017 and be completed in April 2018, while construction for the second unit was expected to begin April 2018 and be completed in August 2018. DSH reports these timelines have been delayed by the inability of the State Fire Marshall to complete approval of the final working plans, as fire resources have been deployed elsewhere in the state to assist with the emergency fire situation in several California counties.

In the Governor's January budget, DSH requested reversion of $2.3 million of anticipated General Fund savings related to the construction delays of the ETP units and reallocation of $2.4 million to fund unanticipated additional costs related to earthquake repairs at Napa State Hospital (see "Program Update: 2014 South Napa Earthquake Repairs"). DSH reported it would only spend $3 million of its $8 million 2017 Budget Act authority for ETP unit construction.

In the Governor's January budget, DSH also requested 23.2 positions and $2.8 million in 2018-19 and 65.7 positions and $8.4 million annually thereafter over the department's 2017 Budget Act authority for ETP unit construction. If approved, these resources would allow DSH to complete staffing and activation for the first two ETP units at Atascadero, as well as the planned activation of two additional ETP units, one at Atascadero and one at Patton State Hospital.

In the May Revision, DSH requests General Fund expenditure authority be increased by $70,000 in 2017-18, decreased by $7.4 million in 2018-19, and decreased by $50,000 in 2019-20. According to DSH, these changes are the result of delayed activation of the ETP units due to delays in receiving required approvals from the State Fire Marshall.

According to DSH, the updated timeline for construction for each of these units is as follows:

Units/Hospital	Construction Initiated	Construction Completed
DSH-Atascadero Unit 1	August 8, 2018	December 26, 2018
DSH-Atascadero Unit 2	December 26, 2018	April 17, 2019
DSH-Atascadero Unit 3	April 17, 2019	August 7, 2019
DSH-Patton Unit 1	April 12, 2019	September 6, 2019

Governor's January Budget Program Updates. The subcommittee also heard the following program updates that were unchanged at the May Revision.

Metropolitan State Hospital Per Patient Operating Equipment and Expenses. DSH requests General Fund expenditure authority of $3.7 million annually to fund the operating equipment and expenses associated with the activation of the additional 236 beds for the treatment of IST patients at Metropolitan State Hospital.

Coalinga State Hospital MDO Bed Activation. DSH requests 81.2 positions and General Fund expenditure authority of $11.5 million in 2018-19 and 96.9 positions and General Fund expenditure authority of $13.7 million in 2019-20 to increase capacity for the treatment of mentally disordered offenders (MDOs) at Coalinga State Hospital. This increased capacity is intended to allow transfer of MDOs from other State Hospitals to create additional capacity in those State Hospitals for the treatment of IST patients. Coalinga has already increased its MDO capacity by 25 beds. This request will allow for a two-phase activation of an additional 80 beds during 2018-19.

Program Update: Lanterman-Petris-Short (LPS) Population and Personal Services Adjustment. LPS patients are individuals that require physically secure 24-hour care and are committed through civil court proceedings that determine the individual is a danger to themselves or others or suffers from a grave disability. LPS patients are discharged when their county of residence places them in a different facility, in independent living, or with family, or if a court removes the conservatorship. Counties reimburse state hospitals for the costs of treatment for LPS patients.

According to DSH, the focus of treatment for the LPS population is on psychiatric stabilization and psychosocial treatments to reduce the risk of danger to themselves or others and develop basic life skills to function optimally in a lower level of care in the community. DSH provided care to a total of 849 LPS patients in 2016-17 with an average daily census of 670, or nine percent of the overall population. Of the 849 LPS patients in the state hospital system, 462 received treatment at Metropolitan, 258 at Napa, 118 at Patton, 10 at Atascadero, and one at Salinas Valley.

DSH requests an increase in reimbursement authority of $20.1 million in 2017-18 and annually thereafter. If approved, these resources would allow DSH to receive reimbursements from counties for the care and treatment of LPS patients. According to DSH, the currently budgeted LPS capacity systemwide is 628. As of June 2017, DSH had a total LPS census of 670.

Program Update: Forensic CONREP – Sexually Violent Predator (SVP) Program. Beginning in 1996, Sexually Violent Predators (SVP) were added to the CONREP population and are conditionally released to their county of domicile by court order with sufficient funding to provide treatment and supervision services. According to DSH, the CONREP-SVP program offers patients direct access to an array of mental health services with a forensic focus, as well as regularly scheduled sex offender risk assessments, polygraph testing, and review of Global Position System (GPS) data and surveillance. DSH reports it is on track to achieve a total 2017-18 caseload of 17 SVPs in CONREP by June 30, 2018.

Although no caseload growth is expected, DSH reports it will achieve $96,000 one-time General Fund savings in 2017-18 in the CONREP-SVP program based on adjustments to caseload due to the timing of conditional release dates from state hospital commitments.

These issues were heard during the subcommittee's April 12th, April 26th, and May 15th hearings.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended the subcommittee approve these program updates, as reflected as of May Revision.

Issue 2: Protected Health Information

DOF Issue#: 4440-001-BCP-2018-MR

May Revision Finance Letter. DSH requests eight three-year, limited-term positions and General Fund expenditure authority of $988,000 in 2018-19, 2019-20, and 2020-21. If approved, these positions and resources would allow DSH to implement new procedures for processing invoices and payments from external medical providers containing Protected Health Information and consolidate financial operations into a single unit.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$988,000	$988,000
Total Funding Request:	**$988,000**	**$988,000**
Total Positions Requested:**	**8.0**	

* Additional fiscal year resources requested: 2020-21: $988,000;
** Positions are limited-term and expire at the end of 2020-21.

This issue was heard during the subcommittee's May 15th hearing.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended the subcommittee approve the requested positions and resources to improve security practices for protected health information by transitioning to a more secure invoice processing system.

Issue 3: Los Angeles County Incompetent to Stand Trial Community Treatment

DOF Issue#: 4440-002-ECP-2018-GB
4440-230-ECP-2018-MR
4440-260-ECP-2018-MR

Background. In the Governor's January budget, DSH requested General Fund expenditure authority of $14.8 million to contract with Los Angeles County for 150 beds to treat IST patients in community settings, based on the county's experience in treating misdemeanor IST patients in similar settings. The contract, currently under negotiation to begin July 2018, would provide a coordinated continuum of mental health placements including five beds in a locked acute psychiatric hospital, 45 beds in a locked Institute for Mental Disease or mental health rehabilitation center, and 100 beds in residential facilities with clinical and supportive services. Los Angeles County has approximately 185 IST offenders awaiting state hospital placement. The contract would also include $2.5 million of funding for Los Angeles County staffing resources for 10-12 positions, including a clinical team of six to eight staff members, which would provide patient support by stabilizing patients on medications and preparing

them for community placement, and a navigation team of two to three staff members to support connections to social services and other needs.

	Locked Inpatient	Locked IMD type IMD Type	Unlocked, secured, Clinically Enhanced Type
Proposed # of Beds	5	45	100
Facility Type	General Acute Care Hospital or Acute Psychiatric Hosptial -- likely Olive View Medical Center	Low acuity hospital, and/or Nursing facility; licenses as an Institute for Mental Disease facility or a Mental Health Rehabilitation Center	Residential site with clinical and supportive services on-site
Facility Bed Capacity	18 total beds with 5 set aside for this project	2 different facilities: 1st up to 15 beds in San Fernando Valley part of LA County; 2nd with up to 35 beds in southern LAC or San Diego County	3-5 sites across LA County with 20-40 beds each
Security	Locked unit	Locked facilities	Open, but gated and with staff and security cameras monitoring entrance/exit
Staffing	24/7 nursing and MD staff, full-time clinical SW and support staff	24/7 nursing staff, M-F and on call MD staff, full-time clinical SW and support staff	24/7 case management and security staff, full-time clinical social work and nursing staff; potentially nurse practitioner on call
Treatment	Stabilization of Acute Mental Health or Medical symptoms	Sub-acute stablization of patients who do not require acute care, but who are not clinically ready for outpatient care and restoration of competency treatment.	Outpatient treatment, maintenance of stabilization, on-site psychiatric care, medication support and monitoring, group and individual therapy and restoration of competency treatment.

Figure 1: Los Angeles County IST Restoration in Community Mental Health Treatment Placements
Source: *2018-19 Department of State Hospitals Governor's Budget Proposals and Estimate*

In the May Revision, DSH requests a reduction in one-time General Fund expenditure authority of $1.7 million in 2017-18 and an increase in ongoing General Fund expenditure authority of $750,000 in 2018-19. According to DSH, the 2017-18 reduction reflects a phase-in of community placements, one-time startup costs, additional clinical team members to work with the courts and to support an "off-ramp" for patients restored to competency before placement in the community or state hospitals. The 2018-19 increase is for additional staff for ongoing support of the "off-ramp" for competency restoration, including one psychiatrist, two social workers, and one support staff.

This issue was heard during the subcommittee's April 12th and May 15th hearings.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended the subcommittee approve the resources for the LA County IST Community Treatment program. Los Angeles County has experienced significant success with community-based treatment and diversion of its misdemeanant IST population. The subcommittee will continue monitoring LA County's progress in reducing its IST referrals and diverting individuals with serious mental illness into treatment.

Issue 4: Metropolitan State Hospital Central Utility Plant

DOF Issue#: 4440-270-ECP-2018-MR

May Revision Issue. DSH requests ongoing General Fund expenditure authority of $2.6 million. If approved, these resources would fund the operation and maintenance of the Central Utility Plant at Metropolitan State Hospital.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$2,580,000	$2,580,000
Total Funding Request:	**$2,580,000**	**$2,580,000**

* Resources ongoing after 2019-20.

This issue was heard during the subcommittee's May 15th hearing.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended the subcommittee approve this request for resources to continue operations of the Metropolitan State Hospital Central Utility Plant.

Issue 5: Hepatitis C Treatment Expansion

DOF Issue#: 4440-370-ECP-2018-MR

May Revision Issue. DSH requests ongoing General Fund expenditure authority of $3.3 million. If approved, these resources would allow DSH to expand treatment eligibility for state hospital patients infected with Hepatitis C.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$3,300,000	$3,300,000
Total Funding Request:	**$3,300,000**	**$3,300,000**

* Resources ongoing after 2019-20.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended the subcommittee approve this request for resources to expand Hepatitis C treatment guidelines to DSH patients at an earlier stage of infection. The subcommittee will continue to monitor DSH's progress in reducing the HCV infection rate at its state hospitals.

Issue 6: Miscellaneous Technical Adjustments

DOF Issue#: 4440-250-ECP-2018-MR

May Revision Issue. DSH requests technical adjustments to reduce reimbursement expenditure authority of $1 million in 2018-19 and $1.2 million in 2019-20. If approved, these adjustments would

allow a one-time increase in reimbursement authority in 2018-19 from a local community college for DSH's Hospital Police Officer Academy program and remove unused reimbursement authority for implementation of the Health Insurance Portability and Accountability Act (HIPAA).

Subcommittee Staff Comment and Recommendation—Approve. It is recommended the subcommittee approve these technical adjustments to department reimbursements.

Issue 7: Competency Restoration Assessments

DOF Issue#: TBL (RN Pending)

May Revision Trailer Bill Language Proposal. DSH proposes trailer bill language to allow for an individual declared incompetent to stand trial to be assessed at any time to determine if the individual has regained competence and may be returned to the referring county for criminal proceedings.

DSH proposes trailer bill language to allow an individual declared incompetent to stand trial pursuant Penal Code Section 1370 to be examined to determine whether the defendant has regained competence. If counsel for the individual, the district attorney, judge, jail medical, or mental health staff reports the individual appears to have regained competence, the court may appoint a psychiatrist, licensed psychologist, or any other expert to perform the examination. If, in the opinion of the expert, the individual has regained competence, the court would reinstate criminal proceedings.

Subcommittee Staff Comment and Recommendation—Adopt Placeholder Trailer Bill Language. It is recommended the subcommittee approve the department's proposed trailer bill language to implement a process for individuals that regain competency to be assessed for restoration.

Issue 8: IST Diversion Proposal – County Mental Health Treatment Partnerships

DOF Issue#: TBL (RN Pending)

Budget Issue and Trailer Bill Language. DSH requests two positions and General Fund expenditure authority of $100 million in 2018-19 and $376,000 to contract with counties to develop new or expand existing diversion programs for individuals with serious mental illness with potential to be found incompetent to stand trial (IST) on felony charges.

Program Funding Request Summary (Budgeting Methodology BCP)		
Fund Source	**2018-19**	**2019-20**
0001 – General Fund	$100,000,000	$376,000
Total Funding Request:	**$100,000,000**	**$376,000**
Total Positions Requested:**	**2.0**	**2.0**

* Mental Health Services Fund is also separately reflected in the MHSOAC budget request.
** Positions are limited-term and would be authorized through 2020-21.

State-County Partnerships for Diversion of Potential IST Offenders. DSH requests trailer bill language and General Fund expenditure authority of $100 million to contract with counties to develop new or expand existing diversion programs for individuals with severe mental illnesses. These

programs would be primarily focused on individuals diagnosed with schizophrenia, shizoaffective disorder, or bipolar disorder with the potential to be found IST on felony charges. Programs components would include:

- Evidence-based community mental health treatment and wrap around services, such as forensic assertive community treatment teams, crisis intervention teams, forensic alternative centers, intensive case management, criminal justice coordination, peer support, supportive housing, and vocational support.
- Targeting of individuals with serious mental illnesses where a nexus exists between the illness and the alleged criminal activity, there is significant evidence of mental illness at the time of the alleged crime, the crime is driven by conditions of homelessness, and the individual does not pose a significant safety risk if treated in the community.

Counties would be required to contribute matching funds of 20 percent of the program costs and provide outcomes data on the success of the program towards the goal of reducing IST referrals by 30 percent. In addition to funding for county diversion contracts, DSH requests one Chief Psychologist and one Health Program Specialist I position on a three-year, limited-term basis to provide diversion and risk assessment expertise and to review and provide technical assistance for county diversion proposals.

Stakeholder Proposal – Community Mental Health Diversion for IST and State Prisoners. Stanford Law School's Three Strikes Project requests trailer bill language to expand upon the Administration's IST diversion proposal to address unmet mental health needs among both State Hospital patients and individuals incarcerated in state prisons. Modeled on similar incentive-based funding programs, such as SB 81 (Committee on Budget and Fiscal Review), Chapter 175, Statutes of 2007, and SB 678 (Leno), Chapter 608, Statutes of 2009, this proposal requires the Department of Finance, in consultation with other law enforcement agencies and entities, to calculate the state costs of incarceration in state prisons or restoration of competency treatment in State Hospitals and share 35 percent of those costs with counties for every individual with mental illness diverted to community-based treatment below a certain baseline threshold.

According to the Three Strikes Project, more than 30 percent of California prisoners currently receive treatment for a serious mental disorder, which represents a 150 percent increase since 2000. In addition, the severity of psychiatric symptoms of state prisoners has risen dramatically over the last five years. Defendants with mental illness receive longer prison sentences, on average, and some counties send a disproportionate number of defendants with mental illness to state prison.

While the Administration's proposed investment in community mental health diversion programs is a necessary component of addressing unmet mental health needs in the community that may lead to involvement in the justice system, the solitary focus on IST referrals ignores the equally challenging public health problem and fiscal impacts of individuals with severe mental illness sentenced to state prisons. The Three Strikes Project proposal, which is also contained in SB 142 (Beall) and would be combined with the Administration's current IST community mental health diversion proposal, incorporates financial incentives for counties to divert more at-risk individuals for community treatment and provides an ongoing funding source for diversion programs.

Subcommittee Staff Comment and Recommendation—It is recommended the subcommittee take the following actions:

1. **Approve** the department's request for resources for its proposed county mental health treatment partnership.
2. **Adopt Modified Placeholder Trailer Bill Language** that makes the following adjustments to the department's proposal as updated at May Revision:
   - Require DSH to enter into an interagency agreement with the Mental Health Services Oversight and Accountability Commission (MHSOAC).
   - Require counties applying for diversion funds to make use of available county allocations of Mental Health Services Act revenues.
   - Require both DSH and MHSOAC approval of all county plans for diversion programs, with an expedited process for concurrent approval by both entities.
   - Establish a shared savings program for counties receiving diversion funds under this program. After the three-year grant period, if a county reduced its IST referrals to state hospitals by a certain threshold, it would be eligible for a fixed amount of General Fund resources per diverted individual per year. Counties would only be eligible for such funding if there was no concomitant increase in individuals sentenced to state prison in those counties that enter the Mental Health Services Delivery System during the same period.

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: County Mental Health Innovation Planning

Budget Issue. MHSOAC requests expenditure authority from the Mental Health Services Fund of $2.5 million in 2018-19 and 2019-20. If approved, these resources would allow MHSOAC to contract with a private entity to provide support to counties in developing plans for innovative programs under the Mental Health Services Act, specifically to address community mental health diversion efforts for individuals found incompetent to stand trial.

Program Funding Request Summary (Budgeting Methodology BCP)		
Fund Source	**2018-19**	**2019-20**
3085 – Mental Health Services Fund	$2,500,000	$2,500,000
Total Funding Request:	**$2,500,000**	**$2,500,000**

This issue was heard during the subcommittee's April 12th hearing.

Subcommittee Staff Comment and Recommendation—Approve. It is recommended the subcommittee approve this request for resources to provide support to counties in developing innovation plans.

Issue 2: Reappropriation of Unexpended Mental Health Triage Funding

DOF Issue#: None – Legislative Proposal

Reappropriation of Unexpended Mental Health Triage Funding. MHSOAC requests reappropriation of expenditure authority from the Mental Health Services Fund of $29.4 million ($2.5 million from 2013-14, $8.8 million from 2014-15, $992,408 from 2015-16, and $17.1 million from 2016-17). These funds were originally appropriated under the Investment in Mental Health Wellness Act for triage personnel to provide intensive case management and linkage to services for individuals with mental health disorders at various points of access. The original appropriation was $54 million ($32 million Mental Health Services Fund and $22 million federal funds) for 600 triage personnel. According to MHSOAC, counties experienced challenges hiring triage personnel and were unable to spend all of their allotted funds during the term of their grants. These unspent funds, once reappropriated and available for encumbrance and expenditure through 2020-21, would allow MHSOAC to award more grants to counties during the next grant cycle.

This issue was heard during the subcommittee's May 3rd hearing.

Subcommittee Staff Comment and Recommendation—It is recommended the subcommittee take the following actions:

1. **Approve** the reappropriation of expenditure authority from the Mental Health Services Fund from 2013-14, 2014-15, 2015-16, and 2017-18.

Issue 3: Stakeholder Contracts for Mental Health Issues Among Immigrants and Refugees

DOF Issue#: None – Legislative Proposal

Stakeholder Advocacy Contracts for Mental Health Issues Among Immigrants and Refugees. The California Pan-Ethnic Health Network (CPEHN) and the California Immigrant Policy Center (CIPC) request $670,000 from the Mental Health Services Fund for MHSOAC to develop stakeholder advocacy contracts to support the mental health and engagement of immigrants and refugees. According to CPEHN and CIPC, the Trump Administration's continued scapegoating and attacking of immigrants has created a hostile atmosphere for many in our communities. The state has taken legislative action to limit the reach of the federal government and invested additional resources in support of immigrant legal services. Immigrants and refugees continue to show their strength and resiliency in weathering these attacks, but the cumulative impact takes a toll on the health and well-being of communities. As part of the MHSA, MHSOAC can support key partnerships, programs, and planning to meet the mental health needs of Californians and their families. In addition, pursuant to Welfare and Institutions Code Section 5892(d), the Mental Health Services administrative fund must include funds to promote stakeholder engagement in decisions concerning the public mental health system. The 2015 Budget Act included funds to increase stakeholder engagement among diverse racial and ethnic communities and among veterans, and the 2016 Budget Act included funds to increase stakeholder engagement among LGBTQ communities. CPEHN and CIPC request funding for stakeholder contracts to include mental health issues among immigrant and refugee communities.

This issue was heard during the subcommittee's April 12th hearing.

Subcommittee Staff Comment and Recommendation—It is recommended the subcommittee take the following actions:

1. **Augment** expenditure authority from the Mental Health Services Fund state administration account of $670,000 annually to fund stakeholder contracts for mental health issues among immigrants and refugees.

Issue 4: Stakeholder Contracts to Reduce Criminal Justice Involvement of MH Consumers

DOF Issue#: None – Legislative Proposal

Stakeholder Contracts To Reduce Criminal Justice Involvement of Mental Health Consumers. MHSOAC requests expenditure authority of $670,000 from the Mental Health Services Fund annually to fund stakeholder advocacy contracts to reduce the involvement of mental health consumers in the criminal justice system. 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. MHSOAC awards a total of $4.7 million contracted funds annually.

According to MHSOAC, for too many Californians becoming involved with law enforcement remains the primary avenue to accessing mental health care. As part of a broader strategy to address this challenge, MHSOAC requests expenditure authority of $670,000 from the Mental Health Services Fund

state administration account for stakeholder advocacy contracts to reduce the number of mental health consumers who become involved in the criminal justice system.

This issue was heard during the subcommittee's May 3rd hearing.

Subcommittee Staff Comment and Recommendation—It is recommended the subcommittee take the following actions:

1. **Augment** expenditure authority from the Mental Health Services Fund state administration account of $670,000 annually to fund stakeholder contracts to reduce criminal justice involvement among mental health consumers.

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 17, 2018
Upon Call of the Chair
State Capitol - Room 4203

PART C

OUTCOMES

Consultant: Scott Ogus

Item **Department**

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Medi-Cal Local Assistance Estimate – May Revision Update
Action: Approve Balance of Estimate (2-1)
Issue 2: Family Health Estimate – May Revision Update
Action: Approve Balance of Estimate (2-1)
Issue 3: Medi-Cal Unanticipated Costs, General Fund Reappropriation and Loan Authority
Action: Approve and Adopt Modified Placeholder Trailer Bill Language (2-1)
Issue 4: County Administration Estimate and Budget Proposals
Action: Approve (3-0)
Issue 5: Homeless Mentally Ill Outreach and Treatment
Action: Approve and Adopt Modified Placeholder Trailer Bill Language (3-0)
Issue 6: Mental Health Services Division Policy Implementation
Action: Approve (3-0)
Issue 7: Mental Health Services Fiscal Oversight and Behavioral Health Data Modernization
Action: Approve (3-0)
Issue 8: California Medicaid Management Information Legacy and Modernization Resources
Action: Approve and Adopt Modified Placeholder Trailer Bill Language (3-0)
Issue 9: Cost-Based Reimbursement Clinic Directed Payment Program
Action: Adopt Placeholder Trailer Bill Language (3-0)
Issue 10: Technical Adjustments-Federal Grant Awards, Reimbursements, and Dist. Admin.
Action: Approve (3-0)

Issue 11: Provisional Changes: Lawsuits/Claims Payment, ICF-DD and Home Health
Action: Approve and Adopt Placeholder Trailer Bill Language (3-0)
Issue 12: Medi-Cal Eligibility Regardless of Immigration Status – Over Age 65
Action: Approve and Adopt Placeholder Trailer Bill Language (2-1)
Issue 13: Expand Aged and Disabled Eligibility to 138 Percent of FPL
Action: Approve and Adopt Placeholder Trailer Bill Language (3-0)
Issue 14: Air Ambulance Rate Increase
Action: Approve and Adopt Placeholder Trailer Bill Language (3-0)
Issue 15: Asthma Home Visiting Benefit
Action: Approve and Adopt Placeholder Trailer Bill Language (3-0)
Issue 16: Restoration of Optional Benefits
Action: Approve and Adopt Placeholder Trailer Bill Language (3-0)
Issue 17: Remove BCCTP Treatment Limits
Action: Approve and Adopt Placeholder Trailer Bill Language (2-0)
Issue 18: Funding for Health Information Exchanges
Action: Approve and Adopt Placeholder Trailer Bill Language (3-0)
Issue 19: SBIRT Expansion for Opioids and Other Drugs
Action: Approve and Adopt Placeholder Trailer Bill Language (3-0)
Issue 20: Substance Use Counselors in Emergency Departments
Action: Approve and Adopt Placeholder Trailer Bill Language (3-0)
Issue 21: LTSS Data in California Health Interview Survey (CHIS)
Action: Approve and Adopt Placeholder Trailer Bill Language (3-0)
Issue 22: Children's Data in California Health Interview Survey (CHIS)
Action: Approve and Adopt Placeholder Trailer Bill Language (3-0)
Issue 23: Federally Qualified Health Centers/Rural Health Clinics Same Day Visits
Action: Approve and Adopt Placeholder Trailer Bill Language (3-0)
Issue 24: Dental Services Managed Care Integration Pilot in San Mateo County
Action: Adopt Placeholder Trailer Bill Language (3-0)
Issue 25: Erroneous Payment Correction Recoupments for Physicians
Action: Adopt Placeholder Trailer Bill Language (3-0)
Issue 26: Collection of AANHPI Data in Eligibility Systems
Action: Approve and Adopt Placeholder Trailer Bill Language (3-0)
Issue 27: Extension and Clarification of Medical Interpreters Pilot
Action: Adopt Placeholder Trailer Bill Language (2-1)
Issue 28: Allocation of Proposition 56 Tobacco Tax Revenue
Action: Approve and Adopt Placeholder Budget Bill Language (3-0)

4265 DEPARTMENT OF PUBLIC HEALTH
Issue 1: AIDS Drug Assistance Program (ADAP) – May Revision Estimate and Adjustments
Action: Approve Balance of Estimate (3-0)

Issue 2: Genetic Disease Screening Program – May Revision Estimate and Adjustments
Action: Approve (3-0)
Issue 3: Women, Infants, and Children Program – May Revision Estimate
Action: Approve (3-0)
Issue 4: Center for Health Care Quality – May Revision Estimate and Adjustments
Action: Approve Balance of Estimate and Adopt Placeholder Budget Bill Language (3-0)
Issue 5: L&C - Los Angeles County Contract Extension and Supplemental Fee Proposal
Action: Modify and Adopt Placeholder Trailer Bill Language (3-0)
Issue 6: Licensing & Certification - Health Care Licensing and Oversight
Action: Approve (3-0)
Issue 7: Use of Federal Standards for State Regulation
Action: Adopt Placeholder Trailer Bill Language (3-0)
Issue 8: Proposition 99 Adjustments – Health Education and Unallocated Accounts
Action: Approve (3-0)
Issue 9: Proposition 56 Authority and Technical Adjustments
Action: Modify and Adopt Placeholder Trailer Bill Language (3-0)
Issue 10: Expansion of Black Infant Health Program
Action: Approve and Adopt Placeholder Trailer Bill Language (3-0)
Issue 11: Local Comprehensive HIV Prevention
Action: Approve and Adopt Placeholder Trailer Bill Language (3-0)
Issue 12: Modify and Expand PrEP Assistance Program
Action: Approve and Adopt Placeholder Trailer Bill Language (2-0)
Issue 13: Demonstration Project for Persons Living with HIV/AIDS Over Age 50
Action: Approve and Adopt Placeholder Trailer Bill Language (3-0)
Issue 14: Demonstration Projects for Transgender Care Coordination
Action: Approve and Adopt Placeholder Trailer Bill Language (3-0)
Issue 15: Substance Use Disorders Treatment Navigators at Harm Reduction Programs
Action: Approve and Adopt Placeholder Trailer Bill Language (3-0)
Issue 16: Systems of Care for Amyotrophic Lateral Sclerosis (ALS)
Action: Approve and Adopt Placeholder Trailer Bill Language (3-0)
Issue 17: Resources for California Safe Cosmetics Program
Action: Approve (2-1)
Issue 18: Mosquito Surveillance Funding
Action: Approve and Adopt Placeholder Budget Bill Language (3-0)
Issue 19: Jordan's Syndrome PPP2R5D Research Grants
Action: Approve and Adopt Placeholder Trailer Bill Language (3-0)
Issue 20: Valley Fever Funding
Action: Approve and Adopt Placeholder Budget Bill Language (3-0)
Issue 21: Hepatitis C Prevention, Testing, Linkage, and Retention in Care
Action: Approve and Adopt Placeholder Trailer Bill Language (3-0)

Issue 22: Integrity of Inspections
Action: Adopt Placeholder Trailer Bill Language (2-1)
Issue 23: Needle Exchange Program Sunset Extension
Action: Adopt Placeholder Trailer Bill Language (3-0)
Issue 24: Lead Certification Application Processing
Action: Approve and Adopt Placeholder Budget Bill Language (3-0)

4440 DEPARTMENT OF STATE HOSPITALS

Issue 1: 2018-19 Program Updates – May Revision Adjustments
Action: Approve (3-0)
Issue 2: Protected Health Information
Action: Approve (3-0)
Issue 3: Los Angeles County Incompetent to Stand Trial Community Treatment
Action: Approve (3-0)
Issue 4: Metropolitan State Hospital Central Utility Plant
Action: Approve (3-0)
Issue 5: Hepatitis C Treatment Expansion
Action: Approve (3-0)
Issue 6: Miscellaneous Technical Adjustments
Action: Approve (3-0)
Issue 7: Competency Restoration Assessments
Action: Adopt Placeholder Trailer Bill Language (3-0)
Issue 8: IST Diversion Proposal – County Mental Health Treatment Partnerships
Action: Approve and Adopt Modified Placeholder Trailer Bill Language (2-1)

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: County Mental Health Innovation Planning
Action: Approve (3-0)
Issue 2: Reappropriation of Unexpended Mental Health Triage Funding
Action: Approve (3-0)
Issue 3: Stakeholder Contracts for Mental Health Issues Among Immigrants and Refugees
Action: Approve (2-1)
Issue 4: Stakeholder Contracts to Reduce Criminal Justice Involvement of MH Consumers
Action: Approve (2-1)