Senate Budget and Fiscal Review

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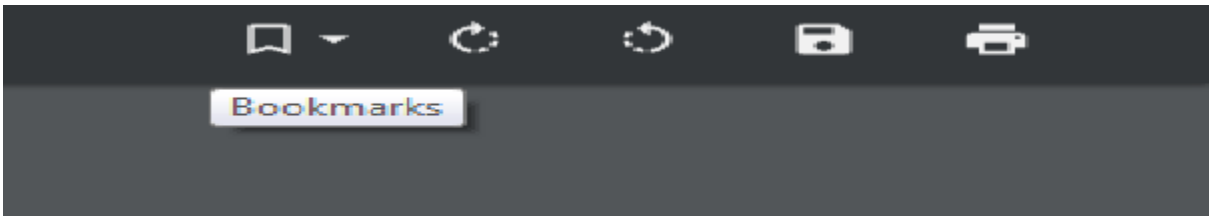

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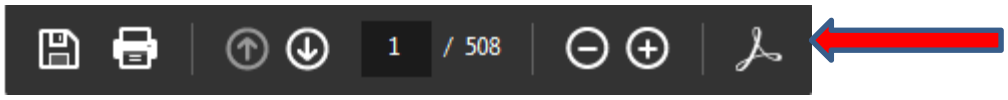

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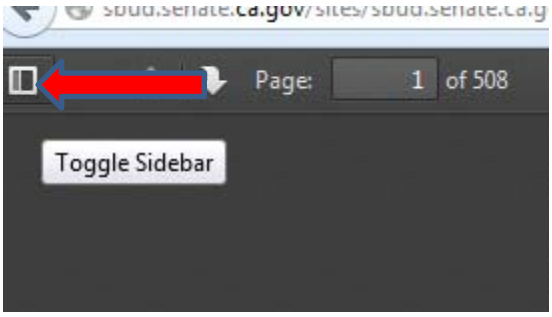

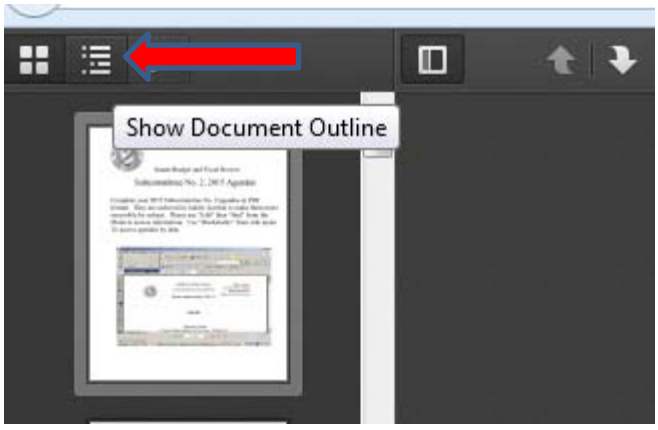

Senate Budget and Fiscal Review—Holly J. Mitchell, Chair

SUBCOMMITTEE NO. 3 Agenda

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

Thursday, February 28, 2019
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Scott Ogus

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PUBLIC COMMENT

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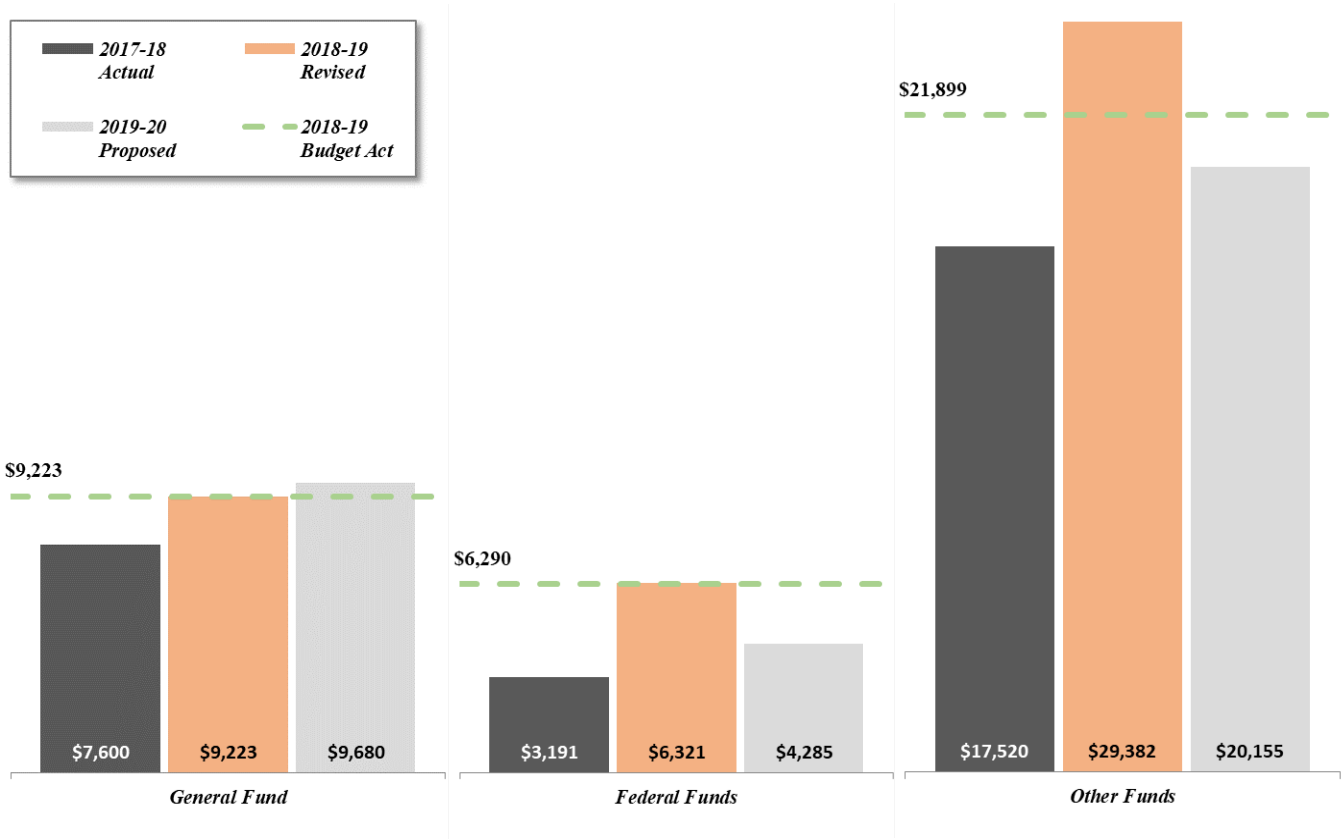
4120 EMERGENCY MEDICAL SERVICES AUTHORITY

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	***2018-19 Budget Act***	***2018-19 Revised***	***2019-20 Proposed***
General Fund (0001)	$9,223,000	$9,223,000	$9,680,000
Federal Funds (0890)	$6,290,000	$6,321,000	$4,285,000
Other Funds (*detail below*)	$21,899,000	$29,382,000	$20,155,000
Total Department Funding:	**$37,412,000**	**$44,926,000**	**$34,120,000**
Total Authorized Positions:	**69.9**	**70.0**	**76.0**
Other Funds Detail:			
EMS Training Prog. Approval Fund (0194)	*$217,000*	*$218,000*	*$218,000*
EMS Personnel Fund (0312)	*$2,608,000*	*$2,630,000*	*$2,682,000*
Reimbursements (0995)	*$17,520,000*	*$24,970,000*	*$15,560,000*
EMT Certification Fund (3137)	*$1,554,000*	*$1,564,000*	*$1,695,000*

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) 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 EMS Personnel Division, and the EMS 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, cardiopulmonary resuscitation (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: Conversion of Blanket Positions to Permanent

Budget Issue. EMSA requests establishment of four positions funded by existing appropriation authority. If approved, these positions would address ongoing Emergency Medical Services Division workload.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$-	$-
Total Funding Request:	**$-**	**$-**
Total Requested Positions:	**4.0**	**4.0**

* Positions are ongoing after 2020-21.

Background. 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.

Federal Preventive Health and Health Services Block Grant. In 2014-15, EMSA received notification that its federal Preventive Health and Health Services Block Grant funding allocation had increased by $1.4 million for a total $2.6 million grant award. These federal grant funds support oversight and administration of the California EMS Information System (CEMSIS), coordination and leadership of local Trauma Care Systems, and other administrative duties in the EMS Systems Division. This workload is currently managed by four temporary help positions supported by the federal grant.

Establish Permanent Positions to Replace Temporary Help. EMSA is requesting establishment of four positions funded by its existing federal fund appropriation authority. If approved, these positions would address ongoing Emergency Medical Services Division workload currently managed by temporary help staff established in response to the increased federal grant award. According to EMSA, the requested positions include:

One Staff Services Manager I – Provides management and oversight of the administration of CEMSIS, grant coordination, and quality improvement programs within the EMS Systems Division.

One Research Program Specialist – Responsible for a wide range of research and analytical duties regarding CEMSIS statistical data, including analysis, for use in the resolution of multiple program-related issues.

One Health Program Specialist II – Functions as the Trauma Care Program Coordinator providing statewide coordination and leadership for the planning, development, and implementation of local

Trauma Care Systems, including technical assistance to the 33 local EMS agencies, and review and approval of local trauma care system plans.

One Office Technician – Performs various clerical duties to support EMS Division activities.

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.

Issue 3: Continued Appropriation for Paramedic Discipline Case Workload

Budget Issue. EMSA requests expenditure authority from the Emergency Medical Services Personnel Fund of $309,000 annually. If approved, these resources would provide permanent funding for two positions authorized in the 2017 Budget Act to address the workload associated with prosecution of Emergency Medical Technician-Paramedic (EMT-P) license violations.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0312 – Emergency Medical Services Personnel Fund	$309,000	$309,000
Total Funding Request:	**$309,000**	**$309,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources are ongoing after 2020-21.

Background. Under its regulatory authority over paramedic licensing, EMSA may deny, revoke, suspend, or place on probation a paramedic's license if there is evidence of a threat to public health and safety. EMSA's legal counsel is responsible for disciplinary actions under this authority. Previously, EMSA's legal unit consisted of one full-time attorney, two retired annuitant attorneys, one retired annuitant staff services analyst, and one student assistant. The full-time attorney provided all legal services to EMSA, including: legal advice to the director, review of contracts, legal support for all EMSA divisions, review of local EMS agency solicitations and ambulance exclusive operating areas, public records act request review, subpoena and litigation response, employee discipline, and paramedic enforcement case supervision. The two retired annuitant attorneys prepared paramedic enforcement cases, negotiate settlements, and represent EMSA at administrative hearings at various locations throughout the state. The remaining staff provide administrative support to all three attorneys.

In response to an increase in litigation related to local EMS plan appeals and local EMS agency Exclusive Operating Area solicitation reviews, the 2017 Budget Act included the establishment of one Attorney I and one Staff Services Analyst, and expenditure authority from the Emergency Medical Services Personnel Fund of $314,000 in 2017-18 and 2018-19 to manage the increased workload related to paramedic licensing enforcement. According to EMSA, the workload related to plan appeals has persisted at the projected level since approval of the 2017 Budget Act request. As a result, EMSA is requesting permanent authority for the resources that support the previously authorized positions.

EMSA requests permanent expenditure authority from the Emergency Medical Services Personnel Fund of $309,000 to continue managing the increased workload related to paramedic licensing enforcement. These resources would continue to support the Attorney I and Staff Services Analyst included in the 2017 Budget Act.

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.

Issue 4: EMT Certification Denial Reporting (AB 2293)

Budget Issue. EMSA requests one position and General Fund expenditure authority of $159,000 in 2019-20 and $152,000 annually thereafter. If approved, these resources would allow EMSA to receive and compile data from local EMS agencies regarding approval or denial of EMT applicants and report on the extent to which prior criminal history may be an obstacle to EMT certification, pursuant to the requirements of AB 2293 (Reyes), Chapter 342, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$159,000	$152,000
Total Funding Request:	**$159,000**	**$152,000**
Total Requested Positions:	**1.0**	**1.0**

* Positions and Resources are ongoing after 2020-21.

Background. The EMS System and the Prehospital Emergency Medical Care Personnel Act requires EMSA to establish training, scope of practice, and continuing education standards for EMTs. Local EMS agencies certify EMT-Is and EMT-IIs, while the statewide EMSA is authorized to license paramedics. Local EMS agencies and EMSA can deny, suspend, revoke, or place on probation EMT or paramedic certification for conduct that violates the Health and Safety Code. These violations include, but or not limited to, acts of theft, violence, negligence, incompetence, abuse of drugs and alcohol, serious felony convictions, certain sexually related offenses, patient mistreatment, and failing to maintain the confidentiality of patient medical information. Since 2008, California law requires that all applicants for EMT or paramedic certification receive a criminal background check prior to approval.

Employment Options for Ex-Offender Firefighters May Be Limited. The California Department of Corrections and Rehabilitation (CDCR) operates the Conservation Camp Program, which provides CDCR inmates with the opportunity to work on meaningful projects throughout the state. 43 conservation camps in 29 counties, many operated jointly with the California Department of Forestry and Fire Protection (CalFIRE), house up to 4,522 adult inmates and 80 juveniles that comprise approximately 219 fire-fighting crews. These crews provide approximately three million person-hours responding to fires and other emergencies and seven million person-hours in community service projects in an average year. All inmates earn the right to work in a conservation camp by their non-violent behavior and conformance to rules while incarcerated. All volunteers are screened and medically cleared prior to acceptance and are ineligible if convicted of sexual offenses, arson, or any history of escape with force or violence. Inmates considered potential fire crew members are evaluated for their physical fitness by CDCR and are trained in fire-fighting techniques by CalFIRE, which includes a week of classroom instruction and a second week of field exercises.

Although firefighters are not required by statute to obtain EMT certification, it is often required by municipal fire departments that provide EMS services. Because applicants seeking EMT certification receive a criminal background check prior to approval, many ex-offender firefighters trained in the Conservation Camp Program may be discouraged from applying for certification, or may be denied certification by local agencies.

AB 2293 Reporting Requirements. In response to concerns that ex-offender firefighters may have limited employment options as firefighters upon release, AB 2293 requires local EMS agencies to report to EMSA data on the approval or denial of EMT-I or EMT-II candidates including:

- The total number of applicants who applied for initial certification;
- The total number of applicants with a prior criminal conviction who applied for initial certification;
- The number of applicants who were denied, the number of applicants who were approved, and the number of applicants who were approved with restrictions;
- The number of applicants with a prior criminal conviction who were denied, the number of applicants with a prior criminal conviction who were approved, and the number of applicants with a prior criminal conviction who were approved with restrictions;
- The reason or reasons stated for denying an applicant with a prior criminal conviction, or the reason or reasons stated for approving with restrictions an applicant with a prior criminal conviction;
- The restrictions imposed on approved applicants with a prior criminal conviction, and the duration of those imposed restrictions; and,
- Race, ethnicity, gender, and age demographic data for all applicants who were denied, approved, or approved with restrictions.

AB 2293 also requires EMSA to report to the EMS Commission and to the Legislature on the extent to which prior criminal history may be an obstacle to certification as an EMT-I or EMT-II.

EMSA is requesting **one Associate Governmental Program Analyst** to manage the process for data collection from local EMS agencies regarding denial for EMT certification. Specifically, this position would convene experts and stakeholders to identify the appropriate data collection fields, update EMSA's Central Registry to allow data collection, establish policies and procedures for local agency data submission, and provide ongoing technical assistance. In addition, this position would analyze the collected data to produce the annual report to the Commission and the Legislature required by AB 2293.

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.

Issue 5: Ambulance Patient Offload Time Reporting (AB 2961)

Budget Issue. EMSA requests one position and General Fund expenditure authority of $189,000 in 2019-20 and $141,000 annually thereafter. If approved, these resources would allow EMSA to analyze ambulance patient offload time data reported by local EMS agencies and report to the Legislature and the EMS Commission, pursuant to the requirements of AB 2961 (O'Donnell), Chapter 656, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$189,000	$141,000
Total Funding Request:	**$189,000**	**$141,000**
Total Requested Positions:	**1.0**	**1.0**

* Positions and Resources are ongoing after 2020-21.

Background. In March 2013, EMSA and the California Hospital Association created the Ambulance Patient Offload Delay Collaborative to analyze and develop solutions to the problem of ambulance patient offload delays. Ambulance patient offload time is defined as the interval between the arrival of an ambulance at an emergency department and the time the patient is transferred to an emergency department gurney, bed, chair or other acceptable location and the emergency department assumes responsibility for the care of the patient. According to the Collaborative, delays in ambulance patient offload time have been a concern in the health care community due to potential impacts on patient safety and quality of care. A national study of 200 cities found the average wait time for offloading ambulance patients doubled between 2006 and 2014 from 20 minutes to over 45 minutes, resulting in a loss of nearly five million hours of EMS system productivity. The Collaborative also reported on survey research that suggested the problem of extended ambulance patient offload times is not uniform or consistently reported, with some hospitals reporting insignificant delays and others disproportionately affected. As of 2015, EMSA reported that 13 of the state's local EMS agencies serving 70 percent of the state's population identified ambulance patient offload time as an issue. According to the Collaborative, many factors have been identified as contributing to decreased patient throughput, including: 1) decreased inpatient capacity, 2) nurse patient ratios, 3) hospital regulations limiting areas of care, and 4) inability to rapidly turn over hospital beds.

Toolkit to Reduce Ambulance Patient Offload Delays. In 2014, the Collaborative published the "Toolkit to Reduce Ambulance Patient Offload Delays in Emergency Department." The toolkit included definitions, process guidelines, and strategies to be considered to evaluate current practices and develop process improvements at the local level. The toolkit identified three key factors employed by hospital emergency departments that reported no or insignificant offload delays: 1) optimization of the intake process, 2) successful hospital process improvement strategies, and 3) hospital and local EMS agency collaboration and ongoing process improvement strategies.

Previous Legislation Sought to Collect Voluntary Data on Offload Times. In response to concerns about a lack of data regarding ambulance patient offload delays, AB 1223 (O'Donnell), Chapter 379, Statutes of 2015, required EMSA to adopt a statewide standardized methodology for calculating and voluntary reporting of ambulance patient offload times by local EMS agencies. EMSA also developed guidance for implementation and reporting of offload times, recommending an average time of 20

minutes. In addition, AB 1129 (Burke), Chapter 377, Statutes of 2015, required EMS providers to use an electronic health record system compliant with EMSA's California EMS Information System (CEMSIS) and ensure their system is integrated with the local EMS agency's system so provider data may be collected.

Despite the system established by AB 1223, EMSA reports statewide statistics for ambulance patient offload times are not currently available due to limited data. As of September 2018, 17 of the 33 local EMS agencies have provided at least one quarter of information for 2017, while 16 have provided at least one quarter of information for 2018.

AB 2961 Requires Local EMS Agencies to Report on Ambulance Patient Offload Times. In response to a lack of statewide data, AB 2961 requires, on or before July 1, 2019, local EMS agencies to transmit ambulance patient offload time data to EMS, calculating average offload times for each agency's total jurisdiction and each facility within the jurisdiction. AB 2961 also requires EMSA to analyze the data collected from the local EMS agencies on ambulance patient offload times and submit a biannual report to the EMS Commission. The bill also requires a one-time report to the Legislature, including recommendations to reduce or eliminate offload delays, on or before December 1, 2020.

EMSA requests one position and General Fund expenditure authority of $189,000 in 2019-20 and $141,000 annually thereafter to implement the workload associated with AB 2961, including **one Research Program Specialist I** to: 1) develop a statewide program to collect, consolidate, analyze and report submitted offload time data from all 33 local EMS agencies; 2) identify an appropriate automation system for data entry and analysis; 3) provide technical assistance and establish relationships with local EMS data staff to facilitate compliance with and consistency in data collection; 4) prepare the one-time report for the Legislature; and 5) prepare biannual reports to the EMS Commission.

Included in this request is a one-time $30,000 General Fund expenditure in 2019-20 for a consultant to assist in setting up the database, program reports, and to train EMSA staff on a statistical software suite to develop 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 EMSA to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 6: Child Care Provider Lead Poisoning Training (AB 2370)

Budget Issue. EMSA requests General Fund expenditure authority of $177,000 in 2019-20. If approved, these resources would allow EMSA to add the topic of lead poisoning prevention to the preventive health practices course for child care providers, pursuant to AB 2370 (Holden), Chapter 676, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$177,000	$-
Total Funding Request:	**$177,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. Existing state law requires some child care providers who work in licensed child care centers and all child care providers who work in child care homes to have 16 hours of training in first aid, cardiopulmonary resuscitation, and preventive health and safety practices. State law also requires EMSA to establish minimum standards for the review and approval of child care provider training programs. The training curricula are developed and submitted to EMSA by private industry health and safety trainers.

EMSA operates the Child Care Training Approval Program within the EMS Personnel Division, which reviews and approves the curricula for 52 first aid, cardiopulmonary resuscitation, and preventative health and safety training programs. Of these 52 training programs, 24 provide preventive health and safety practices training. These programs train approximately 80,000 child care providers annually.

The Child Care Training Approval Program is supported through fees charged on child care provider training programs that are deposited in the EMS Training Program Approval Fund. Training programs pay the EMS Authority a fee of $240 for the bi-annual review of their program curriculum and 40 course completion stickers that they affix to their students' course completion cards. Training programs may receive additional course completion stickers at a cost of $3 per sticker. The majority of EMS Training Program Approval Fund revenues are attributable to course completion sticker fees.

AB 2370 Addresses Potential Lead Contamination in Child Care Facilities. In response to concerns about potential lead exposure for young children, AB 2370 expanded lead testing in drinking water at child care facilities regulated by the Department of Social Services' Community Care Licensing Division. While California previously required school sites to be tested for lead, as of December 2017 only six states required licensed child care centers to test their drinking water for lead.

In addition to expanded lead testing for drinking water at child care centers, AB 2370 also requires instruction in the prevention of lead exposure to be included in training requirements for child care facility staff. This added instruction is required to be consistent with the most recent child care lead poisoning prevention training curriculum from the Department of Public Health (DPH) and will be required for child care facility licenses issued on or after July 1, 2020. According to EMSA, the DPH training curriculum can be completed within 30 minutes to one hour.

EMSA requests General Fund expenditure authority of $177,000 in 2019-20 to allow EMSA to add the topic of lead poisoning prevention to the preventive health practices course for child care providers. These resources will support the equivalent of two positions to update regulations, provide technical assistance to private industry training programs, provide technical assistance to covered child care providers, and review and recertify training programs with the new curriculum. EMSA staff will review the updated training curriculum to verify the existing required topics are covered adequately in addition to the new lead poisoning prevention curriculum within the eight hour training timeframe. According to EMSA, due to the timing of recertification of the existing 24 private industry training programs, 12 to 15 would need to be recertified early for all 24 to meet the deadline of July 1, 2020, imposed by AB 2370.

EMSA also reports it is requesting General Fund expenditure authority because the EMS Training Program Approval Fund cannot absorb the one-time costs. The fund has a structural imbalance, with annual revenues approximately $18,000 lower than expenditures in 2018-19, and projected to be $20,000 lower than expenditures in 2019-20.

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.

Issue 7: Individual Tax ID Number for EMT Certification (SB 695)

Budget Issue. EMSA requests General Fund expenditure authority of $100,000 in 2019-20. If approved, these resources would allow EMSA to conduct outreach and assistance to local EMS agencies to implement acceptance of Individual Taxpayer Identification Numbers and prohibit requiring disclosure of citizenship or immigration status for the purpose of EMT certification, pursuant to the requirements of SB 695 (Lara), Chapter 838, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$100,000	$-
Total Funding Request:	**$100,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. In California, all licensing entities established under the Business and Professions Code are required to accept either an individual taxpayer identification number (ITIN) or a Social Security Number (SSN) for purposes of complying with state and federal requirements. An ITIN is a tax processing identification number issued by the U.S. Internal Revenue Service (IRS) for taxpayers and their dependents that are not eligible to obtain a SSN. The IRS issues ITINs because all wage earners, regardless of their immigration status, are required to pay federal taxes. ITINs allow people who are ineligible for a SSN to comply with tax laws, and are issued regardless of immigration status.

SB 695 (Lara), Chapter 838, Statutes of 2018, expands the requirement to accept ITIN in addition to SSN for licensing or credentialing applications to professions governed by the Department of Public Health (e.g. certified hemodialysis technicians, certified nurse assistants, certified home health aides, and radiologic technicians), the Commission on Teacher Credentialing (e.g. teacher credentialing and renewals), and EMSA (e.g. EMT-Is, EMT-IIs, and paramedics). SB 695 also prohibits licensing entities from requiring disclosure of citizenship or immigration status, and prohibits denial of licensure to otherwise qualified and eligible individuals based solely on citizenship or immigration status.

EMSA requests one-time General Fund expenditure authority of $100,000 in 2019-20 to procure a consultant to conduct outreach and assistance to local EMS agencies to implement acceptance of ITINs and prohibit requiring disclosure of citizenship or immigration status for the purpose of EMT certification, pursuant to the requirements of SB 695. The consultant would evaluate the impact of accepting ITINs for certification, provide outreach to local certifying entities, collaborate with the Department of Justice on ITIN use on fingerprint forms, create training documents for local certifying entities, implement and facilitate statewide training for EMSA and local staff, and work with local certifying entities to include ITINs in local certification systems.

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.

Issue 8: Administrative Support Costs

Budget Issue. EMSA requests expenditure authority of $186,000 ($98,000 General Fund and $88,000 special funds) in 2019-20 and 2020-21, and $190,000 ($98,000 General Fund and $92,000 special funds) annually thereafter. If approved, these resources would allow EMSA to support increased costs associated with contracted fiscal and personnel services, facilities, and utilities.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$98,000	$98,000
0194 – EMS Training Program Approval Fund	$-	$-
0312 – EMS Personnel Fund	$57,000	$57,000
3137 – EMT Certification Fund	$31,000	$31,000
Total Funding Request:	**$186,000**	**$186,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional Resources in 2021-22: $4,000 EMS Training Program Approval Fund. Resources are ongoing after 2021-22.

Background. EMSA contracts with the Department of General Services (DGS) Contract Fiscal Services (CFS) for accounting and budgeting services and with the DGS Office of Human Resources (OHR) for personnel services. According to EMSA, because it is a relatively small state entity, it is more cost-effective to contract with DGS for these services to be provided on a contract basis than to hire staff within the authority to perform this workload. The costs for the contracts with CFS, which has increased from $113,000 to $278,000 between 2014-15 and 2017-18, and OHR, which has increased $166,000 to $236,000 during the same period, are allocated proportionally to all of the funding sources that support EMSA including the General Fund, the EMS Training Program Approval Fund, the EMS Personnel Fund, the EMT Certification Fund, federal funds, and reimbursements. In addition to increases in its DGS contract costs, EMSA also reports its facilities and utilities costs have increased from $830,000 in 2014-15 to $872,000 in 2017-18.

EMSA requests expenditure authority of $186,000 ($98,000 General Fund and $88,000 special funds) in 2019-20 and 2020-21, and $190,000 ($98,000 General Fund and $92,000 special funds) annually thereafter to allow EMSA to support the increased costs associated with the DGS contracted fiscal and personnel services, as well as increased costs of facilities and utilities. According to EMSA, these increased operating costs have been funded by salary savings from vacant positions in the EMT Registry Program, resulting in delays in issuance and renewal of EMT certifications, investigations of paramedic licensure violations, and technical assistance to local EMS agencies.

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

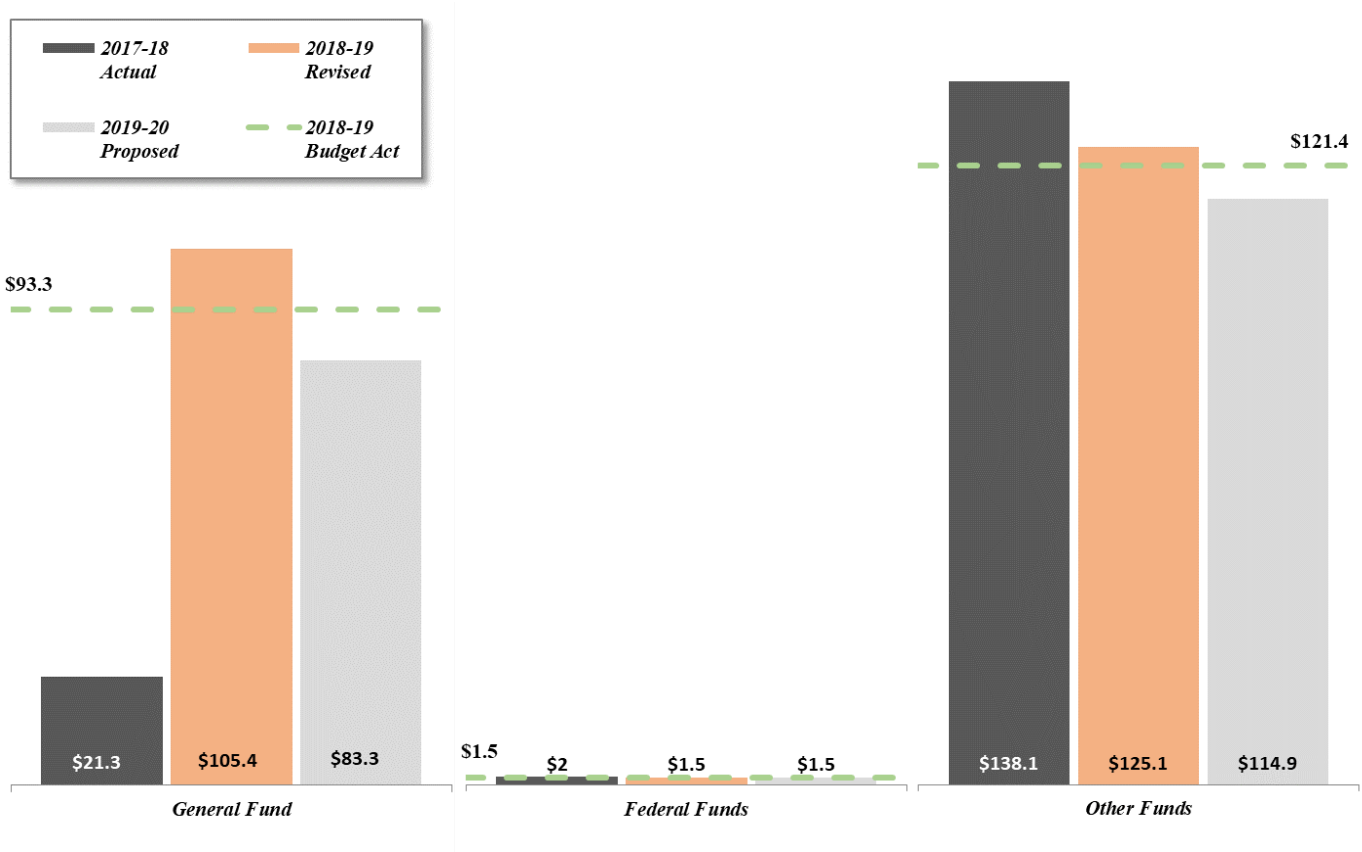
Questions. The subcommittee has requested EMSA to respond to the following:

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	***2018-19 Budget Act***	***2018-19 Revised***	***2019-20 Proposed***
General Fund (0001)	$93,333,000	$105,387,000	$83,333,000
Federal Funds (0890)	$1,464,000	$1,464,000	$1,463,000
Other Funds (*detail below*)	$121,404,000	$125,065,000	$114,918,000
Total Department Funding:	**$216,201,000**	**$231,916,000**	**$199,714,000**
Total Authorized Positions:	**430.5**	**430.5**	**434.5**
Other Funds Detail:			
Hospital Building Fund (0121)	*$63,521,000*	*$65,750,000*	*$65,762,000*
CA Health Data and Planning Fund (0143)	*$31,752,000*	*$32,670,000*	*$33,407,000*
Registered Nurse Education Fund (0181)	*$2,180,000*	*$2,192,000*	*$2,192,000*

Health Fac. Const. Loan Ins. Fund (0518)	*$4,943,000*	*$5,078,000*	*$5,079,000*
Health Professions Education Fund (0829)	*$1,099,000*	*$1,111,000*	*$1,111,000*
Medically Underserved Account/Phys (8034)	*$2,399,000*	*$2,724,000*	*$2,402,000*
Reimbursements (0995)	*$868,000*	*$868,000*	*$868,000*
Mental Health Practitioner Ed. Fund (3064)	*$395,000*	*$396,000*	*$821,000*
Vocational Nurse Education Fund (3068)	*$224,000*	*$225,000*	*$225,000*
Mental Health Services Fund (3085)	*$14,023,000*	*$14,051,000*	*$3,051,000*

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, as well as 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 assistant training.

The 2017 Budget Act authorized $100 million over three years for augmentation of health care workforce initiatives at OSHPD. The $33.3 million annual allocation provides up to $18.7 million for existing primary care residency slots, up to $3.3 million for new primary care residency slots at existing residency programs, up to $5.7 million for primary care residency slots at teaching health centers, up to $3.3 million for newly accredited primary care residency programs, up to $333,000 for the State Loan Repayment Program, and up to $2 million for OSHPD state operations costs. Unspent funds in each of these categories from prior years are available for expenditure for the subsequent five fiscal years. For example unspent funds from 2017-18 are available until June 30, 2023, and unspent funds from 2018-19 are available until June 30, 2024. According to OSHPD, the Song-Brown program awarded the following in 2018-19:

1) *Existing Primary Care Residency Slots* – $20.6 million to support over 160 existing residency slots at 62 existing programs
2) *Newly Accredited Primary Care Residency Programs* - $5.6 million ($3.3 million General Fund, $3.1 million Data Fund, and $273,000 California Endowment Funds) to support seven new programs.
3) *Teaching Health Centers (THC)* - $5.1 million to support residency slots at six existing THCs
4) *New Primary Care Residency Slots at Existing Programs* - $2.1 million to support three new residency slots in existing programs

Song-Brown: Existing Primary Care Residency Slots Awards – August 2018

Residency Program Name	Award	Residency Program Name	Award
Adventist Health Glendale	$625,000	San Joaquin General Hospital (FM)	$500,000
Alameda Health System - Highland Hospital	$185,000	Santa Rosa	$185,000
Charles R. Drew University	$185,000	Scripps Memorial, Chula Vista	$625,000
Citrus Valley Health Partners	$500,000	Shasta Community Health Center	$310,000
Contra Costa FM Residency Program	$625,000	St. Joseph Medical Center - Stockton	$310,000
Dignity Health California Hospital Medical Center	$625,000	Stanford Health Care - O'Connor Hospital	$310,000
Family Health Centers of San Diego	$500,000	UCSD Combined FM and Psychiatry Residency	$125,000
Harbor-UCLA (Pediatrics)	$125,000	UCSF Benioff Children's Hospital Oakland	$310,000
Harbor-UCLA (OB/GYN)	$125,000	UCSF Fresno (FM)	$625,000
Harbor-UCLA (FM)	$625,000	UCSF Fresno (Pediatrics)	$185,000
John Muir	$125,000	UCSF Fresno (IM)	$310,000
Kaiser Permanente Fontana	$185,000	UCSF Fresno (OB/GYN)	$125,000
Kaiser Permanente Los Angeles (Pediatrics)	$125,000	UCSF-SFGH Family and Community Medicine	$625,000
Kaiser Permanente Los Angeles (FM)	$250,000	University of California, Davis (IM)	$185,000
Kaiser Permanente Orange County	$310,000	University of California, Davis (FM)	$125,000
Kaiser Permanente San Diego	$500,000	University of California, Irvine	$500,000
Kaiser Permanente Santa Rosa	$125,000	University of California, Los Angeles (FM)	$625,000

Kaiser Permanente Woodland Hills	$185,000	University of California, Los Angeles (Pediatrics)	$185,000
Loma Linda-Inland Empire Consortium	$125,000	University of California, Riverside (IM)	$500,000
Loma Linda University - Primary Care Track	$185,000	University of California, Riverside (OB/GYN)	$310,000
Long Beach Memorial	$250,000	University of California, Riverside (FM)	$500,000
Marian Regional Medical Center (FM)	$125,000	University of California, San Francisco (IM)	$310,000
Marian Regional Medical Center (OB/GYN)	$185,000	University of California, San Francisco (OB/GYN)	$310,000
Mercy Medical Center Merced	$500,000	Valley Children's Hospital Madera	$125,000
Mercy Medical Redding	$125,000	Valley FM Residency of Modesto	$185,000
Natividad Medical Center	$310,000	Valley Health Team	$500,000
Pomona Valley Hospital	$500,000	Ventura County Medical Center	$310,000
Rio Bravo	$625,000	White Memorial Medical Center (FM)	$625,000
Riverside Community Hospital/UCR (FM)	$500,000	White Memorial Medical Center (OB/GYN)	$125,000
Riverside Community Hospital/UCR (IM)	$185,000	White Memorial Medical Center (IM)	$310,000
Riverside University Health System/UCR	$625,000	**TOTAL - $20,565,000**	
San Joaquin General Hospital (IM)	$125,000		

* FM = Family Medicine, IM = Internal Medicine, OB/GYN = Obstetrics/Gynecology

Song-Brown: New Primary Care Residency Slots Awards – August 2018

Residency Program Name	Award	Residency Program Name	Award
Adventist Health Ukiah Valley	$800,000	North East Medical Services	$800,000
Borrego Community Health	$800,000	St Joseph Med Center-Stockton (IM)	$800,000
Centro de Salud de la Comunidad de San Ysidro	$800,000	St Joseph Med Center-Stockton (OB/GYN)	$800,000
Lifelong Medical Care	$800,000	**TOTAL - $5,600,000**	

* FM = Family Medicine, IM = Internal Medicine, OB/GYN = Obstetrics/Gynecology

Song-Brown: Teaching Health Center Awards – August 2018

Residency Program Name	Award	Residency Program Name	Award
Clinica Sierra Vista – Rio Bravo	$1,020,000	Valley Family Medicine Residency-Modesto	$1,190,000
Family Health Centers of San Diego	$1,020,000	Valley Health Team	$680,000
Loma Linda-Inland Empire Consortium	$680,000	**TOTAL - $5,100,000**	
Shasta Community Health Center	$510,000		

Song-Brown: Primary Care Residency Expansion Awards – August 2018

Residency Program Name	Award	Residency Program Name	Award
Loma Linda-Inland Empire Consortium	$300,000	UCSF-Fresno (IM)	$900,000
UCSF Fresno (FM)	$900,000	**TOTAL - $2,100,000**	

* FM = Family Medicine, IM = Internal Medicine, OB/GYN = Obstetrics/Gynecology

Budget Proposes Ongoing Extension of Song-Brown Funding. The Governor's January budget summary proposes to permanently extend the $33.3 million annual General Fund expenditure authority for the Song-Brown program. The 2019-20 fiscal year will be the final year of the three-year, $100 million General Fund allocation for the program approved in the 2017 Budget Act. The Governor's proposed extension would allocate ongoing funding beginning in 2020-21 and annually thereafter. According to OSHPD, the extended funding would continue to adhere to the current allocations for existing primary care residency slots ($18.7 million), new primary care residency slots at existing programs ($3.3 million), primary care residency slots at teaching health centers ($5.7 million), newly accredited primary care residency programs ($3.3 million), the State Loan Repayment Program ($333,000), and state operations costs ($2 million).

Stakeholder Proposal to Expand Song-Brown Funding for Pediatrics. The California Children's Hospital Association (CCHA) requests an additional $2 million General Fund allocation to the Song-Brown program for pediatric residency programs. According to CCHA, Song-Brown currently allocates between $1 million and $1.3 million for pediatric residencies. This request would augment OSHPD's General Fund expenditure authority by an additional $2 million and designate a total of $3 million of Song-Brown funding for pediatric residency programs.

Stakeholder Proposal to Expand Primary Care and Behavioral Health Workforce Development. California Health+ Advocates requests General Fund expenditure authority of $50 million for grants to eligible safety net organizations, including primary care clinics and public hospitals, to help close existing primary care and behavioral health vacancy gaps by resourcing recruitment strategies. This proposal would allocate $49.5 million to these strategies, including: 1) recruitment/signing incentives, 2) salary/benefit subsidies, or 3) housing or relocation grants. Included in the request would be $300,000 for OSHPD grant administration and technical assistance, and $200,000 for program monitoring and evaluation. According to California Health+ Advocates, without additional tools to recruit this critical healthcare workforce, safety net health care organizations, including community health centers, will be unable to provide high-quality care for the nearly 6.9 million low-income, uninsured and underserved Californians who depend on community health centers each year for their care.

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 directs the majority of revenues to county mental health programs for community services and supports, prevention and early intervention, innovative programs, 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.

WET Program Five-Year Plan 2020-2025. In February 2019, OSHPD released the third five year WET plan covering the period from 2020-2025. After engaging with stakeholders, the report is meant to

guide efforts to improve and expand the public mental health system (PMHS) workforce throughout California. Unlike the previous two plans, there is no funding associated with this plan, which OSHPD designed to be programmatically flexible based on the level of funding provided. The plan sets out the following goals and objectives:

Goals

1. Increase the number of diverse, competent licensed and non-licensed professionals in the PMHS to address the needs of persons with serious mental illness.
2. Expand the capacity of California's current public mental health workforce to meet California's diverse and dynamic needs.
3. Facilitate a robust statewide, regional, and local infrastructure to develop the public mental health workforce.
4. Offer greater access to care at a lower level of intensity that enables consumers to maintain and maximize their overall well-being.
5. Support delivery of PMHS services for consumers within an integrated health system that encompasses physical health and substance use services.

Objectives

1. Expand awareness and outreach efforts to effectively recruit racially, ethnically, and culturally diverse individuals into the PMHS workforce.
2. Identify and enhance curricula to train students at all levels in competencies that align with the full spectrum of California's diverse and dynamic PMHS needs.
3. Develop career pathways for individuals entering and advancing across new and existing PMHS professions.
4. Expand the capacity of postsecondary education to meet the identified PMHS workforce needs.
5. Expand financial incentive programs for the PMHS workforce to equitably meet identified PMHS needs in underrepresented, underserved, unserved, and inappropriately served communities.
6. Expand education and training programs for the current PMHS workforce in competencies that align with the full spectrum of PMHS needs.
7. Increase the retention of PMHS workforce identified as high priority.
8. Evaluate methods to expand and enhance the quality of existing PMHS delivery systems to meet California's PMHS needs.
9. Develop and sustain new and existing collaborations and partnerships to strengthen recruitment, training, education, and retention of the PMHS workforce.
10. Explore stakeholder-identified policies that aim to further California's efforts to meet its PMHS needs.
11. Provide flexibility to allow local jurisdictions to meet their unique needs.
12. Standardize PMHS workforce education and training programs across the state.
13. Promote care that reduces demand for high-intensity PMHS services and workforce.

Stakeholder Proposal to Establish WET Trust Fund to Finance Five-Year Plan. The California Council of Community Behavioral Health Agencies (CBHA) requests General Fund expenditure authority of $70 million over two years for the WET Trust Fund to be administered by OSHPD. The fund would support the workforce efforts outlined in the recently released WET Five-Year Plan 2020-2025. These efforts would include funding for loan repayment programs and stipends for behavioral health clinicians, increasing capacity at universities to train and supervise behavioral health professionals, and regional partnerships where counties can pursue specific strategies to address their communities' needs. CHBA estimates each year of the Five-Year Plan would cost $35 million and this request would fund the first two years of the 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 98 awards totaling $1.3 million in 2018-19.

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 2017-18, the HPEF awarded 1,664 scholarships and loan repayments in its 13 programs for a total award amount of $17.1 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 Program, 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. According to OSHPD, SB 1953 covers 1,162 skilled nursing facilities with 1,200 buildings and 114,333 licensed beds. 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, 2018, Cal-Mortgage insures 82 loans with a total value of approximately $1.7 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 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 OSHPD's mission and programs.

Issue 2: Increased Expenditure Authority for Mental Health Practitioner Education Fund

Budget Issue. OSHPD requests additional expenditure authority from the Mental Health Practitioner Education Fund of $425,000. If approved, these resources would allow OSHPD to increase the grant awards provided through the Licensed Mental Health Service Provider Education Program. These resources would be funded from increased licensure fee revenue approved pursuant to AB 1188 (Nazarian), Chapter 557, Statutes of 2017.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3064 – Mental Health Practitioner Education Fund	$425,000	$425,000
Total Funding Request:	**$425,000**	**$425,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2020-21.

Background. AB 1188 increased the biennial license renewal fee for certain licensed mental health providers from $10 to $20, effective July 1, 2018. These fees are collected by the Board of Psychology and the Board of Behavioral Sciences and are deposited in the Mental Health Practitioner Education Fund, which supports the Licensed Mental Health Service Provider Education Program administered by OSHPD's Health Professions Education Foundation. The Licensed Mental Health Provider Education Program is a loan repayment program that reimburses eligible mental health providers for their education loans, up to $15,000, in exchange for a required service obligation in a mental health shortage area or in a publicly funded mental health facility. The program is intended to increase access to mental health services throughout the state.

The additional revenue collected in 2018-19 from the fee increase is estimated to be $425,000 and will be awarded through the program in 2019-20. The current revenue and expenditure authority for the Mental Health Practitioner Education Fund is $395,000. OSHPD requests additional expenditure authority from the fund of $425,000 for a total of $820,000 to reflect the expected increased revenue and expenditures for the program in 2019-20.

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.

Issue 3: SNFs: Disclosure of Interest in Businesses Providing Services (AB 1953)

Budget Issue. OSHPD requests one position and expenditure authority from the California Health Data and Planning Fund of $369,000 in 2019-20 and $119,000 annually thereafter. If approved, these positions and resources would allow OSHPD to collect data and report on disclosures by skilled nursing facilities regarding ownership interests in related parties that provide services to the facility, pursuant to the requirements of AB 1953 (Wood), Chapter 383, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0143 – CA Health Data and Planning Fund	$369,000	$119,000
Total Funding Request:	**$369,000**	**$119,000**
Total Requested Positions:	**1.0**	**1.0**

* Positions and Resources ongoing after 2020-21.

Background. In May 2018, the California State Auditor released an audit of skilled nursing facilities titled "Absent Effective State Oversight, Substandard Quality of Care Has Continued". The audit reviewed three large private operators of skilled nursing facilities in California finding that, while revenues for the industry as a whole declined, these three operators increased their net income by tens of millions of dollars. The audit found these gains were made, in part, by the ability of these operators to receive revenue from the sale of goods or services provided to their facilities by entities owned or controlled by themselves or family members. These related party transactions are legal, though federal programs like Medicare and Medicaid attempt to limit the possibility these programs are paying for profits from these transactions. The Auditor recommended that OSHPD consolidate facility related party transactions, currently reported in two different areas of facility cost reporting, and expand the detail of the transactions.

In response to these concerns, AB 1953 requires each organization that operates, conducts, owns, or maintains a skilled nursing facility to file with OSHPD whether the management of the facility has an ownership or control interest greater than five percent in a related party that provides services to the facility. The disclosure must include all services provided to the facility, the number of individuals who provide that service at the facility, and any other information requested by the office. AB 1953 also requires the disclosure to include the related party's profit and loss statement and the facility's payroll-based journal, if goods and services were worth more than $10,000.

OSHPD requests one position and expenditure authority from the California Health Data and Planning Fund of $369,000 in 2019-20 and $119,000 annually thereafter. These resources would allow OSHPD to procure contract services for $250,000 to update its data collection forms, accounting systems, and program regulations. Included in the contract request is $75,000 for project management and business analysis and $175,000 for system software development and engineering. These activities would include conducting business analysis, developing system requirements, and designing changes to collect the new data elements, all of which would be subject to the Project Approval Lifecycle at the California Department of Technology.

OSHPD also requests **one Health Program Auditor II** to assist in the development of regulations and accounting system changes, and review submitted data to ensure consistency with OSHPD's accounting and reporting system standards.

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.

Issue 4: Mental Health Workforce Development

Budget Issue. OSHPD requests General Fund expenditure authority of $50 million, available for expenditure until June 30, 2025. If approved, these resources would allow OSHPD to support mental health workforce development through existing loan repayment and scholarship programs that support mental health professions.

Program Funding Request Summary		
Fund Source	**2019-20***	**2020-21**
0001 – General Fund	$50,000,000	$-
Total Funding Request:	**$50,000,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

* One-time funding available for expenditure until June 30, 2025.

Background. According to OSHPD, a 2018 study by the Healthforce Center at the University of California San Francisco for the California Health Care Foundation showed that the projected demand for behavioral health services outpaces projected supply. If current trends continue, between 2016 and 2028, the supply of behavioral health professionals will not be sufficient to meet demand. In addition, the mental health workforce is maldistributed across the state and does not adequately represent the diversity of California's population.

OSHPD requests General Fund expenditure authority of $50 million, available for expenditure until June 30, 2025, to allow OSHPD to support mental health workforce development through existing loan repayment and scholarship programs that support mental health professions. OSHPD's scholarship and loan forgiveness mental health programs serve to increase access to and the retention of providers in mental health professions, especially in underserved areas. According to OSHPD, the funding requested in this proposal would allow for additional loan repayment and scholarship awards for eligible practitioners to increase the number of mental health providers throughout the state. For each of the five years, OSHPD expects 4,212 loan repayment applications with 880 loan repayments awarded, as well as 130 scholarship applications with 50 scholarships awarded.

According to OSHPD, the existing programs funded by the $50 million request, allocated dependent on the number of eligible applications received, are as follows:

Loan Repayment Scholarship Programs	Mental Health Professions	Application Opens	Awards Made	Max Award Amount	Service Obligation Period
Allied Healthcare Loan Repayment Program	Community Health Worker/Promotores Medical Assistant Social Worker	August 2019	May 2020	$8,000	One Year
Licensed Mental Health Services Provider Education Program	Licensed Clinical Social Worker Licensed Marriage and Family Therapist Licensed Professional Counselor Licensed Psychologist Postdoctoral Psychological Assistant Postdoctoral Psychological Trainee	August 2019	May 2020	$15,000	Two Years
Advanced Practice Healthcare Loan Repayment Program	Clinical Nurse Specialist Nurse Practitioner Physician Assistant	August 2019	May 2020	$25,000	Two Years
State Loan Repayment Program	Health Service Psychologist Licensed Clinical Social Worker Licensed Professional Counselor Licensed Marriage and Family Therapist Psychiatric Mental Health Nurse Practitioner Psychiatric Nurse Specialist Psychiatrist	August 2019	December 2019	$50,000	Two Years
Steven M. Thompson Physician Corps Loan Repayment Program	Psychiatrist	December 2019	June 2020	$105,000	Three Years
Allied Healthcare Scholarship Program	Community Health Worker/Promotoras Medical Assistant Social Worker	January 2020	June 2020	$8,000	One Year

Advanced Practice Healthcare Scholarship Program	Clinical Nurse Specialist Nurse Practitioner Physician Assistant	January 2020	June 2020	$25,000	One Year
Mental Health Loan Assumption Program	Consumer or Peer Counselor Licensed Marriage and Family Therapist Licensed Clinical Social Worker Licensed Professional Counselor Licensed Psychologist Mental Health Admin or Support Staff Psychiatric Mental Health Nurse Practitioner Psychiatrist Rehabilitation Counselor	January 2020	June 2020	$10,000	One Year

Stakeholder Proposal to Fund Loan Repayments for Former Foster Youth. Journey House requests an allocation of $750,000 General Fund to the Mental Health Practitioner Education Fund for loan repayment grants for mental health providers who were formerly in the California child welfare system. AB 2608 (Stone), Chapter 585, Statutes of 2018, established an account within the Mental Health Practitioner Education Fund that was earmarked for mental health workforce development for former foster youth. However, no funding was provided for the account. According to the proponents, these grants would target former foster youth who are now mental health providers in public facilities or provider shortage areas to repay educational loans. Outreach to ensure that former foster youth are aware of the availability of loan repayment grants would be performed along with existing outreach efforts for the Licensed Mental Health Service Provider Education Program. This investment would fund loan repayment grants for at least 50 former foster youth, incentivizing former foster youth on their path to a master's degree and expanding the ability of the California child welfare system to recruit dedicated, qualified, and culturally competent service providers. This proposal is consistent with the Governor's proposed allocation of $50 million for mental health workforce development, as a portion of the loan repayment funding could be designated through the administration of current mental health workforce programs for professionals who are former foster youth.

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

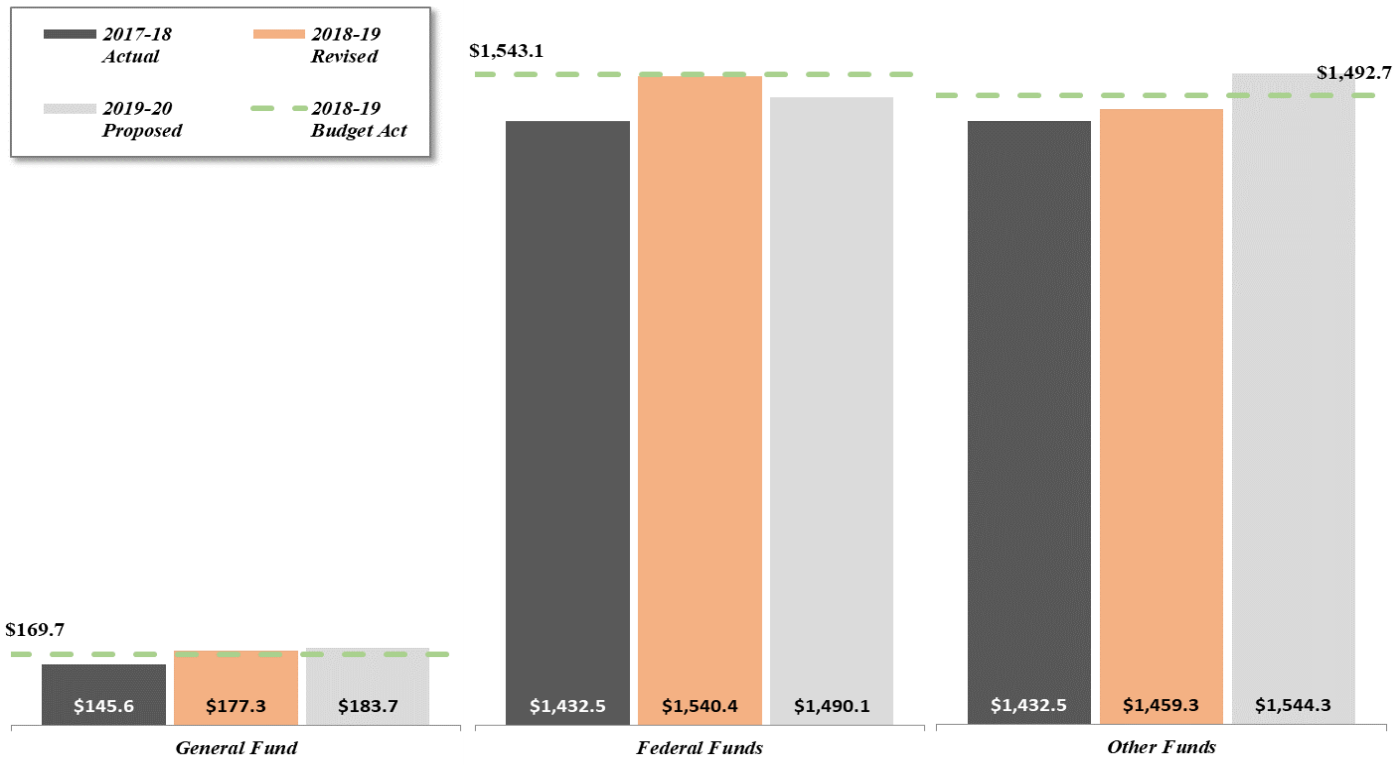
Questions. The subcommittee has requested OSHPD to respond to the following:

1. Please provide a brief overview of this proposal.

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	***2018-19 Budget Act***	***2018-19 Revised***	***2019-20 Proposed***
General Fund	$169,723,000	$177,280,000	$183,686,000
Federal Funds	$1,543,068,000	$1,540,352,000	$1,490,075,000
Other Funds (*detail below)*	$1,492,661,000	$1,459,329,000	$1,544,261,000
Total Department Funding:	**$3,205,452,000**	**$3,176,961,000**	**$3,218,022,000**
Total Authorized Positions:	**3658.7**	**3660.7**	**3773.0**
Other Funds Detail:			
Breast Cancer Research Account (0007)	*$2,104,000*	*$2,104,000*	*$1,179,000*
Nuclear Planning Assessment Acct (0029)	*$984,000*	*$984,000*	*$984,000*
Motor Vehicle Acct, Trans. Fund (0044)	*$1,493,000*	*$1,552,000*	*$1,550,000*
Sale of Tobacco to Minors Ctrl Acct (0066)	*$1,104,000*	*$544,000*	*$1,098,000*

Other Funds Detail (continued):			
Occup. Lead Poisoning Prev Acct (0070)	*$3,653,000*	*$3,755,000*	*$3,585,000*
Medical Waste Management Fund (0074)	*$2,767,000*	*$2,903,000*	*$2,786,000*
Radiation Control Fund (0075)	*$25,704,000*	*$26,923,000*	*$27,319,000*
Tissue Bank License Fund (0076)	*$630,000*	*$659,000*	*$638,000*
Childhood Lead Poisoning Prev Fund (0080)	*$31,588,000*	*$31,992,000*	*$41,402,000*
Export Document Program Fund (0082)	*$758,000*	*$804,000*	*$801,000*
Clinical Lab. Improvement Fund (0098)	*$12,096,000*	*$12,532,000*	*$12,818,000*
Health Statistics Special Fund (0099)	*$27,380,000*	*$28,165,000*	*$29,115,000*
Dept. of Pesticide Regulation Fund (0106)	*$321,000*	*$328,000*	*$328,000*
Air Pollution Control Fund	*$297,000*	*$303,000*	*$303,000*
CA Health Data and Planning Fund (0143)	*$240,000*	*$240,000*	*$240,000*
Food Safety Fund (0177)	*$10,777,000*	*$10,967,000*	*$11,371,000*
Genetic Disease Testing Fund (0203)	*$132,952,000*	*$134,094,000*	*$141,176,000*
Health Education Account, Prop 99 (0231)	*$37,673,000*	*$37,828,000*	*$51,060,000*
Research Account, Prop 99 (0234)	*$5,813,000*	*$5,824,000*	*$6,938,000*
Unallocated Account, Prop 99 (0236)	*$3,311,000*	*$3,337,000*	*$4,415,000*
Infant Botulism Treatment/Prev Fund (0272)	*$6,302,000*	*$10,806,000*	*$14,202,000*
Child Health and Safety Fund (0279)	*$551,000*	*$551,000*	*$551,000*
Registered Enviro. Health Spec Fund (0335)	*$427,000*	*$446,000*	*$446,000*
Indian Gaming Spec Dist Fund (0367)	*$8,238,000*	*$8,270,000*	*$8,270,000*
Vectorborne Disease Account (0478)	*$194,000*	*$204,000*	*$204,000*
Toxic Substances Control Acct (0557)	*$439,000*	*$470,000*	*$468,000*
Domestic Violence Training/Ed Fund (0642)	*$605,000*	*$611,000*	*$617,000*
CA Alzheimers Research Fund (0823)	*$871,000*	*$871,000*	*$657,000*
Special Deposit Fund (0942)	*$5,717,000*	*$6,910,000*	*$6,945,000*
Reimbursements (0995)	*$208,824,000*	*$211,611,000*	*$205,812,000*
Drug and Device Safety Fund (3018)	*$7,135,000*	*$7,322,000*	*$7,212,000*
Tobacco Settlement Fund (3020)	*$0*	*$0*	*$0*
WIC Manufacturer Rebate Fund (3023)	*$229,772,000*	*$229,080,000*	*$214,929,000*
Medical Marijuana Program Fund (3074)	*$191,000*	*$51,000*	*$174,000*
AIDS Drug Assistance Program Fund (3080)	*$311,688,000*	*$288,936,000*	*$323,747,000*
Cannery Inspection Fund (3081)	*$2,748,000*	*$2,889,000*	*$2,931,000*
Mental Health Services Fund (3085)	*$52,384,000*	*$23,845,000*	*$33,307,000*
Licensing and Certification Fund (3098)	*$159,226,000*	*$163,942,000*	*$189,248,000*
Gambling Addiction Program Fund (3110)	*$150,000*	*$150,000*	*$150,000*
Birth Defects Monitoring Prog Fund (3114)	*$2,408,000*	*$2,408,000*	*$2,353,000*
Lead-Related Construction Fund (3155)	*$734,000*	*$758,000*	*$775,000*

Other Funds Detail (continued):			
Cost/Impl Acct, Air Poll. Ctrl Fund (3237)	*$358,000*	*$358,000*	*$358,000*
Cannabis Control Fund (3288)	*$26,590,000*	*$27,304,000*	*$29,011,000*
State Dental Program Acct., Prop 56 (3307)	*$30,000,000*	*$30,048,000*	*$27,523,000*
Tobacco Law Enforc Acct., Prop 56 (3308)	*$0*	*$0*	*$0*
Tobacco Prev/Control Acct., Prop 56 (3309)	*$0*	*$0*	*$0*
DPH Tobacco Law Enforc, Prop 56 (3318)	*$6,000,000*	*$6,000,000*	*$5,237,000*
DPH, Tobacco Prev/Ctrl, Prop 56 (3322)	*$129,464,000*	*$129,650,000*	*$130,028,000*

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 Healthy Communities – 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.

Supplemental Reporting Language – State of the State's Public Health. The 2018 Budget Act included the following supplemental reporting language requiring DPH to provide information on the State of the State's Public Health.

Item 4265-001-0001—Department of Public Health

1. ***State of the State's Public Health***. At its first budget subcommittee hearings of the 2019-20 budget process, the Department of Public Health shall report to the health and human services budget subcommittees of both houses of the Legislature a summary of key public health statistics in California. The briefing and related handout shall include excerpted information from the County Health Status Profiles report on key public health indicators, including available information about these indicators' trends, for issues that the department considers major existing or emerging public health issues. The briefing and related handout may, for example, provide statistics on issues such as opioid overdoses and naloxone treatments, the number of people infected with sexually transmitted diseases (STDs) and the geographic regions in which STD transmissions are highest, rates of diabetes and/or other chronic diseases among various subpopulations, or recent public health outbreaks.

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.

2. Please present the State of the State's Public Health report, pursuant to the supplemental reporting language included in the 2018 Budget Act.

Issue 2: Improving Vital Records Interoperability and Data Quality

Budget Issue. DPH requests three positions and expenditure authority from the Health Statistics Special Fund of $1.2 million in 2019-20 and 2020-21, $1.3 million in 2021-22 and 2022-23, $1.4 million in 2023-24, and $21,000 annually thereafter. If approved, these resources would allow DPH to renew and modify an agreement with the University of California, Davis for vital records system enhancements and operations, and to shift activities performed by the University of California, Santa Barbara to department staff.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0099 – Health Statistics Special Fund	$1,223,000	$1,161,000
Total Funding Request:	**$1,223,000**	**$1,161,000**
Total Requested Positions:	**3.0**	**3.0**

* Additional fiscal year resources requested: 2021-22: $1,327,000; 2022-23: $1,308,000; 2023-24: $1,415,000; 2024-25 and ongoing: $21,000.

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

According to DPH, registration of births, deaths, and fetal deaths are done through electronic web-based registration systems where data necessary for the legal registration of births, deaths, and fetal deaths are entered by hospitals, funeral homes, attending physicians, and medical-examiner/coroners. Demographic and medical information captured during the registration process provide the foundational health data used for measurement of population health, identification of disparities, and assessment of program effectiveness. These vital records registration and reporting systems are housed and managed through two Interagency Agreements, one with the University of California (UC) Davis, which expires December 31, 2019, and the other with UC Santa Barbara, which expires June 30, 2019.

UC Davis maintains the California Integrated Vital Records System (Cal-IVRS) platform, comprised of applications developed for use over the secure internet by funeral directors, coroners, medical examiners, local registration districts, hospitals, physicians, counties and DPH to facilitate the registration and reporting of vital events in California. Cal-IVRS includes the following systems, bringing birth, death, and fetal death registration systems together onto a single platform:

- The California Electronic Birth Registration System (EBRS)
- The California Electronic Death Registration System (EDRS)
- The California Fetal Death Registration System (FDRS)

- The Vital Records Business Intelligence System (VRBIS)

In the 1980s, UC Santa Barbara developed the Automated Vital Statistics System (AVSS), the department's legacy birth registration system, which is set to retire upon completion of the UC Santa Barbara agreement on June 30, 2019. AVSS only supports the birth registration process and produces a paper certificate for signature that must be routed first to the local registration district and then to the state. The paper certificates are scanned and imaged by DPH for issuance.

DPH requests three positions and expenditure authority from the Health Statistics Special Fund of $1.2 million in 2019-20 and 2020-21, $1.3 million in 2021-22 and 2022-23, $1.4 million in 2023-24, and $21,000 annually thereafter. The resources requested reflect a renewed and modified five-year agreement with UC Davis ($3.9 million in 2019-20 and 2020-21, $4 million in 2021-22 and 2022-23, and $4.1 million in 2023-24 from the Health Statistics Special Fund) offset by base funding for the existing agreement with UC Davis ($2.7 million Health Statistics Special Fund) set to expire December 31, 2019. The total requested funding to support the agreement with UC Davis is $1.2 million in 2019-20, $1.1 million in 2020-21, $1.3 million in 2021-22 and 2022-23, and $1.4 million in 2023-24.

The current five-year agreement with UC Davis is estimated to cost $11.9 million Health Statistics Special Fund, while the proposed renewed five-year agreement is estimated to cost $20 million Health Statistics Special Fund. According to DPH, the increased costs reflect the hiring of four new UC Davis positions to oversee vital records system modifications, and adjustments for higher salary and benefits rates, data storage, equipment, and facility costs. These resources would continue development of vital records operating systems to implement interoperability solutions to make data capture more efficient, continuing California's capability for electronic vital records registration and data reporting to federal, state, county partners and researchers, contractors and stakeholders. These partners include the Centers for Disease Control and Prevention, the Social Security Administration, the Department of Health Care Services, the California Secretary of State, the Department of Motor Vehicles, the Department of Social Services, the Department of Child Support Services, the Department of Finance, the California Highway Patrol, the Medical Board of California, the Department of Consumer Affairs, the Department of Industrial Relations, OSHPD, the Department of Developmental Services, the Department of Justice, local health departments, some school districts, and county clerk recorders.

The request also includes three positions and $427,000 annually for DPH to transition workload currently performed by UC Santa Barbara, including data file creation, vital record file distribution, and analyses of data quality issues, to department staff. This workload would be managed by **one Staff Services Manager I and two Research Data Specialist I** positions. The requested amount is offset by existing base funding for the agreement with UC Santa Barbara ($406,000 Health Statistics Special Fund ongoing), as the UC Santa Barbara agreement is set to expire June 30, 2019. The net requested funding to shift these activities is $21,000 Health Statistics Special Fund 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 this proposal.

Issue 3: Gambling Disorder Training and Education Services

Budget Issue. DPH requests establishment of three positions funded by redirection of resources from the Indian Gaming Special Distribution Fund (IGSD) due to an expiring contract. If approved, these positions would allow DPH to conduct public outreach for gambling disorder prevention.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0367 – Indian Gaming Special Distribution Fund	[$451,000]	[$451,000]
Total Funding Request:	**[$451,000]**	**[$451,000]**
Total Requested Positions:	**3.0**	**3.0**

* Positions and Resources ongoing after 2020-21. (Note: funding is non-add and represents savings from expiring contract)

Background. The Office of Problem Gambling (OPG) is responsible for developing a statewide gambling disorder prevention program, which includes training of health care professionals, educators, and nonprofit organizations in the identification of problem gambling behavior and the knowledge of referral services for gambling disorder treatment programs. OPG is funded by an annual allocation of gaming revenue deposited in the Indian Gaming Special Distribution Fund. According to DPH, since 2003, OPG executed a training and technical assistance contract to fulfill its mandated responsibilities. The existing contract for 2014-15 through 2018-19 has an annual cost of $500,000 from the Indian Gaming Special Distribution Fund and expires June 30, 2019.

DPH requests establishment of three positions to conduct public outreach for gambling disorder prevention, funded by redirecting Indian Gaming Special Distribution Fund resources from the expiring training and technical assistance contract. **One Health Program Specialist II**, **one Health Program Specialist I**, and **one Associate Governmental Program Analyst** would be responsible for training and outreach to health care professionals, non-profit organizations, educators, and local health departments throughout the state. These positions would also provide onsite training and outreach within community agencies and at community events, and develop resources such as workbooks, videos, and online training opportunities to make training available to more individuals. The cost of these positions would be $451,000. According to DPH, the remaining $49,000 of savings from the expiring contract would be redirected to OPG's prevention efforts.

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: Oral Health Program Update and Additional Positions Request

Budget Issue. DPH requests establishment of seven positions funded by Proposition 56 tobacco tax revenue allocated to the Oral Health Program. If approve, these positions would allow DPH to continue implementation of the California Oral Health Plan.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3307 – Proposition 56 – State Dental Program Account	$-	$-
Total Funding Request:	**$-**	**$-**
Total Requested Positions:	**7.0**	**7.0**

* Positions ongoing after 2020-21.

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 five million children receiving dental services through Medi-Cal, only 44 percent of beneficiaries enrolled for at least 90 continuous days received at 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. 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 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.

Request for Additional Positions for Implementation of the Oral Health Plan. DPH requests seven positions to continue implementation of the state Oral Health Plan, including development of community water fluoridation, school-based and demonstration programs. The positions are as follows:

- **One Associate Health Program Adviser, two Associate Governmental Program Analysts, one Health Program Specialist I, and one Health Program Specialist I -** These positions would work with local health jurisdictions and contractors to evaluate applications, develop work plans, and negotiate, award, and monitor contracts. In addition, these positions would provide

guidance to local health jurisdictions as they assess their needs, conduct evaluation activities, and perform personnel liaison activities.

- **One Research Scientist Supervisor I (Epi/Bio) –** This position would provide leadership to the Surveillance and Evaluation Section, advise the State Dental Director regarding Oral Health Program activities, procure five demonstration projects, and help implement surveillance and evaluation activities.
- **One Health Education Consultant II** – This position would create a clearinghouse for education materials and develop trainings, work with national and statewide organizations, and identify age-appropriate materials for local jurisdictions, First 5 programs, and dental providers.

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.

Budget Reduces Funding for Oral Health Program Due to Declining Proposition 56 Revenue. According to the text of Proposition 56, if the Franchise Tax Board determines there has been a reduction in revenues resulting from a reduction in the consumption of cigarettes and tobacco products due to the imposition of the additional taxes under the proposition, the amount of funds allocated to the University of California for graduate medical education ($40 million), DPH for the oral health program ($30 million), and DPH for tobacco enforcement ($48 million) shall be reduced proportionately. For the Oral Health Program, the budget includes a reduction of Proposition 56 authority to $28.8 million due to a finding of declining revenue. According to DPH, the Oral Health Program intends to fulfill its commitment to provide local health jurisdictions with $90 million over five years. However, after the five-year period, the program will be encouraging local health jurisdictions to develop their own long-term funding plans, including billing health care service plans or Medi-Cal for provided dental services. During the five-year period, DPH indicates it will scale back state activities to fulfill local 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 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 state is meeting the goals identified in the Oral Health Plan.

3. Please provide a brief overview of the request for additional positions.

4. Please describe the Oral Health Program's response to declining revenue from Proposition 56. What state-level activities will be prioritized with the remaining funding after fulfilling local funding commitments?

Issue 5: Alzheimer's Disease Program Grant Awards and Gov. Task Force on Brain Health

Budget Issue. DPH requests two positions and General Fund expenditure authority of $3 million annually. If approved, these positions and resources would allow DPH to expand research grants in the Alzheimer's Disease Program focused on the prevalence of the disease among women and communities of color. These resources would also support creation and implementation of the Governor's Task Force on Brain Health.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$3,000,000	$3,000,000
Total Funding Request:	**$3,000,000**	**$3,000,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and Resources ongoing after 2020-21.

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 with its ADRDF allocations. The 2018 Budget Act included an additional $3.1 million General Fund allocation for Alzheimer's research. The 2018 research grant cycle included the following categories:

- *Caregiving*: strengthening caregivers' health and effectiveness
- *Prevention*: reducing risk for cognitive decline and dementia
- *Early Diagnosis and Detection*: expanding early detection and diagnosis
- *Long-Term Services and Support Systems/Health Services:* improving safety and quality of care for people living with dementia
- *Health Disparities:* understanding the prevalence, policies, environmental, and social determinants of health affecting California's diverse population.

Focus on Women and Communities of Color. According to DPH, Alzheimer's is the fifth most common cause of death for Americans ages 65 and older. Federal Centers for Disease Control and Prevention data indicates California had 15,570 deaths attributable to Alzheimer's disease in 2016, which made it the 4th leading cause of death in the state. Alzheimer's disease disproportionately impacts women, as nearly two-thirds of Americans with Alzheimer's disease or other dementias are women. While the prevailing view has been that the difference is due to the fact that women, on average, live longer than men and older age is the greatest risk factor for Alzheimer's, more research is needed to support the findings and understand the cause of this disproportionate outcome. Many researchers are questioning whether the risk of the disease is higher for women at any given age due to biological or genetic variations, or due to differences in life experiences.

Alzheimer's disease also disproportionately impacts some communities of color. African-Americans are about two times, and Hispanics are about one and one-half times, more likely than older whites to have Alzheimer's. Among people ages 65 and older, African Americans have the highest prevalence of Alzheimer's disease and related dementias (13.8 percent), followed by Hispanics (12.2 percent).

DPH requests General Fund expenditure authority of $2.7 million annually to focus on research to understand the greater prevalence of Alzheimer's among women and communities of color. In addition, DPH requests General Fund expenditure authority of $300,000 to fund the following positions and workload related to the implementation of the Governor's Task Force on Brain Health:

- **One Health Program Specialist I** would manage Healthy Brain Road Map strategies, convene stakeholders and create reports, provide technical assistance, develop guidelines on healthy brain initiatives, establish a surveillance and evaluation plan, and create a statewide health education campaign that targets women and communities of color.
- **One Associate Governmental Program Analyst** would organize, review, approve, and monitor the grant awards, as well as provide administrative and other support to the Governor's Task Force on Brain Health.

According to DPH, the Governor's Task Force on Brain Health, chaired by Maria Shriver, will be co-chaired by the Governor, will hold listening sessions in different parts of the state and develop guidelines on brain health that can be shared with partners in the public, private, and non-profit sectors. The task force will also look at the effects of Alzheimer's disease and policies that can point the way for brain-healthy families, workplaces, and 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 DPH to respond to the following:

1. Please provide a brief overview of this proposal.

2. Please describe how DPH will evaluate requests for research proposals that target women and communities of color.

3. Please provide an update on the planned activities, composition status, and expected authority of the Governor's Task Force on Brain Health.

Issue 6: Childhood Lead Poisoning Prevention Program IT Project Implementation

Budget Issue. DPH requests eight positions and expenditure authority from the Childhood Lead Poisoning Prevention Fund of $8 million in 2019-20, $9.3 million in 2020-21, $5.9 million in 2021-22, and $3.4 million annually thereafter. If approved, these positions and resources would allow DPH to support the development and implementation of the Surveillance, Health, Intervention, and Environmental Lead Database (SHIELD) Information Technology Project.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0080 – Childhood Lead Poisoning Prevention Fund	$8,005,000	$9,285,000
Total Funding Request:	**$8,005,000**	**$9,285,000**
Total Requested Positions:	**8.0**	**8.0**

* Additional fiscal year resources requested: 2021-22: $5,948,000; 2022-23 and ongoing: $3,376,000.

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

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

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

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

Some of the proposed design components of SHIELD include:

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

The 2017 Budget Act included one position and expenditure authority from the CLPP Fund of $480,000 in 2017-18 and $158,000 annually thereafter to conduct the initial Project Approval Lifecycle analyses to upgrade to the SHIELD system.

Resource Request to Complete Development and Implementation of SHIELD. DPH requests eight positions and expenditure authority from the CLPP Fund of $8 million in 2019-20, $9.3 million in 2020-21, $5.9 million in 2021-22, and $3.4 million annually thereafter. These positions and resources would allow DPH to complete the process of developing and implementing SHIELD, including the following workload:

- **Two Associate Governmental Program Analysts** would provide laboratory program function expertise to make the new data system incorporate all necessary requirements, and to provide expertise in validating the completion and accuracy of blood lead results received through the reporting system.
- **One Environmental Scientist** would assess local agency environmental investigation needs in the new system, and would train local environmental professionals on the functionalities and uses of the new system.
- **One Research Scientist Supervisor I** would serve as a program liaison to the system's vendor and program staff and to coordinate with county lead programs to help meet programmatic needs during requirements gathering, testing and feedback.
- **One Nurse Consultant III** would provide ongoing review and input of the clinical and case management aspects of the SHIELD system, monitoring that they are properly created and functional; gather and categorize local agency clinical and case management needs for a new SHIELD system; and after development is complete, train local nurses and case management staff on use and functionality of the SHIELD system.
- **One Information Technology Specialist I** would perform technical testing during design sessions of each functional roll-out, and provide support for research and evaluation of the new IT system.
- **Two Information Technology Specialist II positions** would install and configure database management software, perform database migrations to production and optimizes performance of SQL programming language services and databases.

In addition to these positions, DPH intends to redirect existing staff in its Information Technology Services Division to manage the SHIELD project. According to DPH, these staff are being redirected from workload related to the existing RASSCLE 2 system.

Included in this request is funding for consultant contracts, including:

- $110,000 in 2019-20, $147,000 in 2020-21, and $110,000 in 2021-22 for services provided by the California Department of Technology for project and planning oversight and statewide IT procurement.
- $5.6 million in 2019-20, $6.5 million in 2020-21, $3.2 million in 2021-22, and $950,000 annually thereafter for design, development and implementation and Tableau contractors. These costs also include Secure File Transfer Protocol for the automated electronic transfer of case files, identity management and health information exchange platforms, geographic information system services, and data cleanup and migration.

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 7: Childhood Lead Poisoning Prevention Program Reporting (SB 1097 and SB 1041)

Budget Issue. DPH requests six positions and expenditure authority from the Childhood Lead Poisoning Prevention Fund of $769,000 annually. If approved, these positions and resources would allow DPH to carry out blood lead screening data collection, analysis, and reporting pursuant to the requirements of SB 1097 (Hueso), Chapter 691, Statutes of 2018, and SB 1041 (Leyva), Chapter 690, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0080 – Childhood Lead Poisoning Prevention Fund	$769,000	$769,000
Total Funding Request:	**$769,000**	**$769,000**
Total Requested Positions:	**6.0**	**6.0**

* Positions and resources ongoing after 2020-21.

Background. The Childhood Lead Poisoning Prevention (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.

SB 1097 and SB 1041 Require Additional Data Collection and Reporting. SB 1097, among its provisions, requires DPH to perform the following activities:

- Include the following data (identified by child's county and year of age) on its biennial lead poisoning case management report:
  - The total number of children tested for lead poisoning;
  - The results of blood lead testing by blood-lead-level range;
  - The number, by blood-lead-level range, who were referred for case management and environmental services and who received home visits, environmental investigations, family education and materials on lead, and nutrition assessment and education;
  - The identified sources of exposure for lead-exposed children and whether or not these lead hazards have been addressed by being removed, ameliorated, or abated.
- Post the biennial report on its website.

- Provide the data collected, along with the report, to the Healthy Communities Data and Indicators Project for its use in planning healthy communities and evaluating the impact of plans, projects, policies, and environmental changes on community health.

According to DPH, this data is not currently reported electronically to the CLPP and must be obtained in paper reports and other sources and manually entered into the program's system. For its requirements under SB 1097, DPH requests the following five positions:

- **Two Program Technician II** positions would perform data entry and extraction of information collected from environmental investigations and nursing case management information.
- **Two Associate Governmental Program Analysts** would detect, analyze, and validate information that accompanies the data that may be incomplete, wrong, or duplicative. These positions would also collaborate with local health jurisdictions to preserve the integrity of critical health data stored in the data systems.
- **One Research Scientist III** would determine the number of children referred for and receiving home visits and environmental investigations, analyze the sources of lead-exposed children, and present the findings to the Healthy Communities Data and Indicators Project.

SB 1041 requires DPH to collect and analyze data on blood lead level screening tests for children enrolled in Medi-Cal. The data will be used to monitor appropriate case management efforts, to advance lead testing of children enrolled in Medi-Cal, and for use in its biennial lead poisoning case management public reporting. While the CLPP data system, RASSCLE 2 contains information about lead screening, databases at the Department of Health Care Services (DHCS) contain the most complete information about Medi-Cal participation and billing of services. According to DPH, **one Research Scientist III** position would be needed to develop expertise in analyzing data from the DPH and DHCS system, and develop protocols for matching data in those systems for the purposes of the biennial reporting requirements of SB 1041.

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. Is DPH pursuing strategies to collect the required data electronically?

Issue 8: Women, Infants, and Children (WIC) Local Assistance Estimate

Budget Issue. The November 2018 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of $1.1 billion ($892.1 million federal funds and $229.1 million WIC manufacturer rebate funds) in 2018-19 and $1.1 billion ($878.2 million federal funds and $214.9 million WIC manufacturer rebate funds) in 2019-20. The federal fund amounts include state operations costs of $63.7 million in 2018-19 and $62.3 million in 2019-20.

Women, Infants, and Children (WIC) Funding Summary			
	2018-19	**2019-20**	**BY to CY**
Fund Source	***Revised***	***Proposed***	***Change***
0890 – Federal Trust Fund			
State Operations:	$63,684,000	$62,270,000	($1,114,000)
Local Assistance:	$828,388,000	$815,905,000	($12,483,000)
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$229,080,000	$214,929,000	($14,151,000)
Total WIC Expenditures	**$1,121,152,000**	**$1,093,104,000**	**($28,048,000)**

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	2018 Budget Act	SFY 2018-19				SFY 2019-20		
		2018-19 Governor's Budget	November Estimate	Change from 2018 Budget Act		November Estimate	Change from 2018 Budget Act	
Pregnant	53,523,000	56,986,000	53,288,000	(235,000)	-0.44%	49,968,000	(3,555,000)	-6.64%
Breastfeeding	49,616,000	53,586,000	48,079,000	(1,537,000)	-3.10%	46,370,000	(3,246,000)	-6.54%
Non-Breastfeeding	26,252,000	27,618,000	26,375,000	123,000	0.47%	25,348,000	(904,000)	-3.44%
Infants	298,083,000	314,878,000	296,531,000	(1,552,000)	-0.52%	286,410,000	(11,673,000)	-3.92%
Children	322,094,000	342,190,000	305,377,000	(16,717,000)	-5.19%	294,416,000	(27,678,000)	-8.59%
Cash Value Voucher Increase	-	-	4,914,000	4,914,000	100.00%	6,194,000	6,194,000	100.00%
Reserve	22,487,000	23,858,000	22,037,000	(450,000)	-2.00%	21,261,000	(1,226,000)	-5.45%
Total Food Expenditures	**772,055,000**	**819,116,000**	**756,601,000**	**(15,454,000)**	**-2.00%**	**729,967,000**	**(42,088,000)**	**-5.45%**
Food Expenditures Paid from Rebate Funds	*229,772,000*	*230,852,000*	*229,080,000*	*(692,000)*	*-0.30%*	*214,929,000*	(14,843,000)	*-6.46%*
Food Expenditures Paid from Federal Funds	*542,283,000*	*588,264,000*	*527,521,000*	*(14,762,000)*	*-2.72%*	*515,038,000*	*(27,245,000)*	*-5.02%*
Other Local Assistance Expenditures (Federal NSA)	300,867,000	300,867,000	300,867,000	-	0.00%	300,867,000	-	0.00%
Total Federal Local Assistance Expenditures (Food + NSA)	**843,150,000**	**889,131,000**	**828,388,000**	**(14,762,000)**	**-1.75%**	**815,905,000**	**(27,245,000)**	**-3.23%**
State Operations (Federal NSA)	63,684,000	63,684,000	63,684,000	-	0.00%	62,270,000	(1,414,000)	-2.22%

The budget assumes 971,979 average monthly WIC participants in 2018-19, a decrease of 52,285 or 5.1 percent from the assumptions in the 2018 Budget Act. The budget assumes 917,057 average monthly WIC participants in 2019-20, a decrease of 54,922 or 5.7 percent from the revised 2018-19 caseload estimate.

Food Expenditures Estimate. The budget includes $756.6 million in 2018-19 for WIC program food expenditures, a decrease of $15.5 million or two percent, compared to the 2018 Budget Act. According to DPH, this decrease is due to lower than projected participation levels. However, the multi-year trend

of declining participation in the WIC program appears to be decelerating. Of these expenditures, federally funded food expenditures are $527.5 million, a decrease of $14.8 million from the 2018 Budget Act, and WIC Manufacturer Rebate Fund food costs are $229.1 million, a decrease of $692,000 from the 2018 Budget Act.

The budget includes $730 million in 2019-20 for WIC program food expenditures, a decrease of $26.6 million or 3.5 percent from the revised 2018-19 food expenditures estimate. According to DPH, this decrease is also due to the continued, though decelerating, downward trend of total participation in the program. Of these expenditures, federally funded food costs are $515 million, a decrease of $12.5 million from the revised 2018-19 food expenditure estimate, and WIC Manufacturer Rebate Fund food costs are projected to be $214.9 million, a decrease of $14.2 million from the revised 2018-19 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 2018-19 and 2019-20, which is unchanged from the level assumed in the 2018 Budget Act. The budget also includes $63.7 million for state operations expenditures in 2018-19, also unchanged from the level assumed in the 2018 Budget Act. The budget includes $62.3 million for state operations expenditures in 2019-20, a decrease of $1.4 million or 2.2 percent compared to the revised 2018-19 estimate.

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 9: California Home Visiting Program Expansion

Budget Issue. DPH requests 13 positions and General Fund expenditure authority of $23 million annually. If approved, these resources would allow DPH to expand participation in current and new sites for the California Home Visiting Program (CHVP), and include new evidence-based home visiting models, with a focus on low-income, young mothers.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$23,000,000	$23,000,000
Total Funding Request:	**$23,000,000**	**$23,000,000**
Total Requested Positions:	**13.0**	**13.0**

* 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, depression, 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 December 2018, CHVP completed 185,422 home visits and served over 9,010 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 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.

[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.

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

Federal Fiscal Year	2010	2011	2012	2013	2014	2015	2016	2017	2018
CA Funding Level (*millions*)	$8.2	$20.9	$20.9	$20.2	$20.6	$22.6	$22.2	$22.0	$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. The 2018 Budget Act reauthorized 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.

Budget Proposes Expansion of CHVP to Additional Evidence-Based Models in New Counties. DPH requests 13 positions and General Fund expenditure authority of $23 million annually to expand participation in current and new sites for CHVP, and include new evidence-based home visiting models, with a focus on low-income, young mothers. This proposed General Fund allocation would more than double the funding for the program.

According to DPH, California selected its current two home visiting models to simplify implementation, data collection, monitoring practices, and overall costs. However, other models have been added to the federally approved list with different target populations and outcome goals. Currently, the following home visiting models meet the U.S. Department of Health and Human Services criteria for evidence of effectiveness according to the Home Visiting Evidence of Effectiveness project (HomVEE).

- Attachment and Biobehavioral Catch-Up (ABC)
- Child First
- Early Head Start Home-Based Option (EHS)
- Early Intervention Program for Adolescent Mothers
- Early Start (New Zealand) '
- Family Check-Up (ECU) -
- Family Connects
- Family Spirit
- Health Access Nurturing Development Services (HANDS)
- Healthy Beginnings
- Healthy Families America (HFA)
- HealthySteps
- Home Instruction for Parents of Preschool Youngsters (HIPPY)
- Maternal Early Childhood Sustained Home-Visiting (MECSH)
- Minding the Baby
- Nurse-Family Partnership (NFP)
- Oklahoma's Community-Based Family Resource and Support (CBFRS) Program
- Parents as Teachers (PAT)

- Play and Learning Strategies (PALS)
- SafeCare

DPH indicates it would examine and include new models as part of the CHVP to add greater flexibility to meet local needs. In order to allow for successful implementation, fidelity to the model, and accountability, DPH requests $21 million General Fund in local assistance to provide additional resources to local health jurisdictions and $2 million in state operations to fund 13 positions.

The local assistance resources would enable DPH to examine and implement new models outside of HFA and NFP, developing an approach to evaluate the various models including enhancing data collection and informatics for effective decision-making in choosing models. The planning process would occur in the first year while existing models at existing sites are expanded, expansion to new models would occur in the second year, and expansion to additional counties would occur in the third year.

The state operations resources would fund **one Health Program Manager II, two Health Program Specialist I** positions, **and two Health Program Specialist II** positions to develop and monitor a systems approach to program evaluation. The resources would also fund **one Research Scientist Supervisor I and three Research Scientist II** positions with a focus on informatics and epidemiology, and **three Associate Governmental Program Analysts** and **one Office Technician** to support the start-up of new home visiting models including new materials, trainings, data collection forms, and data system development.

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 DPH will evaluate adding additional models to CHVP.

3. What additional counties would receive funding from CHVP after expansion?

Issue 10: Black Infant Health Program Expansion

Budget Issue. DPH requests four positions and General Fund expenditure authority of $7.5 million annually. If approved, these resources would allow DPH to expand the Black Infant Health Program to improve African-American infant and maternal health.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$7,500,000	$7,500,000
Total Funding Request:	**$7,500,000**	**$7,500,000**
Total Requested Positions:	**4.0**	**4.0**

* Positions and Resources ongoing after 2019-20.

Background. The Black Infant Health Program, administered by DPH, 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.[2] 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.

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

[2] Ickovics J. Group prenatal care and perinatal outcomes. Obstetrics & Gynecology 2007;110(2 Pt 1): 330-339.

Asian/Pacific Islander (3.50)[3] Californians. In addition, there is some evidence that progress in reducing African American infant mortality has stalled in recent years.[4]

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 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.

[3] 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.

[4] 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

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.

California Perinatal Equity Initiative. The 2018 Budget Act included trailer bill language and General Fund expenditure authority of $8 million annually to expand the Black Infant Health Program to further the goal of reducing the disparities in infant mortality within the black community. The expanded program, the California Perinatal Equity Initiative, will 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. According to DPH, planning grants were awarded to the 13 county health departments currently operating BIH programs for the purpose of improving Black infant birth outcomes and reducing infant mortality. The planning grants contained the following key requirements of county health departments:

1. Conduct an environmental scan to identify gaps in perinatal health care and community services
2. Attend state-hosted community engagement meetings
3. Establish local Perinatal Health Equity Community Advisory Boards
4. Engage hospital partners to conduct black preterm birth chart reviews and focus groups with moms who delivered preterm to gain a deeper understanding of perinatal health care before, during and after delivery
5. Develop and implement a public health awareness campaign to bring focus to maternal and infant health disparities

According to DPH, the planning grants were allocated based on a combination of county population size and need. Need was defined based on the percentage of preterm births in the county and the county's infant mortality rate. The planning grant allocations were as follows:

County	Base Funding	Need-Adjusted Funding	Total Funding
Alameda	$350,000	$151,980	$501,980
Contra Costa	$350,000	$158,532	$508,532
Fresno	$350,000	$179,236	$529,236
Kern	$350,000	$159,747	$509,747
Los Angeles	$350,000	$904,107	$1,254,107
Riverside	$350,000	$116,440	$466,440
Sacramento	$350,000	$238,789	$588,789
San Bernardino	$350,000	$494,862	$844,862
San Diego	$350,000	$98,047	$448,047
San Francisco	$350,000	$52,768	$402,768
San Joaquin	$350,000	$128,119	$478,119
Santa Clara	$350,000	$7,617	$357,617
Solano	$350,000	$21,526	$371,526
Total	$4,550,000	$2,711,770	$7,261,770

Budget Includes Additional Augmentation for Existing Black Infant Health Program. DPH requests General Fund expenditure authority of $7.5 million annually to support expansion of the Black Infant Health Model, including adding strategies to support participant access and engagement and further expansion of sites and participants. According to DPH, $7 million of local assistance funding would provide additional support for the program, including:

- Completing an implementation evaluation to examine the contextual challenges to implementing the program in local health jurisdictions using existing reports and conducting key informant interviews; assess impact of quality improvement efforts.
- Improving data collection measures to capture key outcomes such as stress or baseline depression.

- Implementing technical upgrades to the BIH data system in order to analyze:
  - Additional data not previously reported (e.g., depression, food insecurity, experiences of racism)
  - Participant satisfaction data
  - Outcomes as a function of group size and dosage of intervention
  - Associations between participation and birth outcomes
  - Comparison of outcome with other strategies such as home visiting, preconception counseling, and fatherhood engagement
- Convening a state advisory group with representation of experts in health disparities and shared learning with other efforts, and with specific inclusion through authentic community engagement so that no decisions about black family health are done without inclusion of black families and community leaders.
- Assessing alternative direct service models such as those outlined in the California Perinatal Equity Initiative.

This request also includes $500,000 of state operations funding to support **two Associate Governmental Program Analysts** and **two Research Data Analyst II** positions. These positions will develop funding allocation processes, evaluate integration of additional interventions, research and standardize service interventions, provide technical assistance to local health jurisdictions, provide oversight and monitoring of local health jurisdictions, monitor data system access and training, draft evaluation and progress reports, and provide online and in-person training to state and local staff.

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. How is DPH coordinating these additional resources with the existing allocations, as well as the 2018 Budget Act allocation for the California Perinatal Equity Initiative?

Issue 11: Maternal, Child, and Adolescent Health – Medi-Cal Oversight Activities

Budget Issue. DPH requests five positions and expenditure authority of $656,000 ($328,000 General Fund and $328,000 reimbursements) annually. If approved, these resources would allow DPH to comply with federal claiming and oversight requirements for federal Medicaid funds.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$328,000	$328,000
0995 – Reimbursements	$328,000	$328,000
Total Funding Request:	**$656,000**	**$656,000**
Total Requested Positions:	**5.0**	**5.0**

* Positions and Resources ongoing after 2019-20.

Background. DPH's Maternal, Child and Adolescent Health (MCAH) Division draws down federal Title XIX Medicaid reimbursements for Medi-Cal administrative activities workload on behalf of local health jurisdictions, which primarily assist individuals eligible for Medi-Cal with enrollment into programs or assist insured individuals with access to Medi-Cal providers, care, and services. Local health jurisdictions are required to submit a time study and other documentation on a quarterly basis to MCAH to draw down Medicaid reimbursements for activities that meet claiming requirements. Time studies are the primary documentation to determine the percent of personnel time eligible for Medicaid reimbursements, which must be spent performing Medi-Cal administrative activities.

According to DPH, local health jurisdictions are able to draw down and match more than $35 million of Medicaid reimbursements to supplement local costs to administer programs that link low-income Californians to Medi-Cal, including the Black Infant Health Program, the Adolescent Family Life Program, and MCAH Local Programs. According to DPH, in the past two years local health jurisdictions have been making a concerted effort to increase the amount of Medicaid reimbursements as a means to expand services to local clients in a more cost effective manner.

Medicaid reimbursement is implemented through an interagency agreement with the Department of Health Care Services (DHCS), California's single state Medicaid agency. According to DPH, Medicaid reimbursements were managed as pass-through funding to local health jurisdictions with minimal processing. However, a recent review by DHCS resulted in the identification of oversight requirements that previously had not been provided by DPH, but are important for federal auditing purposes. These oversight requirements include time-study and activity review, position reconciliation, secondary documentations, review of local health jurisdiction objectives, personnel duty statements, and scope of work activities to determine appropriate reimbursement claiming rates.

DPH request **five Associate Governmental Program Analysts** and expenditure authority of $656,000 ($328,000 General Fund and $328,000 reimbursements) to perform programmatic, analytical, technical, fiscal, and administrative tasks necessary to perform oversight responsibilities for the continued claiming of Title XIX Medicaid reimbursement for local health jurisdiction activities.

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 12: Genetic Disease Screening Program (GDSP) Local Assistance Estimate

Budget Issue. The November 2018 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of $134.1 million ($30.6 million state operations and $103.5 million local assistance) in 2018-19, and $141.2 million ($31.4 million state operations and $109.8 million local assistance) in 2019-20.

Genetic Disease Screening Program (GDSP) Funding Summary			
	2018-19	**2019-20**	**BY to CY**
Fund Source	***Revised***	***Proposed***	***Change***
0203 – Genetic Disease Testing Fund			
State Operations:	$30,593,000	$31,351,000	$758,000
Local Assistance:	$103,501,000	$109,825,000	$6,324,000
Total GDSP Expenditures	**$134,094,000**	**$141,176,000**	**$7,082,000**

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 more than 80 separate disorders. Pursuant to SB 1095 (Pan), Chapter 363, Statutes of 2016, two additional disorders, Mucopolysaccharidosis type I (MPS-I) and Pompe disease, were added to the screening panel in 2018. In addition, as conditions are added to the federal Recommended Uniform Screening Panel (RUSP), SB 1095 requires them to be added to the NBS program screening panel within two years. In July, 2018, the U.S. Secretary of Health and Human Services added spinal muscular atrophy (SMA) to the RUSP. As a result, SMA must be added to the NBS program screening panel within two years. DPH is requesting positions and expenditure authority for this purpose. (For more information, see *Issue 13: Newborn Screening Program Implementation of Spinal Muscular Atrophy Screening*). The fee for screening in the NBS program is currently $142.25.

Caseload Estimate: The budget estimates NBS program caseload of 469,150 in 2018-19, a decrease of 9,171 or 1.9 percent, compared to the 2018 Budget Act. The budget estimates NBS program caseload of 468,693 in 2019-20, a decrease of 457 or 0.1 percent, compared to the revised 2018-19 estimate. These estimates are based on state projections of a decrease in the number of live births. DPH assumes 100 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 334,430 in 2018-19, a decrease of 7,867 or 2.3 percent, compared to the 2018 Budget Act. The budget estimates PNS program caseload of 331,979 in 2019-20, a decrease of 2,451 or 0.7 percent, compared to the revised 2018-19 estimate. These estimates are based on state projections of a decrease in the number of live births.

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 13: Newborn Screening Program Implementation of Spinal Muscular Atrophy Screening

Budget Issue. DPH requests 5.8 positions and expenditure authority from the Genetic Disease Testing Fund (GDTF) of $4.3 million ($907,000 state operations and $3.4 million local assistance) in 2019-20, and eight positions and expenditure authority from the GDTF of $2.6 million ($1.2 million state operations and $1.4 million local assistance) annually thereafter. If approved, these resources would allow DPH to comply with expanded testing requirements for spinal muscular atrophy (SMA), pursuant to the requirements of SB 1095 (Pan), Chapter 363, Statutes of 2016.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0203 – Genetic Disease Testing Fund		
State Operations:	$907,000	$1,232,000
Local Assistance**:	[$3,400,000]	[$1,400,000]
Total Funding Request:	**$907,000**	**$1,232,000**
Total Requested Positions:	**5.8**	**8.0**

* Positions and Resources ongoing after 2020-21.

** Local Assistance expenditures 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). Mucopolysaccharidosis type I (MPS-I) and Pompe disease were added to the RUSP in 2016 and 2015, respectively, and were added to the panel for newborn screening in 2018. In July 2018, the U.S. Secretary of Health and Human Services added spinal muscular atrophy (SMA) to the RUSP. As a result, SB 1095 requires SMA be added to the NBS screening panel no later than July 2020.

DPH requests 5.8 positions and expenditure authority from the Genetic Disease Testing Fund of $4.3 million in 2019-20, and eight positions and expenditure authority from the Genetic Disease Testing Fund of $2.6 million annually thereafter. This request includes $3.4 million in local assistance funding in 2019-20 for laboratory supplies, equipment, and modifications to the program's Screening Information System (SIS). Local assistance costs will decrease to $1.4 million annually beginning in 2020-21, as screening will begin at the end of 2019-20. These costs are included in the Genetic Disease Screening Program Local Assistance Estimate and are not reflected separately in this request.

This request also includes $907,000 in state operations for the following positions and workload:

- **One Health Program Specialist I** in the NBS Section would monitor implementation of newborn screening for SMA, including all programmatic and SIS changes.
- **One Research Scientist Supervisor I** and **three Research Scientist II** positions would evaluate, validate, and verify a test method for SMA screenings, including laboratory quality control and quality assurance processes, as well as review and release of all newborn test results.
- **Three Research Scientist I** positions would assist with daily testing of approximately 2,000 new specimens beginning in 2020-21.

According to DPH, the increased expenditures for SMA screening will not result in a program fee increase in 2019-20. However, DPH indicates it may assess whether a fee increase may be needed to support the program after implementation of SMA screening in 2019-20.

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 14: Proposals for Investment

Stakeholder Proposal for Managing Hypertension. The American Heart Association (AHA) requests General Fund expenditure authority of $10 million to create a 5-7 county pilot program for hypertension awareness, education, prevention, and control. The pilot program would be administered by DPH with funding provided to local health jurisdictions, and would be based on best practices as recommended by the AHA or the American Medical Association. According to AHA, the program would fund the following activities:

- Focus on the counties with the highest prevalence of hypertension, higher priority populations and geographic and population size diversity.
- Establish best practices, in participating health care systems, with a focus on federally qualified health centers and rural health centers.
- Increase utilization rates of blood pressure cuffs. Participating providers would prescribe blood pressure cuffs for self-measured home blood pressure monitoring. Formalizing this best practice would empower patients to fully engage in their own self-care through home monitoring. This includes patients recording their own blood pressure readings daily.
- Harness the power of community health workers (CHW) to expand the care team to provide more comprehensive health care. Participating clinics would hire a CHW to 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 CHW would also do community outreach and provide screenings for priority populations.
- Upon completion of the Pilot Project, an evaluation would be conducted of the program.

Stakeholder Proposal to Implement Statewide Alzheimer's Infrastructure. The Alzheimer's Association requests one-time General Fund expenditure authority of $10 million to 1) build statewide public health infrastructure to support early detection and timely diagnosis ($3.7 million), and 2) initiate local public health efforts through community grants to eight pilot counties ($6 million – eight grants of $750,000 each). According to the Alzheimer's Association, more individuals with Alzheimer's live in California than in any other state, and California is home to the largest number of family caregivers in the nation. California is also on track to spend over $5 billion annually on Medi-Cal expenditures for this population, an increase of 36 percent between 2018 and 2025. California has a unique opportunity to be the first in the nation to adopt the Center for Disease Control's Healthy Brain Initiative.

Stakeholder Proposal for Lesbian, Bisexual, and Queer (LBQ) Women's Health. A broad coalition of LGBT organizations, health providers, governmental agencies, coalitions and advocates request General Fund expenditure authority of $17.5 million to 1) create an LBQ Women's Health Equity Fund at DPH to support a local comprehensive grant program to address LBQ women's health disparities ($15.5 million), and 2) fund research targeting LBQ women's health needs and inventory of existing programs ($2 million).

Stakeholder Proposal for Safe Cosmetics Program Augmentation. 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. 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 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 J. Mitchell, Chair

SUBCOMMITTEE NO. 3 Agenda

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

Thursday, March 14, 2019
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Renita Polk

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VARIOUS DEPARTMENTS

Issue 1: Informational Panel – Considerations in Developing a Master Plan on Aging

Panelists:

- **Jacqueline Barocio, Fiscal and Policy Analyst, Legislative Analyst's Office (LAO)**
- **Dr. Kathleen Wilber, Professor of Gerontology, University of Southern California**
- **Ella Jones, Senior Advocate**
- **Clay Kempf, Executive Director, Seniors Council of Santa Cruz and San Benito Counties**
- **Marko Mijic, Acting Deputy Secretary for Program and Fiscal Affairs, California Health and Human Services Agency**

Demographic projections by the Department of Finance and others estimate that the proportion of California residents over age 65 will grow substantially over the coming decades. This "silver tsunami" is likely to have significant impacts on the delivery systems that provide care to seniors, particularly those with disabilities or in need of assistance with activities of daily living (ADLs). The state's programs that provide long-term services and supports such as Medi-Cal, In-Home Supportive Services (IHSS) and various Medicaid waiver programs, as well as the vast population of unpaid family caregivers, will bear the financial and operational impacts of increased need and utilization of services represented by this population.

Long-Term Services and Supports. Long-term services and supports (LTSS) refers to services and care provided to individuals who have difficulty performing daily activities, generally due to age, physical, cognitive, developmental, or chronic health conditions, or other functional limitations. LTSS can be provided in the home by family caregivers or paid in-home health workers, in other community-based settings such as assisted living homes, or in institutional settings such as skilled nursing facilities. LTSS may include assistance with ADL, which are routine, daily personal care activities such as eating, bathing, mobility, toileting, and dressing. LTSS may also include instrumental activities of daily living, which are more complex skills necessary for living independently, such as medication management, cooking, money management, transportation, and housework.

Aging Population in California. According to demographic projections by the Legislative Analyst's Office (LAO), the population of California seniors, defined as adults aged 65 and older, will increase from roughly 5.3 million in 2017 to 13.4 million in 2060. The LAO report, titled "A Long-Term Outlook: Disability Among California's Seniors," projects that for California, the growth in the senior population will be primarily driven by the aging Baby Boomer cohort and the largest growth will be for seniors over 85 years old.

LTSS is provided to those in need through several sources, including the state and federal government, private insurers, and individuals. In California, Medi-Cal and Medicare are two of the primary public sector payers for LTSS; generally, the federal government pays for one-half of most Medi-Cal costs.

Medi-Cal generally pays for a broader array of LTSS than Medicare, which covers some LTSS services on a short-term basis. Medi-Cal covers hospital inpatient, outpatient, and institutional long-term care services. Optional services include Home and Community-Based Services (HCBS). However, the SCAN foundation points out that nearly two-thirds of older adults with LTSS needs living at home receive all help from unpaid caregivers, typically family and friends.

LTSS costs often exceed what individuals and families can afford given other personal and household expenses. According to the SCAN Foundation, 53 percent of LTSS costs are covered out-of-pocket, 42 percent are covered by Medicaid, and the other five percent are covered through private long-term care insurance. Institutional settings, such as assisted living facilities or residential care facilities for the elderly, are the most costly. In 2017, the annual private pay cost for a nursing facility was $97,367.1 Generally, HCBS are less expensive than institution-based LTSS, but may still represent a major financial burden for individuals and their families. In 2015, the median costs for one year of home health aide services (at a $13.06 median hourly wage) was $39,000 and adult day services totaled $20,020.

The primary California programs that provide LTSS services to seniors, which are most likely to be impacted by the expected aging of the state's population, are administered by three state departments: the Department of Social Services (DSS), the California Department of Aging (CDA), and the Department of Health Care Services.

In November 2018, the Senate Budget and Fiscal Review Subcommittee No. 3 on Health and Human Services held an informational hearing on the status of LTSS for California seniors. During that hearing the subcommittee discussed data gaps in needs and utilization of services, existing LTSS programs, and future planning. There is a need for additional data on whether the current LTSS system is meeting the needs of seniors, how many seniors will need services in the future, and how future utilization will impact state-funded programs. In the committee's 2019 annual overview of the Governor's budget, published on the committee website, the status of the state's LTSS and challenges associated with the system were also discussed. Some of these challenges included changing demographics, gaps in data to identify service needs, gaps in utilization data, coordination within the system, and caregiver support.

Since that hearing and the publication of the annual overview, both the Legislature and the Governor have expressed commitments to addressing the issues and challenges affecting California's senior community. Part of that commitment includes the development of a state plan on aging. In his State of the State Address, Governor Newsom called for a Master Plan for Aging. In addition, the Legislature has introduced more than two dozen bills addressing issues that seniors face.

Today's panel will further the discussion on what a state plan will look like and what it should include.

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

1 AARP Public Policy Institute. "Across the States 2018: Profile of Long-Term Services and Supports in California" August 27, 2018. https://www.aarp.org/content/dam/aarp/ppi/2018/08/california-LTSS-profile.pdf

4170 DEPARTMENT OF AGING (CDA)

Background: The Department of Aging's mission is to promote the independence and well-being of older adults, adults with disabilities, and families through:

- Access to information and services to improve the quality of their lives,
- Opportunities for community involvement,
- Support to family members providing care, and
- Collaboration with other state and local agencies.

Issue 1: Overview

Budget Summary. With a proposed 2019-20 budget of $206.3 million ($36.7 million General Fund), the CDA administers community-based programs that serve older adults, adults with disabilities, family caregivers, and residents in long-term care facilities throughout the state. As the federally designated State Unit on Aging, the department administers federal Older Americans Act (OAA) programs and the Health Insurance Counseling and Advocacy Program.

California Department of Aging
Funding Authority by Fund Source
* Dollars in thousands

Grand Total By Fund	Fiscal Year	
	2018-19	2019-20
General Fund	$37,107	36,749
State HICAP Fund	$2,501	$2,501
Federal Fund	$187,286	$150,835
State Health Facility Citations Penalty Account	$1,207	1,208
State Department of Public Health Licensing and Certification Program Fund	$400	$400
Skilled Nursing Facility Quality & Accountability Fund	$1,900	$1,900
Reimbursements	$12,242	$12,661
Total All Funds	$242,643	$206,254

Overview of Programs.

Medi-Cal Programs. The department administers two Medi-Cal programs: it contracts directly with agencies that operate the Multipurpose Senior Services Program (MSSP) and provides oversight for the MSSP waiver, and certifies Community-Based Adult Services (discussed further in next item) centers for participation in Medicaid. The department administers most of these programs through contracts with the state's 33 local Area Agencies on Aging (AAA). At the local level, AAAs contract for and coordinate this array of community-based services to older adults, adults with disabilities, family caregivers, and residents of long-term care facilities.

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. CDA implements MSSP under the supervision of the Department of Health Care Services (DHCS) through an interagency agreement. The current year 2018-19 MSSP budget is approximately $23.2 million and the proposed 2019-20 MSSP budget remains unchanged.

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 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), 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. 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. MSSP sites that provide waiver services in a CCI county have agreements with managed care plans to deliver MSSP services to eligible plan members. 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. MSSP sites serving non-CCI counties deliver MSSP services as a Medi-Cal fee-for-service benefit.

Senior Nutrition. This is the largest OAA program in terms of funding and the most well-known. It consists of the Congregate Nutrition Program and the Home Delivered Meal Program. The Congregate Nutrition program targets individuals age 60 or older with the greatest economic or social need. In 2016-17, approximately 28,694 meals a day were served at these sites; 7.2 million a year -- and approximately 27 percent of the participants were at high nutritional risk. The Home Delivered Meal Program serves older adults who are not able to attend congregate programs. In addition, programs provide nutrition education at least four times per year and nutrition counseling is available in some areas. In 2016-17, approximately 44,000 meals were delivered each day; 11 million annually. The 2019-20 budget provides total funds of $44.9 million ($3.8 million General Fund) for Congregate

Nutrition Program, and $38.9 million ($4.7 million General Fund) for the Home Delivered Meal Program.

Supportive Services. The Supportive Services Program assists 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. The Senior Legal Services Program assesses 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. The Family Caregiver Support Program provides support to unpaid family caregivers of older adults and grandparents (or other older relatives) with primary caregiving responsibilities for a child or individual with a disability. Each AAA is responsible for determining the array of services provided to unpaid family caregivers. Those services can include respite care, support services (such as support groups and training), supplemental services (such as assistive devices and home adaptations), access assistance, and information services.

Long-Term Care Ombudsman (LTCO). The LTCO identifies, investigates, and resolves community complaints made by, or on behalf of, individual residents in long-term care facilities. These facilities include nursing homes, residential care facilities for the elderly, and assisted living facilities. The LTCO Program is a community-supported program, of which volunteers are an integral part. Approximately, 180 staff and 730 volunteers advocate on behalf of residents of long-term care facilities. These include 1,244 skilled nursing and intermediate care facilities and 7,406 residential care facilities for the elderly. The office also maintains a 24-hour, seven days a week crisis line to receive complaints by, and on behalf of, long-term care residents.

Elder Abuse Prevention. The Elder Abuse Prevention Program develops, strengthens, and implements programs for the prevention, detection, assessment, and treatment of elder abuse. Most programs educate the public about how to prevent, recognize, and respond to elder abuse

Health Insurance Counseling and Advocacy (HICAP). The HICAP Program provides personalized counseling, outreach and community education to Medicare beneficiaries about their health and long-term care (LTC) coverage options. In 2016-17, the program counseled approximately 79,000 clients, provided telephone help to 44,000 individuals and close to 3,700 interactive consumer presentations. This program utilizes 799 active counselors (volunteers and paid) who provide this assistance under the direction of the paid program staff.

Senior Community Service Employment Program (SCSEP). The SCSEP Program 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.

Aging and Disability Resource Connection (ADRC). The ADRC program's purpose is to improve consumers' experience by having a trusted point-of-contact that can provide reliable information and facilitate access to services for people of all ages, incomes, and disabilities. CDA collaborates with the DHCS to provide these services. However, the interagency agreement between the two is set to expire on June 30, 2019. The core partnership of an ADRC is between the regional Area Agency on Aging (AAA) and Independent Living Center (ILC). Neither CDA nor DHCS provide local assistance funding to ADRC. Since the federal ADRC demonstration grant funding ended in 2009, regional ADRCs have had to rely on either federal and state Older Americans Act and Older Californians Act funding, or the existing ILC funding.

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. Estimated total expenditures for the program in 2017-18 is $7.9 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 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. 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. The 2018-19 budget increased the base allocation for the 35 local LTCO offices to $100,000 annually. Local Assistance funding for the Ombudsman in the current year is approximately $9.6 million and for the Budget Year is $9.5 million. This includes federal and State funds from the Skilled Nursing Facility Quality Assurance Fund and the State Citation Penalties Account funds.

- In federal fiscal year 2018, CDA received an increase of $17 million in Supportive Services (Title III-B services) funding from the federal Administration on Community Living. These funds can be used for supportive services, congregate nutrition, home-delivered meals, health promotion, caregiver support, the LTCO, and the Nutrition Services Incentive Program.

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

Questions.

1. Please describe recent major successes and challenges the department has experienced during program implementation.

2. Please provide a brief overview of MSSP and its transition into managed care.

Issue 2: BCP – Community Based Adult Services Additional Staffing for Mandate Compliance

Governor's Proposal. The Administration requests $751,000 ($427,000 federal funds and $324,000 General Fund) and four positions to ensure that Community Based Adult Services (CBAS) provider recertification is occurring within the statutorily required timeframe and those providers are complying with new federal rules.

Background. The CBAS program is one of two Medi-Cal programs administered by the CDA. It is a community-based day health program that provides services to older persons and other adults with chronic medical, cognitive, or behavioral health conditions and/or disabilities and are at risk of needing institutional care. The purpose is to delay or prevent institutionalization and maintain individuals in their homes for as long as possible. The CBAS program provides skilled nursing care, social services, therapies, personal care, meals, and transportation at outpatient facilities that are licensed as CBAS centers.

The program is administered under an interagency agreement among the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), and the CDA. By statute, CDA is responsible for initial certification of new CBAS centers as Medi-Cal providers and must monitor and recertify each CBAS provider at least once every two years. The recertification process consists of analyzing and processing CBAS provider renewal paperwork and fingerprinting, onsite monitoring and interviews, follow-up surveys, written reports, and additional related activities.

At current staff levels, the thoroughness of the certification renewals has been a challenge and the department has employed five retired annuitants to address the workload. In the past five years, the days between the onsite provider survey and issuance of a report has increased from 49 to 121, and the percentage of quarterly monitoring calls completed has decreased from 70 percent to 25 percent. The budget proposal includes a request for three Associate Governmental Program Analyst (AGPA) positions and one Nurse Evaluator position to help address the workload.

New federal requirements, including the California Medi-Cal 2020 waiver, the Affordable Care Act, and Home and Community Based (HCB) Settings regulations, have contributed to this increased workload and subsequent delays. Now that CBAS is a Medi-Cal managed care benefit, additional standards and processes must be met. The Affordable Care Act also established new requirements that requires ongoing provider review. New HCB regulations that the program must meet by March 2022 will also place an additional workload on the department.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

Issue 3: Proposals for Investment

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

1. Local Long-Term Care Ombudsman Augmentation

Budget Issue. The California Long-Term Care Ombudsman Association requests $5.2 million General Fund to augment the 35 local LTCO offices. The increase in funds would allow local programs to conduct additional unannounced facility visits ($3.7 million) and investigate an additional 8,000 complaints ($1.5 million).

Staff Comment and Recommendation. The 2018-19 budget included an increase in base allocation for local LTCO offices of $100,000 annually. Hold open.

2. Supplemental Rate Adjustment MSSP Sites

Budget Issue. The MSSP Site Association (MSA) requests a one-time $25 million General Fund augmentation over three years to provide supplemental increases 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. MSSP sites spend up to 30 percent of their overall program allocation purchasing critical services and equipment needed by clients when other public or private resources are not available.

Staff Comment and Recommendation. Hold open.

3. Increased Funding for Senior Nutrition Programs

Budget Issue. The California Association of Area Agencies on Aging and Meals on Wheels California request an ongoing $17.5 million to increase funding for senior nutrition programs. The organizations note that the increase is crucial in light of the fact that funding for these programs has been flat and has not seen an increase in a decade. The requested amount would provide for an extra 1.2 million meals per year, and serve an additional 12,000 Californians.

Staff Comment and Recommendation. Total funding for Senior Nutrition programs dropped from $108.7 million ($9.1 million General Fund) in 2018-19 to $83.8 million ($8.5 million General Fund) in the proposed 2019-20 Governor's budget. Hold open.

4185 CALIFORNIA SENIOR LEGISLATURE

Issue 1: Overview

Background. SCR 44 (Mello), Chapter 87, Statutes of 1982, established the California Senior Legislature (CSL). The CSL is a nonpartisan, volunteer organization comprised of 40 senior senators and 80 senior assembly members, who are elected by their peers in elections supervised by the Advisory Councils in 33 Planning and Services Areas (PSAs). 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, hearing up to 120 legislative proposals.

For the 2019-20 Legislative session, CSL is sponsoring nine bills. In 2018, CSL sponsored six bills but none were signed into law. In 2017, CSL sponsored six bills, four of which were signed into law.

Funding. 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. 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. However, in 2015, the new VCF revenue was only $60,000, and the California Senior Legislature Fund was removed from the tax check-off list once again. 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 2016-17 budget year, and the remaining $265,000 were reappropriated and carried into 2017-18.

AB 519 (Levine), Chapter 443, Statutes of 2017, established the California Senior Citizen Advocacy Voluntary Contribution Fund. The bill also required the CSL to spend ten percent of the fund balance to market and promote the fund, and removed the inflation factor on the $250,000 minimum contribution.

The 2019-20 Governor's budget includes $315,000 (California Senior Citizen Advocacy Voluntary Tax Contribution Fund) for the CSL. CSL has estimated their expenditures for 2019-20 to be $425,000. The voluntary contribution fund received $91,625 in donations in 2018.

Three-Year Financing Plan. The Budget Act of 2017 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 plan 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 out years.

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

Questions.

1. Please provide a brief overview of the three-year financing plan.

Issue 2: Proposals for Investment

1. Increased Funding to Maintain CSL Operations

Budget Issue. The California State Legislature is requesting an ongoing appropriation of $425,000 to be able to remain operative. The requested funding would cover salary staff and benefits, and other administrative costs. Donations would cover costs for the annual model legislative session held by CSL.

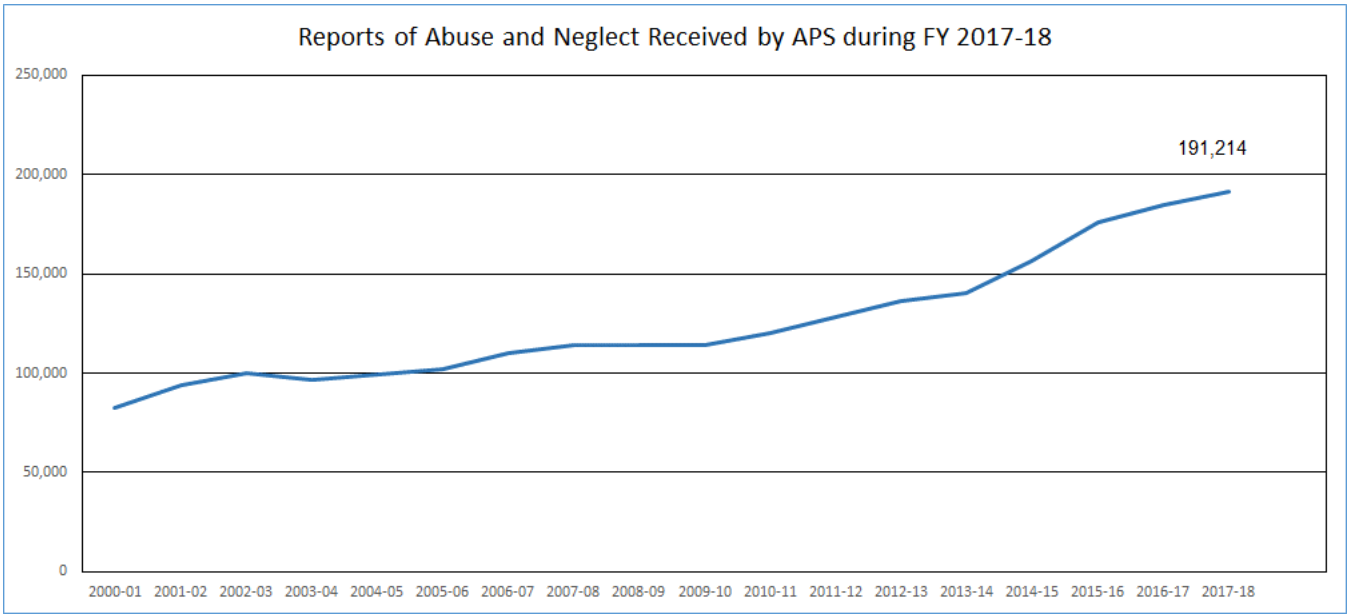
Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – ADULT PROTECTIVE SERVICES

Issue 1: Overview – Adult Protective Services

Background. Each of California's 58 counties has an Adult Protective Services (APS) agency to aid 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 a 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 significantly since 2000-01. The graph below shows the upward trend of reports of abuse and neglected received by APS.



Between 2014 and 2018, APS received 710,898 reports. During that same time, 623,127 cases were opened and 551,461 cases were resolved.

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.[2] The Department of Social Services, (DSS) retains program oversight and regulatory and policymaking 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. The 2014 Budget Act included $150,000 in funding for one staff position within the department to assist with APS coordination and training. In 2015, trailer bill language was adopted that codified the responsibilities of this staff person. In addition, $176,000 ($88,000 General Fund) was allocated to DSS for APS training. The 2016 Budget Act included one-time funding of $3 million General Fund for APS training for social workers. This investment was matched with Medi-Cal funds. The funding has been used to:

- Add new contracts with the three Regional Training Academies (RTAs) (San Diego State University, UC Davis, and Cal State Fresno) to provide two "APS Core Competency Academies," provide tracking and documentation for national APS certification, coaching tools for core competency courses, and two advanced trainings and two supervisor trainings.

- Add new $200,000 contract with the Public Administrators (PA), Public Guardians (PG) and Public Conservators (PC) Association to support their need to train their employees.

- Provide $560,000 to each of the five training regions (Los Angeles, Southern, Central, Bay Area, and Northern).

APS Expenditures by Fiscal Year

Fiscal Year	Expenditures
2011-12	$119.7 million
2012-13	$120.7 million
2013-14	$126.3 million
2014-15	$137.6 million
2015-16	$147.6 million
2016-17	$159.7 million
2017-18*	$169.9 million

*Expenditures for 2017-18 are as of January 2019 and are not final.

Home Safe Program. The Home Safe Program was established by AB 1811 (Committee on Budget), Chapter 35, Statutes of 2018. The program serves APS clients that are homeless or at risk of

[2] 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.

homelessness due to elder or dependent adult abuse, neglect, or financial exploitation. Local APS agencies provide homelessness prevention and short-term housing interventions to support safety and housing stability. The Budget Act of 2018 provided $15 million General Fund (one-time) to fund the program over a three-year period, ending on June 30, 2021. The program is funded with a dollar-for-dollar match requirement, and a portion of funds are reserved for program evaluation purposes.

DSS released a Request for Proposals to local agencies in October 2018. The department received proposals from 36 counties, requesting a total of $29.5 million in total. The proposals were evaluated based on local need, the ability to use evidence-based practices, the ability to quickly implement with strong partnerships, and the ability to provide quality data to facilitate program evaluation. In December 2018, DSS allocated funds to the following 24 counties: Alameda, Contra Costa, Fresno, Humboldt, Kern, Kings, Los Angeles, Mariposa, Mendocino, Merced, Nevada, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, Santa Cruz, Shasta, Sonoma, Tehama, Ventura, and Yuba. DSS is also initiating data collection and collaborating with Dr. Margot Kushel at the University of California – San Francisco to provide an external evaluation of the program.

Federal Grants. APS received a federal Administration for Community Living (ACL) grant of $198,665 to study and develop an improved comprehensive data collection system in line with the National Adult Maltreatment Reporting System (NAMRS). With that funding, DSS developed a report on the costs, pros, and cons of a variety of mechanisms to provide de-identified case level data to the federal government. Additionally, state aggregate data was improved by revising the data collection system to include aggregate data on clients, perpetrators, and services provided.

APS received another federal ACT grant of $373,259 per year from federal fiscal year 2018-19 through 2020-21 to increase the capacity of APS managers to drive program improvements. These improvements would be made by providing training to APS managers by national experts, and a pilot of the first ever APS Master of Social Work stipend program with a two year employment payback requirement.

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 its funding.

2. Please provide an update on the implementation of the Home Safe Program.

Issue 2: Proposals for Investment

1. Increased Funding for APS Social Worker Training

Budget Issue. The California Welfare Directors Association (CWDA), the California State Association of Public Administrators/Guardians/Conservators, the California Commission on Aging, and the California Elder Justice Coalition request $5.75 million General Fund over three years to provide additional resources for APS social worker training.

Staff Comment and Recommendation. The $3 million in funding for APS training provided in 2016 will expire at the end of this fiscal year. **Hold open**.

5180 DEPARTMENT OF SOCIAL SERVICES – SSI/SSP

Issue 3: 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 (29 percent), are blind (one percent), or have disabilities (70 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.

Budget Issue. The budget proposes $9.9 billion ($2.8 billion General Fund) for SSI/SSP. The revised 2018-19 budget provides $9.8 billion ($2.8 billion General Fund) for the programs. The decrease is due to a lower than previously projected caseload. The state pays administration costs to the Social Security Administration (SSA) to distribute SSP, around $186.7 million for the budget year. Costs for SSI/SSP include the Cash Assistance Program for Immigrants and the California Veterans Case Benefit Program.

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. 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 2019-20, the estimated monthly average caseload is 1,036 cases for CAPI and 14,158 for extended CAPI. Effective June 1, 2019, CAPI recipients will receive a $10 grant increase for individuals and a $20 grant increase for couples to create parity with SSI/SSP program benefits.

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 2019-20, the department estimates that the average caseload is around 174 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 2019-20 Governor's

budget, DSS projects that the caseload for 2018-19 will decrease by 1.1 percent and the caseload for 2019-20 will decrease by another 1.2 percent. The department suggests possible reasons for the slight decline in SSI/SSP caseload include increased financial stability, healthier behavior and lifestyles, improvements in medical technology, less income eligible individuals, and asset limits. SSI asset limits of $2,000 for individuals and $3,000 for couples prevent many from qualifying for SSI. These asset thresholds have not been updated since 1989 and would be about twice as high today had they been indexed to inflation.

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.

Grant Levels. The table below displays the maximum monthly SSI/SSP grant for individuals and couples proposed in the Governor's budget, as compared to grant levels for 2018–19.

Figure 15

SSI/SSP Monthly Maximum Grant Levels[a] Governor's Proposal

	2018-19	2019-20 Governor's Estimates[b]	Change From 2018-19
Maximum Grant—Individuals			
SSI	$771.00	$790.00	$19.00
SSP	160.72	160.72	—
Totals	**$931.72**	**$950.72**	**$19.00**
Percent of Federal Poverty Level[c]	90%	91%	
Maximum Grant—Couples			
SSI	$1,157.00	$1,186.00	$29.00
SSP	407.14	407.14	—
Totals	**$1,564.14**	**$1,593.14**	**$29.00**
Percent of Federal Poverty Level[c]	111%	113%	

[a] The maximum monthly grants displayed refer to those for aged and disabled individuals and couples living in their own households, effective as of January 1 of the respective budget year.
[b] Reflects Governor's budget estimate of the January 2020 federal cost-of-living adjustment for the SSI portion of the grant.
[c] Compares grant level to federal poverty guidelines from the U.S. Department of Health and Human Services for 2019.

Source: Legislative Analyst's Office

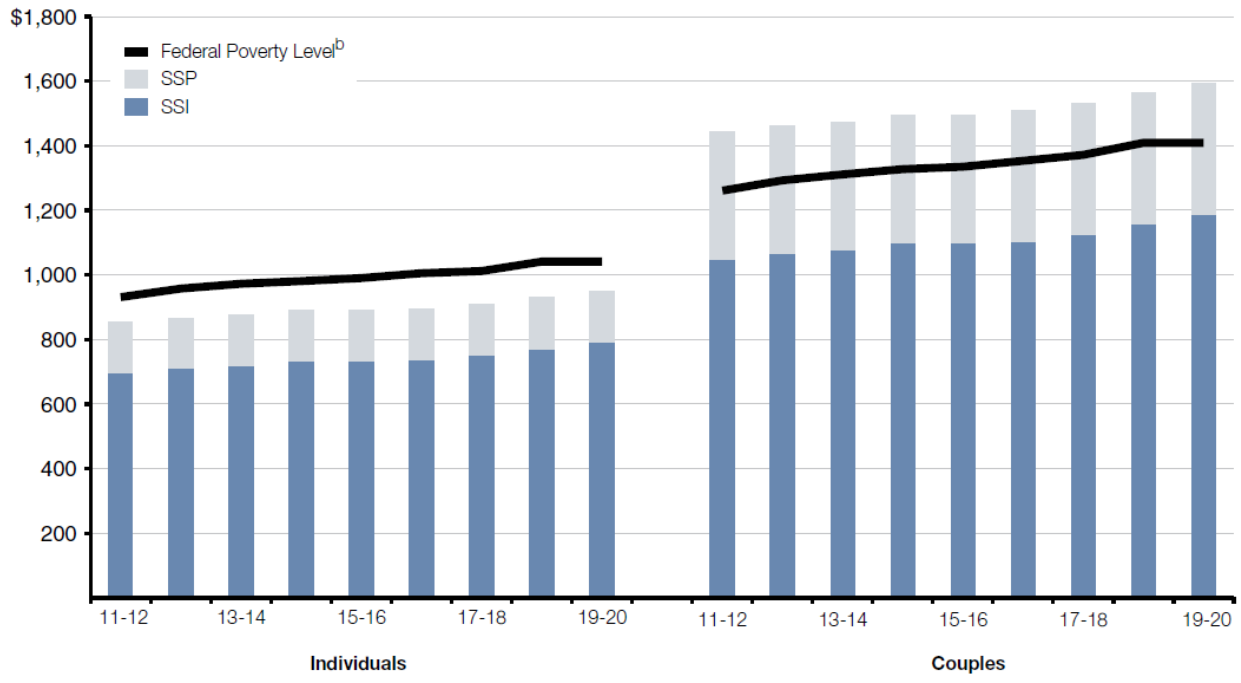
Under current law, the federal SSI grant payments for SSI/SSP recipients are adjusted for inflation each January through cost-of-living adjustments (COLAs). The Governor's budget estimates that the federal government will adjust the SSI portion by 2.5 percent in 2020. This equates to an increase in the maximum monthly SSI/SSP grant by $19 for individuals and $29 for couples. However, the actual increase will not be known until the fall.

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. 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. The 2019-20 Governor's budget does not include an increase to the SSP grant, however the 2018 Budget Act included trailer bill language that codified COLAs to SSP grants beginning in 2022-23, subject to funding in the annual Budget Act.

The maximum grants for individuals and couples have gradually increased since 2011-12. Even with these increases, current maximum SSI/SSP grants for individuals are below the federal poverty level (FPL), and grants for couples are just above the FPL. As of January 2019, the federal poverty level for individuals is $1,041 per month and $1,409 per month for couples. The graphic below compares maximum grant amounts for couples and individuals compared to the federal poverty level.

Figure 14

Maximum SSI/SSP Grants for Individuals and Couples[a] Compared to Federal Poverty Level[b]



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

[b] Federal poverty guidelines as established by U.S. Department of Health and Human Services, effective as of January 1 of the respective budget year.

SSI/SSP = Supplemental Security Income/State Supplementary Payment.

LAO

Source: Legislative Analyst's Office.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide a brief overview of the SSI/SSP program, caseload levels, and budget.

2. Please summarize the changes to SSI/SSP grant levels in recent years.

Issue 4: SSI/SSP and CalFresh Expansion – BCP and Update

Governor's Proposal. The Administration requests a total of $1.4 million ($711,000 General Fund and $710,000 federal funds) to expand CalFresh to SSI/SSP recipients (also known as reversal of the SSI Cash-out policy), along with the Supplemental and Transitional Nutrition Benefit programs. The request includes two-year limited-term funding for eleven positions.

The revised 2018-19 budget estimates a total of $35.2 million for implementation, and the 2019-20 proposed budget estimates a total of $105.2 million for 2019-20 implementation.

Background. The "SSI Cash-out" is a state policy that provides SSI/SSP recipients with an extra $10 payment in lieu of their being eligible to receive federal food benefits through the CalFresh program. AB 1811 (Committee on Budget), Chapter 35, Statutes of 2018, ended this policy. This expansion of benefits is effective beginning June 1, 2019. It is estimated that the policy change will increase the CalFresh caseload by approximately 370,000 new households, or 20 percent.

The Supplemental Nutrition Benefit (SNB) and Transitional Nutrition Benefit (TNB) programs were established to offset the loss of food benefits among impacted CalFresh households when CalFresh is expanded. Current CalFresh households with a previously excluded SSI/SSP recipient member may experience a change in benefits, depending on the household's specific circumstances, upon adding that previously excluded household member. To be eligible for either the SNB or TNB, households must be participating in CalFresh on June 1, 2019, and have included a previously excluded SSI/SSP recipient in the household at that time. Once a household becomes ineligible for either program, eligibility cannot be regained.

SNB Program. For households that see a decrease in benefits a monthly supplemental benefit will be provided through the SNB program. Households determined eligible for the program will continue to be eligible until all previously excluded SSI/SSP recipient members are no longer in the household or the household is no longer participating in CalFresh. The department estimates that approximately 73,000 households will experience a decrease in CalFresh benefits and become eligible for the SNB. However, not all of those households will come into the program at the same time. Enrollment in the program will be phased in based on when the households mid-period report, recertification, or voluntary request occurs. In June 2019, the department estimates 11,655 households' will be eligible for the SNB. In 2019-20, 58,631 households are anticipated to be determined eligible for the SNB. For most of these households, the benefit amount will be higher than the potential loss. The SNB program will provide an average state-funded monthly benefit of approximately $110 per month.

TNB Program. For households that become ineligible for CalFresh a transitional benefit will be provided through the TNB. Households determined eligible for the program will continue to be eligible until all previously excluded SSI/SSP recipient members are no longer in the household or the household regains CalFresh eligibility. The department estimates that approximately 7,000 households will become ineligible for CalFresh and become eligible for the TNB. As with the SNB program, not all

of those households will come into the program at the same time. Enrollment in the program will be phased in based on when the household's mid-period report, recertification, or voluntary request occurs. In June 2019, the department estimates 1,130 households will be eligible for the TNB. In 2019-20, 5,687 households are anticipated to be determined eligible for the TNB. The TNB program will provide an average state-funded monthly benefit of approximately $174 per month.

Funding. The Budget Act of 2018 provided a total of $220 million General Fund (one-time) for implementation. The revised 2018-19 budget includes $35 million General Fund for implementation, as this reflects the estimated costs necessary for each fiscal year of implementation instead of the entire $220 million originally appropriated in 2018-19. The 2019-20 proposed budget estimates $105.2 million for implementation. A further breakdown of the estimated costs for 2018-19 and 2019-20 is reflected below. Note that the 2018-19 costs only reflect June 2019, the first month of implementation.

FY 2018-19 Estimated Total Costs: $35.2 million General Fund
- $22.5 million for administration related to newly eligible CalFresh households
- $200,000 for SNB/TNB administration
- $12 million for automation
- $400,000 for SNB/TNB benefits
- $100,000 for CAPI parity

FY 2019-20 Estimated Total Costs: $105.2 million General Fund
- $15.4 million for administration related to newly eligible CalFresh households
- $1.3 million for SNB/TNB administration
- $86.7 million for SNB/TNB benefits
- $1.8 million for CAPI parity

Requested Positions. The Administration requests limited-term funding for eleven positions. The table below provides a list of the positions and the sections the positions will be assigned to.

Position(s)	Section	Issue to Address
One Staff Services Manager I (SSM) and two Associate Governmental Program Analysts (AGPA)	Management Evaluation Section, Operations Bureau, CalFresh Branch	To address the increase in county management evaluations triggered by the caseload increase.
One AGPA	Quality Control Section, Operations Bureau, CalFresh Branch	To conduct additional quality control reviews in order to meet federal review requirements.
Two AGPAs	Policy Bureau, CalFresh Branch	To provide additional policy guidance and interpretation related to elderly and disabled CalFresh recipients.
One AGPA	Automation, Integrity, and Client Initiatives Branch	To support automation needs resulting from the policy change and the SNB and TNB.
One AGPA	Civil Rights Unit, Housing, Homelessness and Civil Rights Branch	To respond to an increase in discrimination complaints arising from increase in CalFresh recipients.
One Research Analyst	Fiscal Forecasting and Policy Branch, Administrative Division	To provide analysis of caseload increase, benefit issuance, and use of county administration dollars.
Two Accounting Officers	Accounting and Fiscal Systems Branch, Administrative Division	To address implementation using an EBT card methodology that will require additional record keeping, bank account reconciliation, ledger account updates, and increased reporting.

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

- Andrew Cheyne, Director of Government Affairs, California Association of Food Banks (CAFB)
- Frank Mecca, Executive Director, California Welfare Director's Association (CWDA)
- Trinh Phan, Staff Attorney, Justice in Aging

CWDA requests an additional one-time augmentation of $15.4 million ($5.3 million General Fund) to address county administrative costs of implementing the CalFresh expansion.

A coalition of advocates request budget trailer bill language to address issues and concerns relating to the SNB and TNB programs, including language to make the programs entitlements.

Staff Comment and Recommendation. Hold open.

Questions.

For DSS:

1. Please provide an overview of the budget change proposal.

2. Please provide an update on the implementation of the CalFresh expansion.

3. Describe the outreach efforts the department is undertaking around the SNB and TNB. Is the department working with other agencies on outreach efforts?

For Frank Mecca, California Welfare Director's Association (CWDA):

4. Please provide an update on the implementation from the perspective of the counties.

For Trinh Phan (Justice in Aging) and Andrew Cheyne (CAFB):

5. Please provide your perspective on the implementation process.

Issue 5: Housing and Disability Advocacy Program (HDAP)

Governor's Proposal. The Administration requests an additional $25 million General Fund ongoing for the program.

Background. Applying to SSI is a complicated and challenging process, particularly for applicants that are homeless or have severe mental disabilities. HDAP offers assistance in applying for disability benefit programs and offers housing supports to individuals who are disabled and experiencing homelessness. The program is administered by individual counties. Counties provide a variety of services such as outreach, case management, advocacy, and housing support to all recipients. Counties must ensure that those with the highest needs are given priority, such as those experiencing chronic homelessness and those that most heavily rely on state- and county-funded services.

Funding. 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 the Housing and Disability Advocacy Program (HDAP) was established. $513,000 of the $45 million was reserved for staffing the program and to make it operational as soon as possible. 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 funds are now available through June 30, 2020. HDAP has a dollar-for-dollar county match requirement, bringing the total budget for the program to $90 million.

Below is a list of the 39 counties that received HDAP funding and the total amount allocated to each county.

County	Funding Allocated	County	Funding Allocated	County	Funding Allocated
Alameda	$1.96 million	Modoc	$75,000	San Mateo	$538,684
Butte	$433,038	Mono	$75,000	Santa Clara	$2.4 million
Colusa	$75,000	Monterey	$568,670	Santa Cruz	$741,277
Contra Costa	$746,546	Napa	$186,488	Shasta	$300,000
Fresno	$755,864	Nevada	$151,062	Sonoma	$1.1 million
Glenn	$75,000	Orange	$2.1 million	Stanislaus	$440,662
Humboldt	$296,003	Placer	$197,002	Tulare	$291,046
Inyo	$75,000	Riverside	$1.4 million	Tuolumne	$75,000
Kern	$600,000	Sacramento	$1.3 million	Ventura	$190,483
Lassen	$75,000	San Benito	$142,052	Yolo	$190,483
Los Angeles	$17.6 million	San Bernardino	$1 million	Yuba	$111,188
Marin	$385,924	San Diego	$3.1 million		
Mendocino	$215,771	San Francisco	$2.5 million		
Merced	$261,788	San Luis Obispo	$414,294		

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 a total of 41 counties applied. The department allocated funds in two rounds. Round one allocations (November 2017-January 2018) were based on need. Funds remaining after round one were allocated on a competitive basis in April 2018. $41 million was allocated to 39 counties during round one, and an additional $3 million was available for allocation in round two.

Between January 2018 and November 2018:

- 2,161 total referrals have been received.
- 1,153 participants have been approved for or engaged in services.
- 385 disability benefit applications have been submitted.
- 110 applications for disability benefits have been approved.
- 215 participants have been permanently housed.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an update on HDAP implementation.
2. How will the success of the program be measured?
3. Please provide detail on how the requested $25 million will be used.

Issue 6: Proposals for Investment

1. SSI Grant Increase and Restoration of COLA for SSP

Budget Issue. Californians for SSI requests that SSI grants be augmented to bring them to 100 percent of the federal poverty level, resulting in total costs of close to $1 billion. In addition, the proposal requests the re-establishment of the statutory COLA for the SSP grant portion, effective January 1, 2020. Restoration of the SSP COLA would result in roughly $50 million total costs in 2019-20 and approximately full year costs of $100 million.

Staff Comment and Recommendation. SSI/SSP grant amounts will be a maximum of $950 beginning January 1, 2020, but the 2020 federal poverty level for a single individual is estimated to be $1,056 a month. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – IN-HOME SUPPORTIVE SERVICES (IHSS)

Issue 7: Overview

The In-Home Supportive Services (IHSS) program provides personal care services to approximately 560,000 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 $12.7 billion ($4.3 billion General Fund) for services and administration. The 2018-19 budget provided $11.5 billion ($3.7 billion) for the program. Overall, the increased costs for IHSS in 2019-20 are due to a higher projected caseload, an increase in paid hours per case, and the increase in the hourly minimum wage from $12.00 to $13.00, effective January 1, 2020. The average monthly cost of services per IHSS client is estimated to be approximately $1,647 for 2019-20. This estimate averages 564,330 consumers will be authorized for an average of 110.1 hours per month.

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 annually reassess 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.

As of December 31, 2018, 15 percent of IHSS consumers are 85 years of age or older, 40 percent are ages 65-84, 38 percent are ages 18-64, and seven percent are 17 years of age or younger. There are approximately 500,000 IHSS providers.

Program Funding. The program is funded with federal, state, and county resources. Federal funding is provided by Title XIX of the Social Security Act. About 98 percent of the IHSS caseload receives federal funding. Depending on the circumstances, the federal government provides a 50 percent or 56 percent match. Historically, the state and counties split the non-federal share of IHSS program costs at 65 and 35 percent, respectively. When the state transferred various programs from the state to county control during 1991 Realignment, 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

With the enactment of the Coordinated Care Initiative (CCI), the funding structure changed as of July 1, 2012, with county IHSS costs based on a maintenance-of-effort (MOE) requirement, meaning county costs would reflect a set amount of IHSS costs as opposed to a certain percent of costs. 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 2019-20 budget proposes changes to the MOE, which will be discussed further in the next item.

Other Policy Changes. Several recently enacted policies impact the IHSS program – both fiscally and programmatically, 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 for the duration of the Managed Care Organization (MCO) tax. Under current law, the MCO tax will expire on July 1, 2019. The proposed 2019-20 budget does not include a renewal of the MCO tax, however, it does propose to restore the seven percent reduction effective July 1, 2019. The budget includes $342.3 million General Fund for this purpose. Note that the Administration is not proposing to eliminate the current statutory language that ties the seven percent restoration to the existence of the MCO tax, however the Administration has expressed its intent that the restoration be ongoing.

- **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, moved the state's $10 per month minimum wage to $10.50 at the beginning of 2017, and scheduled annual increases to $15 for most employers by 2022. As of January 1, 2019, the minimum wage is set at $12.00. The budget includes $552.7 million ($252.7 million General Fund) to reflect the impact of the increasing state minimum wage. An additional $340.9 million ($155.8 million General Fund) is included in the budget to reflect the impact of the minimum wage increasing to $13.00 on January 1, 2020.

  SB 3 also provided 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. $29.3 million General Fund is included in 2019-20 for this purpose, assuming all providers use eight hours. Another crucial component of implementing sick leave is the provider back-up system for recipients. 2018-19 budget trailer bill language directed DSS, in consultation with the Department of Finance and stakeholders, to reconvene the paid sick leave workgroup for IHSS no later than February 1, 2019, to discuss the issue.

- **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 workweek. 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. $264 million General Fund is included in the current year, and $292.4 million General Fund is included in the budget year, for these purposes.

- **Electronic Timesheets.** In an effort to streamline timesheet processing, and in response to requests from IHSS stakeholders, DSS implemented online IHSS timesheets in three pilot counties (Sacramento, Yolo, and Riverside) 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 December 2018, 177,758 (35 percent) providers and 157,309 (27 percent) recipients are enrolled to use electronic timesheets. The department is also working on plans to increase the use of direct deposit as well as other electronic funds transfer options.

- **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, (3) the location of the service, and (4) the identities of the provider and consumer. California has until January 2020 to comply for personal care services, and until January 2023 for home care services, or escalating penalties will be incurred.

  In October 2018, the department submitted a request for $8 million ($800,000 General Fund and $7.2 million federal reimbursements) to the Department of Finance (DOF) in order to comply with the federal mandate to implement EVV. The department will use the funds to modify its

existing Case Management, Information, and Payrolling System (CMIPS). The department will leverage and enhance its existing Electronic Services Portal and Telephonic Timesheet System to meet EVV requirements. The requested funds will be used to develop a workable prototype of both of these enhanced systems. As of December 2018, the department has held four statewide stakeholder meetings that included representatives of recipients, providers, advocacy groups, labor unions, counties, the Legislature, and the Administration. The department plans to begin stakeholder demonstrations of the enhanced EVV web portal in the spring of 2019.

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 reconvening of the paid sick leave workgroup and its discussion of a provider back-up system.

3. Please provide an update on the status of EVV, stakeholder engagement, and the development of prototypes for the enhanced systems.

4. Please summarize current implementation and usage of electronic timesheets. How is the department encouraging providers and recipients to enroll?

5. Please identify how many individuals have been sanctioned for time card errors to date under FLSA and any steps the department is taking to reduce the sanction rate.

Issue 8: IHSS Maintenance-of-Effort (MOE) TBL

Governor's Proposal. The Administration proposes changes to the IHSS county MOE in the 2019-20 budget. Specifically, the following changes are suggested:

- Adjust the county MOE to $1.56 billion, reducing it from $1.9 billion.

- Apply annual inflation factor of four percent to the MOE beginning in 2020-21. Once the state minimum wage reaches $15 per hour, future county negotiated IHSS wage and health/non-health benefit increases will be shared 35 percent state and 65 percent county, with no state participation cap.

- Eliminate the General Fund mitigation and end redirection of health and mental health Vehicle License Fee (VLF) revenue. Counties currently receive assistance from the General Fund and VLF revenue that would otherwise go to health and mental health programs, to cover counties' IHSS costs. The budget proposes to eliminate the General Fund Assistance and the redirection of VLF revenue in 2019-20.

- Apply the MOE to fund only IHSS services. A General Fund appropriation will support administration costs for the program and any expenditures over the appropriation amount will be paid by counties.

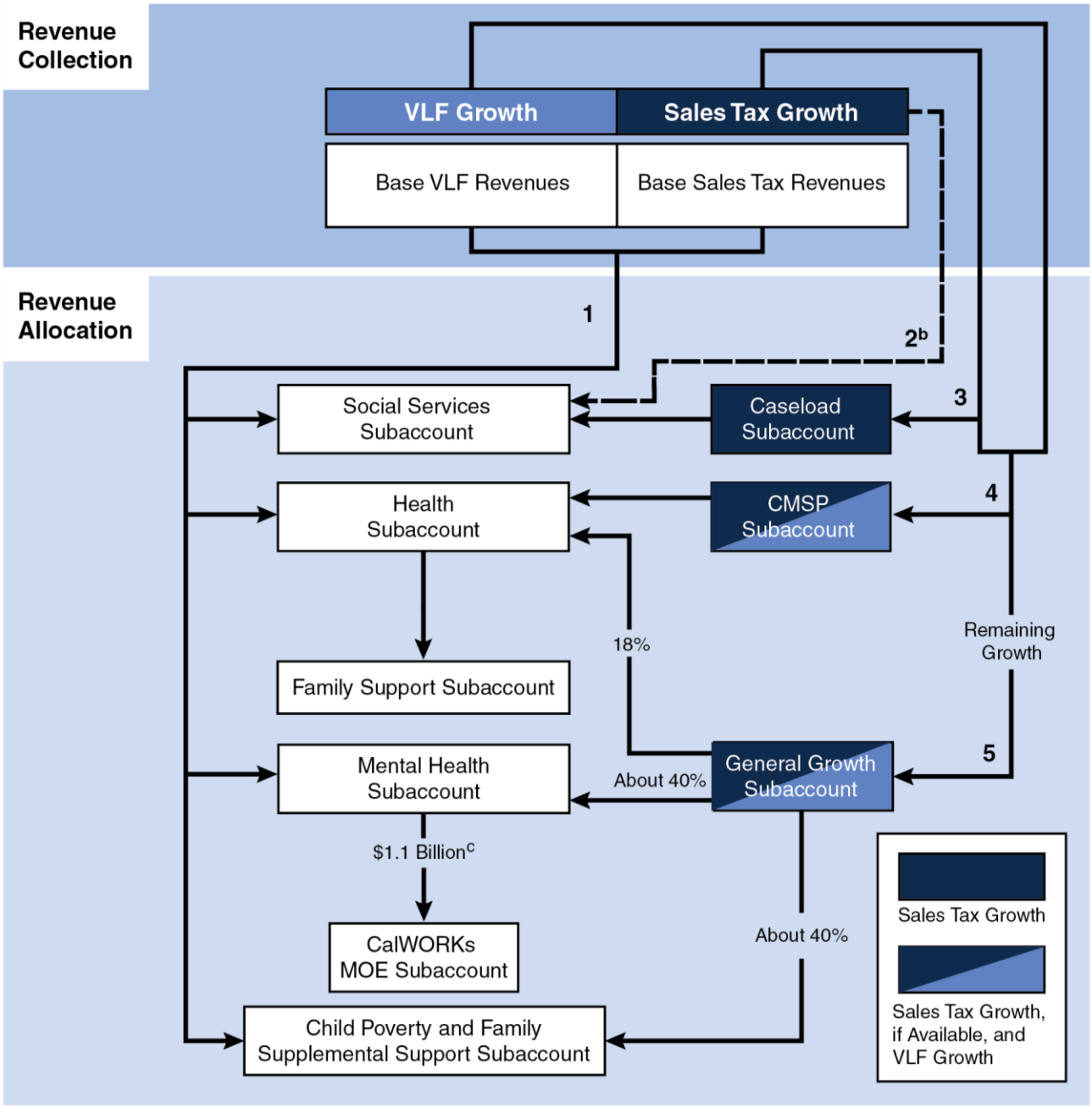
The proposed changes would increase General Fund costs for IHSS by $241.7 million in 2019-20, $369.4 million in 2020-21, $454.4 million in 2021-22, and $537.3 million in 2022-23. The Department of Finance also estimates that there would be a Realignment revenue shortfall of about $9.5 million in 2021-22, and almost $25 million in 2022-23.

1991 Realignment. In 1991, the Legislature shifted significant fiscal and programmatic responsibility for many health and human services programs from the state to counties—referred to as 1991 realignment. The 1991 realignment package: (1) transferred several programs and responsibilities from the state to counties, (2) changed the way state and county costs are shared for certain social services programs, (3) transferred health and mental health service responsibilities and costs to the counties, and (4) increased the sales tax and VLF and dedicated these increased revenues to the new financial obligations of counties for realigned programs and responsibilities. Today, counties receive about $6.5 billion (over $3 billion from sales tax, $2 billion from VLF, and about $1 billion transferred from another realignment for mental health) through 1991 realignment.

The figure on the next page provides an overview of how funds flow in 1991 realignment.

How Funds Flow in 1991 Realignment[a]

Local Revenue Fund



[a] Figure generally shows how funds flowed before 2017-18 and how funds will flow after 2022-23.

[b] This allocation of the sales tax growth did not occur until 2017-18, but will continue after 2022-23.

[c] Funds transferred to the CalWORKs MOE Subaccount are backfilled by 2011 realignment funds.

VLF = vehicle license fee; CMSP = County Medical Services Program; and MOE = maintenance of effort.

LAO

IHSS County Costs. Historically, counties paid 35 percent of the nonfederal—state and county—share of IHSS service costs and 30 percent of the nonfederal share of IHSS administrative costs. Beginning in 2012-13, however, the historical county share of cost model was replaced with an IHSS county

maintenance-of-effort (MOE), meaning county costs would reflect a set amount of nonfederal IHSS costs as opposed to a certain percent of nonfederal IHSS costs. In 2017-18, the initial IHSS MOE was eliminated and replaced with a new county MOE financing structure—referred to as the 2017 IHSS MOE. Under this MOE, counties are responsible for paying based on 2017-18 actual expenditures, which is adjusted for locally negotiated, mediated, imposed, or adopted by ordinance increases to wages and/or benefits and an annual inflation factor. The county MOE will increase by an inflation factor – five percent for 2018-19, and seven percent for the following fiscal years.

The 2018-19 IHSS county MOE is $1.87 billion, which includes the inflation factor amount of $88.2 million and the 2018-19 pending MOE adjustments for wage/health benefits/non-health benefit increases of $15.8 million. The MOE provides fiscal relief to counties for IHSS program costs through a combination of General Fund offsets and temporary redirection of 1991 Realignment growth funds from county indigent health and mental health services. For 2018-19, the county mitigation is $318.7 million.

The table below provided by the Legislative Analyst's Office (LAO) breaks out IHSS administration and service costs under the current MOE and the adjusted MOE proposed in the Governor's Budget.

	IHSS County MOE Costs *(In Thousands)*			
	2017-18	**2017-18**	**2018-19**	**2019-20**
	Actual (based on 2017 May)	**Final FY 2017-18** (based on 2018 May)	**Revised Estimate** (based on 2019-20 GB)	**Estimate** (based on 2019-20 GB)
Total IHSS County MOE Costs	**$1,769,443**	**$1,761,202**	**$1,868,731**	**$1,559,201**
Share of IHSS Service Costs	$1,672,127	$1,663,659	$1,766,31	N/A
Share of IHSS Administrative Costs	$97,316	$97,543	$102,420	N/A

Senate Bill 90 – 1991 Realignment Report. The Budget Act of 2017 included a requirement for the Department of Finance (DOF) to submit a report to the Legislature that would review the funding structure of the 1991 realignment. More specifically, the Budget Act required the report to include the following:

1) The extent to which revenues available for 1991 realignment are sufficient to meet program costs that were realigned.

2) Whether the IHSS program and administrative costs are growing by a rate that is higher, lower, or approximately the same as the MOE, including the inflation factor.

3) The fiscal and programmatic impacts of the IHSS MOE on the funding available for the Health Subaccount, the Mental Health Subaccount, the County Medical Services Program Subaccount, and other social services programs included in 1991 Realignment.

4) The status of collective bargaining for the IHSS program in each county.

DOF Report Findings. The DOF released the report with the Governor's 2019-20 budget. The report includes background on 1991 Realignment and the IHSS program, responses to the specific questions posed above, and findings and recommendations. The report acknowledged that the revenue sources for 1991 Realignment are not sufficient to cover increased program costs due to several changes in the structure of 1991 Realignment including collective bargaining, minimum wage increases, and federal overtime rules. IHSS has been one of the fastest growing programs within the state budget with mostly double-digit growth rates each year, with the exception of years where reductions were made in order to balance the budget. The 2017 MOE included an inflation factor of seven percent annually, which is below the average annual growth rate of eleven percent.

In the years that CCI was in effect and the annual county MOE growth was 3.5 percent, both the Mental Health and Health Subaccounts received growth funding. With the elimination of CCI and the subsequent 2017-18 budget agreement, the Health, CMSP and Mental Health Subaccounts would, after the period of redirection, only receive VLF growth. All available sales tax growth would now go to fund the increased caseload costs for the social services programs. There have been very few times since 2005-06 when both mental health and health received growth funding.

As of November 2018, twenty-seven counties were engaged in collective bargaining. Fourteen counties had expired MOUs with no negotiations reported. Fourteen other counties have MOUs that have not yet expired. Only one county reported being at impasse.

The report proposed a number of recommendations that are reflected in the proposed changes to the IHSS MOE in the Governor's budget. These changes would make it so county general purposes funds would not be needed to cover IHSS costs, and the Mental Health and Health Subaccounts can receive growth based on the historical formula.

LAO Comments. The graphic below provides a brief summary of the Governor's proposed changes to the IHSS MOE, as well as an assessment of each change by the LAO.

Summary of LAO's Assessment on Governor's Proposals

Governor's Proposal	Primary Principle Addressed	LAO's Assessment
IHSS-Related Changes		
Rebase IHSS County MOE	Counties' share of costs reflect their ability to control costs in the program.	Reduced share of cost in IHSS for counties is a move in the right direction. However, IHSS MOE is based on available revenue, rather than counties ability to control costs in the program.
	Revenues generally cover costs over time.	Realignment revenues would generally cover county costs, at least in near term, but would place significant and growing cost pressures on General Fund.
Lower the Annual Adjustment Factor for IHSS MOE	Revenues generally cover costs over time.	Lower adjustment factor generally aligned with recent growth in annual realignment revenues, thereby improving the chances of revenues covering total county IHSS costs over time. However, the adjustment factor is far less than average annual growth in IHSS costs, resulting in growing cost pressures on General Fund.
Eliminate General Fund Assistance and Redirected VLF Growth Funds	Funding is transparent and understandable.	Reasonable to eliminate General Fund assistance to counties given financial relief provided by rebased MOE and lower annual adjustment factor. Redirection frees up revenue for health, mental health, and CalWORKs. While complexity remains, these changes unwind some of the complexity introduced by the 2017 IHSS MOE.
Increase County Share of Cost for Locally Established IHSS Wage and Benefit Increases	Counties' share of costs reflect their ability to control costs in the program.	Increase to counties' share of nonfederal costs for county negotiated wage and benefit increases seems to right-size counties fiscal responsibility over a cost counties can control.

In their publication, "Assessing the Governor's 1991 Realignment Proposals," the LAO notes that 1991 realignment revenues do not cover county costs, and finds that the Governor's proposals provides a reasonable approach for bringing 1991 realignment into financial balance. However, it is also noted that a trade-off of the reduction in counties' costs is increased state costs. The LAO recommends that the Legislature begin to plan for the impact of the state's growing elderly population on the state budget. In addition, the LAO notes that it is unclear whether realignment revenues will be sufficient to cover counties' costs long-term.

Panel. The subcommittee has requested the following panelists, in addition to DSS and the LAO, to provide comment on the proposed changes to the IHSS MOE:

- Graham Knaus, Executive Director, California State Association of Counties

Staff Comment and Recommendation. Hold open. The higher state share of cost for IHSS is appropriate, however the state is limited in its ability to control increasing cost pressures associated with IHSS. The Legislature should plan for the impact these increasing costs will have on the state budget and consider monitoring realignment revenues through the annual budget process.

Questions.

For LAO:

1. Please provide a walkthrough of the graphic on page 35 that shows how funds flow in 1991 realignment.

For DOF:

2. Please provide a brief summary of the recent DOF report, "Senate Bill 90 – 1991 Realignment Report," and how the 2019-20 Governor's budget, particularly as it relates to IHSS, reflects the report's recommendations.

For Graham Knaus, CSAC:

3. Please provide comment on the proposed changes to the IHSS MOE, and any concerns you may have.

Issue 9: BCP – IHSS State Administrative Review and Data Analysis

Governor's Proposal. The Administration requests $235,000 for the permanent extension of two three-year limited-term positions to support ongoing workload for the State Administrative Review (SAR) process and data analysis.

Background. The Fair Labor Standards Act (FLSA) is the primary federal statute dealing with minimum wage, overtime pay, child labor, and related issues (discussed in issue 7). The statute 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. IHSS providers who have received FLSA violations can appeal through the SAR process, which was implemented as part of the FLSA. Upon FLSA implementation, the department redirected one position to the Appeals and Administrative Review Unit (AARU) to process SAR requests. This proposal requests a permanent extension of funding for this position to continue processing of SAR requests.

The Research and Data Analysis Unit (RADU) within the department is responsible for creating custom data queries to produce IHSS program data reports. Examples include daily and monthly data extraction and reporting on FLSA violations, overtime hours and payment, wait time, and travel time. The department redirected one position to the unit in order to meet the complex and increasing workload demand in the unit and to replace a limited-term position that had previously expired. The funding associated with the redirected position is set to expire on June 30, 2019. This request for a permanent extension of the funding will help meet the workload demands of the RADU.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

Issue 10: Proposals for Investment

1. Codify EVV Protections

Budget Issue. The California Association of Public Authorities (CAPA) for IHSS, UDW/AFSCME Local 3930, and SEIU California requests the Legislature codify protections that were made in the 2018 Budget Act to protect IHSS providers and consumers. Those protections were in effect for one year, and included the prohibition of GPS tracking technology among other protections.

Staff Comment and Recommendation. Hold open.

2. Actuarial Study for LTSS Financing and Service Options

Budget Issue. The California Aging and Disability Alliance (CADA) request a one-time $1 million General Fund augmentation for a feasibility study and actuarial analysis of long-term services and supports financing and services options. CADA notes that by 2030, more than one million older adults in California will require some assistance with self-care. Despite this, LTSS are not adequately covered by Medicare and most Californians cannot afford to purchase private long-term care insurance. The requested study will identify the costs and benefits to the state of establishing LTSS financing options.

Staff Comment and Recommendation. Hold open.

3. Permanent Restoration of 7 Percent Cut in IHSS Service Hours

Budget Issue. CAPA, UDW/AFSCME Local 3930, and SEIU California requests the Legislature include trailer bill language to rescind Welfare and Institutions Code Sections 12301.01 through 12301.05 to permanently restore the 7 percent across-the-board IHSS service hours. The Governor's budget proposes to restore the 7 percent service hours, but this restoration could be rescinded in future years. Making this restoration permanent would equate to a $342 million ongoing allocation.

Staff Comment and Recommendation. Hold open. Note that the Administration is not proposing to eliminate the current statutory language that ties the 7 percent restoration to the existence of the MCO tax, however the Administration has expressed its intent that the restoration be ongoing.

4. Public Authority Administrative Funding

Budget Issue. The California Association of Public Authorities (CAPA) for IHSS requests an additional $5 million to cover administration costs for IHSS Public Authorities.

Staff Comment and Recommendation. Hold open. CAPA is working with the department to resolve this issue.

5. Link IHSS County MOE to Collective Bargaining

Budget Issue. UDW/AFSCME Local 3930 and SEIU California request that the state reduce a county's IHSS MOE annual inflation factor to 4 percent only when a collective bargaining agreement is in place in which the negotiated wage for IHSS providers is at least above the state minimum wage. The proponents note that only seven of the 21 counties represented by UDW have collective bargaining agreements in place, and 14 of the 37 counties SEIU represents have a collective bargaining agreement.

Staff Comment and Recommendation. Hold open. Counties without a collective bargaining agreement in place would have an annual inflation factor that is consistent with current law - five percent or seven percent, depending on the circumstances.

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

SUBCOMMITTEE NO. 3 Agenda

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

Thursday, March 21, 2019
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Scott Ogus

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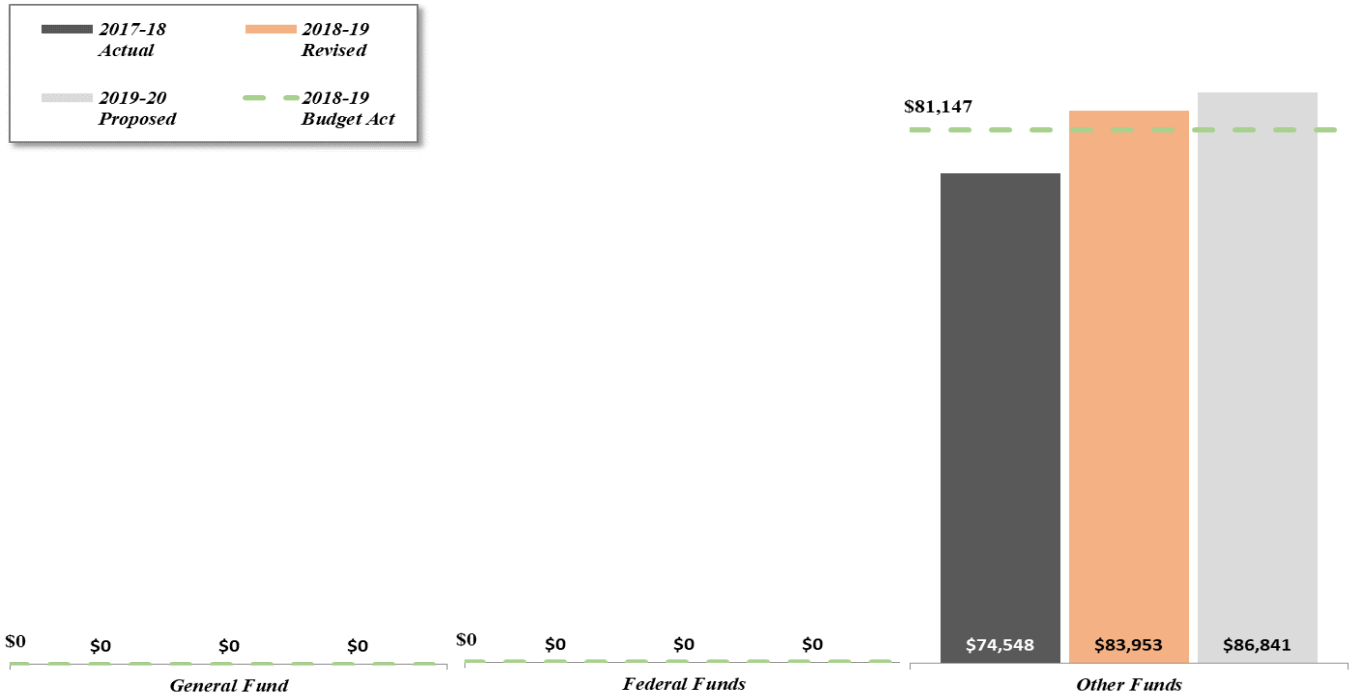
PUBLIC COMMENT

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

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	***2018-19 Budget Act***	***2018-19 Revised***	***2019-20 Proposed***
General Fund (0001)	$0	$0	$0
Federal Funds (0890)	$0	$0	$0
Other Funds (*detail below*)	$81,147,000	$83,953,000	$86,841,000
Total Department Funding:	**$81,147,000**	**$83,953,000**	**$86,841,000**
Total Authorized Positions:	**417.6**	**417.6**	**437.6**
Other Funds Detail:			
Managed Care Fund (0933)	*$80,976,000*	*$83,782,000*	*$86,670,000*
Reimbursements (0995)	*$171,000*	*$171,000*	*$171,000*

Background. The Department of Managed Health Care (DMHC) is the primary regulator of the state's 126 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 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.

In December 2018, DMHC published its timely access report for calendar year 2017. According to DMHC, although the data reporting suffered from some of the same individual categories of inaccuracies, the overall quality of the data improved significantly. The key findings for calendar year 2017 were as follows:

Full-Service Health Plans:

- The percentage of all surveyed providers who had appointments available within the wait time standards (urgent and non-urgent) ranged from a high of 99 percent to a low of 63 percent.
- For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 99 percent to a low of 70 percent.
- For urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 99 percent to a low of 52 percent

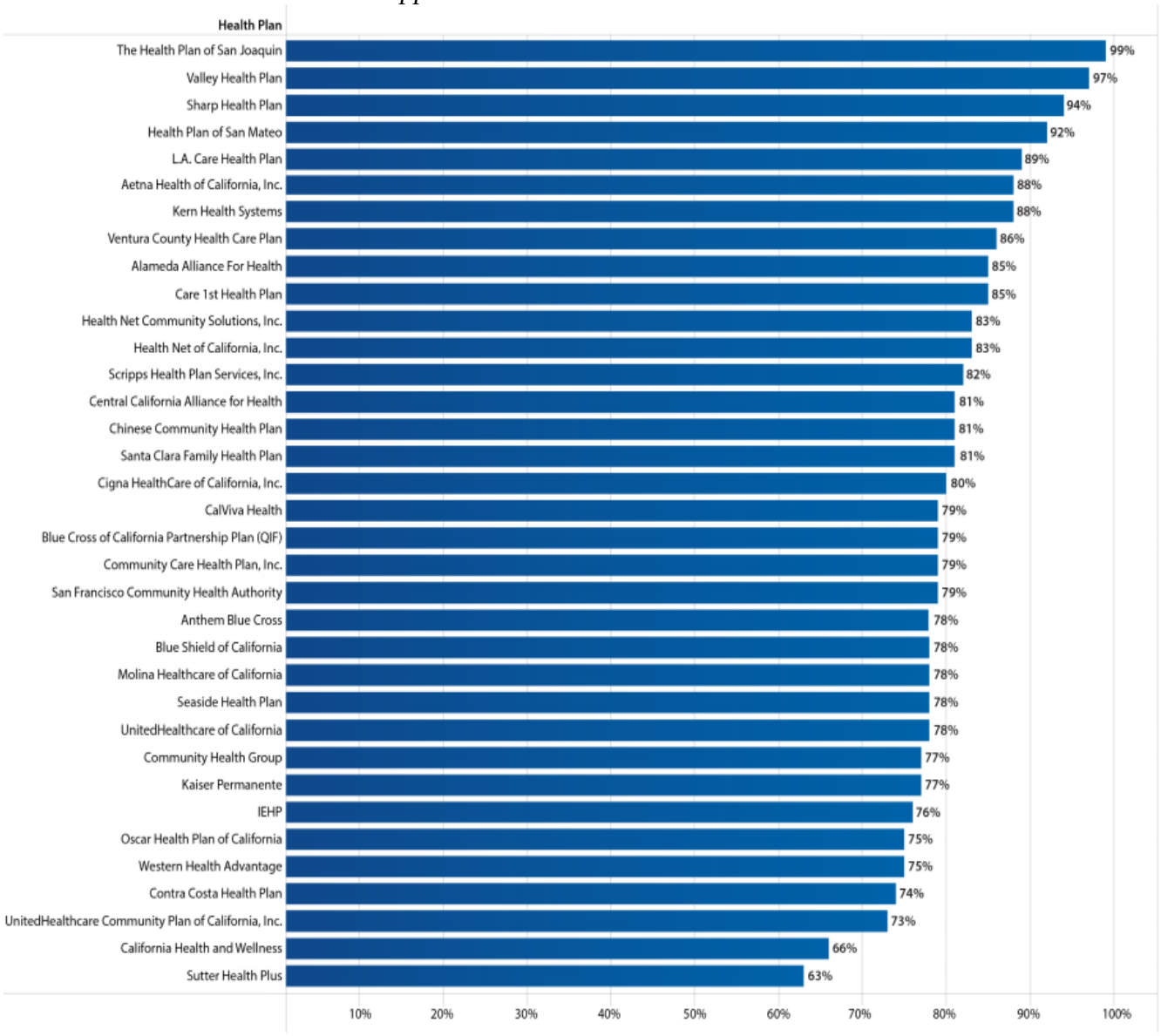
Behavioral Health Plans:

- The percentage of all surveyed providers who had appointments available within the wait time standards (urgent and non-urgent) ranged from a high of 83 percent to a low of 64 percent.
- For non-urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 87 percent to a low of 71 percent.
- For urgent appointments, the percentage of all surveyed providers who had appointments available within the wait time standards ranged from a high of 80 percent to a low of 57 percent.

Kaiser Permanente:

- The percentage of all audited providers meeting appointment wait time standards across all provider types and appointment types (urgent and non-urgent) was 92 percent.
- The percentage of all audited providers meeting non-urgent appointment standards was 91 percent.
- The percentage of all audited providers meeting urgent appointment standards was 98 percent.

Full-Service Health Plans: Percentage of Surveyed Providers Meeting both Urgent and Non-Urgent Appointment Wait Time Standards



According to DMHC, it is working with statisticians to quantify how the percentage of providers meeting appointment time standards translates into a reliable estimate of an enrollee's ability to obtain timely appointments.

Managed Care Prescription Drug Expenditures Reporting (SB 17). SB 17 (Hernandez), Chapter 603, Statutes of 2017, 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 specialty 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.

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.

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.

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. DMHC published its first SB 17 Prescription Drug Cost Transparency Report in December 2018 covering information received for calendar year 2017. The report included the following key findings:

- Health plans paid nearly $8.7 billion for prescription drugs in 2017.
- Prescription drugs accounted for 13.1 percent of total health plan premiums.
- Health plans' prescription drug costs increased by 5 percent in 2017, whereas medical expenses increased by 5.9 percent. During the same period, health plan premiums increased 4.8 percent.
- Health plans received manufacturer drug rebates of approximately $915 million or about 10.5 percent of the $8.7 billion spent on prescription drugs.
- While specialty drugs accounted for only 1.6 percent of all prescription drugs, they accounted for 51.5 percent of total annual spending on prescription drugs.
- Generic drugs accounted for 87.8 percent of all prescribed drugs but only 23.6 percent of the total annual spending on prescription drugs.
- Brand name drugs accounted for 10.6 percent of prescriptions and constituted 24.8 percent of the total annual spending on prescription drugs. The 25 most frequently prescribed drugs

represented 47.7 percent of all drugs prescribed and approximately 42.8 percent of the total annual spending on prescription drugs.

- For the 25 most frequently prescribed drugs enrollees paid 2.9 percent of the cost of specialty drugs and 56.6 percent of the cost of generics.
- Overall, plans paid 91.2 percent of the cost of the 25 most costly drugs across all three categories (generic, brand name and specialty).

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 provide a brief overview of the key findings from the department's Managed Care Timely Access Report for 2017.

3. Please provide a brief overview of the key findings from the department's Prescription Drug Cost Transparency Report for 2017.

Issue 2: Division of Plan Surveys Workload

Budget Issue. DMHC requests four positions and expenditure authority from the Managed Care Fund of $2.1 million in 2019-20 and $2 million annually thereafter. If approved, these resources would allow DMHC to manage increased workload from a higher number of licensed health plans and increased expenditures from higher rates for clinical consultants.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0933 – Managed Care Fund	$2,077,000	$2,045,000
Total Funding Request:	**$2,077,000**	**$2,045,000**
Total Requested Positions:	**4.0**	**4.0**

* Positions and resources ongoing after 2020-21.

Background. DMHC's Division of Plan Surveys within the Office of Plan Monitoring is responsible for evaluating and promoting health plan regulatory compliance and quality improvement related to health care delivery systems. The division's public health and clinical professionals evaluate each health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975. At least once every three years, the division conducts a routine survey of each plan that covers eight major areas of the plan's health care delivery system. The survey includes a review of the procedures for obtaining health services, the procedures for providing authorizations for requested services (utilization management), peer review mechanisms, internal procedures for assuring quality of care, and the overall performance of the plan in providing health care benefits and meeting the health needs of the subscribers and enrollees in the following areas:

- *Quality Management* – Each plan is required to assess and improve the quality of care it provides to its enrollees.
- *Grievances and Appeals* – Each plan is required to resolve all grievances and appeals in a professional, fair, and expeditious manner.
- *Access and Availability of Services* – Each plan is required to ensure that its services are accessible and available to enrollees throughout its service areas within reasonable timeframes.
- *Utilization Management* – Each plan manages the utilization of services through a variety of cost containment mechanisms while ensuring access and quality care.
- *Continuity of Care* – Each plan is required to ensure that services are furnished in a manner providing continuity and coordination of care, and ready referral of patients to other providers that is consistent with good professional practice.
- *Access to Emergency Services and Payment* – Each plan is required to ensure that emergency services are accessible and available, and that timely authorization mechanisms are provided for medically necessary care.
- *Prescription Drugs* – Each plan that provides prescription drug benefits must maintain an expeditious authorization process for prescriptions and ensure benefit coverage is communicated to enrollees.
- *Language Assistance* – Each plan is required to implement a Language Assistance Program to ensure interpretation and translation services are accessible and available to enrollees.

The division may also perform follow-up surveys to monitor correction of deficiencies identified during routine surveys, as well as non-routine surveys as needed to monitor ongoing compliance with the provisions of the Knox-Keene Act and other applicable laws and regulations. According to DMHC, follow-up surveys are performed when deficiencies identified in a routine survey preliminary report remain uncorrected at the time of the final report. The purpose of a follow-up survey is to determine and report on the status of the health plan's efforts to correct uncorrected deficiencies within 18 months of issuance of the routine survey's final report. Non-routine surveys may be performed when deficiencies remain uncorrected at the issuance of the follow-up report, or when DMHC discovers, or is alerted to, potential flaws in health plan business processes. Findings from non-routine surveys may result in a referral to DMHC's Office of Enforcement and be subject to enforcement action.

Division of Plan Surveys Monitors Compliance With Other State and Federal Requirements. In addition to monitoring compliance with provisions of the Knox-Keene Act, DMHC is also required to monitor compliance with various other state and federal requirements. For example, the Division of Plan Surveys, during its survey process, reviews plans for compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA), which requires health plans that offer mental health and substance use disorder services to provide those services with no more restrictive treatment limitations than required for medical or surgical services. MHPAEA reviews generally require evaluation of quantitative and non-quantitative treatment limitations for the mental health, substance use disorder and medical and surgical services to determine whether the limitations are equivalent. The division is also responsible for monitoring compliance with SB 137 (Hernandez), Chapter 649, Statutes of 2015, which requires plans to maintain accurate provider directories, and AB 72 (Bonta), Chapter 492, Statutes of 2016, which implemented a process for health plans to reimburse out-of-network providers delivering services in an in-network hospital.

According to DMHC, the division currently has 31 authorized positions, which is based on assumed workload of 28 routine surveys, five follow-up surveys, and five non-routine surveys annually. The division also contracts with clinical consultants to perform clinical and medical compliance reviews of health plan programs, policies, procedures, reports and other documents to evaluate the delivery of health care. The work performed by these consultants requires the use of highly specialized medical, dental, and other clinical expertise that is not available through the civil service system.

DMHC reports the number of licensed health plans has increased by 23 percent in the last ten years and, based on survey workload over the last two fiscal years, the division estimates it will instead be required to conduct 35 routine surveys, 25 follow-up surveys, and five non-routine surveys annually. In addition, the hourly rates for the division's clinical consultants have increased significantly, rising from $183 per hour in 2016-17 to $325 per hour for 2019-20.

DMHC requests four positions and expenditure authority from the Managed Care Fund of $2.1 million in 2019-20 and $2 million annually thereafter. This request includes $1.4 million for the increased hourly costs of its clinical consultants. The four positions are as follows:

- **Two Associate Health Care Service Plan Analysts** would serve as the primary contacts with health plans and coordinate routine and follow-up surveys, including the drafting and finalizing of reports. These analysts would also prepare and review on-site document submissions, lead the survey teams and conduct interviews with health plan staff.

- **One Attorney** would perform complex legal reviews and analyses for routine and follow-up survey findings, and develop strategies to respond to unconventional and sensitive matters. This Attorney would also provide legal support for review of health plan deficiencies.
- **One Senior Health Care Service Plan Analyst** would manage and oversee activities for routine and follow-up surveys, and provide technical assistance and guidance to associate analysts with planning, coordination and evaluation of medical surveys.

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: Conversion of Blanket Positions to Permanent

Budget Issue. DMHC requests 16 positions funded by existing Managed Care Fund expenditure authority. If approved, these positions would allow DMHC to convert temporary help positions to permanent that more accurately reflect the department's current workload needs.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0933 – Managed Care Fund	$0	$0
Total Funding Request:	**0**	**$0**
Total Requested Positions:	**16.0**	**16.0**

* Positions ongoing after 2020-21.

Background. According to DMHC, 16.0 positions were eliminated pursuant to budget bill language and Department of Finance budget policies implemented during the 2012 Budget Act to improve transparency regarding actual state expenditures on salaries and wages. Although the position authority was eliminated, the budget maintained the expenditure authority associated with the eliminated positions and reallocated it to the department's budget for other operating expenses. Since the elimination of those positions, DMHC has utilized temporary help positions to complete administrative tasks to support workload including hiring employees, providing department-wide training, developing and implementing the department's strategic plan, completion of timely financial reports and other administrative tasks. As this workload been performed by temporary help since 2012, DMHC requests to convert these 16.0 temporary help positions to permanent authorized positions to accurately reflect the department's staffing needs, allowing the department to receive accurate funding for employee compensation and retirement adjustments not provided for temporary help positions.

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 4: Health Care Service Plan Mergers and Acquisitions (AB 595)

Budget Issue. DMHC requests expenditure authority from the Managed Care Fund of $1 million annually. If approved, these positions would allow DMHC to analyze and assess the impact of mergers and other transactions on subscribers, enrollees, provider networks, the overall stability of the health care delivery system, and anti-competitive impacts, pursuant to the requirements of AB 595 (Wood), Chapter 292, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0933 – Managed Care Fund	$1,031,000	$1,031,000
Total Funding Request:	**$1,031,000**	**$1,031,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2020-21.

Background. Prior to passage of AB 595, a health plan regulated under the Knox-Keene Act was required to obtain DMHC approval prior to merging with or acquiring another plan. However, DMHC's review of health plan mergers and acquisitions focused on organizational and administrative changes, health delivery system changes, changes to products and subscriber contracts, the effect on the health plan's financial viability, the financing for the transaction and the merger's impact on consumers. DMHC's approval of a merger is also frequently contingent on the health plan fulfilling certain commitments, called undertakings, to benefit California enrollees. DMHC's previous merger review did not include review for the impact on competition, as those considerations were outside of DMHC's authority. Although the Department of Insurance has broad authority to deny insurance company transactions that have negative impacts on competition, DMHC does not possess similar authority over health care service plan transactions.

AB 595 authorizes DMHC to disapprove a health plan merger or acquisition upon finding the merger either violates the Knox-Keene Act, substantially lessens competition in health care service plan products or creates a monopoly in the state. AB 595 also clarifies DMHC's existing authority to review mergers and secure health plan undertakings to benefit consumers, and adds requirements to ensure transparency and public participation for major mergers. AB 595 requires the following of plans and DMHC:

- Requires a health plan that intends to merge or consolidate with, or enter into an agreement resulting in its purchase, acquisition or control by, any entity, including another health plan or health insurer, to give notice to, and secure prior approval from, DMHC.
- Requires the health plan to provide all information necessary for DMHC to approve, conditionally approve, or disapprove the transaction or agreement.
- Allows DMHC to conditionally approve the transaction or agreement, contingent on the health plan's agreement to fulfill required undertakings to benefit enrollees or provide for a stable health care delivery system. DMHC shall engage stakeholders in determining the measures for improvement included in the required undertakings.

- Requires DMHC to obtain an independent analysis of the impact of the transaction or agreement on subscribers and enrollees, the stability of the health care delivery system and other relevant provisions of the Knox-Keene Act, for major transactions or agreements.
- Allows DMHC to disapprove a transaction or agreement if it fails to satisfy the Knox-Keene Act, substantially lessens competition in health care service plan products or creates a monopoly in the state. DMHC may obtain an opinion from an expert consultant to assess the competitive impact of a transaction.
- Requires DMHC, prior to approving, conditionally approving, or denying a major transaction or agreement, to hold a public meeting on the proposal in accordance with the Bagley-Keene Open Meetings Act. DMHC must consider public comments and testimony from the meeting in making its decision regarding the proposed transaction or agreement.
- Requires DMHC to prepare a statement describing the transaction or agreement if the department determines a material amount of health plan assets is subject to purchase, acquisition, or control, and to make the statement available to the public before any public meeting.
- Requires DMHC to specify fees and obtain reimbursement of reasonable costs payable by the health plans involved in the proposed transaction or agreement.

DMHC requests expenditure authority from the Managed Care Fund of $1 million annually to allow DMHC to analyze and assess the impact of mergers and other transactions on subscribers, enrollees, provider networks, the overall stability of the health care delivery system, and anti-competitive impacts, pursuant to the requirements of AB 595. DMHC's Office of Financial Review would contract with an external consultant to perform the independent analyses of the impact of mergers or other transactions. DMHC assumes 10 transactions per year will require this independent analysis at a cost of $100,000 per analysis.

Included in the request is $31,000 for DMHC's Office of Administrative Services. These resources would allow DMHC to cover venue costs and staff travel for the public meetings required prior to approval or denial of major transactions.

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.

4260 DEPARTMENT OF HEALTH CARE SERVICES
4800 CALIFORNIA HEALTH BENEFIT EXCHANGE (COVERED CALIFORNIA)

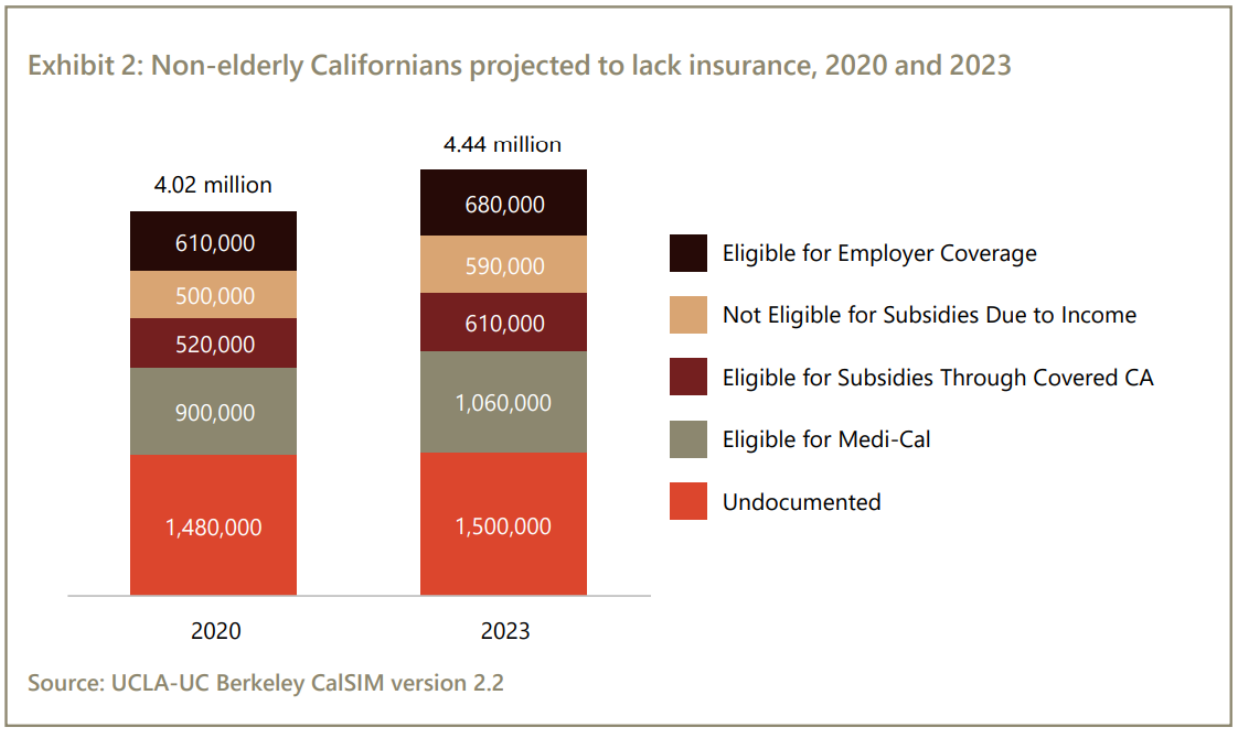
Issue 1: Overview – Expanding Health Coverage and Affordability

Background. On January 7, 2019, the Governor announced several health care proposals intended to reduce the number of Californians that remain uninsured. Although California has reduced its uninsured population more than any other state, from 17.2 percent in 2013 to 7.2 percent in 2017, millions of California residents remain without adequate health coverage. Of the categories of individuals remaining uninsured, the largest group remains undocumented residents. According to the Berkeley Labor Center, approximately 1.5 million undocumented residents are expected to be uninsured by 2020, 90 percent of whom would otherwise be eligible for coverage under the Medi-Cal program, but for their immigration status.

The next largest group of uninsured are individuals that are eligible, but not enrolled in Medi-Cal. The Berkeley Labor Center estimates there will be 900,000 individuals uninsured in this category by 2020. In addition, by 2020 there are estimated to be 520,000 uninsured individuals eligible for subsidies through the Covered California health benefit exchange but who remain uninsured, 500,000 individuals not eligible for subsidies due to higher income, and 610,000 who are eligible for employer coverage.

Presentation on the Remaining Uninsured. The subcommittee has requested a brief presentation from the Berkeley Labor Center of their research on characteristics of the remaining uninsured in California.

- **Laurel Lucia –** Director, Health Care Program, UC Berkeley Labor Center



Issue 2: Expanding Affordability in the Individual Health Insurance Market

Budget Issue. The budget proposes to increase premium subsidies to individuals with incomes between 250 and 400 percent of the federal poverty level (FPL) who are purchasing coverage on the Covered California health benefit exchange. All of these individuals currently receive premium subsidies from the federal advance premium tax credit (APTC). The budget also proposes to expand premium subsidies to individuals with incomes between 400 and 600 percent of the FPL, all of whom are currently ineligible for premium subsidies from the federal APTC. The Administration proposes to fund the increased and expanded subsidies by implementing a state-based individual mandate penalty. Similar to the recently reduced federal mandate penalty, under the state-based mandate penalty, individuals would be required to purchase minimum essential coverage or face a penalty modeled on the federal requirement prior to its reduction under the federal tax bill. The Administration has not provided estimates of the revenue it expects to receive from the state-based penalty, nor the level of premium subsidies it expects to provide to individuals purchasing coverage.

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 with incomes 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, 87 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 December 2018, approximately 1.3 million individuals covered by exchange products received an average of $445 per month in APTC subsidies. Approximately 103,000 individuals receive exchange-based coverage, but are not eligible for APTC subsidies.

Individual Mandate Penalty 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 penalty. The individual mandate penalty 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 penalty, 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 with incomes 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 prevented premium growth due to ACA requirements that limited cost-sharing for health plan beneficiaries with incomes 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 resulting cost-sharing reduction surcharges ranging from seven to 38 percent on premiums beginning in 2018. In addition, recently enacted federal tax legislation included a reduction to zero of the individual mandate penalty for failing to purchase health care coverage. The reduction takes effect for coverage in the 2019 calendar year.

The reduction of the federal mandate penalty led health plans participating in the Covered California exchange to prospectively increase premium rates in anticipation of lower enrollment and a resulting higher acuity risk pool. In August 2018, Covered California reported a preliminary overall weighted increase in premium rates of 8.7 percent if existing consumers renewed coverage in the same plans. The increase in premium rates net of APTC subsidies was six percent. Of these rate increases, plans reported adding an average of 3.5 percent to premiums, with a range of 2.5 to six percent, exclusively due to reduction of the federal mandate penalty.

Covered California Enrollment Slightly Lower for 2019. According to Covered California, at the end of the open enrollment period for 2019 coverage, the exchange finished with a total of 1,513,833 plan selections, a decrease of 7,641 or 0.5 percent compared to 2018. Of these plan selections, renewals accounted for 1,217,903 of the total, which is an increase of 84,723 or 7.5 percent compared to 2018. 295,980 consumers were newly enrolled in the exchange, which is a decrease of 92,364 or 23.8 percent compared to 2018. Covered California's analysis suggests the significant decline in new enrollments, which is a greater decline than that of states with a federally-facilitated marketplace (FFM), may be due

to the reduction of the federal individual mandate penalty to zero. This greater decline may be due to California's success in preventing reductions in enrollment in prior years compared to other states. Between 2016 and 2019, Covered California total enrollment has been between 1.5 and 1.6 million plan selections, while FFM states have declined from 9.6 million to 8.4 million plan selections, a decline of 13 percent.

AB 1810 Affordability Workgroup Recommendations. AB 1810 (Committee on Budget), Chapter 34, Statutes of 2018, required Covered California to develop options for providing financial assistance to help low- and middle-income Californians with incomes up to 600 percent of the FPL access health care coverage. Covered California created the AB 1810 Affordability Workgroup composed of health care advocates, health insurance issuers, health care associations, legislative staff, and two Covered California board members. The workgroup held five meetings between October 2018 and January 2019 to discuss options for health insurance affordability including premium and cost-sharing subsidies for various income groups, establishment of a state-based individual mandate penalty, and implementing a state-based reinsurance program offset by additional federal funding available under Section 1332 of the Affordable Care Act. The workgroup and Covered California staff collaborated with economists at the University of California at Los Angeles and the University of Illinois at Chicago to model the effects of each of these affordability options, alone and in combination, on enrollment, premium affordability, and consumers' out-of-pocket costs.

The workgroup issued its final report on February 1, 2019 and included the following estimates of new total enrollment and state costs for each of the potential policy options for the 2021 calendar year.

Policy Objective	Policy Options	New Enrollment	New State Cost
Targeted improved affordability for consumers earning less than 400 percent FPL	**T1. Premium support** that lowers premium contributions for consumers earning less than 400 percent FPL	70,000	$425,000,000
	T2. Cost-sharing support that reduces out-of-pocket costs for consumers between 200-400% FPL who do not qualify for more generous federal cost-sharing subsidies	27,000	$215,000,000
Targeted improved affordability for consumers earning less than 600% FPL	**T3. Premium support** that lowers premium contributions for consumers earning between 0 and 600 percent FPL	125,000	$765,000,000
	T4. Premium support that lowers premium contributions for consumers earning between 0 and 600 percent FPL **and an individual mandate**	478,000	$891,000,000 *($482,000,000 potential offset from penalty revenue)*
Targeted improved affordability for consumers earning more than 400% FPL	**T5. Premium support** that lowers premium contributions for consumers earning between 400 and 600 percent FPL	47,000	$285,000,000
	T6. Premium support that lowers premium contributions for consumers earning more than 400 percent FPL	50,000	$324,000,000
	T7. Reinsurance that lowers gross premiums by 10 percent per year	118,000	$1,456,000,000 *($878,000,000 potential offset from 1332 reinsurance waiver)*
Targeted improved affordability for all consumers generated by reinstating the mandate penalty	**T8. Reinstate individual mandate penalty** which increases enrollment and lowers premiums by improving the risk mix in the individual market	359,000	*($526,000,000 potential penalty revenue)*

Source: Covered California. "Options to Improve Affordability in California's Individual Health Insurance Market". (February 1, 2019)

The workgroup report model indicates that implementation of a state-based individual mandate penalty would have the largest single impact on coverage, with 359,000 additional enrollments and estimated revenue to the state of $526 million. The average net premium reduction would be zero for subsidy-eligible enrollees and $24 per month for off-exchange enrollees due to the improved risk pool. Premium support that caps premiums at no more than 15 percent of income for individuals with incomes under 600 percent of the FPL would result in 125,000 new enrollments, premium reduction for subsidy-eligible enrollees of $21 per month and $14 per month for off-exchange enrollees, and result in state costs of $765 million. Reinsurance would result in 118,000 additional enrollments, a premium reduction of $70 per month or ten percent for off-exchange enrollees, and a net state cost of $578 million.

The report also modeled three options in combination: 1) premium and cost-sharing support, 2) premium and cost-sharing support with an individual mandate penalty, and 3) premium and cost-sharing support with a penalty and reinsurance.

	Option 1: Premium and Cost Sharing Support	Option 2: Premium and Cost Sharing Support with Penalty	Option 3: Premium and Cost Sharing Support, Penalty and Reinsurance
New Enrollment	**290,000**	**648,000**	**764,000**
<250% FPL	*66,000*	*120,000*	*139,000*
250-400% FPL	*153,000*	*342,000*	*358,000*
400%+ FPL	*71,000*	*187,000*	*267,000*
Individual Market Take-up Rate*	58%	67%	70%
Percent of Enrollees in Silver Coverage or Higher**	79%	77%	79%
Benefits to Existing Enrollees			
On-Exchange Number Benefitting	1,292,000	1,292,000	1,292,000
On-Exchange Average Monthly Premium Reduction	$39/m	$39/m	$39/m
Off-Exchange Number Benefitting	662,000	662,000	662,000
Off-Exchange Average Monthly Premium Reduction	$18/m	$41/m	$111/m
Spending Impacts			
New State Spending	**$2,190,000,000**	**$2,562,000,000**	**$4,201,000,000**
Premium Support	*$1,561,000,000*	*$1,886,000,000*	*$1,874,000,000*
Cost-Sharing Support	*$629,000,000*	*$676,000,000*	*$604,000,000*
Reinsurance	*None*	*None*	*$1,724,000,000*
Potential State Spending Offsets			
Penalty Revenue	None	**$441,000,000**	**$393,000,000**
Potential 1332 Funding			**$1,132,000,000**
Potential Net State Spending***	**$2,190,000,000**	**$2,121,000,000**	**$2,676,000,000**
Change in Federal Tax Credit Expenditures	$670,000,000	$975,000,000	($331,000,000)

* 51% under Affordable Care Act Baseline 2021
** 69% under Affordable Care Act Baseline 2021
*** Net State Spending assumes all offsets are applied to reduce State expenditures

Source: Covered California. "Options to Improve Affordability in California's Individual Health Insurance Market". (February 1, 2019)

Each of the three options have the same impact on subsidy-eligible enrollees, reducing premiums by $39 per month, while Option 1 reduces off-exchange premiums by $18 per month, Option 2 by $41 per month, and Option 3 by $111 per month. However, additional state costs needed per additional enrollment vary between the three options. Option 1 results in annual costs of approximately $7,552 per new enrollee, Option 2 results in annual costs of approximately $3,273 per new enrollee, and Option 3 results in annual costs of approximately $3,503 per new enrollee.

Stakeholders Propose Package of Premium and Cost-Sharing Subsidies and Mandate Penalty. Health Access California, Western Center on Law and Poverty, and a broad coalition of advocacy organizations request $2.1 billion additional General Fund dollars to establish comprehensive affordability enhancements. The recent estimates done for Covered California indicate that subsidies for premiums and cost sharing for those below 400 percent of the FPL and for premiums for those above 400 percent of the FPL combined with an individual mandate penalty, would cut in half the number of

uninsured who are not excluded due to immigration status. Getting to universal coverage with affordable access to care for those in the individual market requires spending on this scale. While Covered California outlined a buffet of options with lesser price tags, those individual options are insufficient to get California to near-universal levels of coverage comparable to European countries such as France or Germany.

Under the Governor's proposal, California would be the first state in the nation, post-Affordable Care Act, to offer additional help for those between 250 to 400 percent of the FPL while providing financial help to middle-income Californians between 400 and 600 percent of the FPL, who get no affordability help now. According to the proponents, this proposal ignores two realities: first, for those 200 to 250 percent of the FPL, the current federal affordability assistance in the form of cost sharing reductions is utterly insufficient. As a result, many consumers in this income category select bronze coverage with a $6,300 deductible, something that no one living on $24,000 to $30,000 a year can afford. Second, while most of those who are over 400 percent of the FPL are between 400 percent and 600 percent of the FPL, there are those in their late 50s and early 60s who make more than 600 percent of the FPL who need help affording premiums. Cutting off help at 600 percent of the FPL just creates a cliff at a different point on the income scale. A married couple in their early 60s living on $75,000 a year gross income is not poor, but not rich either. The Governor's proposal builds on the underlying structure of the ACA, in which the sliding scale for premiums provides greater affordability to those at the end of the income scale and with the most help for those who have the least. Californians who need more help to afford care and coverage in our high cost state would now get that support.

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

Panel Discussion. The subcommittee has requested the following panelists to discuss the Administration's coverage affordability proposal, as well as other options for expanding affordability in the individual health insurance market:

- **Jacob Lam, Principal Program Budget Analyst, Department of Finance**
- **Aleksander Klimek, Finance Budget Analyst, Department of Finance**
- **Katie Ravel, Director of Policy, Eligibility, and Research, Covered California**
- **Beth Capell, Policy Advocate, Health Access California**
- **Jen Flory, Policy Advocate, Western Center on Law and Poverty**

Issue 3: Full-Scope Medi-Cal Expansion to Undocumented Young Adults

Budget Issues. The budget proposes to expand full-scope Medi-Cal coverage to approximately 138,000 income-eligible young adults up to age 26, regardless of immigration status. DHCS requests expenditure authority of $257.1 million ($194 million General Fund and $63.1 million federal funds) for the expansion of coverage. In addition, DHCS requests two positions and expenditure authority of $624,000 ($237,000 General Fund and $387,000 federal funds) in 2019-20 and $306,000 ($153,000 General Fund and $153,000 federal funds) annually thereafter. If approved, these resources would allow implementation and make necessary system changes for the expansion of coverage.

Trailer Bill Language Proposals. The cost of the Governor's expansion proposal would be partially offset by redirecting county realignment funding for indigent health care to the state. DHCS is proposing two trailer bill language changes related to the expansion proposal: 1) Implementation of the expansion of coverage to undocumented young adults, and 2) increasing the percent of realignment funds redirected from certain counties from 60 percent to 75 percent.

Program Funding Request Summary – State Operations		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$237,000	$153,000
0890 – Federal Trust Fund	$387,000	$153,000
Total Funding Request:	**$624,000**	**$306,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and Resources ongoing after 2020-21.

State Operations Budget Change Proposal for Implementation of Coverage Expansion. DHCS requests two positions and expenditure authority of $624,000 ($237,000 General Fund and $387,000 federal funds) in 2019-20 and $306,000 ($153,000 General Fund and $153,000 federal funds) annually thereafter. If approved, the requested resources would support key planning activities for the implementation of the full scope Medi-Cal coverage expansion for all income-eligible immigrants from 19 through 25 years of age, regardless of immigration status. This expanded Medi-Cal coverage will require DHCS to develop key policy and implementation instructions for counties, update application materials and develop outreach materials for applicants and transitioning populations, collaborate extensively with all DHCS program areas, including counties and consumer advocates, oversee all eligibility, enrollment, and billing system changes, and respond to beneficiary and stakeholder inquiries.

DHCS is requesting **one Associate Governmental Program Analyst** to manage changes to eligibility systems, serve as a subject matter expert on immigration, and oversee development of policy letters and regulatory development. DHCS is also requesting **one Information Technology Specialist I** position to provide technical guidance for updating eligibility systems. The requested resources also include $300,000 one-time resources for technical upgrades to the eligibility systems.

Background. Although California has reduced its uninsured population more than any other state, from 17.2 percent in 2013 to 7.2 percent in 2017, millions of California residents remain without adequate health coverage. In particular, approximately 1.5 million undocumented residents are expected to be uninsured by 2020, 90 percent of whom would otherwise be eligible for coverage under the Medi-Cal

program, but for their immigration status. The Legislature has proposed state-funded coverage for all or portions of this population several times in recent years, including a successful effort in 2015 to provide full-scope Medi-Cal coverage to income-eligible children up to age 19, regardless of immigration status.

Medi-Cal Covers One in Three Californians. Medi-Cal covers 13.2 million Californians, including more than five million children, at a total estimated cost of $98.5 billion in 2018-19 and $100.7 billion in 2019-20. Of that amount, the federal government is expected to contribute $62.7 billion in 2018-19 and $65.4 billion in 2019-20 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, family planning expenditures, and improvements to information technology systems.

Limitations on Health Care Options for Undocumented Californians. Federal Medicaid law prohibits federal matching fund payments to states for full-scope coverage of undocumented residents. However, federal law does allow payments for emergency and pregnancy (restricted-scope) services provided to undocumented residents. According to DHCS, the total cost of providing restricted-scope services was $1.6 billion in 2016-17. As of July 2018, DHCS estimates that 952,683 undocumented adults are enrolled in restricted-scope Medi-Cal. 268,811 undocumented children up to age 19 are also eligible and enrolled in state-funded full-scope Medi-Cal benefits. The state continues to be eligible for federal matching funds for emergency and pregnancy services for this population. (For more information, see *Medi-Cal Eligibility for Children Regardless of Immigration Status*, below).

Federal law also prohibits undocumented residents from participating in the Covered California health benefit exchange established after passage of the federal Affordable Care Act. Covered California provides health care service plan coverage options in the individual market for eligible citizens and legal permanent residents. Covered California participants with incomes up to 400 percent of the federal poverty level (FPL) receive federally financed premium subsidies to make coverage more affordable. Covered California also serves as an active purchaser, utilizing its selective contracting authority to negotiate with health plans to lower premiums for California health care consumers. Undocumented residents may enroll in off-exchange coverage options similar to those negotiated by the exchange, but are ineligible for federally financed premium subsidies that make such coverage affordable.

County Indigent Health Programs Provide Coverage for the Uninsured. State law requires counties to serve as the health care provider of last resort for residents age 18 and over who cannot afford care, known as medically indigent adults. The services offered and requirements for eligibility vary significantly by county. County indigent programs generally fall into two categories:

1. *County Medical Services Program (CMSP)* – 35 mostly small and rural counties contract with Advanced Medical Management to administer a standardized benefit for limited-term health coverage for uninsured low-income, indigent adults not otherwise eligible for publicly funded health care programs. An eleven member CMSP Governing Board sets program eligibility requirements, determines the scope of covered health care benefits, and sets the payment rates

paid to providers. CMSP counties include: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Modoc, Mono, Napa, Nevada, Plumas, San Benito, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, Tuolumne, Yolo, and Yuba.

2. *Medically Indigent Service Program* – 23 counties manage their own medically indigent programs with different service delivery options and eligibility requirements. These counties include: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Merced, Monterey, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Stanislaus, Tulare, and Ventura.

1991 Realignment Funds County Indigent Programs. County indigent health programs are generally funded by revenues received under 1991 Realignment, which shifted significant fiscal and programmatic responsibility for certain health and human services programs from the state to the counties. 1991 Realignment revenues have historically allowed county indigent health programs to provide care for the uninsured and those ineligible for other coverage. Prior to 2014, county indigent programs covered childless adults that were previously ineligible for Medi-Cal coverage, but few covered undocumented residents.

The federal Affordable Care Act authorizes states to expand their Medicaid programs to previously uninsured individuals. AB 1 X1 (Pérez) and SB 1 X1 (Hernandez), Chapters 3 and 4, Statutes of 2013, First Extraordinary Session, 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 with incomes at or below 138 percent of the federal poverty level. Optional expansion beneficiaries are mandatorily enrolled in managed care for their Medi-Cal benefits.

As a result of the expansion of coverage to previously uninsured individuals through the state's Medi-Cal program, county indigent health programs were no longer responsible for providing care for this population. AB 85 (Committee on Budget), Chapter 24, Statutes of 2013, provides for the redirection of health-related 1991 Realignment revenues from counties to offset state General Fund costs to account for this shift in responsibility and health care expenditures for the Medi-Cal expansion population. The redirection of 1991 Realignment funds offsets expenditures in the California Work Opportunity and Responsibility to Kids (CalWORKs) program that were previously funded through the state's General Fund.

AB 85 requires CMSP counties to redirect 60 percent of the realignment funds they would have previously received. That legislation also gave another group of counties the option to redirect 60 percent of realignment funds or base the redirection amount on a formula that takes into account a county's cost and revenue experience. Counties with public hospitals, except Los Angeles, base redirection amounts on the cost and revenue formula. Los Angeles County adheres to a county-specific formula.

Administration Proposes to Increase AB 85 Redirection from 60 to 75 Percent. DHCS is proposing trailer bill language to amend the redirection percentages implemented in AB 85 for certain counties. For CMSP counties, as well as the counties that chose to implement a 60 percent redirection amount, the proposed trailer bill language would instead redirect 75 percent of 1991 Realignment funds from those

counties. According to the Administration, this additional redirection would result in approximately $63 million of additional offset General Fund costs in the CalWORKs program. According to the Administration, the increased redirection amount is meant to account for the reduced burden on county indigent programs achieved by enrolling undocumented young adults in full-scope Medi-Cal coverage.

Certain County Indigent Health Programs Offer Non-Emergency Care for Undocumented. After implementation of the Medi-Cal expansion, undocumented residents are the largest proportion of the remaining uninsured for whom county indigent health programs are responsible to provide care. While all programs offer emergency care covered by Medi-Cal to undocumented residents, some counties have recently expanded the scope of coverage to include non-emergency, limited primary care benefits.

CMSP Counties: Eligibility Expansion and Primary Care Benefit. Beginning in 2016, the CMSP Governing Board approved an expansion of eligibility requirements for its 35-county indigent health program from 200 percent to 300 percent of the FPL. In addition, the board approved the Primary Care Benefit program, a two-year pilot to provide CMSP participants, including undocumented residents, with certain non-emergency benefits for a renewable, six-month enrollment period. These benefits include:

1. Up to three office visits for primary care, specialty care, or physical therapy,
2. Preventative health screenings and lab tests,
3. Prescription drugs with a five dollar co-pay and up to $1,500 in benefits, and
4. Services provided by contracting community health centers, clinics, and other providers.

Beginning September 2018, the CMSP Governing Board authorized the Primary Care Benefit program to be permanently incorporated into the CMSP standard benefit package in its indigent health program.

Los Angeles County: My Health LA. Los Angeles County implemented My Health LA in 2014 to provide primary and specialty care services to more than 144,319 uninsured county residents. The program provides primary preventive, specialty care, hospital inpatient, urgent and emergency care through county public hospitals, clinics and other providers. In addition, the program provides prescription drugs, mental health/substance use treatment, lab tests, and other health care services.

According to an analysis by Health Access California, the following counties also provide some non-emergency coverage for undocumented residents through their county indigent programs: Fresno, Sacramento, Contra Costa, Monterey, and Santa Clara.

Source: Health Access California. "Profiles of Progress: California Counties Taking Steps to a More Inclusive and Smarter Safety-Net". (May 2016)

Full-Scope 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 only eligible for restricted-scope Medi-Cal coverage, which receives a federal match depending on the child's eligibility category, while the additional non-emergency services provided under the full-scope expansion are funded entirely by state General Fund. DHCS estimated that 250,000 undocumented children under age 19 would become eligible under the expansion. As of January 2019, a total of 268,811 undocumented children have enrolled in full-scope Medi-Cal, in two distinct populations:

1. *Previous Restricted-Scope Medi-Cal Beneficiaries:* As of January 2019, 120,614 undocumented children previously enrolled in restricted-scope Medi-Cal coverage have transitioned into full-scope Medi-Cal coverage.

2. *Not Previously Enrolled:* As of January 2019, 148,197 undocumented children who were previously eligible, but not enrolled in, restricted scope Medi-Cal have enrolled in full-scope benefits.

Full-Scope Medi-Cal Coverage for Children Regardless of Immigration Status, by County (Jan. 2019)							
County	**Covered Children**	**County**	**Covered Children**	**County**	**Covered Children**	**County**	**Covered Children**
Alameda	11,472	Kings	1,105	Placer	744	Sierra	*
Alpine	*	Lake	559	Plumas	*	Siskiyou	99
Amador	62	Lassen	*	Riverside	14,284	Solano	2,088
Butte	565	Los Angeles	97,628	Sacramento	7,838	Sonoma	2,194
Calaveras	69	Madera	1,320	San Benito	356	Stanislaus	4,447
Colusa	193	Marin	1,752	San Bernardino	11,572	Sutter	487
Contra Costa	6,416	Mariposa	*	San Diego	13,254	Tehama	404
Del Norte	*	Mendocino	730	San Francisco	4,904	Trinity	*
El Dorado	372	Merced	2,970	San Joaquin	5,038	Tulare	4,415
Fresno	6,387	Modoc	34	San Luis Obispo	1,040	Tuolumne	67
Glenn	234	Mono	101	San Mateo	6,479	Ventura	5,211
Humboldt	348	Monterey	4,886	Santa Barbara	4,250	Yolo	1,020
Imperial	732	Napa	703	Santa Clara	10,278	Yuba	370
Inyo	63	Nevada	208	Santa Cruz	1,441	**Statewide**	**268,811**
Kern	7,544	Orange	19,398	Shasta	462		

***** = Value suppressed due to low enrollment totals.

Proposals to Expand Medi-Cal Eligibility to Remaining Uninsured Populations. Legislators and stakeholders have expressed interest in expanding Medi-Cal coverage to undocumented families and individuals not currently eligible due to immigration status, including adults up to age 26, adults ages 26 to 64 and seniors age 65 and older. Prior to approval of the 2018 Budget Act, the Assembly adopted a proposed expansion of full-scope Medi-Cal to undocumented young adults up to age 26, while the Senate adopted a proposed expansion of full-scope Medi-Cal to undocumented seniors over age 65. The 2018 Budget Act ultimately included neither proposal. In addition, SB 29 (Lara and Durazo) and AB 4 (Arambula, Bonta, and Chiu) were introduced in the current legislative session to provide full-scope Medi-Cal coverage to all adults regardless of immigration status. These bills are awaiting their first committee hearings.

The California Immigrant Policy Center, Health Access California, and a coalition of 80 organizations request resources to fund expansion of full-scope Medi-Cal services to otherwise eligible adults regardless of immigration status. The Administration estimates expansion of full-scope Medi-Cal to undocumented individuals age 26 to 64 would enroll 1,043,614 individuals and result in costs of $2 billion ($1.5 billion General Fund and $507.6 million federal funds) in the Medi-Cal program. The Administration also estimates expansion of full-scope Medi-Cal to undocumented seniors 65 years of

age and older would enroll 28,379 undocumented seniors and result in costs of $115.3 million ($94.5 million General Fund and $20.9 million federal funds) in the Medi-Cal program. These costs do not reflect expenditures for In-Home Supportive Services (IHSS). The Administration indicates it is in the process of preparing fiscal estimates of the IHSS costs for these populations.

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.

Counties Concerned About Impacts of AB 85 Redirection Proposal. Several counties have submitted opposition to the Administration's proposed increase in the redirection of 1991 Realignment funds to offset the costs of the expansion of Medi-Cal coverage to undocumented young adults. According to the County of Santa Barbara, part of the funding mechanism is based on an inaccurate financial premise and will have dire consequences on the essential core public health services provided by Santa Barbara County, Stanislaus County, Yolo County, Sacramento County, and Placer County Public Health Departments. The Governor's proposed budget inaccurately assumes that county costs will decrease because of this proposed Medi-Cal expansion to cover more indigents. In actuality, any savings would be nominal and in no way offset the redirection of realignment as proposed. Specific consequences to public health programs if this change is implemented include reductions in support of communicable disease control and epidemiology, vaccination services, contact investigations and surveillance, public health nursing interventions, public health laboratory testing and epidemiologic investigations, and public health outreach initiatives to promote healthy lifestyles.

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

Panel Discussion. The subcommittee requests the following panelists to discuss the Administration's proposed expansion, resource request, trailer bill language proposals, stakeholder proposals for additional expansion of eligibility, and concerns about the redirection of county realignment funds:

- **Jennifer Kent,** Director, Department of Health Care Services
- **Guadalupe Manriquez,** Principal Program Budget Analyst, Department of Finance
- **Laura Ayala,** Staff Finance Budget Analyst, Department of Finance
- **Ronald Coleman**, Director of Policy and Legislative Advocacy, Health Access California
- **Deepen Gagneja,** Senior Legislative Advocate, CA Immigrant Policy Center
- **Dr. Peter Beilenson**, Director, Sacramento County Health Services Department

Issue 4: Stakeholder Proposals: Expansion of Medi-Cal Eligibility and Enrollment

Background. Medi-Cal covers 13.2 million Californians, including more than five million children, at a total estimated cost of $98.5 billion in 2018-19 and $100.7 billion in 2019-20. Of that amount, the federal government is expected to contribute $62.7 billion in 2018-19 and $65.4 billion in 2019-20 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. AB 1 X1 (Pérez) and SB 1 X1 (Hernandez), Chapters 3 and 4, Statutes of 2013, First Extraordinary Session, 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, a six percent General Fund share beginning January 1, 2018, a seven percent General Fund share beginning January 1, 2019, and will assume a ten percent share beginning January 1, 2020 and ongoing. 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 $17.3 billion ($1.5 billion General Fund and $15.7 billion federal funds) in 2018-19 and $20.1 billion ($2.2 billion General Fund and $17.8 billion federal funds) in 2019-20 for coverage of the optional expansion population. The department estimates optional expansion enrollment of approximately 3.8 million beneficiaries in 2018-19 and 2019-20.

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 January 2019, a total of 268,811 undocumented children have enrolled in full-scope Medi-Cal, in two distinct populations:

1. *Restricted-Scope Medi-Cal Beneficiaries* 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 January 2019, 148,197 children in this category have enrolled in full-scope benefits, or 113.2 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 because certain income limits for those eligible due to age or disability differ from those of other populations. In addition, stakeholders have expressed interest in expanding various outreach and assistance efforts to enroll individuals that are currently eligible, but not enrolled. These proposals are as follows:

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 123 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 64 organizations request resources 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.

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. SB 1 X1 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 six children's advocacy organizations requests General Fund resources of approximately $5 million to establish an Express Lane program for children and a presumptive eligibility program for pregnant women participating in the WIC program, effective April 2020. Approximately $100,000 would fund needed administrative expenses to establish the program, while $4 million would fund health care services for the additional children and $700,000 for pregnant women enrolled in Medi-Cal as a result of the program. The coalition estimates full-year costs for implementation of the proposal would be $26 million General Fund. 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

The California Pan-Ethnic Health Network, Maternal and Child Health Access, and Community Health Councils request $15 million General Fund per year for two years to reinstate and continue outreach, enrollment, retention, and utilization assistance in Medi-Cal. 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, for the first time in years, California is seeing a substantial decline in enrollment in health care coverage both in Medi-Cal and Covered California. For a number of compounding reasons, such as fear of immigration consequences generated by the federal Administration, unaffordable premium costs, and the end of the individual mandate penalty, the communities most in need are declining to enroll in, retain, or use life-saving coverage. Now more than ever, it is time for the state to reinvest in outreach, enrollment, and utilization assistance for low-income families and individuals eligible for Medi-Cal, the Medi-Cal Access Program, or Covered California.

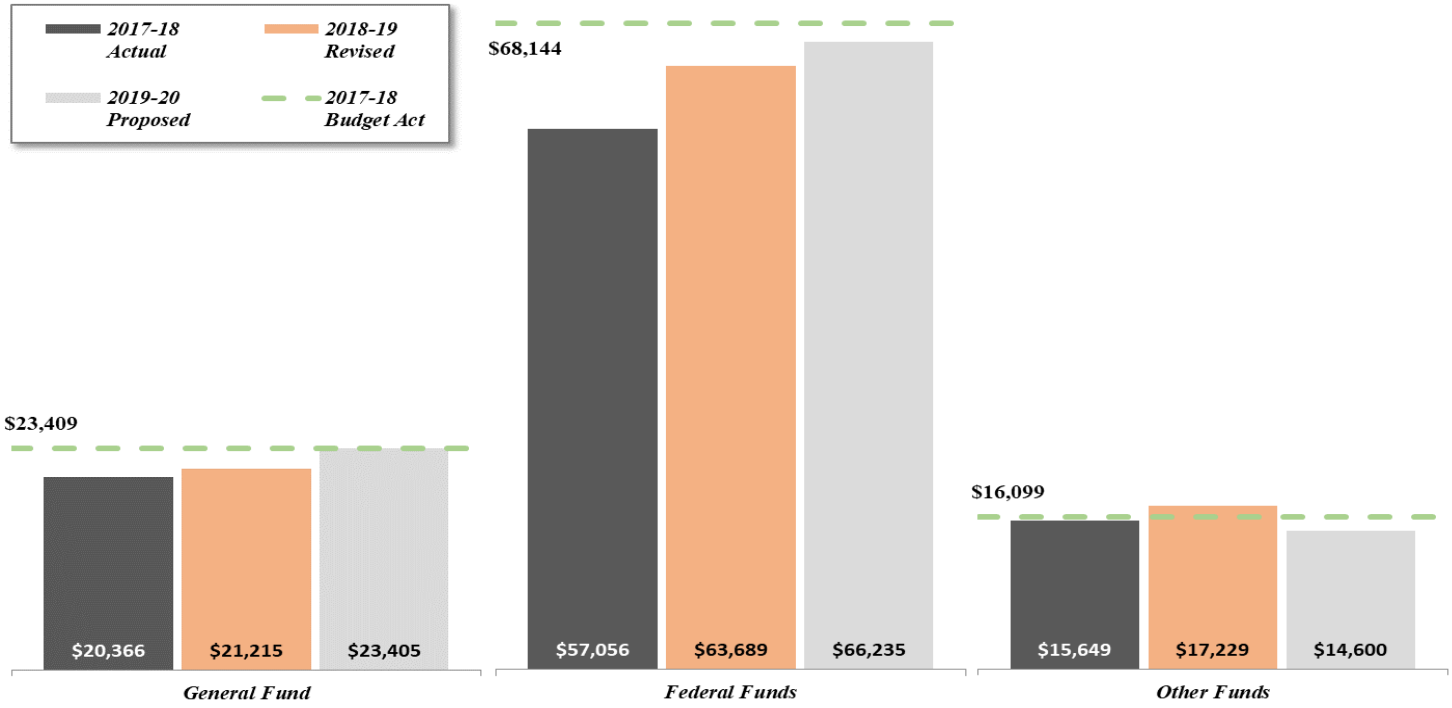
Subcommittee Staff Comment and Recommendation—Hold Open. Subcommittee staff recommends holding these items open to allow continued discussions in advance of the May Revision.

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

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Overview

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



Department of Health Care Services - *Department Funding Summary*			
Fund Source	***2018-19 Budget Act***	***2018-19 Revised***	***2019-20 Proposed***
General Fund	$23,408,652,000	$21,215,355,000	$23,405,017,000
Federal Funds	$68,143,762,000	$63,689,469,000	$66,234,871,000
Other Funds	$16,098,932,000	$17,228,907,000	$14,600,085,000
Total Department Funding:	**$107,651,346,000**	**$102,133,731,000**	**$104,239,973,000**
Total Authorized Positions:	**3434.5**	**3434.5**	**3557.8**
Other Funds Detail:			
Breast Cancer Control Account (0009)	*$11,692,000*	*$11,790,000*	*$11,965,000*
Childhood Lead Poisoning Prev Fund (0080)	*$867,000*	*$867,000*	*$867,000*
DUI Program Licensing Trust Fund (0139)	*$1,212,000*	*$1,269,000*	*$1,270,000*
Hospital Svc. Account, Prop 99 (0232)	*$73,335,000*	*$73,335,000*	*$125,979,000*
Physician Svcs. Account, Prop 99 (0233)	*$22,496,000*	*$22,496,000*	*$39,526,000*
Unallocated Account, Prop 99 (0236)	*$46,804,000*	*$46,834,000*	*$74,491,000*

Narc Treatment Prog Lic Trust Fund (0243)	*$1,757,000*	*$1,801,000*	*$1,802,000*
Perinatal Insurance Fund (0309)	*$12,105,000*	*$16,396,000*	*$20,113,000*
Audit Repayment Trust Fund (0816)	*$67,000*	*$67,000*	*$67,000*
Medi-Cal Inpt Payment Adj Fund (0834)	*$152,040,000*	*$166,513,000*	*$144,465,000*
Special Deposit Fund (0942)	*$67,040,000*	*$59,305,000*	*$74,553,000*
Reimbursements (0995)	*$1,599,713,000*	*$1,209,167,000*	*$1,625,642,000*
County Health Init Matching Fund (3055)	*$176,000*	*$176,000*	*$176,000*
Childrens Med Services Rebate Fund (3079)	*$16,259,000*	*$11,000,000*	*$8,300,000*
Mental Health Services Fund (3085)	*$1,841,437,000*	*$2,023,841,000*	*$2,024,179,000*
Nondesig Public Hosp Supp Fund (3096)	*$0*	*$525,000*	*$0*
Priv Hospital Supplemental Fund (3097)	*$19,500,000*	*$19,500,000*	*$19,500,000*
Mental Heath Facility Lic Fund (3099)	*$375,000*	*$375,000*	*$375,000*
Residential/Outpatient Prog Lic Fund (3113)	*$6,903,000*	*$7,120,000*	*$7,122,000*
Childrens Health/Human Svcs Fund (3156)	*$21,286,000*	*$286,000*	*$0*
Hosp Qual Assurance Revenue Fund (3158)	*$4,872,901,000*	*$6,278,091,000*	*$4,361,024,000*
SNF Quality & Accountability Fund (3167)	*($1,899,000)*	*($2,194,000)*	*($2,833,000)*
Emerg Air Trans/Children's Fund (3168)	*$8,525,000*	*$7,576,000*	*$8,090,000*
Public Hosp Invest, Improve, Inc Fund (3172)	*$762,447,000*	*$843,924,000*	*$666,000,000*
LongTerm Care Qual Assurance Fund (3213)	*$460,098,000*	*$899,759,000*	*$503,268,000*
Health and Human Svcs Spec Fund (3293)	*$2,520,163,000*	*$2,526,905,000*	*$806,432,000*
Healthcare Treatment Fund, Prop 56 (3305)	*$1,259,038,000*	*$935,138,000*	*$1,053,518,000*
Health Plan Fines/Penalties Fund (3311)	*$8,700,000*	*$10,595,000*	*$9,096,000*
Medi-Cal Emerg Med Transport Fund (3323)	*$61,887,000*	*$63,121,000*	*$69,959,000*
Medi-Cal Drug Rebate Fund (3331)	*$0*	*$0*	*$1,440,526,000*
Whole Person Care Pilot Spec Fund (8107)	*$437,421,000*	*$419,861,000*	*$323,365,000*
Global Payment Program Spec Fund (8108)	*$1,246,043,000*	*$1,213,940,000*	*$1,026,722,000*
Desig Public Hosp GME Spec Fund (8113)	*$568,544,000*	*$359,528,000*	*$154,526,000*

Department of Health Care Services – *Changes to State Operations and Local Assistance*				
Fiscal Year:	**2017-18**	**2018-19 (CY)**	**2019-20 (BY)**	**CY to BY**
STATE OPERATIONS				
Fund Source	***Actual***	***Revised***	***Proposed***	***Change***
General Fund	$203,063,000	$246,958,000	$237,675,000	($9,283,000)
Federal Funds[1]	$327,832,000	$467,752,000	$448,476,000	($19,276,000)
Special Funds/Reimb	$41,887,000	$60,973,000	$57,914,000	($3,059,000)
Total Expenditures	**$572,782,000**	**$775,683,000**	**$744,065,000**	**($31,618,000)**
Total Auth. Positions	**3502.9**	**3434.5**	**3557.8**	**123.3**
LOCAL ASSISTANCE (*MEDI-CAL AND OTHER PROGRAMS)*				
Fund Source	***Actual***	***Revised***	***Proposed***	***Change***
General Fund	$20,366,160,000	$21,215,355,000	$23,405,017,000	$2,189,662,000
Federal Funds[1]	$57,055,664,000	$63,689,469,000	$66,234,871,000	$2,545,402,000
Special Funds/Reimb	$15,648,623,000	$17,228,907,000	$14,600,085,000	($2,628,822,000)
Total Expenditures	**$93,070,447,000**	**$102,133,731,000**	**$104,239,973,000**	**$2,106,242,000**
[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 13.2 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 2018 Medi-Cal Estimate - Overview

Budget Issue. The November 2018 Medi-Cal Local Assistance Estimate includes $98.5 billion ($20.7 billion General Fund, $62.7 billion federal funds, and $15.1 billion special funds and reimbursements) for expenditures in 2018-19, and $100.7 billion ($22.9 billion General Fund, $65.4 billion federal funds, and $12.5 billion special funds and reimbursements) for expenditures in 2019-20.

Medi-Cal Local Assistance Funding Summary			
Fiscal Year:	**2018-19 (CY)**	**2019-20 (BY)**	**CY to BY**
Benefits			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$19,695,653,000	$21,851,207,000	$2,155,554,000
Federal Funds	$58,756,149,000	$61,717,409,000	$2,961,260,000
Special Funds/Reimbursements	$15,079,839,000	$12,458,842,000	($2,620,997,000)
Total Expenditures	**$93,531,641,000**	**$96,027,458,000**	**$2,495,817,000**
County Administration			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$808,388,000	$906,788,000	$98,400,000
Federal Funds	$3,793,253,000	$3,410,136,000	($383,117,000)
Special Funds and Reimbursements	$4,997,000	$4,589,000	($408,000)
Total Expenditures	**$4,606,638,000**	**$4,321,513,000**	**($285,125,000)**
Fiscal Intermediary			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$175,298,000	$119,024,000	($56,274,000)
Federal Funds	$192,408,000	$231,883,000	$39,475,000
Special Funds and Reimbursements	$-	$-	$-
Total Expenditures	**$367,706,000**	**$350,907,000**	**($16,799,000)**
TOTAL MEDI-CAL LOCAL ASSISTANCE EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$20,679,339,000	$22,877,019,000	$2,197,680,000
Federal Funds	$62,741,810,000	$65,359,428,000	$2,617,618,000
Special Funds and Reimbursements	$15,084,836,000	$12,463,431,000	($2,621,405,000)
Total Expenditures	**$98,505,985,000**	**$100,699,878,000**	**$2,193,893,000**

Caseload. In 2018-19, the budget assumes annual Medi-Cal caseload of 13.2 million, a decrease of 1.2 percent compared to assumptions in the 2018 Budget Act. The department estimates 81.9 percent of

Medi-Cal beneficiaries, or 10.8 million, will receive services through the managed care delivery system while 18.1 percent, or 2.4 million, will receive services through the fee-for-service delivery system.

In 2019-20, the budget assumes annual Medi-Cal caseload of 13.2 million, a 0.4 percent increase compared to the revised caseload estimate for 2018-19. The department estimates 81.8 percent of Medi-Cal beneficiaries, or 10.8 million, will receive services through the managed care delivery system while 18.2 percent, or 2.4 million, will receive services through the fee-for-service delivery system.

Significant General Fund Adjustments. The November 2018 Medi-Cal Local Assistance Estimate includes the following significant adjustments to General Fund expenditures:

2018-19 General Fund Savings - The budget includes decreased General Fund expenditures in the Medi-Cal program of $2.3 billion in 2018-19 compared to the 2018 Budget Act. These savings are primarily attributable to the following factors:

- Successful resolution of federal Centers for Medicare and Medicaid Services (CMS) deferrals and a lower amount of projected deferrals – ($418 million savings)
- Long-Term Care Quality Assurance Fund transfers from providers who failed to pay the Quality Assurance Fee, which offsets General Fund expenditures in Medi-Cal – ($307 million savings)
- Hospital Quality Assurance Fee payments increased due to prior year adjustments and changes in timing – ($428 million savings)
- Drug rebate projections increased based on more recent data and rebate timing shifts – ($390 million savings)
- Base managed care projections decreased based on reduced caseload projections – ($248 million savings)

Medi-Cal Optional Expansion – The budget includes $17.3 billion ($1.5 billion General Fund and $15.7 billion federal funds) in 2018-19 and $20.1 billion ($2.2 billion General Fund and $17.8 billion federal funds) in 2019-20 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, a seven percent share in calendar year 2019, and will assume a ten percent share in calendar year 2020 and beyond.

Proposition 56 Supplemental Payments - The budget allocates $2.1 billion ($710.5 million Proposition 56 funds and $1.4 billion federal funds) in 2018-19 and $2.2 billion ($769.5 million Proposition 56 funds and $1.4 billion federal funds) in 2019-20 for supplemental provider payments for services provided by physicians, dentists, women's health providers, intermediate care facilities for individuals with developmental disabilities, AIDS Waiver providers, home health providers, pediatric day health centers, and free-standing pediatric subacute facilities. The budget also includes three new investments with Proposition 56 revenues:

- Value-Based Payment Program – The budget includes $360 million ($180 million Proposition 56 funds and $180 million federal funds) to establish a Value-Based Payment Program through Medi-Cal managed care plans that will provide incentive payments to providers for meeting specific measures aimed at improving care for certain high-cost or high-need populations.

- Developmental and Trauma Screenings – The budget includes $105 million ($52.5 million Proposition 56 funds and $52.5 million federal funds) to support the provision of developmental screenings for all children in Medi-Cal ages zero to 21 and trauma screenings for all adults and children in Medi-Cal. These payments will be in addition to the amounts paid generally for an office visit in fee-for-service delivery models or capitation paid in managed care delivery models.
- Family Planning – The budget includes $500 million ($50 million Proposition 56 funds and $450 million federal funds) to provide additional fiscal support for family planning services in the Medi-Cal program.

Including these new proposals, the budget includes a total of $3.2 billion ($1.1 billion Proposition 56 funds and $2.1 billion federal funds) in 2019-20 for all supplemental payments related to Proposition 56 tobacco tax revenues.

Full-Scope Medi-Cal Expansion to Undocumented Young Adults - The budget includes $257.1 million ($194 million General Fund and $63.1 million federal funds) to expand full-scope Medi-Cal benefits to individuals age 19 to 25 who would otherwise be eligible for Medi-Cal, regardless of immigration status. DHCS estimates 138,000 undocumented young adults would receive full-scope Medi-Cal coverage under the expansion. DHCS is also proposing trailer bill language to increase redirection of county realignment funds from County Medical Services Program and other non-formula based counties under AB 85 (Committee on Budget), Chapter 24, Statutes of 2013. According to the Administration, this redirection would provide approximately $63 million of offsetting savings for the expansion of coverage.

Whole Person Care Housing Services - The budget includes $100 million General Fund in 2019-20 to provide counties and local entities with funding for supportive housing services for individuals who are homeless or are at risk of becoming homeless, with a focus on people with mental illness. These funds would be available for expenditure through June 30, 2025.

Drug Rebates Fund - The budget proposes to create a new special fund, the Medi-Cal Drug Rebates Fund, beginning July 1, 2019. The newly established fund would fund health care services for Medi-Cal beneficiaries and would enhance management of drug rebate accounting and transparency. DHCS expects to deposit $1.4 billion of rebate revenues into the new special fund in 2019-20, all of which would offset General Fund expenditures in the Medi-Cal program.

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 and 2019-20 fiscal years.

Issue 3: County Administration Estimate

Budget Issue. The budget includes $2 billion ($1 billion General Fund and $1 billion federal funds) in 2018-19 and $2.1 billion ($1 billion General Fund and $1 billion federal funds) in 2019-20 for the base allocation to counties for eligibility determinations for Medi-Cal beneficiaries. The base allocation for county administration in 2018-19 is unchanged from the amount included in the 2018 Budget Act, while the allocation in 2019-20 reflects an increase of $53 million ($26.5 million General Fund and $26.5 million federal funds) compared to the revised 2018-19 estimate. The increase in the 2019-20 allocation is due to an adjustment that reflects an increase in the California Consumer Price Index.

County Administration Base* Funding Summary			
Fiscal Year:	**2018-19 (CY)**	**2019-20 (BY)**	**CY to BY**
Fund Source	***Revised***	***Proposed***	***Change***
0001 – General Fund	$1,007,289,500	$1,033,781,000	$26,491,500
0890 – Federal Trust Fund**	$1,007,289,500	$1,033,781,000	$26,491,500
Total Expenditures	**$2,014,579,000**	**$2,067,562,000**	**$52,983,000**

*As of the 2018 Budget Act, the County Administration Base includes ACA expenditures, no longer reflected separately.
** 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.

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 to account for the increase in workload. As of the 2018 Budget Act, 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 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.

Cost-of-Doing-Business-Adjustment. DHCS reports it was unable to secure a vendor to develop the new budgeting methodology required by SB 28. The 2018 Budget Act included $54.8 million ($18.5 General Fund and $36.3 million federal funds) for a cost-of-doing-business adjustment for county eligibility workload. The 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 Consumer Price Index, which was estimated to be 2.8 percent in 2018-19. The Administration reported at the time that a similar increase would be applied in 2019-20 and 2020-21 as the county eligibility systems move to a single Statewide Automated Welfare System. The adjustment to the county eligibility base for 2019-20 reflects an estimated increase in the California Consumer Price Index of 2.63 percent.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this item 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.

Issue 4: 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. AB 5 X3 (Evans), Chapter 20, Statutes of 2009, Third Extraordinary Session, 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, 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 2019-20 are as follows:

Optional Benefits	FFS	Managed Care	TF	GF
Audiology	$3,814,000	$6,126,000	$9,940,000	$3,085,000
Chiropractic	$477,000	$4,714,000	$5,191,000	$1,371,000
Incontinence Creams/Washes	$7,019,000	$8,984,000	$16,003,000	$5,105,000
Optician/Optical Lab*	$16,939,000	$58,645,000	$75,584,000	$22,024,000
Podiatry	$2,105,000	$11,721,000	$13,826,000	$3,397,000
Speech Therapy	$243,000	$2,159,000	$2,402,000	$676,000
Grand Total	**$30,597,000**	**$92,349,000**	**$122,946,000**	**$35,658,000**

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

Budget Does Not Include Restoration of Optical Benefits Approved in 2017. The 2017 Budget Act included restoration of full adult dental services effective January 1, 2018, and optical services effective January 1, 2020. The restored funding for optical services was accompanied by trailer bill language conditioning the restoration of the benefit on the Legislature "including funding for these services in the state budget process". However, the budget does not include funding for restoring the optical benefit effective January 1, 2020. According to the Administration, while funding was included in totals for the 2019-20 fiscal year at the time of the final 2017 Budget Act, the funding was removed from base totals in the subsequent fiscal year and is currently no longer reflected for 2019-20. It is unclear what action the Legislature would be required to take to fulfill the statutory requirement of including funding for optical services in the state budget process.

Various stakeholders have proposed restoration of previously discontinued optional benefits, addition of new benefits, and modification of existing benefits in 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 $47.4 million ($13.6 million General Fund and $33.7 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 creams and washes benefits would only cost the state about $13 million in General Fund dollars but would greatly improve health outcomes for many low-income 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 reinstate treatment performed by podiatrists in the Medi-Cal system and eliminate the unnecessary authorizations, billing, and service policies that apply to them, but not physicians, within the Medi-Cal system. 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 Education and Environmental Remediation Benefit – The California Pan-Ethnic Health Network (CPEHN), Children Now, and Regional Asthma Management and Prevention (RAMP) request total expenditure authority of $15 million ($7.5 million General Fund and $7.5 million federal funds) to provide access to medically necessary asthma education and home environmental trigger remediation 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 the proponents, 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 quality of care, improving health outcomes, reducing health care costs and advancing health equity.

Extension of Medi-Cal Eligibility for Post-Partum Women Suffering from Mental Health Disorders– The American College of Obstetricians and Gynecologists (ACOG) requests resources to expand Medi-Cal benefits for a postpartum woman from 60 days to one year if that woman is diagnosed with a maternal mental health disorder. According to ACOG, maternal mental health is of increasing concern because of the high prevalence of depression and anxiety during the perinatal period and the resulting long-term implications of delayed, inconsistent, or absent treatment. Maternal mental health conditions influence the well-being of mothers, children, families, and communities. Low-income women and women of racial and ethnic minorities are disproportionately affected by maternal mental health disorders, as they face unique barriers to diagnosis and treatment. While many of these women may already be enrolled in Medi-Cal, others, who do not meet Medi-Cal's income eligibility, are not.

Under current law, the income eligibility requirements for pregnancy-related Medi-Cal increases from 138 percent of the federal poverty level (FPL) to 213 percent of the FPL for women who are pregnant. Pregnant women whose income is above 213 percent of the FPL up to and including 322 percent of the FPL may qualify for assistance through the Medi-Cal Access Program (MCAP). While MCAP is comprehensive coverage, it does require a small fee (1.5 percent of annual family income) to participate. These programs enable more low-income women who may not otherwise qualify for Medi-Cal to receive medically necessary treatment to ensure the health of their pregnancy and baby.

These benefits end after 60 days from the birth of the child. Unless the new mom enrolls in a Covered California program, which requires her to pay a premium, any treatment she would be receiving would no longer be covered. She would either need to obtain commercial insurance or explore community resources that offer appropriate mental health services. This disruption in coverage could break the continuity of care and potentially halt treatment altogether. This is unhealthy for the mother and the baby.

Audiology Benefit Liaison Staff – The California Academy of Audiologists (CAA) requests funding and establishment of a position within DHCS to serve as a liaison between department program staff and audiologists providing services to Medi-Cal and California Children's Services (CCS) program beneficiaries. According to CAA, California audiologists have been forced to withdraw from the CCS program due to a number of problems, including insufficient reimbursement allowances and rates, delays in reimbursement requiring providers to pay out of pocket, and significant delay in CCS authorization for cochlear implants, which can be used for early intervention for children with hearing loss. The significant delay in obtaining early intervention puts these children at risk of language delay or aberrant language development.

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 provide the Administration's rationale for not including funding for optical benefits restored as part of the 2017 Budget Act effective January 1, 2020.

Issue 5: Managed Care Enrollment Tax

Budget Issue. SB 2 X2 (Hernandez), Chapter 2, Statutes of 2016, Second Extraordinary Session, authorized a three-year tax on enrollment of health care service plans operating in California. The revenue from this tax serves as the non-federal share of increased capitation payments to managed care organizations providing services to Medi-Cal beneficiaries, as well as other expenditures in the Medi-Cal program. Because the revenue provides the non-federal share for these expenditures, overall General Fund spending in the program is reduced. The budget includes a total General Fund offset related to the managed care organization (MCO) enrollment tax of $1.9 billion in 2018-19 and $583.4 million in 2019-20. Although the MCO enrollment tax expires on July 1, 2019, there is a three-month lag in collections of the tax, which leads to the additional General Fund offset in 2019-20. SB 2 X2 also contained tax reform components that exempted payers of the MCO enrollment tax from liability for the state's gross premiums tax and from the business and corporations tax.

The budget does not include a proposal to reauthorize the MCO enrollment tax. As a result, expiration of the tax as scheduled on July 1, 2019, will result in a reduction in tax revenue available to offset General Fund expenditures in the Medi-Cal program of approximately $1.3 billion.

Federal Requirements for Health Care Related Taxes. Section 433.68 of Title 42 of the Code of Federal Regulations (42 CFR 433.68) authorizes state Medicaid programs to receive federal financial participation for expenditures using health care-related taxes, as long as certain conditions are met. The MCO enrollment tax qualifies as a health care-related tax. Taxes must be:

1) Broad-based – For a health care related tax to be considered broad based, it must be imposed on all non-federal and non-public providers in the state or jurisdiction imposing the tax.
2) Uniformly imposed – For a health care related tax to be considered uniform, it must be applied at the same rate for all affected providers.
3) No hold-harmless provisions – A taxpayer cannot be held harmless for the amount of the tax. A taxpayer is considered to be held harmless if there is a correlation between their Medicaid payments and the tax amount, all or any portion of the Medicaid payment varies based only on the tax amount, or the state or other taxing jurisdiction provides for any direct or indirect payment or other offset for all or any portion of the tax amount.

States may apply for waivers to both the broad-based and uniform requirements.

For a waiver of the broad-based requirements, a state must demonstrate that the tax is "generally redistributive" by calculating the proportion of tax revenue applicable to Medicaid under a broad-based tax (P1) and comparing it to the same proportion under the proposed tax (P2). A waiver may be approved if the ratio of P1/P2 is at least 0.95, and the excluded providers are in a list of providers defined in the regulation.

For a waiver of the uniform requirements, a state must measure the ratio of the slope of a linear regression equation of a broad-based and uniform tax (B1) compared to the proposed tax (B2). The ratio of B1/B2 must be at least 0.95, and the excluded providers are in a list of providers defined in the regulation. The MCO enrollment tax applied for a waiver of the uniform requirement, and its structure was designed to comply with the required B1/B2 ratio.

Offsets of General Fund Expenditures with the MCO Enrollment Tax. The MCO enrollment tax provides General Fund savings of between $1.2 billion and $1.9 billion annually over the three years of the tax. The flow of funds that allows this tax revenue to be used for costs that would have otherwise been borne by the General Fund are as follows:

1) Tax revenue is received from health care service plans based on the tiered tax structure in SB 2 X2. This revenue is deposited into the Health and Human Services Special Fund (Fund 3293). The 2018 Budget Act assumed total revenue of $2.3 billion in 2016-17 and $2.4 billion in 2017-18. The 2019 January budget assumes total revenue of $2.6 billion in 2018-19.
2) Tax revenue is used to offset General Fund expenditures for capitation rate increases to cover the MCO enrollment taxes paid by Medi-Cal managed care plans. The 2017 Budget Act assumed the General Fund expenditures offset for this purpose were $521.7 million in 2016-17. The 2018 Budget Act assumed a General Fund expenditure offset of $809.8 million in 2017-18. The 2019 January budget assumes a General Fund expenditure offset of $660.3 million in 2018-19 and $223 million in 2019-20.
3) The remaining tax revenue is used to offset other expenditures that would have been funded by the General Fund. The 2017 Budget Act assumed General Fund savings of $1.2 billion in 2016-17. The 2018 Budget Act assumed $1.6 billion General Fund savings in 2017-18. The 2019 January budget assumes $1.9 billion General Fund savings in 2018-19 and $583.4 million in 2019-20.

History of Provider-Related Taxes on Managed Care. 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 (MCO Enrollment Tax). Provider-related taxes on managed care organizations were first authorized in 2003.

2003 - Quality Improvement Fee. AB 1762 (Committee on Budget), Chapter 230, Statutes of 2003, authorized the state's first provider fee on Medi-Cal managed care organizations. The fee was implemented in July 2005 as a quality improvement fee of 5.5 percent of a plan's revenue. The 2005 Governor's Budget assumed net General Fund savings of $37.7 million as a result of the fee. The fee was allowed to expire in October 2009, as the federal government disallowed the fee because it was not sufficiently broad-based and, therefore, in violation of the relevant Medicaid regulations.

2009 - Gross Premiums Tax. AB 1422 (Bass), Chapter 157, Statutes of 2009, replaced the previous quality improvement fee with an extension of the state's existing gross premiums tax of 2.35 percent to Medi-Cal managed care plans. The tax had previously only been levied on insurance products, but taxation of Medi-Cal managed care plans under this existing tax regime was sufficient to comply with federal Medicaid regulations and guidance that the tax be broad-based. AB 1422 provided that revenue from the tax would serve as the non-federal share for expenditures in both the Medi-Cal program and the state's program for the federal Children's Health Insurance Program, known as the Healthy Families Program. The 2010 Budget Act assumed the gross premiums tax would provide $99.8 million to Medi-Cal and $82 million to Healthy Families in the 2009-10 fiscal year. The gross premiums tax was extended by SB 853 (Committee on Budget and Fiscal Review), Chapter 717, Statutes of 2010, and

again by AB 21 X1 (Blumenfield), Chapter 11, Statutes of 2011, First Extraordinary Session, until June 30, 2012.

2012 - Managed Care Organization Tax. The gross premiums tax expired on July 1, 2012, as the Legislature was unable to approve trailer bill language to continue the tax after its expiration. This left the Medi-Cal and Healthy Families Programs with a significant deficiency in their budgets. SB 78 (Committee on Budget and Fiscal Review), Chapter 33, Statutes of 2013, extended the gross premiums tax at its previous rate of 2.35 percent until June 30, 2013. SB 78 then authorized a tax of 3.9375 percent, equal to the state's portion of the sales and use tax, on the operating revenue of Medi-Cal managed care organizations, known as the MCO tax. The tax was authorized for three years, until June 30, 2016. The 2013 Budget Act assumed General Fund savings of $304.6 million for the Medi-Cal program from the MCO tax. Over subsequent years, additional populations began to enroll in Medi-Cal managed care, particularly related to the optional expansion of Medi-Cal authorized by the federal Affordable Care Act. As a result, General Fund savings from the MCO tax grew significantly because the tax was a percentage of overall expenditures on Medi-Cal managed care. The 2016 Budget Act assumed $971.2 million of annual General Fund savings in the 2015-16 fiscal year, the last year of operation of the sales-tax-related structure of the MCO tax.

Managed Care Enrollment Tax. In 2014, the federal government released guidance indicating that the structure of the state's MCO tax did not comply with federal Medicaid regulations. The state was instructed to make any necessary statutory changes to bring the tax into compliance by the end of the next scheduled legislative session, or the end of 2016. SB 2 X2, authorized the current tax on enrollment of managed care plans statewide, along with certain tax reform provisions. SB 2 X2 created a tiered tax on the enrollment of health care service plans based on their enrollment as reported to the Department of Managed Health Care for the 12 month period of October 1, 2014 through September 30, 2015, known as the "base year". There are three sets of tiers : 1) Medi-Cal enrollees, 2) Alternate Health Care Service Plan (AHCSP) enrollees (such as Kaiser), and 3) all other enrollees. Each tier, based on the number of member months, has a different tax rate per enrollee. DHCS used the following taxing tier structure to determine the MCO enrollment tax for 2018-19:

Medi-Cal			
Enrollees (Member Months)	Rate	Average Enrollment/Entity	Tax Revenue
0-2,000,000	$45.00	39,161,294	$1,762,259,000
2,000,001-4,000,000	$21.00	21,180,988	$444,801,000
Over 4,000,000	$1.00	48,831,000	$48,831,000

Non-Medi-Cal (including AHCSP)			
Enrollees (Member Months)	Rate	Average Enrollment/Entity	Tax Revenue
0-4,000,000	$8.50	25,757,753	$218,941,000
4,000,001-8,000,000	$3.50	16,832,337	$58,913,000
Over 8,000,000	$1.00	20,244,000	$30,244,000

Prospects for Federal Approval of a Reauthorized MCO Enrollment Tax. DHCS reports that, while CMS expressed concerns about the structure of the current MCO enrollment tax, no change in federal regulations was implemented in response to those concerns. In addition, CMS approved a similar tax on managed care organizations in Michigan in December 2018. Similar to California's MCO enrollment tax, Michigan's Insurer Provider Assessment taxes managed care plans in a tiered structure and the state reduced or eliminated other state taxes to reduce the overall tax liability on plans. These developments suggest CMS is likely to approve a reauthorization of a California MCO enrollment tax with similar features.

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. Why did the Administration elect not to propose reauthorization of the MCO enrollment tax?

3. Is the Administration aware of any federal or other barriers to reauthorization of the MCO enrollment tax?

Issue 6: Cybersecurity Program Augmentation

Budget Issue. DHCS requests three positions and expenditure authority of $1.2 million ($591,000 General Fund and $591,000 federal funds) in 2019-20 and $1.2 million ($578,000 General Fund and $577,000 federal funds) annually thereafter. If approved, these resources would allow DHCS to address cybersecurity risks identified by independent security assessments conducted by the California Military Department and the Office of Health Information Integrity. Included in the resource request is $575,000 ($288,000 General Fund and $287,000 federal funds) annually for the ongoing costs of additional enterprise security infrastructure tools.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$591,000	$578,000
0890 – Federal Trust Fund	$591,000	$577,000
Total Funding Request:	**$1,182,000**	**$1,155,000**
Total Requested Positions:	**3.0**	**3.0**

* Positions and Resources ongoing after 2020-21.

Background. According to DHCS, cyberattacks have been on the rise every year and the department has seen a dramatic increase in the sophistication and volume of attacks. International cybercriminal organizations and nation states have access to state-of-the-art tools and experts that work continuously to attack organizations with large amounts of data. Currently, DHCS averages between one and four million attacks per month against its firewall, and these are only the attacks that get past the state data center's firewall and their own sophisticated intrusion prevention system. Should an attack be successful and get past the firewall, there is a significant chance it could result in a data breach of protected health information. As of June 2018, there have not been any significant breaches of the DHCS firewall. However, industry breaches at major organizations have shown they can go undetected for months or even years.

Security Assessments of DHCS Systems. 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.

As required by AB 670, the California Military Department's CND Team performed an independent security assessment (ISA) of DHCS in 2017. The assessment criteria was based upon agreed standards set forth by the California Information Security Office. The ISA identified areas with low maturity in cybersecurity. The CND report dated January 10, 2018, identified 14 findings requiring remediation. DHCS will be able to partially remediate some of these findings using existing resources, however additional permanent staff and software tools are required for complete and ongoing remediation. CND will re-assess DHCS every two years, so temporary remediation is not sufficient.

The California Office of Health Information Integrity (CalOHII) has statutory authority over all Health Insurance Portability and Accountability Act (HIPAA) impacted state entities within the executive branch and implements statewide policy according to the requirements of the HIPPA Implementation Act of 2001 (Health and Safety Code Section 130300, et seq.). CalOHII completed a compliance review of DHCS in 2017 based upon its requirements under the Statewide Health Information Policy Manual (SHIPM).

The CalOHII compliance assessment dated April 7, 2017, identified 26 areas of non-compliance with SHIPM. The assessment included 16 high-risk, eight medium-risk, and two low-risk areas of non-compliance. DHCS has identified three of the CalOHII findings (two high-risk, one medium-risk) as requiring additional resources to remediate. Similar to the CND findings, complete and ongoing remediation requires additional permanent staff and software tools.

DHCS requests three positions and expenditure authority of $1.2 million ($591,000 General Fund and $591,000 federal funds) in 2019-20 and $1.2 million ($578,000 General Fund and $577,000 federal funds) annually thereafter. If approved, these resources are intended to address 17 of 40 total findings between the two assessments which are resource constrained, with work prioritized by risk level. The other 23 findings are being remediated using existing DHCS staff and tools.

Included in the resource request is $575,000 ($288,000 General Fund and $287,000 federal funds) annually for the ongoing costs of additional enterprise security infrastructure tools. These tools include a firewall rules analyzer ($50,000), an application audit log analytics monitoring tool ($475,000), and a web application firewall ($50,000). The requested staffing resources are as follows:

- **One Information Technology Specialist II - Configuration Management, Patching and Hardening -** This position would lead the effort to improve secure configuration and patching of all IT assets, including secure management of end point configurations, patching, hardening, access controls, validating least administrative privilege, IT asset management, encryption, malicious code protection, port hardening, credentials, accounts, sensitive data leakage, and phishing prevention.

- **One Information Technology Specialist II - IT Application Security -** This position would lead the effort to improve application level security for over 40 DHCS critical IT applications including: 1) performing vulnerability and penetration tests of IT applications, 2) managing web application firewalls, 3) managing audit trail monitoring, 4) configuring and validating secure and compliant IT applications, 5) monitoring IT applications for anomalous activity, 6) network zone security, and 7) managing a centralized IT application inventory.

- **One Information Technology Specialist II - Technical Risk Management -** This position would lead the effort to improve conduct of continuous, thorough, enterprise level risk assessments of common controls, IT application controls, policies, procedures, and training. This position would manage a centralized enterprise-level process to track, mitigate and resolve all identified deficiencies, including risk reporting.

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: Electronic Health Record Incentive Program Audits

Budget Issue. DHCS requests expenditure authority of $294,000 ($29,000 General Fund and $265,000 federal funds) in 2019-20, 2020-21, and 2021-22. If approved, these resources would allow DHCS to support program and audit close outs associated with the Medi-Cal Electronic Health record Program.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$29,000	$29,000
0890 – Federal Trust Fund	$265,000	$265,000
Total Funding Request:	**$294,000**	**$294,000**
Total Requested Positions:	**0.0**	**0.0**

* Positions and Resources requested until 2021-22.

Background. The Health Information Technology for Economic and Clinical Health (HITECH) Act, a component of the American Recovery and Reinvestment Act (ARRA) of 2009, authorizes approximately $4.5 billion for California for both the Medicare and Medi-Cal Electronic Health Records (EHR) incentive programs. Of the $4.5 billion for California, it is estimated that approximately $2 billion in incentive payments will be made through the Medi-Cal EHR Incentive Program to qualified Medi-Cal health care providers who adopt, implement, or upgrade and meaningfully use electronic health records in accordance with federal requirements. DHCS' Office of Health Information Technology (OHIT) manages and administers the incentive payments to eligible Medi-Cal providers and hospitals.

Since the implementation of the Medi-Cal EHR Incentive Program, OHIT has authorized more than 48,000 incentive payments to over 25,000 providers and over 300 hospitals. This has resulted in more than $1.5 billion in federal incentive payments made to date. DHCS expects to distribute between $100 and $200 million per year for the remainder of the program for an estimated total of approximately $2 billion distributed over the course of the program.

The Medi-Cal EHR Incentive Program is currently scheduled to operate through December 31, 2021. However, according to DHCS, the program and audit close outs would extend beyond 2021 based on recent federal guidance. The 2016 Budget Act included three-year, limited-term expenditure authority of $403,000 ($41,000 General Fund and $362,000 federal funds) for the Medi-Cal EHR Incentive Program to provide extensive data analysis, policy analysis, enrollment and eligibility support, and pre- and post-payment audits and investigations for program eligible managed care and fee-for-service providers. These resources support **two Health Program Auditor IV (HPA IV)** positions in the Audits and Investigations unit to perform pre-payment and post-payment audits of applicants for EHR incentive payments. These audits include review of first-year applications and follow-up review for verification of provider meaningful use of the technology.

DHCS requests expenditure authority of $294,000 ($29,000 General Fund and $265,000 federal funds) for an additional three years. These resources would continue to support the two HPA IV positions and their audit workload to allow close-out of the Medi-Cal EHR Incentive Program consistent with federal guidance.

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 8: Every Woman Counts Program Staffing

Budget Issue. DHCS requests conversion of one expiring, limited-term position to permanent and expenditure authority of $175,000 from the Breast Cancer Control Account annually. If approved, this position and resources would allow DHCS to continue ongoing data management, programming, and data analysis requirements for the Every Woman Counts program.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0009 – Breast Cancer Control Acct, Breast Cancer Fund	$175,000	$175,000
Total Funding Request:	**$175,000**	**$175,000**
Total Requested Positions:	**1.0**	**1.0**

* Position and Resources ongoing after 2020-21.

Background. The Every Woman Counts (EWC) program, established in 1991, 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). EWC serves as the California site of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), which is funded through federal grant funds, and the state and federal Breast Cancer Control Program.

According to DHCS, Detecting Early Cancer (DETEC) is a web-based data collection system where providers enter client level data reported to the Centers for Disease Control and Prevention (CDC) and NBCCEDP. The NBCCEDP grant requires grantees to submit the program's data deliverables twice a year and, starting in 2018-19, EWC will be required to submit additional clinic-based data on patient navigation, program evaluation, and evidence-based interventions.

The 2016 Budget Act included federal fund expenditure authority of $399,000 for three years to perform programming, data analysis, and data management functions for the EWC program. These resources supported three positions, including **one Information Technology Specialist I (ITS I)** position in the program's Benefits Division. DHCS requests conversion of this position to permanent and expenditure authority of $175,000 from the Breast Cancer Control Account annually.

This position has been responsible for data collection for federal grant reporting, claims data import and processing, conducting record linkages, monitoring and troubleshooting DETEC data import, data cleaning and monitoring, and creating and exporting databases and tables. In addition, according to DHCS, a contract with San Diego State University Research Foundation (SDSURF) will expire on June 30, 2018. The contractor was responsible for oversight of the Regional Contractors Management Information System (RCMIS) data system used to collect and manage the scope of work deliverables of EWC's regionally contracted Health Educators and Nurses. Currently, monthly data files are shared with SDSURF and on July 1, 2018, this activity will cease. The Clinical Coordination and Health Education for EWC Regions (CHEER) data system is being developed by a contractor to replace RCMIS. According to DHCS, the existing ITS I designed the specifications and system logics for the CHEER system, is responsible for overseeing development of the system by the contractor, and would be responsible for system management once 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.

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

1. Please provide a brief overview of this proposal.

Issue 9: Office of Legislative and Governmental Affairs Staffing

Budget Issue. DHCS requests two positions and expenditure authority of $247,000 ($124,000 General Fund and $123,000 federal funds) annually. If approved, these resources would allow DHCS to support workload in the Office of Legislative and Governmental Affairs, which responds to external inquiries and prepares fiscal and programmatic analyses of pending legislation or budget proposals.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$124,000	$124,000
0890 – Federal Trust Fund	$123,000	$123,000
Total Funding Request:	**$247,000**	**$247,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and Resources ongoing after 2020-21.

Background. According to DHCS, the Office of Legislative and Governmental Affairs (LGA) provides guidance to the California Health and Human Services Agency (CHHSA), the Department of Finance, the Governor's Office, and to other department divisions. LGA also coordinates the provision of technical assistance to legislative staff on legislative policy and budget issues, and serves as the direct contact point for legislative offices, Department of Finance and the Governor's Office regarding constituent and legislative inquiries. LGA's staff assignments include researching, reading and drafting complex documents, coordinating and attending inter- and intra-departmental and external meetings, coordinating stakeholder input and communications, and preparing briefings for legislators and their staff.

In response to increased workload, DHCS reports it redirected two limited-term Associate Governmental Program Analyst (AGPA) positions to LGA in 2017-18 to augment the four existing legislative coordinators. LGA reports the number of bill analyses it coordinates increased 29 percent in 2017 and 22 percent in 2018. LGA prepares evaluations of the fiscal impact for each bill affecting the department, which are shared with the Senate and Assembly Appropriations Committees and the Department of Finance. After legislation is approved and sent to the Governor, LGA completes an Enrolled Bill Report to advise the Governor's Office of DHCS' position on the bill.

DHCS requests establishment of **two AGPA positions** to replace the limited-term resources utilized to redirect the two existing positions in 2017-18. According to DHCS, the current workload level for LGA is ongoing and these permanent positions and resources are required to support the high volume of legislative and constituent inquiries.

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 10: Whole Child Model Evaluation Contract Funding

Budget Issue. DHCS requests expenditure authority of $1.6 million ($800,000 General Fund and $800,000 federal funds), available for expenditure or encumbrance until June 30, 2021. If approved, these resources would allow DHCS to secure a contractor to perform an independent evaluation of the Whole Child Model implementation. An identical level of one-time resources was previously approved, but unspent, in the 2018 Budget Act.

Program Funding Request Summary		
Fund Source	**2018-19***	**2019-20**
0001 – General Fund	[($800,000)]	$800,000
0890 – Federal Trust Fund	[($800,000)]	$800,000
Total Funding Request:	**[($1,600,000)]**	**$1,600,000**
Total Requested Positions:	**0.0**	**0.0**

* Unspent expenditure authority approved in 2018-19 will revert to the General Fund and Federal Trust Fund.

Background. 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. Services previously provided to CCS beneficiaries on a fee-for-service basis will be delivered by Medi-Cal managed care plans. After stakeholder discussions, DHCS will implement 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

Six COHS counties implemented the Whole Child Model on July 1, 2018. Partnership Health Plan, operating in 14 counties, implemented the Whole Child Model on January 1, 2019. CalOptima, operating in Orange County, is scheduled to implement the Whole Child Model no sooner than July 1, 2019. The budget includes $28.5 million ($12.8 million General Fund and $15.7 million federal funds) in 2018-19 and $791,000 ($365,000 General Fund and $426,000 federal funds) in 2019-20 for implementation of the Whole Child Model.

SB 586 requires DHCS to contract with an independent entity to conduct an evaluation to assess Medi-Cal managed care plan performance and the outcomes and experience of CCS-eligible children and youth participating in the Whole Child Model program. The evaluation is required to: (1) compare plan performance to performance of the CCS program prior to implementation in each county; (2) compare plan performance in participating counties to CCS program performance in non-participating counties; and (3) evaluate whether inclusion of CCS services in managed care improves access, quality, and the

patient experience. The evaluation must also, when possible, disaggregate results based on the child's or youth's race, ethnicity, and primary language spoken at home.

The 2018 Budget Act included $1.6 million for DHCS to secure a contractor to perform this evaluation. The resources were included in a budget change proposal related to California's Section 1115 Waiver: Medi-Cal 2020. According to DHCS, due to the delay of Whole Child Model implementation from 2017 to 2018, the finalization of the evaluation design and associated metrics was postponed and the previously allocated funding will remain unspent.

DHCS requests expenditure authority of $1.6 million ($800,000 General Fund and $800,000 federal funds), available for expenditure or encumbrance until June 30, 2021. If approved, these resources would allow DHCS to conduct the program evaluation of the Whole Child Model required pursuant to SB 586.

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: CA Dental Medicaid Management Information System Contract Management Staffing

Budget Issue. DHCS requests four positions and expenditure authority of $700,000 ($175,000 General Fund and $526,000 federal funds) annually. If approved, these resources would allow DHCS to support the transition to two new vendors for the California Dental Medicaid Management Information System.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$175,000	$175,000
0890 – Federal Trust Fund	$526,000	$526,000
Total Funding Request:	**$700,000**	**$700,000**
Total Requested Positions:	**4.0**	**4.0**

* Positions and Resources ongoing after 2020-21.

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. DHCS provides dental services to Medi-Cal beneficiaries through two primary delivery systems: 1) dental managed care (DMC) and 2) fee-for-service. For DMC beneficiaries, 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.

For fee-for-service beneficiaries, the department contracts with fiscal intermediary (FI) and administrative services organization (ASO) vendors to manage the delivery of dental care to Medi-Cal beneficiaries and oversee administrative processes such as claims processing, provider enrollment, and beneficiary outreach. Beginning in 2004, Delta Dental provided both FI and ASO services under a multi-year contract with DHCS for the administration of the Denti-Cal program and delivery of benefits. However, in 2012, the federal Centers for Medicare and Medicaid Services (CMS) determined the contract with Delta Dental did not meet federal regulatory criteria and conditions as a Medicaid Management Information System (MMIS). CMS asked DHCS to modify the contracting delivery model or risk losing the enhanced 75 percent federal match for MMIS activities. According to DHCS, the main concerns identified by CMS were:

- Non-compliance with MMIS requirements,
- Non-enforcement of Knox-Keene licensure requirements, and
- Use of a hybrid model of MMIS and administration within one contract with underwriting risk sharing.

In 2016, DHCS awarded two separate contracts for the FI and ASO responsibilities in the Denti-Cal program. DXC Technology Services was awarded the FI contract, which includes responsibility for operation of the California Dental Medicaid Management Information System (CD-MMIS), including claims processing, quality management operations, and system enhancements. Delta Dental was awarded the ASO contract, which includes responsibility for claims and treatment authorization request processing, telephone service center operations, provider enrollment, and beneficiary outreach. The

contract takeover process began in January 2017, with the two vendors assuming operational responsibilities in February 2018.

The 2016 Budget Act included three-year expenditure authority of $2.1 million ($514,000 General Fund and $1.5 million federal funds) to support the equivalent of seven three-year limited-term positions and contractual services to address workload related to the turnover and takeover of the Medi-Cal Dental FI contract into two separate FI and ASO services contracts. The limited-term expenditure authority supported four positions in the Enterprise Innovation and Technology Services (EITS) division, two positions in the Medi-Cal Dental Services Division (MDSD), and one position in the Office of Legal Services (OLS).

DHCS requests establishment of four positions and expenditure authority of $700,000 ($175,000 General Fund and $526,000 federal funds) annually to continue to support the transition to two new vendors. The department is requesting permanent establishment and funding, previously supported by the limited-term resources, for the following positions:

EITS

- **Two Information Technology Specialist I** positions would assess vendor deliverables and work products, review and approve invoices, apply principles of the Software Development Life Cycle to change instrument processes in the contracts, attend weekly project and operational status meeting with contractors, ensure contractors are on schedule with implementation of operational tasks, and prepare written status reports as required.

MDSD

- **One Associate Governmental Program Analyst** will review, assess, analyze, track and report on the new contract requirements, as well as conduct quality assessments, monitor contractor performance, interpret and research terms and conditions of the contracts, analyze and identify contract impact of legislative changes on the contracts, and serve as liaison between the state and the contractors.

OLS

- **One Attorney III** position will review and approve all contract amendments and change orders, provide legal analyses, serve as point of contact for all litigation issues, advise on disputes related to the contracts, monitor compliance with CMS guidance and state contracting rules, and respond to legal inquiries and correspondence from outside entities.

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: Childhood Lead Poisoning Prevention (SB 1041)

Budget Issue. DHCS requests one position and expenditure authority of $144,000 ($72,000 General Fund and $72,000 federal funds) annually. If approved, these resources would allow DHCS to provide Medi-Cal data to the Department of Public Health for additional blood lead level reporting pursuant to SB 1041 (Leyva), Chapter 690, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$72,000	$72,000
0890 – Federal Trust Fund	$72,000	$72,000
Total Funding Request:	**$144,000**	**$144,000**
Total Requested Positions:	**1.0**	**1.0**

* Position and Resources ongoing after 2020-21.

Background. The Childhood Lead Poisoning Prevention (CLPP) program was established in 1986 at the Department of Public Health 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 the state. 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.

SB 1041 Requires Additional Reporting on Blood Lead Testing for Children in Medi-Cal. SB 1041 requires the Childhood Lead Poisoning Prevention Program (CLPP) within the Department of Public Health to collect and analyze data on blood lead level screening tests for children enrolled in Medi-Cal. The data will be used to monitor appropriate case management efforts, to advance lead testing of children enrolled in Medi-Cal, and for use in its biennial lead poisoning case management public reporting. While the CLPP data systems contain information about lead screening, the Management Information System/Decision Support System (MIS/DSS) and Medi-Cal Eligibility Data System (MEDS) databases at DHCS contain the most complete information about Medi-Cal participation and billing of services.

DHCS requests **one Research Data Specialist II** position and expenditure authority of $144,000 ($72,000 General Fund and $72,000 federal funds) annually. This position would support the data analytics necessary to provide CLPP with analysis and other support of Medi-Cal client-level data to

prepare the report required by SB 1041. This position would also be responsible for developing a methodology to identify children enrolled in Medi-Cal who are at the required ages for blood lead level testing or in an age range requiring catch-up testing.

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: Strengthening Fiscal Estimates and Cash Flow Monitoring

Budget Issue. DHCS requests 25 positions and expenditure authority of $3.8 million ($1.8 million General Fund and $2 million federal funds) in 2019-20 and $3.6 million ($1.7 million General Fund and $1.9 million federal funds) annually thereafter. If approved, these resources would allow DHCS to improve the accuracy of the Medi-Cal and Family Health Local Assistance Estimates and provide additional oversight and monitoring of the department's cash flow.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$1,814,000	$1,706,000
0890 – Federal Trust Fund	$1,998,000	$1,881,000
Total Funding Request:	**$3,812,000**	**$3,587,000**
Total Requested Positions:	**25.0**	**25.0**

* Positions and Resources ongoing after 2020-21.

Background. According to DHCS, the Medi-Cal budget makes up a significant portion of the state's annual General Fund expenditures, estimated to be $98.5 billion ($20.7 billion General Fund, $62.7 billion federal funds, and $15.1 billion special funds and reimbursements) for expenditures in 2018-19, and $100.7 billion ($22.9 billion General Fund, $65.4 billion federal funds, and $12.5 billion special funds and reimbursements) for expenditures in 2019-20. The Medi-Cal budget is on a cash basis, rather than an accrual basis, of accounting, which means the timing of transactions can significantly disrupt fiscal year budgetary estimates. Currently, DHCS' fiscal functions are performed by the Administration Division's Financial Management Branch, which manages budgets and accounting, and the Fiscal Forecasting Division, which develops the Medi-Cal and Family Health Local Assistance Estimates.

Welfare and Institutions Code section 14100.5 requires DHCS to submit an estimate of Medi-Cal expenditures twice a year: once in November for release with the Governor's Budget, and once in April for release with the May Revision. At the same time, DHCS prepares a twice-yearly Family Health Estimate for several non-federal programs. These two estimates are highly detailed and forecast expenditures, caseload, and the impact of regulatory and state and federal policy changes in these programs. The estimates include base program estimates, plus over 300 policy changes that itemize specific programs or changes to base expenditures. The estimates are subject to the analysis of the Department of Finance, the Legislative Analyst's Office, the Legislature, and other stakeholders. The Fiscal Forecasting Division is the primary division responsible for preparing the estimates, based on input from all other DHCS divisions.

During 2017 and 2018, DHCS found variances in excess of $500 million General Fund between the estimates and actual expenditures. Monthly General Fund cash flow projections significantly fluctuated in 2016-17 and 2017-18. DHCS, in partnership with the Department of Finance, initiated a comprehensive, ongoing effort to identify the major programs and factors contributing to the fluctuations in cash flow and Medi-Cal Estimate variances, and the solutions and associated resources needed to improve the accuracy of the Estimates and implement a monthly cash reconciliation process.

DHCS requests 25 positions and expenditure authority of $3.8 million ($1.8 million General Fund and $2 million federal funds) in 2019-20 and $3.6 million ($1.7 million General Fund and $1.9 million federal funds) annually thereafter to improve the accuracy of the Medi-Cal and Family Health Local Assistance Estimates and provide additional oversight and monitoring of the department's cash flow. These positions would be distributed among eight department divisions, as follows:

Executive – Director's Office – One position

- **One Chief Financial Officer** would provide heightened, consolidated, deputy-level leadership of DHCS' fiscal operations, including Budgets, Accounting, and Fiscal Forecasting.

Administration – Accounting Section – Four positions

- **One Accounting Administrator I** position would centralize accounting responsibilities for monitoring and managing the department's cash flow.
- **Three Associate Accounting Analysts** would assist with reconciling cash balances with projected and actual expenditures.

Capitated Rates Development Division – Two positions

- **One Associate Governmental Program Analyst** would assist with compiling and providing monthly managed care payment rate updates to internal DHCS programs.
- **One Research Data Specialist** would research differences between projected and actual expenditures for the managed care program.

Fiscal Forecasting Division: Oversight and Monitoring Cash – Four positions

- **One Staff Services Manager II** position would lead a unit of five total staff dedicated to the development and tracking of monthly cash management reporting.
- **Two Research Data Specialist I** positions and **one Research Data Analyst I** position would develop monthly cash management reports, assist in researching differences between estimated cash flows and actual expenditures, and coordinate cash management within DHCS.

Fiscal Forecasting Division: Strengthening Local Assistance Estimates – Six positions

- **Two Health Program Specialist I** positions would perform detailed analyses of proposed policy changes in the local assistance estimates, perform data verification and engage more frequently and closely with program staff.
- **Three Research Data Specialist II** positions and **one Research Data Specialist I** position would coordinate the impact of changes in statewide eligibles for specialty mental health services and apply consistent cash-basis methodology, manage changes in estimation methods for the Medi-Cal dental program, research and develop changes to overall estimate methodology, provide timely estimate-specific data, expand the Medi-Cal data knowledge base of existing staff, and build innovative analytical datasets to aid in evaluating trends and future projections.

Managed Care Operations Division – Two positions

- **One Research Data Specialist II** position would conduct complicated fiscal research and analysis using advanced research methodologies and statistical procedures, and would be responsible for cash management, reconciliation, and reporting activities.

- **One Information Technology Specialist II** position would oversee and monitor all project management activities related to the Medi-Cal managed care program fiscal efforts, and would serve as a liaison between several divisions for system updates and refinements.

Office of HIPAA Compliance – Two positions

- **One Information Technology Specialist I** position would serve as a software developer to continue development efforts within the department's capitation payment system, implementing change requests from program areas to streamline payments, modernize outdated system modules, transition to electronic delivery of invoices, and assist with development of the managed care portion of the system.
- **One Information Technology Specialist I** position would serve as a systems analyst to initiate knowledge transfer from vendor staff, build documentation in various parts of the system, lead implementation of onboarding of new managed care plans, assist existing managed care plans with inquiries about system-related transactions, and perform systems analysis and quality assurance testing for future releases in a new system.

Pharmacy Benefit Division – One position

- **One Health Program Specialist I** position would work with divisions impacted by Medi-Cal drug rebates, oversee and manage all related efforts to address the tracking and monitoring of the drug rebate program, and develop and document processes within and across divisions to provide information for monthly cash reconciliation.

Third Party Liability Recovery Division – Three positions

- **Two Research Data Analyst II** positions would independently analyze collection activity for all quality assurance fee programs, maintain and create statistical reports to update management on program status, recommend changes to enhance program collections, initiate and track withhold transfers on debt collected, and keep stakeholders informed of program collection activities.
- **One Associate Governmental Program Analyst** would independently analyze fee collection activity and review changes in Medi-Cal and Medicare laws and regulations that could impact fee recovery 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 DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

2. Please describe the steps DHCS is taking to better manage its cash flow and estimates to avoid the substantial General Fund variances typical of recent fiscal years.

Issue 14: Medi-Cal Drug Rebate Fund

Budget Issue and Trailer Bill Language Proposal. DHCS requests trailer bill language to establish the Medi-Cal Drug Rebate Fund to deposit the proceeds of rebates on prescription drugs purchased on behalf of Medi-Cal beneficiaries. If approved, DHCS estimates $1.4 billion would be deposited in the fund in 2019-20, which would offset General Fund expenditures in the Medi-Cal program.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20**
0001 – General Fund	$-	($1,440,526,000)
3331 – Medi-Cal Drug Rebate Fund*	$-	$1,440,526,000
Total Funding Request:	**$-**	**$-**

* Fund proposed to be created by trailer bill language.

Background. 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.

Currently, when rebates are first received, the funding split between the General Fund and federal funds is unknown and the initial funding is credited back assuming a 50 percent federal match until reconciled with actual claims data. The timing of these later adjustments have varied, and have shifted from one fiscal year to another. For example, federal reimbursement was never remitted for drug rebates on claims between April 2015 and June 2016. For this period and the period between January and March 2017, DHCS remitted several one-time repayments to the federal government related to the higher federal matching rate for Affordable Care act beneficiaries after reconciliation of actual claims data. The 2017 Budget Act reflected a federal repayment of $487.3 million in 2016-17. The 2018-19 January budget included an additional federal repayment of $303.1 million in 2017-18 and offsetting savings of $280.7 million in 2018-19. The 2019-20 January budget includes additional rebates of $390 million for 2018-19. This uncertainty of when drug rebates are received and adjusted poses challenges for the department's overall fiscal management.

DHCS proposes to establish the Medi-Cal Drug Rebate Fund to manage the impact on the department's General Fund cash flow due to the uncertain timing of drug rebates and funding adjustments. The fund would allow for a specific amount to be budgeted and transferred to offset General Fund expenditures in the Medi-Cal program. If additional rebates are received, the department would be able to validate the rebates and have increased flexibility on the timing of the impact to the General Fund, reducing volatility in Medi-Cal General Fund expenditures.

Specifically, the proposed trailer bill language would:

- Create the Medi-Cal Drug Rebate Fund in the State Treasury to hold the state share of federal and state supplemental drug rebates collected by DHCS, including all interest and dividends earned.
- Continuously appropriate the funds, without regard to fiscal year, for expenditures in the Medi-Cal program.
- Authorize the State Controller to use the funds for cash flow loans to the GF, as specified.

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. The budget allocates all rebate proceeds to offset General Fund expenditures in Medi-Cal. How does DHCS propose to use this fund in the future to manage the volatility of rebate collections?

Issue 15: Medi-Cal Checkwrite Contingency Payments

Trailer Bill Language Proposal. DHCS requests adoption of trailer bill language to authorize contingency payments to Medi-Cal providers during periods of delay, non-functionality, or system errors in the Medi-Cal Checkwrite Schedule provider claims processing system. If approved, this statutory authority would allow DHCS to maintain continuity of access to Medi-Cal healthcare services for beneficiaries and payments to providers in the event of a disruption in the Medi-Cal Checkwrite service.

Background. DHCS contracts with a fiscal intermediary (FI) to maintain and operate the California Medicaid Management Information System (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 existing 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.

CA-MMIS processes payments to providers of medical care to Medi-Cal certified eligible beneficiaries, via the Medi-Cal Checkwrite. The FI provides other related services including, but not limited to, the operation of a telephone service center and provider relations functions; system operations, updates and enhancements; processing eligibility inquiry transactions, treatment authorization requests, and service authority requests. According to DHCS, in 2017-18, the total amount paid by the Medi-Cal Checkwrite was $17,942,540.22 and averaged $345,048,851 weekly.

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. 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 FI contract requires development of an automated contingency payment process to ensure payments to providers will continue uninterrupted in the event of a Medi-Cal Checkwrite disruption. Such a disruption could be caused during implementation of new system functionality, emergencies, or other unplanned interruptions. DHCS reports it has not recently experienced a Checkwrite delay, but notes it relies on aging information technology systems and views the contingency payment process as a responsible precaution. The contingency payment process developed by the FI would calculate contingency payment amounts based on the provider's payment history for the prior twelve months, validate the provider is in good standing, and allow DHCS to determine which providers receive

contingency payments for which service dates. Once the Medi-Cal Checkwrite disruption ends, DHCS would reconcile the contingency payments against actual adjudicated claims for the contingency payment period and adjust future payments accordingly.

DHCS requests adoption of trailer bill language to authorize contingency payments to Medi-Cal providers during periods of delay, non-functionality, or system errors in the Medi-Cal Checkwrite Schedule provider claims processing system. DHCS reports that, although it has the technical ability to calculate contingency payments to providers when there is a disruption to the Medi-Cal Checkwrite process, the State Controller's Office requires statutory authority to process such contingency payments. Therefore, DHCS is seeking statutory authority to make contingency payments to providers for claims if there is a disruption to the Medi-Cal Checkwrite process upon approval of the Department of Finance.

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: Health Homes Program Funding Extension

Trailer Bill Language Proposal. DHCS requests the adoption of trailer bill language to extend the period of availability of funding for implementation of the Health Homes Program from June 30, 2020, to June 30, 2023. If approved, this language would allow DHCS to continue implementation and funding for the Health Homes Program, which began July 1, 2018.

Background. AB 361 (Mitchell), Chapter 642, Statues of 2013, authorizes DHCS to implement the Medicaid Health Home Program (HHP) Services benefit, which provides enhanced care coordination benefits for members with chronic conditions with the goal reducing state Medi-Cal costs by decreasing avoidable emergency department and inpatient stays, and improving health outcomes for Medi-Cal's most vulnerable beneficiaries. Established under Section 2703 of the federal Affordable Care Act, states that adopt the HHP benefit receive a 90 percent federal match for program services for two years. After two years, the federal match converts to the 50 percent federal matching rate.

AB 361 specifies that DHCS may only implement the HHP if prior and ongoing projections show no additional General Fund monies will be used to fund the program's administration, evaluation, and services. DHCS may use General Fund monies to operate the program if ongoing General Fund costs for the Medi-Cal program do not result in a net increase. In January 2013, the California Endowment (TCE) Board of Directors approved a $25 million commitment in each of the first two years to provide the 10 percent non-federal match for program services and related state operations activities.

SB 75 (Committee on Budget and Fiscal Review), Chapter 18, Statutes of 2015 established the Health Home Program Account in the Special Deposit Fund within the State Treasury in order to collect and allocate non-General Fund public or private grant funds to be used for HHP implementation. The TCE funding of $50 million for the first two years of implementation was deposited into this account.

SB 75 also appropriated $50 million from the account for the purposes of administering the HHP. The appropriation was made available for encumbrance or expenditure until June 30, 2020.

After significant stakeholder engagement, DHCS began implementing HHP in 14 counties beginning July 1, 2018. Counties will implement HHP in four groups and each group will implement its program in two phases. Phase 1 will implement HHP services for members with certain chronic conditions and substance use disorders. Phase 2 will implement HHP services for members with certain serious mental illness conditions. AB 361 also requires DHCS, within two years of implementation, to provide an evaluation of the program to the fiscal and policy committees of the Legislature. As of September 2018, the implementation schedule for the program is as follows:

Groups	Counties	(Phase 1) Implementation date for members with eligible chronic physical conditions and substance use disorders	(Phase 2) Implementation date for members with eligible serious mental illness conditions
Group 1	San Francisco	July 1, 2018	January 1, 2019
Group 2	Riverside San Bernardino	January 1, 2019	July 1, 2019
Group 3	Alameda Fresno Imperial Kern Los Angeles Sacramento San Diego San Mateo Santa Clara Tulare	July 1, 2019	January 1, 2020
Group 4	Orange	January 1, 2020	July 1, 2020

DHCS requests the adoption of trailer bill language to extend the period of availability of funding for implementation of the Health Homes Program from June 30, 2020, to June 30, 2023. As implementation of the program will continue through July 1, 2020, this language would allow DHCS to continue implementation and funding from the original TCE contribution for an additional three years.

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 plan to continue funding of this program after 2023, given the statutory requirement to utilize non-General Fund sources?

Issue 17: Family Health Estimate Overview

Budget Issue. The November 2018 Family Health Local Assistance Estimate includes $251.3 million ($206.8 million General Fund, $5.1 million federal funds, and $39.4 million special funds and reimbursements) for expenditures in 2018-19, and $257 million ($215.2 million General Fund, $5.1 million federal funds, and $36.7 million special funds and reimbursements) for expenditures in 2019-20.

Family Health Local Assistance Funding Summary			
Fiscal Year:	**2018-19 (CY)**	**2019-20 (BY)**	**CY to BY**
California Children's Services (CCS)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$78,356,000	$80,318,000	$1,962,000
Special Funds/Reimbursements	$5,453,000	$5,453,000	$-
County Funds [non-add]	[$84,124,000]	[$86,088,000]	[$1,962,000]
Total CCS Expenditures	**$83,809,000**	**$85,771,000**	**$1,962,000**
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	$112,315,000	$118,146,000	$5,831,000
Special Funds and Reimbursements	$11,462,000	$8,762,000	($2,700,000)
Total GHPP Expenditures	**$123,777,000**	**$126,908,000**	**$3,131,000**
Every Woman Counts Program (EWC)			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$16,105,000	$16,737,000	$632,000
Federal Funds	$5,128,000	$5,128,000	$-
Special Funds and Reimbursements	$22,504,000	$22,504,000	$-
Total EWC Expenditures	**$43,737,000**	**$44,369,000**	**$632,000**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***Revised***	***Proposed***	***Change***
General Fund	$206,779,000	$215,201,000	$8,422,000
Federal Funds	$5,128,000	$5,128,000	$-
Special Funds and Reimbursements	$39,419,000	$36,719,000	($2,700,000)
County Funds [non-add]	[$84,124,000]	[$86,088,000]	[$1,964,000]
Total Family Health Expenditures	**$251,326,000**	**$257,048,000**	**$5,722,000**

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 176,591 in 2018-19, a decrease of 708 or 0.4 percent, compared to the 2018 Budget Act. The budget estimates Medi-Cal CCS caseload of 178,371 in 2019-20, an increase of 1,780 or one percent, compared to the revised 2018-19 estimate.
  Caseload Estimate (State-Only): The budget estimates state-only CCS caseload of 15,131 in 2018-19, a decrease of 312 or 2.1 percent, compared to the 2018 Budget Act. The budget estimates state-only CCS caseload of 15,131 in 2019-20, unchanged compared to the revised 2018-19 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 22 in 2018-19, unchanged compared to the 2018 Budget Act. The budget estimates state-only CHDP caseload of zero in 2019-20, a decrease of 22 or 100 percent compared to the revised 2018-19 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 988 in 2018-19, a decrease of 23 or 2.3 percent, compared to the 2018 Budget Act. The budget estimates Medi-Cal GHPP caseload of 1,009 in 2019-20, an increase of 21 or 2.1 percent, compared to the revised 2018-19 estimate.
  Caseload Estimate (State-Only): The budget estimates state-only GHPP caseload of 783 in 2018-19, an increase of 62 or 8.6 percent, compared to the 2018 Budget Act. The budget estimates state-only GHPP caseload of 785 in 2019-20, an increase of two or 0.3 percent, compared to the revised 2018-19 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 26,963 in 2018-19, an increase of 543 or 2.1 percent, compared to the 2018 Budget Act. The budget estimates EWC caseload of 26,963 in 2019-20, unchanged compared to the revised 2018-19 estimate.

Elimination of Treatment Limits in Breast and Cervical Cancer Treatment Program. The 2018 Budget Act included trailer bill language and General Fund expenditure authority of $8.4 million annually to eliminate treatment limitations in the Breast and Cervical Cancer Treatment Program (BCCTP). The state-funded BCCTP previously limited the period of coverage to 18 months for breast cancer and 24 months for cervical cancer, with no similar treatment limitations for BCCTP coverage for Medi-Cal beneficiaries.

According to DHCS, during the six months between July 2018 and January 2019, 608 beneficiaries that would have lost coverage under the previous treatment limitations were allowed to continue receiving treatment under the BCCTP program. For the 2018 Budget Act, DHCS had estimated 777 beneficiaries would benefit from lifting the treatment limitations during the 2018-19 fiscal year.

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 significant changes in Family Health Estimate programs in the 2019-20 fiscal year.

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

SUBCOMMITTEE NO. 3 Agenda

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

Thursday, March 28, 2019
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Renita Polk

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4700 DEPARTMENT OF COMMUNITY SERVICES AND DEVELOPMENT

Issue 1: Overview

The mission of the Department of Community Services and Development (CSD) is to reduce poverty for Californians by partnering with a network of private, non-profit, and local government community service providers dedicated to helping low-income families achieve and maintain self-sufficiency and meet their home energy needs. Members of the statewide network are commonly referred to as Community Action Agencies or Local Service Providers.

Funding. The Governor's budget proposes total spending of $297.5 million (no General Fund) for CSD for 2019-20. Below is a summary of the Governor's proposed funding for 2018-19 and 2019-20:

Funding for Department of Community Services and Development
(Dollars in millions)

Funding Source	Federal FY 2018	Federal FY 2019
Low Income Home Energy Assistance Program	$191.1	$204.3
Community Services Block Grant	$63.5	$63.8
Dept. of Energy Weatherization Assistance Program	$6.9	$7.5
	State FY 2018-19	**State FY 2018-19**
Greenhouse Gas Reduction Fund	$10	$10

Programs. CSD's programs include:

- Community Services Block Grant (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, tax preparation, and nutrition and emergency services. In 2017, the department administered $56.9 million in CSBG funds to 59 community action agencies, and provided services to 2.1 million individuals.

- Low-Income Home Energy Assistance Program (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 (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.

- 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. The following counties will be receiving services under the Farmworker Housing component of the program: Fresno, Madera, Merced, Monterey, San Joaquin, Stanislaus, Imperial, Kern, Riverside, Santa Barbara, Tulare, and Ventura.

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. The Department of Energy WAP may also be eliminated under the proposed federal budget, but that is still unclear. These programs have been proposed for elimination in the past, but have never been cut.

LIWP Update. In past years, there has been some concern about CSD's Regional Administrator approach for LIWP by various stakeholders. In particular, stakeholders were concerned 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 provided its most recent briefing in fall of 2018, and published a LIWP program update in March 2019.

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

Questions.

1. Please provide an update on current funding levels and any new or significant developments.

5175 DEPARTMENT OF CHILD SUPPORT SERVICES

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 parentage, and establish and enforce orders for financial and medical support. DCSS estimates that there are approximately one million child support cases in California, serving approximately one in ten Californians.

Local and regional child support agencies deliver services, which are available to all California residents. There are a total of 49 local child support agencies (LCSAs) across the state. The majority of LCSAs serve one county, with the exception of seven regionalized LCSAs that serve multiple counties.

Families can be referred to CSP through public assistance programs, or may apply for services at an office or online. When a current child support payment is collected for a party receiving public assistance benefits, the custodial party will receive the first $50 of the child support payment. The balance of the payment is used to reimburse federal, state and county governments for the cost of the benefits. After the initial application or referral, the family proceeds to case intake. In federal fiscal year 2017, there were 974,273 non-custodial parents (NCP), approximately 1 million custodial parties (CP), and approximately 1.7 million dependents served by the program. About 50,000 of the NCPs were also CPs on a separate case.

Budget. The Governor's budget provides $1.08 billion ($339.2 million General Fund) for 2019-20. The table below provides a summary of the CSP's proposed funding in 2019-20.

Child Support Program Costs for 2019-20[1]					
	Federal	State	County	Reimbursements	Total
State Operations	$126.6 million	$56 million	$0	$123,000	$182.7 million
Local Assistance	$615.9 million	$283.3 million	$13.6 million	$0	$912.8 million
				Total	**$1.1 billion**

Total child support collections are projected to be $2.5 billion ($175.8 million General Fund) in 2018-19 and $2.54 billion ($175.5 million General Fund) for 2019-20. Total costs for local assistance are estimated to be $856.7 million ($264.2 million General Fund) for 2018-19 and $912.8 million ($283.3 million General Fund) for 2019-20.

Administration and Funding. The Child Support Program is locally administered and funded through federal (66 percent) and state funds (34 percent). The program earns federal incentive funds based on the state's performance in five federal performance measures (to be discussed below). Additionally, counties match funds for Local Child Support Agencies (LCSAs) that elect to supplement the program with local matching funds. Funding for the county match is 34 percent county funds and 66 percent federal funds. More detail on local administration and costs is provided in the following issue.

[1] Total program costs minus county funds equals total enacted budget.

Local Child Support Agency Revenue Stabilization. Since 2009, the budget has provided $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. 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 in arrears. According to 2017-18 data, DCSS found that revenue stabilization funds have assisted in retaining:

- 202 child support caseworkers.
- $15.5 million ($7.4 million General Fund) in net total assistance collections.
- $130 million in total non-assistance collections.

Collections. Basic collections represent the ongoing efforts of LCSAs to collect child support payments from parents paying support. The department gathers basic collections 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 public assistance are retained and serve as recoupment of past welfare costs.

Total Collections Received, By Source (2017-18)	
Wage Withholding	$1.67 billion
IRS federal income tax refund	$136.6 million
FTB state income tax refund	$40.9 million
Unemployment Insurance Benefits	$36.3 million
Collections from tribes, counties, or other IV-D states	$99.5 million
Non-custodial parents regular payments	$370.3 million
Other sources* (Liens, workers' compensation, disability insurance benefits offset, California insurance intercepts, and full collections program without wage levies)	$115.8 million
Total	$2.48 billion

Total projected child support collections are $2.54 billion for 2019-20 ($2.13 billion non-assistance payments; $408.7 million assistance payments). According to the Administration, wage withholding continues to be the most effective way to collect child support, constituting 67.6 percent ($1.67 billion) of the total collections received in 2017-18. For more information about total collections received by source, please see the table above. Of the total collections received in federal fiscal year 2017, $377 million was recouped by government agencies for past welfare costs. ($183.3 million federal, $169.6 million state, and $23.6 million county). That number constituted approximately 15.3 percent of total collections.

Cost Avoidance. Cost avoidance, or the costs avoided as a result of the child support program, due to decreased expenditures for public assistance programs for families that otherwise would have been on public assistance, is recognized as a benefit of the program. A 2004 report for the Child Support

Directors Association of California found the primary programs with cost avoidance are CalWORKs, CalFresh, Medi-Cal, Supplemental Security Income (SSI), and public/subsidized housing. The department has estimated total cost avoidance for 2017-18 based on 2000-01models. However, the department recommends an updated study be performed since these estimates are based on 2000-01 models. The department is currently identifying options to update that study. The table below, provided by the department, displays the estimated cost avoidance in 2017-18.

	Federal Share	California Share	Total
Entitlement Programs			
Food Stamps	$99.9	$0.0	$99.9
Medi-Cal	$21.9	$20.8	$42.7
SSI	$24.6	$0.0	$24.6
Total	$146.4	$20.8	$167.2
Block Grant / Discretionary Programs			
CalWORKs	$0.0	$169.5	$169.5
Housing	$6.1	$6.1	$12.3
Total	$6.1	$175.6	$181.8
All Programs	$152.5	$196.4	$349.0

*Dollars in millions

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 93.6 percent in FFY 2018. 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 91.6 percent for FFY 2018. 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 2018. The federal minimum performance level is 40 percent.

4. **Cases with Collections in 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 66.8 percent for FFY 2018, meaning the program collected payments on 66.8 percent of cases owing arrearages. The federal minimum performance level is 40 percent.

5. **Cost Effectiveness** compares the total amount of 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 2018. The federal minimum performance level is $2.00.

If any state falls below one or more of the performance measures or does not meet the data reliability criteria, then an automatic corrective action period of one year will ensue. If not corrected during that period, a penalty will be imposed at the end of that year. Failure to meet the data reliability standard puts states at risk of losing eligibility for incentive funds and incurring penalties. DCSS estimates that California will be entitled to $43.6 million in federal incentive funds for fiscal year 2018-19 and $43.8 million in the budget year.

DCSS has also developed a set of 28 measures called practice indicators to track other key metrics that are important to customers and to the performance of the program. These measures are meant to help to inform strategies and practices that the LCSAs adopt and include in their annual performance improvement plans.

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). 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 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 met with LCSAs and the Judicial Council of California throughout 2018 to review both the Final Rule provisions related to Guideline, and the Quadrennial Review report. Since last year the department has implemented many provisions required by the Final Rule but is still working on implementing a few others. The department is awaiting feedback from its workgroup on those implementation decisions. All the provisions awaiting a decision are optional or have a compliance date of January 1, 2022.

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: Local Child Support Agencies (LCSA) Administrative Funding Augmentation

Budget Issue. The Governor's proposal includes an increase of $56 million ($19 million General Fund) in 2019-20 for LCSA administration costs based on a new budgeting methodology. The new funding formula for LCSAs will ultimately result in an additional $180.8 million ($61.5 million General Fund) for LCSA operations, which will be phased in over four years. The table below contains cost information for all four years.

	2019-20 Year 1	2020-21 Year 2	2021-22 Year 3	2022-23 Year 4
General Fund	$19,053,000	$38,106,000	$57,159,000	$61,455,000
Federal Funds	$36,986,000	$73,972,000	$110,958,000	$119,294,000
Total Funds	$56,039,000	$112,078,000	$168,117,000	$180,749,000

In the fourth year, $12.6 million ($4.3 million General Fund) will be tied to performance incentive funding for LCSAs (discussed further below). The department estimates that total collections will increase by 15 percent (about $347 million) as a result of the proposed increased funding.

The 2019-20 budget includes $283.3 million General Fund for local assistance costs, including LCSA administration costs.

LCSA Administration. Administration costs include salaries and benefits of LCSA staff as well as operating costs. LCSAs are responsible for case intake, court preparation to establish paternity and support obligations, and the enforcement of support obligations, including locating absent parents. In 2018-19, LCSA administration costs were funded at $664.4 million and proposed funding for 2019-20 is $720.5 million. Funding is 34 percent General Fund and 66 percent federal matching funds.

Historic LCSA Funding Levels. Beginning in 2003-04, the baseline administrative funding level for LCSAs was $710 million ($241 million General Fund and $469 million federal funds). In 2005-06, the LCSAs received a one-time augmentation of $4.2 million for outreach and transition workload. In response to dwindling resources and flat funding the Legislature provided an ongoing revenue stabilization funding augmentation of $18.7 million ($6.4 million General Fund) in 2008-09. That same year, $12.6 million was redirected from local assistance to state operations as the state centralized the printing and mailing of child support forms and notices at the Office of State Publishing. Funding levels for LCASs remained flat until 2018-19, when DCSS received an ongoing augmentation of $9 million ($3 million General Fund and $6 million federal funds) to address the rise in LCSA operational costs.

Proposed Budgeting Methodology. The DCSS, in collaboration with the Child Support Directors Association (CSDA), developed a LCSA funding methodology that the department believes represents a balanced approach of improving existing practices, addressing LCSA current and future cost pressures, and the efficiencies of shared services. The methodology seeks to hold harmless LCSAs that are currently funded more than what the methodology calculated. The proposed budgeting methodology encompasses three components: base level of staffing for casework operations, call center operations, and performance incentives.

- The department identified the staffing ratio needed to effectively carry out case management activities, and found the effective ratio to be 187.7 cases per full time equivalent (FTE). In federal fiscal year 2017, the average statewide ratio was 192 cases per FTE. The proposed methodology funds each LCSA based on a Case-to-FTE ratio predetermined by a Level of Effort Study (LOE) conducted by 15 sample LCSAs ranging from very large in size to very small. According to DCSS, the ratio reflects the staffing levels needed to maintain a per FTE caseload that allows sufficient time for staff to effectively manage cases and achieve the most positive outcomes. The ratios also include staffing for supervisors, managers, and staff for LCSAs. 20.9 percent of personnel costs is applied to cover non-employee operating expenses & equipment such as contracts, facility leases, maintenance, utilities, office supplies and equipment, etc.

- The Call Center methodology focuses on establishing an average number of calls a call center FTE can answer. The methodology establishes an efficiency expectation of 6,030 Calls-per-worker. This is the statewide average, and many LCSAs (some large ones) fall below this threshold. The methodology seeks to establish performance improvement without punishing LCSAs currently experiencing poor performance.

- The Performance Incentive funding is based on how well an LCSA is improving from one year to the next, comparing to itself. Each county has different caseload demographics, and by comparing a LCSA's performance against itself, the department seeks to maintain fairness in the different demographics. Performance is measured by the average of percent increase to total collections, and percent increase to collections per case. If the average of the two metrics is greater than zero percent, the LCSA will receive a portion of the Performance Incentive funding pool of $15 million. Note that the department also has a proposal to suspend performance incentives that would provide payments to the top ten performing LCSAs (discussed further in item three). The performance incentives proposed would replace the existing incentive formula in order to spread the rewards more broadly.

LAO Comments and Recommendation. The LAO recent released a report[2] on the proposed funding augmentation for LCSAs. In the report, the LAO lays out its analysis and recommendations on the proposal. The LAO notes that there have been longstanding differences in funding across LCSA, leaving some LCSAs with resources that may not be sufficient to carry out the work. However, the LAO believes that the Governor's proposal is premature at this time. The Legislature directed the department and LCSAs to identify operational efficiencies that would make the program more cost-effective by July 1, 2019. In addition, the federal government has issued policy guidance on child support operations, known as the Final Rule. The LAO believes it is premature to institute a new funding formula before the required report is published and prior to updating law to align with federal guidance. The LAO also points out that the administration has not proposed language to codify the intent of the proposal or outline how it will be used in the future. Moreover, the proposal does not consider the possibility of reducing the proposed agumentation by "right-sizing" funding levels for all LCSAs, not just those that are seen as underfunded.

The LAO recommends that the Legislature withhold action until the administration submits the required report identifying operational efficiencies and a proposal to refine the current budget methodology based on the finding of the report.

[2] Report available at : https://lao.ca.gov/reports/2019/3989/child-support-032619.pdf

Staff Comment and Recommendation. Hold open. LCSA funding levels have not been updated in quite some time and it is clear that an update to these funding levels is needed. However, there are some remaining questions about the proposed augmentation that have not been answered. For example, the department is unsure whether the funding levels for each LCSA will be recalculated every year or at some other interval. The subcommittee may also want to consider whether it agrees with the "hold harmless" approach taken by the department. The department sought to hold harmless LCSAs that are currently funded at a level higher than what the proposed funding methodology calculated. The subcommittee may want to consider whether it agrees with this approach, as some LCSAs will be funded at levels higher than what the department's methodology deems necessary.

AB 1811 (Committee on Budget), Chapter 35, Statutes of 2018, required the department to engage in conversations with the Child Support Director's Association on identifying program wide operational inefficiencies and refinements to the budget methodology. The department must submit a report on this topic by July 1, 2019. The subcommittee may want to consider whether to augment funding prior to the submission of this report, which should consider refinements to the budget methodology.

Questions.

1. Please provide an overview of the proposal.

2. What is the status of conversations with the Child Support Director's Association on identifying operational inefficiencies and refinements to the budget methodology? Did the department consider these conversations while developing the proposed methodology?

Issue 3: TBL – Improved Performance Incentives

Budget Issue. The Governor's budget includes trailer bill language that would suspend Family Code Section 17706 until 2021-2022. The statute provides performance incentives to the top ten performing LCSAs. The General Fund would fund these incentives. As the top ten performing counties fluctuate from year to year, the annual General Fund impact is uncertain but could be as high as $6 million without this suspension.

Background. Family Code allocates additional funding to provide performance incentives to the top ten performing LCSAs. Currently, the funding level is set at five percent of the state's share of collections from the respective counties. These incentives have been suspended since 2002-03.

DCSS seeks to suspend these performance incentives as its proposed budget methodology (discussed in the previous item) includes a new incentive model. The department believes this new incentive model will target incentives towards specific reforms or innovations that could improve collections and the reliability of child support payments owed by non-custodial parties. The new incentive model would give the department more flexibility to disseminate incentive funding to the most deserving counties. The department seeks to continue the suspension for two additional years while it evaluates the effectiveness of the new proposed incentive process.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

2. Please explain how the proposed performance incentive model (discussed in the previous item) would provide more flexibility, compared to the current method that is proposed for suspension.

Issue 4: TBL – Federal Deficit Reduction Act (FDRA) Mandatory Fee Increase

Budget Issue. The Governor's budget includes trailer bill language that would raise the administrative services fee on a never-assisted custodial party receiving services from the child support program for order establishment, enforcement, and collection services provided. The first automated assessment of the increased fee would be October 1, 2020, resulting in an estimated additional $1.6 million in assessed fees.

Background. Family Code 17208(c) and the FDRA require the department to impose on administrative service fee on certain cases. The annual amount of child support payments collected on behalf of the custodial party must be $500 or more before an administrative fee is imposed. Currently, the administrative fee is $25. The language would raise the fee to $35 and the disbursement threshold to $550.

In accordance with Section 53117 of H.R. 1892, amendments to section 454(6)(ii) of the Social Security Act (42 U.S.C. 654(6)(B)ii)) were enacted, effective October 1, 2019, to increase the annual FDRA mandatory fee to $35 and the disbursement threshold to $550. The proposed language is necessary to align California's statute with federal changes.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

Issue 5: Human Services Technical BCP - Voluntary Parentage Establishment Program

Budget Issue. The Governor's budget includes three-year limited-term funding in the amount of $596,000 ($199,000 General Fund) for the implementation of AB 2684 (Bloom), Chapter 876, Statutes of 2018.

In addition to the costs identified in this budget request, LCSAs are required to pay ten dollars ($10) to birthing hospitals and other entities for each completed declaration filed with DCSS per California Family Code Section 7571. AB 2684 increases the number of people eligible to sign a declaration. Currently, LCSAs pay approximately $1.5 million annually for these forms. Assuming a 15 percent increase in declarations of parentage for new births, costs for this process are expected to increase by $225,000 annually. The funding for this increase is reflected in the DCSS Local Assistance estimate and is not included in the state operations budget.

Background. Each year, the departments within the Health and Human Services (HHS) Agency submit a number of proposals requesting various technical adjustments, largely related to workload adjustments and resources needed to implement new legislation. The proposal discussed in this item is a piece of that larger Agency BCP.

The California Paternity Opportunity Program (POP) was established in 1995 to comply with federal mandate that requires the program to operate a single system to establish paternity, or a legal determination for fatherhood for unmarried biological parents. Establishment of paternity is established by either obtaining a court order or completing a declaration of paternity. The declaration of paternity holds the same legal weight as a court order and is offered free of charge by authorized agencies.

AB 2684, effective January 1, 2020, revised the procedures for establishing and challenging parentage, ensuring that parents and children are treated the same, whether the children are born to same-sex or opposite sex couples. The statute requires the department to expand the POP to include voluntary declaration of parentage procedures to unmarried couples, including unmarried same-sex couples. The department requests three-year limited-term resources to revise forms, modify data systems, provide training, answer inquiries, and process additional declarations related to this new process of establishing parentage. Currently, the department receives approximately 150,000 completed declarations annually and estimates that this number will increased by about 15 percent once the statute goes into effect.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

Issue 6: Proposals for Investment

1. Language on Child Support Collections

Budget Issue. The Western Center on Law and Poverty, PolicyLink, the Good+ Foundation, the Anti-Recidivism Coalition, Tipping Point, and the Insight Center for Community Economic Development request language to accompany the request for a funding increase for LCAs. Specifically, the coalition asks for language that would require the department to:

- Conduct a collectability study of the outstanding debt that is owed to the government by low-income parents to pay back the cost of public assistance,
- Minimize the use of driver's license suspensions in the collection of child support, and
- End the use of incarceration in the collection of child support.

Staff Comment and Recommendation. Hold open.

0530 HEALTH AND HUMAN SERVICES AGENCY OFFICE OF SYSTEMS INTEGRATION
5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: Overview – Office of Systems Integration and Automation Projects

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

OSI currently oversees a number of human services projects, 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). OSI helped 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 creates 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 Governor's proposed budget for 2019-20 provides resources to transition the project from the development phase to the maintenance and operations phase.

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 contract with the current vendor, DXC, is scheduled to complete in the spring of 2019. As a result, the OSI CMIPS Office conducted a competitive procurement for a follow-on contract. In February 2018, the CMIPS Office announced notification of award of the new contract to CGI. The CMIPS Office is currently engaged in transition planning activities to ensure a smooth transition of CMIPS and associated services from the current contract to the new contract. Transition is scheduled to complete in April 2019.

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 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. This project will be discussed further later in the agenda.

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-CARES.

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. A 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 was complete in January 2018.

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.

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 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). This system will be discussed further later in the agenda.

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. WDTIP eliminates the need for counties to contact other counties outside their respective consortia system and/or other states to obtain information relative to the TANF 60-month and CalWORKs 48-month time limitations for time-on-aid by providing eligibility workers an automated tool from which they can obtain up-to-date information.

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.

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

Issue 2: Child Welfare Services – California Automated Response and Engagement System (CWS-CARES) Update

Budget Issue. The Governor's budget includes $99.8 million ($49.9 million General Fund) for the CWS-CARES Project in the current year and $26 million ($13 million General Fund) in the budget year. The table below breaks down the 2018-19 budget and expenditures.

2018-19 CWS-CARES Budget/Expenditure Report Summary

OSI Spending Authority Budget Item	2018-19 Budget	Actual Expenditures	Projected Expenditures	Total Actuals/ Projections
Personnel Services*	9,935,256	1,436,178	6,546,115	7,982,293
Other OE&E**	5,717,563	1,071,752	4,033,669	5,105,421
Data Center Services**	2,660,542	1,623,152	1,037,390	2,660,542
Contract Services**	55,892,379	16,779,430	23,051,487	39,830,917
Enterprise Services*	5,420,394	550,227	836,174	1,386,401
OSI Spending Authority Total	**79,626,134**	**21,460,739**	**35,504,835**	**56,965,574**
CDSS Local Assistance Budget Item	**2018-19 Budget**	**Actual Expenditures**	**Projected Expenditures**	**Total Actuals/ Projections**
Contract Services***	1,074,180	268,916	635,040	903,956
Other OE&E***	3,400,732	-	3,400,732	3,400,732
County Participation Costs***	19,157,746	335,418	18,822,328	19,157,746
CDSS Local Assistance Total	**23,632,658**	**604,334**	**22,858,100**	**23,462,434**
CDSS State Operations Budget Item	**2018-19 Budget**	**Actual Expenditures**	**Projected Expenditures**	**Total Actuals/ Projections**
Personnel Services****	1,930,359	1,103,236	827,123	1,930,359
Facilities****	568,000	600	567,400	568,000
Other OE&E****	224,497	9,623	214,874	224,497
CDSS State Operations Total	**2,722,856**	**1,113,459**	**1,609,397**	**2,722,856**
CWS-CARES Project Total	**105,981,648**	**23,178,532**	**59,972,332**	**83,150,864**

* Actuals through November 2018 per FI$Cal Report

** Actuals from November 2018 Fi$CAL Reports, in addition to processed invoices through February 27, 2019

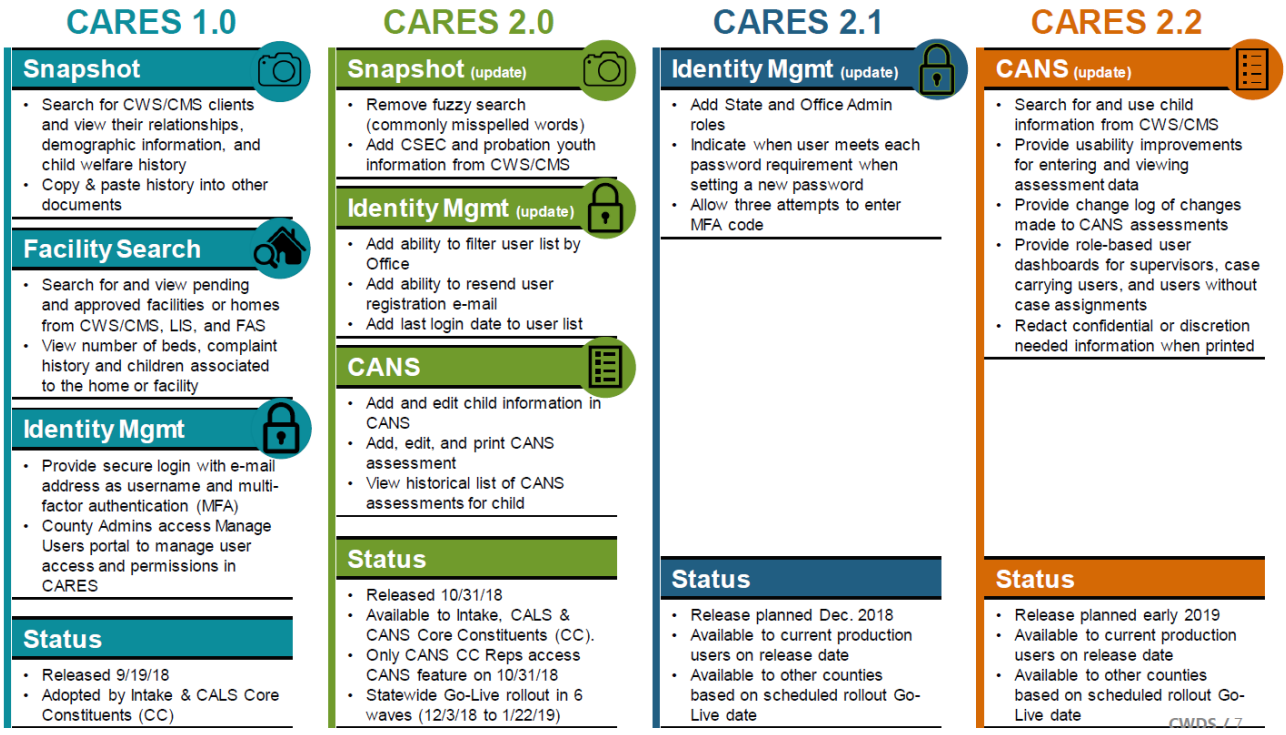
*** Actuals from CDSS as of December 2018

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.

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 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. 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, an RFP is broken into a set of smaller modules that can be delivered in short periods 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 module. The new digital services are also being designed around the principles of human/user centered design and free/open source software (FOSS).

Implementation Update. In August 2018, the federal Administration on Children, Youth, and Families (ACYF) visited California to check-in on the development of CWS-CARES. After that visit, ACYF recommended that development focus on one product set at a time, instead of developing multiple features simultaneously. The state heeded that advice and is now only developing one product feature set at a time. 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.

A summary of the contents in the released updates to CARES, from October 2018, is shown below. CARES 2.1 was released statewide on January 22, 2019, and CARES 2.2 was released statewide on February 25, 2019. CARES 2.3, scheduled for an April 2019 release, will contain new identity management and facility search features.



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

Questions.

1. Please summarize the current CWS-CARES timeline and overall project costs.

2. Please provide a brief overview of the significance of the change in process that the AYCF is requesting and how that changes the project timeline and costs.

Issue 3: Statewide Automated Welfare System (SAWS) Update

Budget Issue. The budget includes $43.7 million ($8.6 million General Fund) in 2018-19 and $155.5 million ($31.2 million General Fund) in 2019-20 for SAWS automation costs.

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 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). In December 2016, CMS and FNS issued a requirement for SAWS to be a single system by 2023 in order to continue to receive federal funds. Going forward, the state will work to implement this single system, to be known as CalSAWS.

Implementation Update. The state must take several steps before consolidating the consortia into one system. A county-based governance structure for CalSAWS has been developed during the planning process. Plans for the structure have been submitted to the 58 counties, and it is expected that it will be adopted by all 58 counties by June 2019. The LRS system is the base system that will be modified to create CalSAWS. C-IV counties (39 counties) have begun migrating over to the LRS system. Once migration is complete, the LRS and C-IV systems will be known as CalACES. Currently, work is being done to migrate the LRS system into the cloud, which should be complete by November 2019. The deployment of CalSAWS changes into LRS is expected to be complete by January 2021, and CalSAWS will be live in all 39 C-IV counties by September 2021. There is a need for additional support in order to merge the CalWIN system with CalACES. Thus, the migration of CalWIN counties to CalSAWS will take longer to complete, and is not expected to finish until January 2023.

Stakeholder Concerns. Due to stakeholder concerns presented during the 2018-19 budget process the 2018 Budget Act included language that stated it was the intent of the Legislature that the agencies and consortia implementing CalSAWS meet with stakeholders and clients on a regular basis to review and discuss implementation and development status of the project. The Budget Act also included language requiring a formal process for advocates and clients to provide input into new or changing elements of CalSAWS. Since that time stakeholders have come forward with additional concerns regarding their participation and input into CalSAWS workgroups. CalSAWS representatives held a meeting this past week with stakeholders to discuss these concerns, and have committed to sharing agendas and meetings from the workgroup meetings with stakeholders.

Panel. The subcommittee has requested the following panelists, in addition to the Office of Systems Integration, Department of Social Services, and Department of Finance, to discuss stakeholder concerns with CalSAWS:

- Alliance to Transform CalFresh Representative
- Kevin Aslanian, Coalition of California Welfare Rights Organizations
- John Boule, Executive Director, CalACES

Staff Comment and Recommendation. No action required. Item included for oversight and discussion purposes.

Questions.

1. Please provide an update on CalSAWS development and implementation.

2. Please provide an update on the stakeholder engagement process for CalSAWS.

Issue 4: BCP – Electronic Visit Verification

Governor's Proposal. The Governor's budget includes a one-time increase of $24.3 million ($2.7 million General Fund) for CDSS and a corresponding increase of $22.2 million for OSI to implement the federally mandated Electronic Visit Verification project. The requested resources would be for six permanent positions, two-year limited-term funding for 7.5 positions for CDSS.

Note that the subcommittee received an update on the project and its total budget at the March 14, 2019, hearing.

Background. 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, (3) the location of the service, and (4) the identities of the provider and consumer. California has until January 2020 to comply for personal care services, and until January 2023, for home care services, or escalating penalties will be incurred.

The department will modify its existing Case Management, Information, and Payrolling System (CMIPS) to meet the EVV requirements. The six requested permanent positions will aid with system design, testing, and stakeholder involvement. The two-year limited-term funding will support positions that will provide technical assistance and guidance to stakeholders during the implementation of EVV. The requested positions will staff two units within CDSS. One unit will support policy development, and the other unit will work with OSI and legal counsel to ensure the system designed aligns with EVV policies.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

Issue 5: TBL – Statewide Fingerprinting Imaging System (SFIS) Technical Clean-up

Budget Issue. The Governor's budget includes trailer bill language (TBL) to remove obsolete references to a now defunct fingerprint imaging system, and instead reference identity verification requirements.

Background. The SFIS was developed by OSI in conjunction with the California Department of Social Services (CDSS). The system applied fingerprint-imaging technology as an identity verification method for the state's CalWORKs program. Senate Bill 89 (Committee on Budget and Fiscal Review), Chapter 24, Statutes of 2017, repealed SFIS and required the department to implement a non-biometric identity verification method for the program. The proposed language would remove references to the repealed system.

As of January 30, 2019, the de-commissioning of SFIS is complete and all equipment has been collected.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

5180 DEPARTMENT OF SOCIAL SERVICES – STATE HEARINGS DIVISION

Issue 1: BCP – Appeals Case Management System (ACMS) Permanent Maintenance & Operations Support

Governor's Proposal. The Administration requests $395,000 ($151,000 General Fund) and three positions to be a part of the state's maintenance and operations and project management support team for the Appeals Case Management System (ACMS).

Background. California Welfare and Institutions Code Section 10950 and the Federal Patient Protection and Affordable Care Act (ACA) of 2010, provide that dissatisfied applicants or recipients of California's public social services have the right to request a state hearing and the opportunity to present their case directly to the department. This work is processed and managed through CDSS's State Hearings Division (SHD). The division provides hearings to recipients of CalWORKs, CalFresh, IHSS, foster care, adoptions assistance programs, Medi-Cal, and Covered California. In 2017-18, there were 85,503 requests filed.

The recent ACMS project brought a modern solution to an outdated, manual hearing process. The ACMS project is transitioning from the development phase to maintenance and operations and now requires full-time technology resources for continued maintenance and support within CDSS. A team from the Office of Systems Integration and vendors led the ACMS project. The three requested positions will provide permanent project management support, and will work with the SHD to determine program needs and implement them.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

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

SUBCOMMITTEE NO. 3 Agenda

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

Thursday, April 4, 2019
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Part A

Consultant: Renita Polk

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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.

5180 DEPARTMENT OF SOCIAL SERVICES – COMMUNITY CARE LICENSING

Issue 1: Overview

Background. The Community Care Licensing (CCL) Division in the Department of Social Services (DSS) oversees the licensure or certification of 59,655 licensed facilities that include childcare, 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. Licensing program analysts investigate any complaints lodged, and conduct inspections of the facilities. The division consists of 1,316 staff, 590 of which are in the field and operate out of 30 field offices.

2017-18 and 2018-19 funding is displayed below:

	2017-18		**2018-19**
	Authorized	Actual	Authorized
State Operations Total: *(in thousands)*	**$154,957**	**$143,897**	**$164,288**
General Fund	$69,168	$58,699	$77,693
Federal Funds	$47,891	$48,640	$48,755
Reimbursements	$6,496	$6,584	$28,119
Special Funds:	$31,402	$29,974	$31,342
Continuing Care Provider Fee Fund	$938	$1,035	$974
Technical Assistance Fund	$19,999	$19,937	$19,891
Certification Fund	$1,590	$1,676	$1,590
Child Health And Safety Fund	$3,272	$3,335	$3,272
Home Care Fund (AB 1217)[1]	$5,603	$3,991	$5,615

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 childcare 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 in a group setting with the ability to provide a secure environment.
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 (FFA)	Organizations that recruit, certify, train and provide professional support to certified 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 (STRTP)	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 in the licensee's home for 6 or less children, who have mental disorders or developmental or physical disabilities.
Transitional Housing Placement Provider	Provides supervised transitional housing services to foster 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 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 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 be 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.

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 a 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

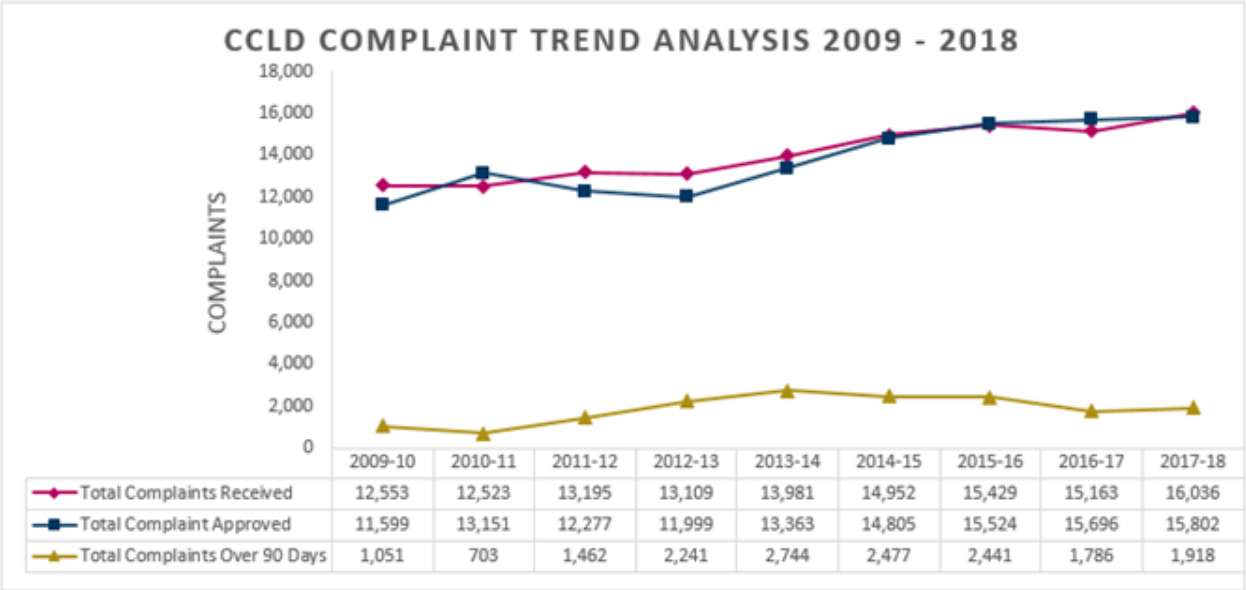
with a facility that cares for children, an additional background check is required through the Child Abuse Central Index.

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 (FFAs) and Short-term Residential Therapeutic Programs (STRTPs), 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 the Department of Social Services (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 2015 budget 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 went into effect incrementally through 2018-19. Currently, childcare facilities must be inspected at least once every three years, children's residential care facilities must be inspected at least once every two years, and adult and senior care facilities must be inspected at least once every year.

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. For the 2018-19 fiscal year, CCL estimates it will receive 14,606 complaints. As of February 2019, CCL has received 9,737 complaints. The information below provides an analysis of DSS' complaint activity for the years of 2009-10 through 2017-18.



	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	16,036
Total Complaint Approved	11,599	13,151	12,277	11,999	13,363	14,805	15,524	15,696	15,802
Total Complaints Over 90 Days	1,051	703	1,462	2,241	2,744	2,477	2,441	1,786	1,918

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.

Key Indicator Tool. After various changes in 2003, and because of other personnel reductions,[1] 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 CCLD began using several KITs as complements to their comprehensive inspection processes. KITs are intended to (1) standardize the inspection protocol between facilities and between inspectors, (2) enhance the efficiency of the inspection process, and (3) appropriately identify whether a more comprehensive inspection is warranted. Some facilities, such as facilities on probation, those pending administrative 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.

In 2017, 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. In September 2017, the department released a report detailing its planned approach for a new tool.

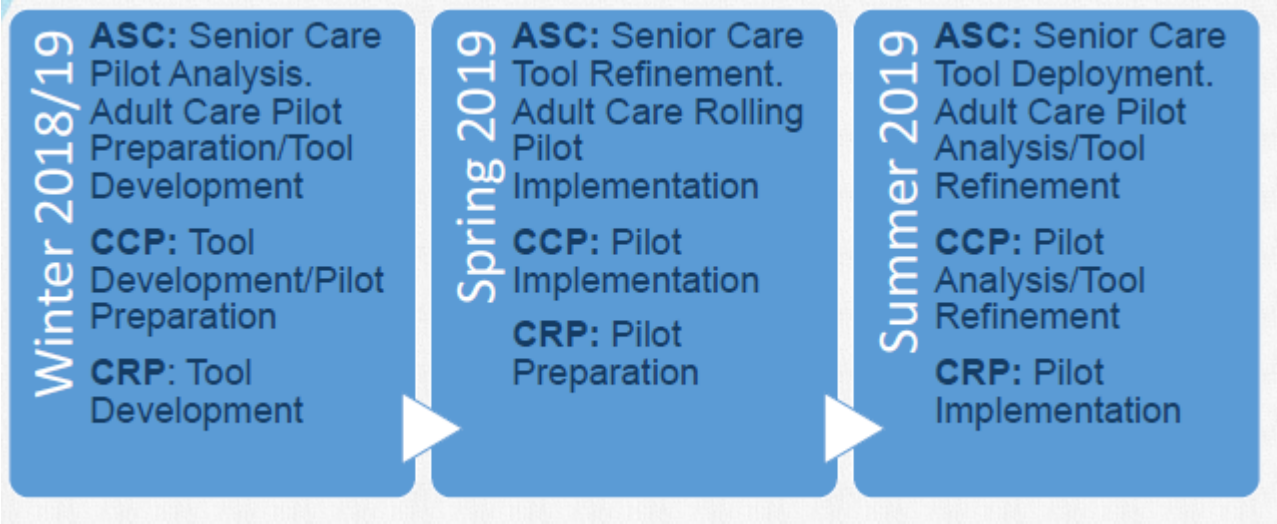
New Inspection Tools. In light of the absence of a standardized inspection tool, CCL is developing a variety of standardized inspection tools to improve the effectiveness and quality of the inspection process. These tools will also be developed differently for the various licensing categories,

1 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.

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. These tools will replace the KITs, designed for each CCL program type.

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. Specialty tools will be used with both comprehensive and domain-focused tools if a deeper dive into a specific area is identified. The Community Care Licensing Division (CCLD) began with the development and deployment of tools for the Adult and Senior Care (ASC) Program and will subsequently complete tools for the Children's Residential and Child Care programs.

Below is a timeline provided by the department showing the various phases of development and implementation of the tools, as of November 2018:



*ASC – Adult Senior Care Program, CCP – Child Care Program, CRP – Children's Residential Program

The Senior Care pilot was carried out from July to September 2018. The pilot consisted of 320 visits to 164 facilities, carried out by 20 licensing program analysts. The pilot tested process measures, such as the duration of the inspection and the learnability of the tools, and looked at the validity and reliability of the tool, particularly inter-rater reliability. As of November 2018, the tools for the Senior Care program were in post-pilot analysis and tool revision based on that analysis. Preliminary findings from the pilot are shown below.

Pilot Findings Compared to 2-Year Compliance History						
Deficiencies & Advisories	Type A		Type B		TA	TV
	Issued During Pilot	2-Year Average*	Issued During Pilot	2-Year Average*	Issued During Pilot*	Issued During Pilot*
Total	112	115	400	148	354	332

Note: Fiscal years 2015-16 and 2016-17 were used to calculate the two year averages above. In addition, comparison data in relation to number of technical assistance and technical violations issued in prior years was not available, as those items were not previously tracked.

As of November 2018, the CCLD was in the process of drafting the comprehensive and specialty tools for the Adult Care program. Interim standard tools for the Child Care program were in development, and comprehensive/specialty tools were being developed for the Children's Residential program.

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

2. Please provide an overview of CCL's Inspection Process project and include a discussion on how the success of the new inspection process will be measured.

3. Please provide a brief history of problems with the KIT tool and a description of how the new tools will be validated.

Issue 2: BCP – Data Migration for Legacy Systems

Governor's Proposal. The Administration requests a total of $7.1 million for contract funds and two three-year limited-term positions to support data migration from the information technology systems that serve the Community Care Licensing Division. One position will be placed in the Community Care Licensing Division (CCLD) and the other will be placed in the department's Information Services Division.

Background. The information systems that provide the backbone of the CCLD's regulatory oversight include the Field Automation System (FAS), the Licensing Information System (LIS), the Caregiver Background Check (CBC), and the Legal Case Tracking system (LCTS). These systems were developed almost twenty years ago. The effectiveness and efficiency of the CCLD's oversight efforts are constrained by these aging systems. Staff require immediate access to real time data, which these systems cannot provide.

The requested funding will be used to migrate data from the FAS, LIS, CBC, and the LCTS. Historical data is essential to licensing practice, and acquiring any, new functionality will require that the data be migrated to a modern structure. Pursuing this critical step now will allow new technology to be utilized by a new system or software immediately, rather than requiring a prolonged transition period necessitating the maintenance of the existing systems.

The selected vendor will develop a process for exploring, combining, cleaning, and transforming data into curated data sets for data integration and data discovery from the four IT systems. They will work on curated data sets to understand data lineage and relationships to design data models using a bottom-up approach. The team will further focus on activities such as validating data quality and designing security strategies. Work will also include collaborating with the CCL program's administrators and staff to catalog and share datasets and models. These steps will ensure that whatever system/functionality is acquired can easily migrate and utilize the data sets.

The department is looking for a modern licensing system that will provide statewide tools for inspections, complaint tracking, performance dashboards, and business analytics to identify and address emerging trends and issues. The data preparation, analysis, design data modeling, and actual data migration activities are prerequisites and agnostic to new software or systems. The additional positions requested in this proposal will help in training and transitioning legacy technical staff to modern technology infrastructure seamlessly. By beginning the efforts of data migration early, the time to implementation of new functionality to the field is greatly enhanced. Allowing new functionality to be delivered more quickly will provide access to real-time information for staff in the field.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

2. Please describe the purpose of initiating data migration technology prior to determining a plan and contract to build a new system for CCLD.

Issue 3: BCP – Reducing Law Enforcement Contacts in Children's Residential Facilities

Governor's Proposal. The Governor's budget includes $341,000 Technical Assistance Fund for three two-year limited-term positions to strengthen the Department's effort to curb the usage of law enforcement in the management of behaviors for youth placed in residential facilities.

Background. Current law requires reports to CCLD "upon the occurrence of any incident concerning a child in the facility involving contact with law enforcement," which captures more than calls a facility makes to law enforcement in response to incidents on the premises, as anticipated. The law requires reports for anytime a child who resides at a facility encounters law enforcement whether at school or while a child has left the facility. The department is also required to annually post facility specific information identifying the number of law enforcement contacts and their outcomes. Although incident reports have always included whether law enforcement was involved, the frequency with which any single licensed facility contacted law enforcement was not tracked by CDSS.

At the time the law was enacted the department indicated that it would evaluate its impacts and return with a subsequent request, if necessary. At the time of that initial request, the program had only been implemented for six months and the department's workload estimates were preliminary. Since 2016 when statistics were first tracked, the number of law enforcement incident reports has nearly doubled, nearing 32,000 for these facilities in 2017, and over 21,000 for just the first six months of 2018. The number of law enforcement contact reports is increasing as more affected facilities become compliant with their duty to report law enforcement contacts. Subsequent legislation expanded the number of different facility types that are now required to report law enforcement contacts. The table below shows the number of reports received within the last three years.

Number	Original BCP Assumptions	2016	2017	As of November 2018
Facilities reporting this information	1,200	1,106	1,064	1,027
Law Enforcement (LE) related reports received	N/A	27,997	33,548	21,720
Current Backlog		0	0	16,000
Completed Complaint Investigations	*	4,416	3,995	2,230
Open Complaint Investigations	*	1,428	1,532	2,881

The additional requested staff would help meet the additional workload increase that requires the review, analysis, and disclosure of information reported by children's residential facilities when contact with a local law enforcement agency is made. Additionally, the staff will be responsible for conducting inspections of those facilities identified as having significant law enforcement contacts. With the requested resources, the department will ensure more timely review, analysis, posting and inspections of facilities with high rates of law enforcement contact, offer technical assistance to these facilities, and engage and collaborate with county stakeholders.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

Issue 4: CCL-related Human Services Technical BCPs

Each year, the departments within the Health and Human Services (HHS) Agency submit a number of proposals requesting various technical adjustments, largely related to workload adjustments and resources needed to implement new legislation. The proposals discussed in this item are included in that larger Agency BCP.

1. AB 605 Implementation. The Governor's budget includes $394,000 General Fund in 2019-20; $253,000 General Fund in 2020-21; and $127,000 General Fund in 2021-22 in order to implement AB 605 (Mullin), Chapter 574, Statutes of 2018. AB 605 requires the CCLD to adopt regulations by January 1, 2021 that would create a childcare center license with individual program components that service infant, toddler, preschool, and school age children. Resources are necessary to develop and implement regulations for the new license category, and to provide technical assistance, training, and policy clarifications to childcare facilities. Additionally, the requested resources will be used for information technology contracts to update the department's Licensing Information System and Field Automation System to reflect the new license,

2. AB 2370 Implementation. The Governor's budget includes $142,000 General Fun in 2019-20 and $127,000 General Fund ongoing to implement AB 2370 (Holden), Chapter 676, Statutes 2018. AB 2370 requires the CCLD, in consultation with the State Water Resources Control Board, to adopt regulations to test a licensed child day care facility's drinking water for lead contamination levels beginning January 1, 2020, but no later than January 1, 2023 and every five years thereafter. Additional ongoing resources are necessary for increased workload, including written guidance and developing procedures.

3. AB 2455 Implementation. The Governor's budget includes a one-time augmentation of $300,000 to implement AB 2455 (Kalra), Chapter 917, Statutes of 2018. AB 2455 requires the CCLD, after July 1, 2019, to share, upon a labor organization's request, the name, phone number, and cell phone number, if available, of each newly registered or renewed Home Care Aide, who has not opted-out of sharing this information. It also requires CDSS to develop a simple opt-out procedure for aides and applicants to request that their contact information not be disclosed. There is a need for the department to plan, develop, and monitor an opt-out and opt-in process, revise regulations, and to provide notification, instructions, and training on the new requirements, forms and processes. CDSS requests funding to support overtime activities and to modify the existing information systems to accommodate the requirements of AB 2455.

4. Strengthening Program Infrastructure. The Governor's budget includes $2.5 million in 2019-20; $2.5 million in 2020-21; and $375,000 General Fund every year thereafter for three permanent positions and the extension of $1.92 million temporary Technical Assistance Fund (TAF) through 2020-21. The requested resources will address workload associated with Adult and Senior Care Residential Facility license application processing and a backlog of complaint investigations in the Children's Residential Program. Permanent positions will true-up staffing levels of the Centralized Application Bureau based on current caseload trends. Extension of temporary limited-term TAF resources will allow the department to

continue improving the timeliness of the facility licensing review process and continue reducing a backlog of complaint investigations.

Staff Comment and Recommendation. Hold open.

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, extended foster care, and out-of-home foster care. The total funding for CWS is estimated to be approximately $6.4 billion ($607.5 million General Fund) for 2018-19. This is a net increase of $136.7 million over the 2018 enacted budget. The 2019-20 budget includes $6.3 billion ($546.1 million General Fund), a net increase of $718,000 total funds ($29.7 million General Fund) over the 2018 enacted budget. The increase is due to higher costs for the Kin-GAP program and the Home Based Family Care rate structure. The increased costs are offset by the end of funding investments in components of the Continuum of Care Reform (CCR).

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. Average total CWS caseload is 136,914 children for 2018-19, and an estimated 136,289 for 2019-20. As of October 2018, approximately 59,000 children were in foster care. The 2019-20 budget estimates total caseload for foster care at 41,530.

Temporary placement types. There are four primary placement types — kinship care, a foster family home (FFH), foster family agency (FFA), or group homes:

- Kinship care comprises care from relatives and nonrelative extended family members, and is the state's most utilized placement option. Established policy and practice prioritizes placement with a noncustodial parent or relative.

- FFHs are licensed residences that provide care for up to six children. Under the Continuum of Care Reform (CCR), these families are known as resource families. Counties recruit FFH caregivers and provide basic social work services to children residing in FFHs.

- 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. FFAs recruit and approve foster caregivers and provide supportive services to children in their care.

- 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, the state is phasing out group homes and replacing them with Short-Term Residential Treatment Placements (STRTPs). STRTPs are intended to provide care, supervision, and expanded services and supports on a short-term basis. Existing group homes have until January 2020 to convert to STRTPs. If an existing group home has been approved to transition to an STRTP or has an open application to transition, it can accept new placements. If a group home has not applied to transition, or has had its application rejected, it cannot accept new placements and must submit a plan for closure and transfer of the children currently under its care to new placements.

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. As of October 2018, more than 4,000 foster children in both the CWS and probation systems remained in congregate care. The department estimates less than 2,700 congregate care placements by the end of 2019-20. Of those placements, 2,366 will be in STRTPs, while 314 placements will be in group homes and transition out in later years. Placement movements will be discussed further in the following agenda issue.

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 two years. 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, which began 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, which began 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 was approved by the federal Administration for Children and Families (ACF) in September 2018.

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 consists 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).

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 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 2018 Child Welfare Services Realignment Report 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 48 percent from 101,241 in 2000 to 53,095 in 2017. Caseloads were lowest in July 2012 at 51,782.

- Between 2009-10 and 2016-17, the number of children for whom the first placement is with a relative/kin increased from 18 percent to 27 percent, while the proportion of children placed in group homes decreased from 16 percent to 12 percent. Relative homes continue to be the predominant placement.

- The proportion of children who entered foster care and subsequently exited to permanency due to guardianship, adoption or reunification within 12 months dropped from 40.6 percent in 2009-10 to 34.6 percent in 2015-16.

The department is currently drafting the 2019 Realignment Report.

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. Some counties in California have a Title IV-E waiver which provides a capped amount of funds, but allows those counties more flexibility in the use of those funds compared to non-waiver counties. Alameda, Los Angeles, Butte, Lake, Sacramento, San Diego, San Francisco, Santa Clara, and Sonoma counties all have IV-E waivers. It is still unclear what direct effect FFPSA will have on these waiver counties.

In November 2018, the federal Administration for Children and Families (ACF) released guidelines relating to new IV-E funding for one year prevention services for mental health/substance and in-home parent skill-based programs. 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.

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. Title IV-E funding is based solely on actual cost of care; if a county's preventive 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 waiver allows flexibility in the use of a fixed funding amount for the specified counties. The core concept of the waiver is to allocate fixed dollar amounts to child welfare agencies to provide new or expanded services that prevent out-of-home placement and/or facilitate permanency. 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.

  Proposed funding for the state CSEC program is $16.2 million General Fund in 2019-20. According to the 2017 CSEC Program Report to the Legislature, the most common and promising CSEC service interventions supported by 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.

- **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. CDSS provides regular technical assistance to the counties with monthly calls, webinars, and in-person learning forums that provide training on facilitating collaboration. BFH data will be formally evaluated by third party researchers to assess program outcomes and effectiveness.

- **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. 46 counties opted in for the 2018-19 fiscal year.

Final award amounts were issued in January 2018, and DSS currently holds monthly technical assistance calls.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide a brief overview of any new or significant program updates, including recent accomplishments and challenges.

2. Please provide an update on the implementation of the Program Improvement Plan, required by the 2016 CFSR.

3. Please provide an update on the Bringing Families Home program.

4. Please briefly describe federal requirements for implementation of the Families First Prevention Services Act and its impact on California's Child Welfare system.

5. What effort is being made to identify and implement best practices in caring for youth who have been victims of commercial sexual exploitation?

Issue 2: BCP – The Office of Foster Care Ombudsperson Foster Child Complaint Investigation

Governor's Proposal. The Governor's budget proposes an increase of $894,000 ($407,000 General Fund) in 2019-20 and $779,000 ($354,000 General Fund) in 2020-21 for limited-term two-year resources to address an increased caseload backlog associated with the investigation of complaints about child welfare and foster care.

Background. The Office of the Foster Care Ombudsperon (OFCO) was created in 1998 to protect the interests and rights of children in foster care by providing them a means to make complaints and resolve issues related to their care, placement, and services. The office conducts investigations and recommends system-wide improvements to the Legislature, Governor's Office, and child welfare organizations.

Over the past twenty years, additional legislative mandates have increased the role and responsibilities of the OFCO, even though staffing levels have remained the same. The office consists of seven total positions: one career executive assignment, one staff services manager, and five associate governmental program analysts. The office receives approximately 1,800 monthly in-bound hotline calls and investigates 500 new cases per month. Staff also conduct visits to county child welfare agencies, foster family agencies, and group homes or short-term residential treatment programs to engage in monitoring and resolution activities. Caseload growth and limited resources have resulted in a backlog of nearly 400 active cases that have been open for more than three months. The requested resources will allow the office to respond and investigate the increased volume of cases it receives, and to address the backlog of cases.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

Issue 3: BCP – State-Tribal-County Engagement and Indian Child Welfare Act Compliance

Governor's Proposal. The Governor's budget proposes an increase of $797,000 ($392,000 General Fund) in 2019-20 and 2020-21 for limited-term two-year resources to address workload associated with new state and federal regulations and to support counties with technical assistance and specialized training.

Background. The Office of Tribal Affairs (OTA) was instituted in 2017 to fulfill legal and regulatory mandates involving compliance with the Indian Child Welfare Act (ICWA) and engagement with Indian tribes in California. The OTA has the primary responsibility of building better government-to-government relationships with California Indian Tribes. Additionally, Welfare and Institution Code (WIC) Section 16500.9 requires the OTA to assist counties with ICWA compliance such as supplying up-to-date information on tribes both within and outside of the state, providing information and support regarding juvenile dependency cases involving the ICWA, and providing training and technical assistance for counties on the ICWA mandates.

The ICWA compliance workload stems from federal regulations adopted in 2016, including the Bureau of Indian Affairs (BIA) ICWA regulations and Assembly Bill 3176 (Waldron), Chapter 833, Statutes of 2018. BIA and the U.S. Health and Human Services Administration for Children and Families (ACF) Division finalized federal regulations which include:

- Affirmative and continuing duty of inquiry in all cases, beginning at initial contact.
- Presumption – application of ICWA mandates whenever there is reason to know the child is an Indian child within the meaning of the Act.
- Active efforts beginning at initial contact.
- Stricter approach to what constitutes voluntary proceedings.
- Increased emphasis on tribal jurisdiction.

Additionally, the federal regulations create new data elements for reporting. However, work is needed to achieve uniformity of meaning and practice (to achieve reliable data and meet federal reporting requirements). Reporting on these new data elements begins October 1, 2019. Amended regulations and guidance, comprehensive training, and significant levels of consultation with tribes is essential in order to meet these requirements. To achieve these goals, OTA staffing must be adequate for meeting these challenges and avoiding compliance litigation and regulatory penalties. The requested resources would allow the OTA to assist and consult with 109 tribes, engage with 58 counties, and strengthen relationships with additional diverse stakeholders to meet these goals, as well as provide training to implement consistent data compilation and analysis.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

Issue 4: CWS-related Human Services Technical BCPs

Each year, the departments within the Health and Human Services (HHS) Agency submit a number of proposals requesting various technical adjustments, largely related to workload adjustments and resources needed to implement new legislation. The proposals discussed in this item are part of that larger Agency BCP.

Governor's Proposal. The Governor's budget includes the following CWS-related proposals.

1. Child Wellbeing Waiver Project. The Governor's budget includes $1.6 million ($454,000 General Fund) in 2019-20 and $909,000 ($454,000 General Fund) in 2020-21 to extend limited-term resources for the phase-down of the Child Well-being Waiver Project. Additionally, funding would be used for the project evaluation contract that was funded, but not executed in 2014-15. The requested resources are necessary to administer county funding for the duration of the claiming timeframe following the end of the Project and to support ongoing state negotiations and reconciliations with the Administration for Children and Families grant of supplemental federal funds.

2. AB 2967 – Ensuring Foster Youth Have Access to Vital Documents. The Governor's budget includes $122,000 ($56,000 General Fund) in 2019-20 and $114,000 ($52,000 General Fund) in 2020-21 in order to implement AB 2967 (Quirk-Silva), Chapter 551, Statues of 2018. AB 2967 requires a county welfare agency to verify the eligibility of an applicant requesting a free copy of their birth certificate, based on the qualification of being a current or former foster youth. The requested resources would help address the workload required to provide verification of time in foster care, and assistance in obtaining certified copies of birth certificates for current and former foster youth. Additionally, the Office of the Foster Care Ombudsman (OFCO) anticipates an increase in hotline calls and cases received from current foster youth who wish to work, but whose social worker or caregiver does not provide the required documentation. In these cases, the OFCO must intervene and advocate for the youth.

Staff Comment and Recommendation. Hold open.

Issue 5: Proposals for Investment

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

1. Child Welfare Training System

Budget Issue. The California Welfare Director's Association (CWDA), the National Association of Social Workers (NASW), California chapter, and Service Employees Union (SEIU) International request $10 million General Fund for the Child Welfare Training System. The requested funds could be leveraged with federal funding to increase funding to $22 million total. The requested funds would support the development of skill-based learning outside of the classroom, expand opportunities for cross-training with partner agencies and stakeholders, update and expand advanced training offerings, and ensure meaningful stakeholder involvement by establishing a Child Welfare Workforce Development Board.

Staff Comment and Recommendation. Hold open.

2. Bringing Families Home

Budget Issue. CWDA, the California Association of Counties (CSAC), the Corporation for Supportive Housing, and Housing California requests a one-time appropriation of $25 million for 2019-20 and 2020-21 to continue and expand the existing Bringing Families Home program.The program provides housing supports to child-welfare involved homeless families and those at risk of homelessness. The program promotes supportive housing and rapid re-housing of families, with first priority to support family reunification and to maintain families together when children are at risk of abuse and neglect.

Staff Comment and Recommendation. Hold open. The 2016 budget provided a one-time augmentation of $10 million for the program that will expire on June 30, 2019.

3. 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 of California, and Tipping Point Community request a $1.7 million General Fund to ensure youth in need of services are able to enter or re-enter extended foster care. The funding will help to address unintended barriers that youth may encounter when trying to enter or re-enter extended foster care.

Staff Comment and Recommendation. Hold open.

4. Housing and Related Supports in the Extended Foster Care Program

Budget Issue. The Alliance for Children's Rights, Children NOW, CWDA, and SEIU California request a $50 million General Fund investment to provide housing stability for transition-age foster youth and young adults in the extended foster care program. The requested funds would: (1) enable county caseworkers to better support youth; (2) fund housing navigators to help young adults find and keep housing, (3) provide housing-related financial assistance such as security deposits, and (4) support foster homes transitioning to become host families for youth in extended foster care.

Staff Comment and Recommendation. Hold open.

5. Addressing Impact of State Minimum Wage on Foster Family Agencies (FFAs)

Budget Issue. NASW, the California Alliance, The California Alliance of Caregivers, John Burton Advocates for Youth, the California Coalition for Youth, the Inland Empire Alliance, the Orange County Alliance for Children and Families, and the Association of Community Human Services Agencies request $26.8 million to address the impact of the state minimum wage increases on the salaries of social workers employed by FFAs. California law requires that salaries must be at least double the minimum wage in order for professionals to be considered exempt from overtime requirements. This pushes up the threshold for classification of professionals as salaried exempt employees. In 2019, FFA social workers must receive a minimum annual salary of $49,920 in order to retain their status as salaried, exempt professionals. The amount available for FFA social work salaries in the current FFA rate must increase by $151 per child per month in 2019 simply to meet the $49,920 minimum salary requirement. The requested funds would increase FFA rates for social work activities and ensure social work staff can retain their exempt status.

Staff Comment and Recommendation. Hold open.

6. Child Welfare Public Health Nursing Early Intervention Pilot Program

Budget Issue. SEIU California requests $16.5 million ($8.25 million General Fund and an anticipated $8.25 million federal match) to create the Child Welfare Public Health Nursing Early Intervention Pilot Program. The pilot program would build upon the existing use of public health nurses in the field in Los Angeles County. The program would provide families with children who are at risk of being placed in the child welfare system with preventive services. The purpose of the program is to improve outcomes for an expanded population of at-risk youth and families before entering the foster care system.

Staff Comment and Recommendation. Hold open.

7. Fostering Success: Supporting Vulnerable Foster and Crossover Youth

Budget Issue. The National Center for Youth Law requests an investment of $9 million General Fund to augment the fund creating a community-based foster youth development system. Investments 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 statewide, including expanding the capacity to serve youth in families rather than in congregate care; and (3) provide permanency services for older youth in congregate care to ensure California's foster youth transition successfully into adulthood.

Staff Comment and Recommendation. Hold open. The 2018 budget allocated $4 million General Fund for a one-time competitive grant process to provide community-based programs as alternatives to arrest and detention of foster children.

8. Parents Anonymous

Budget Issue. Parents Anonymous, an organization that implements evidence-based prevention and treatment programs that strengthen families involved in the child welfare system or at risk of becoming involved in the system, requests a $2 million augmentation in 2019-20 and $1 million in 2020-21 and

2021-22. The funding would allow the organization to expland its programs and services tatewide, including its 24 hour California Parent Helpline.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – CHILD WELFARE SERVICES
4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Continuum of Care Reform (CCR) Implementation

Governor's Proposal. The 2019-20 Governor's budget proposes $386.2 million ($270.4 million General Fund) to continue implementation of CCR activities.

The table below provides a high-level summary of changes between the 2018-19 Budget Act and the 2019-20 Governor's budget.

Continuum of Care Reform

Funding (millions)	2018-19 Appropriation	FY 2018-19 Revised Budget	FY 2019-20 Governor's Budget	FY 2018-19 Change from Appropriation	FY 2019-20 Change from Appropriation
Total	$267.0	$398.0	$386.2	$131.0	$119.3
Federal/ TANF	61.4	102.1	115.2	40.7	53.8
State	205.2	295.3	270.4	90.1	65.2

*The total includes county funds.

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

TOTAL CCR PROGRAM COSTS

CCR Components (values in 000s)	FY 2018-19 Total	FY 2018-19 Federal[1]	FY 2018-19 Non-Fed	FY 2019-20 Total	FY 2019-20 Federal[1]	FY 2019-20 Non-Fed
Home-Based Family Care Rate[2]	$225,596	$52,048	$173,548	$253,202	$69,194	$184,008
Placement Prior to Approval	12,365	10,931	1,434	13,229	11,795	1,434
Accreditation	2,265	1,133	1,132	0	0	0
Contracts (in CCR Administration)	4,996	1,568	3,428	8,052	2,456	5,596
Contracts (in Child Welfare Training)	2,815	1,116	1,699	2,401	946	1,455
Second Level Administration Review	135	25	110	151	41	110
Child and Family Teams	64,641	12,395	52,246	72,780	19,928	52,852
Foster Parent Recruitment, Retention and Support	26,955	5,325	21,630	0	0	0
RFA	34,149	11,004	23,145	12,067	3,880	8,187
SAWS	500	250	250	500	250	250
LOC Protocol Tool	9,163	1,872	7,291	10,261	2,970	7,291
RFA Backlog (One-time funding)	13,839	4,378	9,461	0	0	0
Services Only (One-time funding)	500	0	500	0	0	0
CANS Implementation (One-time funding)	0	0	0	13,531	3,715	9,816
CDSS Local Assistance Total	**$397,919**	**$102,045**	**$295,874**	**$386,174**	**$115,175**	**$270,999**

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 placement of maltreated children in group care settings has been increasingly viewed as a temporary solution in instances where emergency or crisis treatment is warranted. Yet, as of January 2015, 48 percent of

youth placed in group homes in California through the child welfare services system had been there more than two years, and 23 percent had been there more than five years.

In 2012, the Legislature passed SB 1013 (Budget and Fiscal Review Committee), Chapter 35, Statutes of 2012, which authorized CDSS to convene a working group and to develop recommendations to the current rate-setting system, services, and programs serving children and families in the continuum of foster care settings. The legislation mandated the workgroup consider, at a minimum, reforms to programs provided by Foster Family Agencies and group homes, and how to ensure the provision of services in family-like settings, including after care services, when appropriate.

In January 2015, the department released the report "California's Child Welfare Continuum of Care Reform", which listed recommendations to improve assessment of children 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 report emphasized that reform efforts cannot focus on stand-alone innovations, but rather must be an interconnected system with an array of services for youth and families. It noted that underpinning the change in service delivery is the belief that "all children, including those in out-of-home care, deserve to grow up in families and develop a sense of community."

The Legislature subsequently passed AB 403 (Stone), Chapter 773, Statutes of 2015, to implement the CCR, which codified the recommendations. In subsequent years, 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. 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.

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. However, the department has not released multiyear cost projections since 2017 and it is expected that CCR costs will remain for the near future.

Some of the main components of the CCR are:

- Family Finding Efforts - the department and county agencies have made significant efforts to help foster life-long familial connections for children and youth in care.

- The required use of child and family teams (CFTs) in decision-making.

- Integration of mental health services – continued work in the institutional settings and expansion of community-based services is expected. Placements for children with higher-level treatment needs will be required to ensure access to specialty mental health services and strengthen their permanency placement services.

- 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.

- Resource Family Approval (RFA) is a new, streamlined assessment that replaces the existing

multiple approval, licensing, and certification processes for home-based family caregivers.

- A new Home-Based Family Care (HBFC) rate structure. Prior to CCR, foster family rates were generally based on the age of the child. A new HBFC Rate Structure is based on the needs of the child. In order to implement the rate structure, a tool must be developed to aid in assessing foster youth and placing them in the appropriate Level of Care (LOC). Work on this tool is ongoing. However, all new FFA entries into foster care are being assessed with a LOC tool. Below is the 2019-20 rate structure:

Resource Family	Basic Level	LOC-2	LOC-3	LOC-4
Basic Rate[2]	$1,001	$1,113	$1,226	$1,338

Foster Family Agency	Basic Level	LOC-2	LOC-3	LOC-4
Basic Rate[2]	$1,001	$1,113	$1,226	$1,338
Social Worker	$340	$340	$340	$340
Social Services & Support	$156	$200	$244	$323
RFA	$48	$48	$48	$48
Administration	$672	$672	$672	$672
Total	**$2,217**	**$2,373**	**$2,530**	**$2,721**

Resource Family for Intensive Services Foster Care (ISFC)	
ISFC Rate[2]	$2,611

Foster Family Agency for ISFC (including ISFC Administration)	
ISFC Administration	$3,482
ISFC Social Services & Support	$200
Total	**$6,293**

Short-Term Residential Therapeutic Program (STRTP)	
STRTP Rate[2]	$13,543

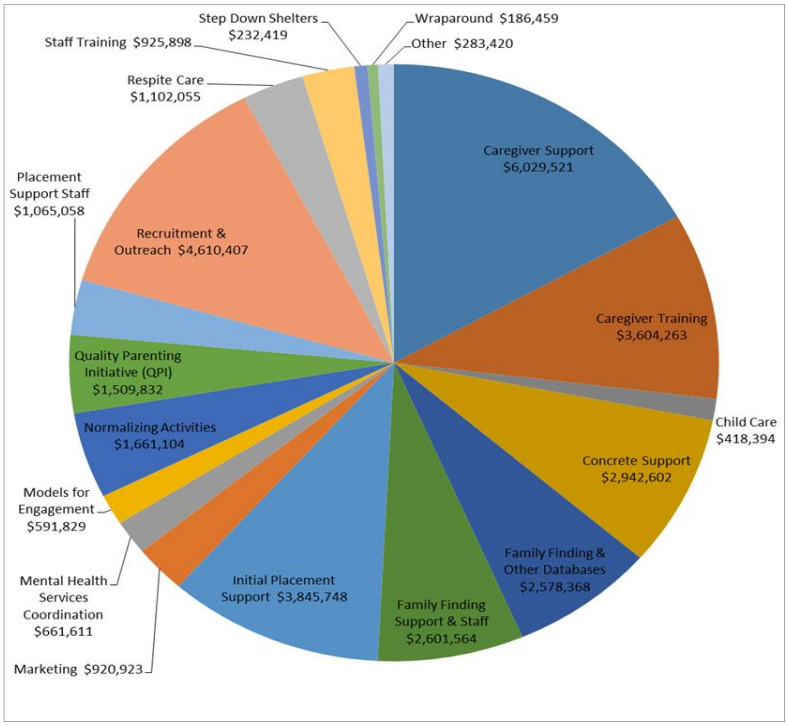
Foster Family Agency or Community-Based Organizations for Services Only Administration	
Total Rate	$833

CCR 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 for these other activities 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 December 1, 2017, and includes the use of all LOCs of the HBFC rate structure, limited to FFAs.

Implementation is an ongoing, evolving effort that will take at least several years to successfully roll out all components. CDSS, along with various stakeholders, engages in individual county calls to discuss CCR implementation and provide technical assistance. 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:

Foster Parent Recruitment Retention and Support (FPRRS). 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 FPFRS activities. Below is a chart showing the top uses for FPPRs funds for counties in 2017-18.



Additionally, the department has hired a consultant, Dr. Denise Goodman, to provide direct onsite training and technical assistance on family recruitment to six counties (Shasta, Sacramento, San Joaquin, Riverside, Kings, and Sonoma) until 2020. Her team is also providing regional trainings and consultations available to all 58 counties to assist in targeted and child-specific recruitment, retaining and supporting resources families, and the RFA process.

The CFT Process. The number of children receiving a CFT meeting is increasing. As of January 1, 2019, 46.7 percent of children and non-minor dependents in foster care have received a CFT. This number has risen by approximately six percentage points since October 2018. CFTs are the primary vehicle through which the Integrated Core Practice Model (ICPM) is implemented. The ICPM provides guidance and direction to support county child welfare, juvenile probation, behavioral health agencies and their partners in delivery of timely, effective and collaborative services to children, youth and families. The department has provided two ICPM trainings for CDSS staff with additional trainings scheduled through May 2019. The department is also developing a webpage, projected to launch in spring 2019 that will provide a single source of information on ICPM for all relevant stakeholders.

The CFT implementation team, comprised of CWDA, DHCS, the County Behavioral Health Directors Association, California Youth Connection, and representatives from various county child welfare agencies, has been holding monthly meetings since November 2018. In those meetings the team has focused on the following:

- Identifying the skills, competencies, and values of the Child and Adolescent Needs and Strengths (CANS) assessment to inform curriculum development,

- Developing communications that convey the vision and importance of using CANS within the CFT, and

- Identifying new ways to compile and analyze data to enhance the CFT process.

Mental Health and STRTPs. DSS and DHCS are conducting regional provider and county meetings to support implementation efforts related to STRTPs, presumptive transfer, therapeutic foster care, and intensive services foster care (ISFC). The departments also continue to work together on the DHCS Mental Health Program Approval process for STRTPs. DHCS is currently updating the interim STRTP regulations, the interim STRTP Mental Health Program Approval Protocol, and the STRTP Mental Health Program Approval application. These documents are expected to be issued by April 2019.

An STRTP has 12 months from the date of licensure to obtain a mental health program approval, or the license is invalid. As of February 22, 2019, DHCS has received approximately 200 applications for Mental Health Program approval. 81 onsite reviews have been conducted and 66 approvals have been granted. In October 2018, DHCS issued an information notice regarding the delegation of the Mental Health Program Approval to mental health plans. As of February 2019, 11 plans have accepted delegation, and another 45 have declined. DHCS works together with the respective mental health plans to conduct these reviews.

Group homes are no longer a placement option unless the homes have been approved to transition to an STRTP or have an open application to transition. As of March 2019, 208 STRTPs have been licensed, 319 group homes have in-process applications to transition to STRTPs, and 22 group homes were denied STRTP applications. Foster youth in homes that have had their transition application denied must be transitioned to other placements. In 2018-19, the department assumes 28 group home placements will move to an ISFC placement, 1,409 will move to an STRTP, and 53 will move to family-based placements. In 2019-20, it is assumed 351 group home placements will move to an ISFC placement, 2,366 will move to an STRTP, and 1,497 will move to a family-based placement. Many youth that are a part of the remaining 314 group home placements do not qualify under CCR and will continue as group homes for specialized populations.

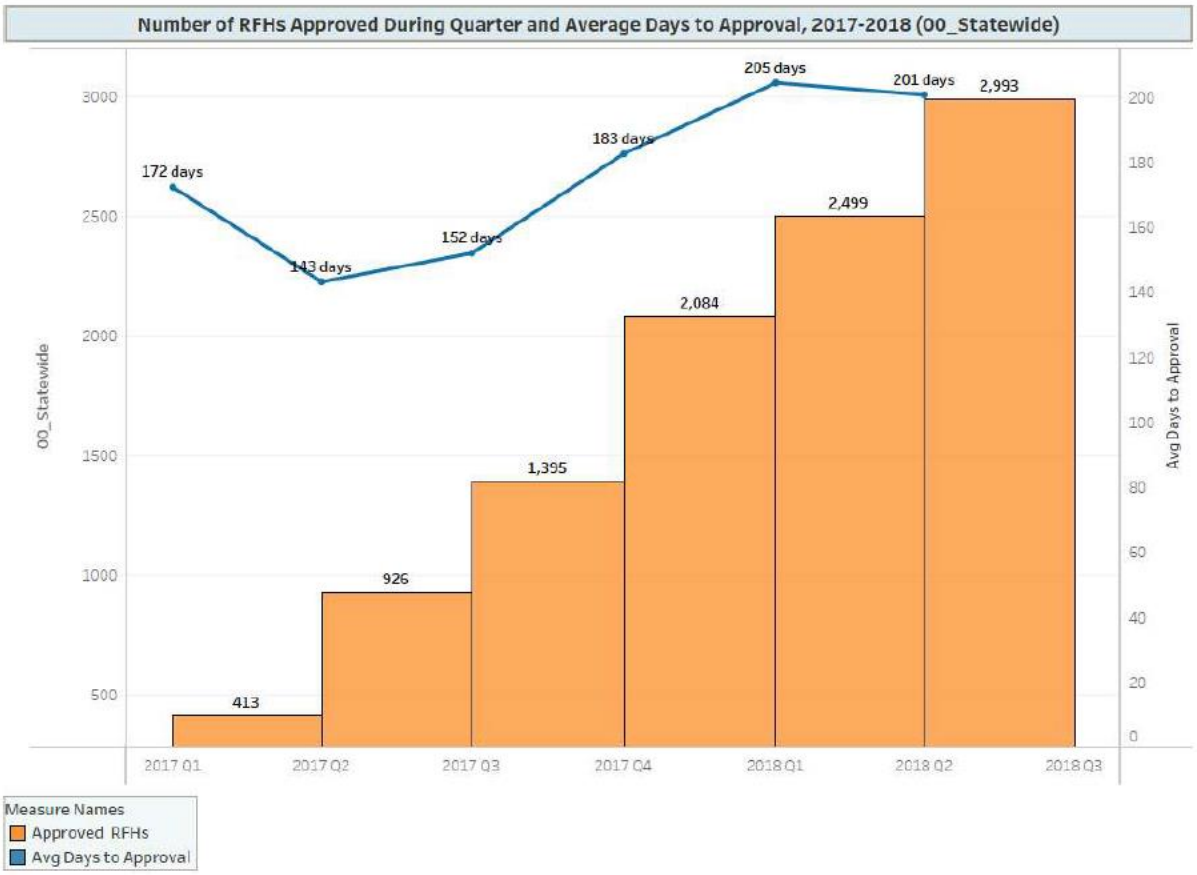
Below is a table with a further breakdown of movement from group homes for 2019-20.

Table 1. HBFC Rate Caseload - 2019-20 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)		**40,531**	**40,531**	**40,531**	**40,531**	**40,531**	
FFA		12,736	12,736	12,736	12,736	12,736	
FFH/Relative		23,268	23,268	23,268	23,268	23,268	
Prospective AAP		1,924	6,870	13,465	14,014	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		4,298	3,692	4,873	5,269	5,560	
Total GH RCL 1-9	*486*						
GH RCL 1-9 Shifting to ISFC		-	-	15	24	24	5%
GH RCL 1-9 Shifting to STRTP		-	-	29	48	49	10%
GH RCL 1-9 Shifting to FFA		-	5	15	190	194	40%
GH RCL 1-9 Shifting to FFH		-	-	15	166	170	35%
GH RCL 1-9 Shifting to Relative		-	-	15	48	49	10%
GH not moving		486	481	398	10	-	0%
Total GH RCL 10-12	3,612						
GH RCL 10-12 Shifting to ISFC		-	-	-	283	289	8%
GH RCL 10-12 Shifting to STRTP		-	71	1,266	2,087	2,203	61%
GH RCL 10-12 Shifting to FFA		-	-	-	495	578	16%
GH RCL 10-12 Shifting to FFH		-	-	-	407	397	11%
GH RCL 10-12 Shifting to Relative		-	-	-	71	144	4%
GH not moving		3,612	3,540	2,346	270	-	0%
Total GH RCL 14	429						
GH RCL 14 Shifting to ISFC		-	-	13	44	43	10%
GH RCL 14 Shifting to STRTP		-	8	114	231	258	60%
GH RCL 14 Shifting to FFA		-	-	8	59	64	15%
GH RCL 14 Shifting to FFH		-	-	-	53	52	12%
GH RCL 14 Shifting to Relative		-	-	-	8	13	3%
GH not moving		429	421	295	34	-	0%

RFA. All counties began using RFA as part of CCR implementation effective January 1, 2017. Unfortunately, the RFA process has experienced many delays despite efforts to speed up the process. There is a significant backlog of RFA applications, and counties are taking longer than the 90-day timeframe to process them. To aid counties in this process, DSS has engaged in regular technical assistance calls and has issued revised instructions (in May 2018) to streamline the process. Counties have also submitted plans to the department for how they plan to mitigate the backlog of applications. Counties originally had until the end of 2019 to convert all certified family homes to resource families but that deadline has been extended until the end of 2020.

The department provided figure below depicts the average days to RFA approval (as of October 2018) as well as the number of RFA applications approved per quarter in 2017-18.



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. AB 1811 (Committee on Budget), Chapter 35, Statutes of 2018, provided additional funding for placements prior to approval. In 2018-19, recipients are generally eligible for this funding for up to 180 days until their applications are approved or denied. However, the length of funding is reduced to 90 days, beginning in 2019-20.

In 2018-19, the budget included a total of $32.5 million General Fund in RFA funding, including $23 million to help counties implement the conversion of the previous caregiver approval systems to RFA, as well as $9.5 million that was provided one-time to reduce the RFA approval backlog. The 2019-20 Governor's budget proposes to reduce total state funding for RFA to counties by more than $24 million—leaving about $8 million General Fund for this purpose.

CDSS is responsible for tracking the usage and duration of payments and evaluating the duration of time a child or non-minor dependent is in a home pending RFA. Counties submit forms regarding reasons for delays in processing RFA applications for applicants waiting more than 90 days for approval. The table below depicts county data regarding RFA placement prior to approval and emergency caregiver funding caseloads as of January 31, 2019. Note that this table only includes aggregate data for 48 counties.

Placements Prior to Approval/Emergency Caregiver Funding: January, 2019	
Total # of RF applicants with preapproval placements over 90 days	1,808
Total # of RF applicants with preapproval placements over 180 days	772
Total # applicants that were determined to be good cause by the county	1,102
Total % pending over 90 days that were determined to be good cause by the county	61%
Total # of pre-approval placements	5,060
Total # placements receiving funding over 90 days	2,572
Total % of placements receiving funding over 90 days	50.8%

Rates Implementation and Assessment Tools. The department has selected the Child and Adolescent Needs and Strengths (CANS) tool to be used within the CFT process. Agencies will use CANS to inform placement and service decisions. 33 counties began a phased implementation of CANS in June 2018, and most remaining counties began implementation later in 2018. The last county to begin implementation, Los Angeles County, began in January 2019. As of October 2018, nearly 45 percent of children entering foster care were documented as having participated in the CANS process. The 2019-20 proposed budget includes close to $10 million in one-time funds to counties to implement CANS.

The department has developed another assessment tool to determine the foster care payment rate that caregivers will receive - the level of care (LOC) Protocol. The LOC tool is designed to identify the care needs of the child and to translate those needs into an appropriate foster care payment rate. The LOC tool began to be used for new FFA entries into foster care in March 2018. Originally, it was estimated that the tool would be used for all out-of-home placements beginning in May 2018. The department is currently collecting data on the use of the LOC for FFA placements, and it is unclear when the next phase of implementation for the LOC tool will begin. However, the department is finalizing an all-county letter (ACL) that will provide further clarification and guidance to counties on the continued use of the LOC tool for FFA placement, regardless of when they entered care. The department has indicated that it intends to conduct a validity study on the FFA rollout of the tool before expanding its use to all placements. The department is in the process of planning that study. All placements, other than new FFA placements, receive the LOC 1 rate (see table on page 27).

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. All counties have updated their SCI plan to account for offset associated with the new HBFC rate structure. However, those plans will not go into effect until all placement types are included in the LOC protocol. Currently, SCI rates vary widely from county to county.

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 an early intervention to avoid STRTP placement. The number of ISFC homes

that was anticipated in the initial planning stages of CCR has not materialized, however DSS and advocates say that child-specific matching to foster families may result in increases in ISFC placements over time.

Lessons Learned and New Directions within CCR Implementation.

- *Family finding.* Family finding is a broad concept which encompasses not only the statutory requirements pertaining to identifying, locating and notifying the relatives of a child in foster care, but also related efforts to foster life-long familial connections for children and youth in care. The department has made noteworthy efforts to ensure relatives for youth and children in care are found, including hiring consultants and holding trainings for social workers on the use of innovative approaches to identify and locate relatives and other potential familial and non-related connections.

- *Family recruitment and support.* The LAO points out that there are concerns over the availability and the capacity of home-based family placements, 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. However, the Governor's budget proposes to eliminate funding for foster parent recruitment, retention, and support. $23.6 million General Fund was provided for these activities in 2018-19, and $43.3 million was provided the two previous fiscal years. Stakeholders argue that continued funding for FPRRs would be extremely beneficial in light of the fact that implementation of CCR is not complete, and given the unexpected delays in its implementation.

- *STRTP capacity.* 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 2019 deadline for group home extensions comes.

- *RFA process.* The RFA process is taking longer than anticipated. The prolonged RFA process is a direct impediment to the success of CCR and can have harmful impacts on children and families. While the solutions provided by AB 110 and AB 1811 to fund families until the end of June 2019 has been useful, counties are still dealing with the backlog and other issues with RFA implementation that need to be addressed. Emergency funding provided by those bills will be provided for up to 90 days beginning in 2019-20, instead of the current 180 days. Additionally, the 2019-20 Governor's budget proposes to reduce General Fund support to help counties with RFA implementation from $32.5 million to $8 million.

Panel. The Subcommittee has requested the following panel, in addition to the Department of Social Services and the Department of Health Care Services, to provide comment on the implementation of the CCR and discuss some of the lessons learned and new directions CCR is taking:

Panel:

- Frank Mecca, Executive Director, County Welfare Directors Association of California
- Vanessa Hernandez, Statewide Policy Coordinator, California Youth Connection
- Meg Easter-Dawson, Volunteer Program Manager, Sonoma County Human Services Department
- Stephanie Montez, Support Supervisor, Sonoma County Human Services Department

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 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.

Questions.

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

2. Please provide an update on how mental health is integrating with CWS under CCR.

    a. How are DHCS and DSS tracking whether mental health services are being provided to all children who need these services?

    b. Please discuss the department's approach to ensuring children are receiving the required amount of support services in the community upon release from an STRTP. How is the state approaching ensuring that foster children receive services in order to stabilize their foster placements and avoid placement in an STRTP? How are

3. Please provide an update on the mental health program approval and the development of the updated regulations for STRTPs.

4. Please discuss how the one-time $9.5 million investment provided in last year's budget has helped to address the RFA backlog.

5. What are the next steps to reach the ultimate goal of using the LOC tool for all placements? When does the department estimate this final goal will occur?

6. Why did the Administration eliminate FPRRs funding in 2019-20? Does the Administration see a need for continued FPRRS funding? What additional efforts does the department have in place to ensure that there are enough foster families and that existing families have the support they need? Please include a discussion of past efforts the Administration has carried out with FPRRs funding.

Issue 2: CCR-related Human Services Technical BCPs

Each year, the departments within the Health and Human Services (HHS) Agency submit a number of proposals requesting various technical adjustments, largely related to workload adjustments and resources needed to implement new legislation. The proposals discussed in this item is a piece of that larger Agency BCP.

Governor's Proposal. The Governor's budget includes the following CCR-related technical BCPs.

1. AB 2083 Implementation. The Governor's budget includes $413,000 in 2019-20 and $292,000 ongoing to implement AB 2083 (Cooley), Chapter 815, Statutes of 2018. AB 2083 requires both the state and local governments to create integrated programs serving children under both the STRTP and Therapeutic Foster Care models of care, as well as through integrated implementation of CFTs and the CANS tool. CDSS requests two positions to meet the new workload, including expanded case-specific technical assistance and interagency policy collaboration.

2. CCR Increased Workload. The Governor's budget includes $4.4 million ($3.1 million General Fund) in 2019-20 and 2020-21 for 34 limited-term positions to address additional workload and compliance requirements associated with CCR. Previously approved limited-term resources will expire on June 30, 2019. These positions will aid in implementing the various components of CCR.

Staff Comment and Recommendation. Hold open.

Issue 3: Proposals for Investment

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

1. Family Stability Fund (Funding for Recruitment, Retention, and Support of Resource Families)

Budget Issue. CWDA, the California Alliance of Caregivers (CAC), the Chief Probation Officers of California, the Alliance for Children's Rights, and CSAC request $43.2 million General Fund to maintain supports to resource family caregivers and the children and youth in their care. Funding provided in previous years has established many new supports that resource families have come to rely upon. For example, previous funding has allowed the use of foster parent mentors to provide extra suport for relatives through the RFA process.

Staff Comment and Recommendation. Hold open. In 2015-16, the budget included initial funding of $17.2 million. This funding increased to $43.3 million in 2016-17 and 2017-18. The fund was cut to $23.6 million in 2018-19, and is proposed to be eliminated in the 2019-20 budget.

2. Family Urgent Response System (FURS)

Budget Issue. CWDA, Children NOW, SEIU California, and the County Behavioral Health Directors Association (CBHDA) request $15 million in 2019-20 and $30 million ongoing to support foster youth and caregivers. FURS provides foster youth and their caregivers with immediate trauma-informed support when issues arise, and link youth and families to community-based supports and services. The requested funds would help to establish and maintain a statewide hotline availble 24/7 for caregivers and youth who experience emotional, behavioral, or other difficulties in need of immediate help. It would also allow counties to establish mobile response teams to provide in-home response on a 24/7 basis to stabilize the situation, assess needs, and develop an action plan.

3. Resource Family Approval and CANS Assessments

Budget Issue. CWDA and CSAC request the Legislature restore $24.4 million General Fund to allow county welfare agencies to continue to approve resource families in an efficient manner. The organizations also request the consideration of trailer bill language that would require the tracking of actual expenditures related to the CANS assessment tool.

Staff Comment and Recommendation. Hold open. The 2018 Budget Act allowed for emergency caregivers to receive payment at the time of placement for up to 180 days. However, that emergency funding will be provided for only up to 90 days beginning in 2019-20, instead of the current 180 days. Additionally, the 2019-20 Governor's budget proposes to reduce General Fund support to help counties with RFA implementation from $32.5 million to $8 million.

4. Continued Emergency Caregiver Funding at Time of Placement

Budget Issue. The Alliance for Children's Rights and Children NOW request language to revise the timeframes for emergency caregiver funding that are in effect for the 2019-20 fiscal year to allow families to receive emergency caregiver funding for 120 days. The Alliance also requests language allowing the timeframe to be extended past 120 days upon a showing of good cause. Then, for fiscal

year 2020-21, reduce the timeframe for receipt of emergency caregiver funding to 90 days but ensure there is still a good cause exemption to allow families that are taking longer. The Alliance estimates that the proposed language will incur a cost of $1.2 million General Fund in 2019-20.

Staff Comment and Recommendation. Hold open.

5. Transportation to School of Origin at Time of Placement

Budget Issue. The Alliance for Children's Rights and Children NOW request trailer bill language that would allow transportation reimbursement to a foster youth's school of origin at the time of placement and ensure all families receive notification of their eligibility for funding for transportaiton reimbursement. California law mandates school of origin rights for youth in foster care and reimbursement for transporting the foster child to their school of origin is available as part of the foster care maintenance payment. However, funding does not begin until commencement of the foster care maintenance payment, which means children placed in homes prior to the caregiver being approved have to wait for many months before funding to transport them to their school of origin is available. It is estimated that these reimbursements will cost about $2.1 million General Fund.

Staff Comment and Recommendation. Hold open.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: BCP - Foster Youth: Trauma-Informed Systems of Care (AB 2083)

Budget Issue. DHCS requests three positions and expenditure authority of $438,000 ($219,000 General Fund and $219,000 federal funds) in 2019-20 and $411,000 ($206,000 General Fund and $205,000 federal funds) annually thereafter. If approved, these resources would allow DHCS to participate on an interagency team and provide recommendations to the Legislature for increasing capacity and delivery of trauma-informed care to foster children and youth with intensive needs, pursuant to the requirements of AB 2083 (Cooley), Chapter 815, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$219,000	$206,000
0890 – Federal Trust Fund	$219,000	$205,000
Total Funding Request:	**$438,000**	**$411,000**
Total Requested Positions:	**3.0**	**3.0**

* Positions and Resources ongoing after 2020-21.

Background. AB 403 (Stone), Chapter 773, Statutes of 2015, known as Continuum of Care Reform (CCR), was intended to improve California's child welfare system by using comprehensive initial child assessments, increasing the use and support of home-based family care, reducing the use of congregate care placement settings, and creating faster paths to permanency to shorten the duration of a child's involvement in the child welfare and juvenile justice system. For DHCS, CCR eliminated the ability of group homes to accept children assessed as being seriously emotionally disturbed, including foster children and youth, and established a new licensure category of short-term residential treatment programs (STRTPs), certified by DHCS or local mental health programs to provide services.

AB 2083 (Cooley), Chapter 815, Statutes of 2018, builds on the framework of CCR to better serve the needs of foster children and youth who have experienced severe trauma. AB 2083 was intended to develop a coordinated, timely, and trauma-informed system of care approach by: 1) identifying and addressing gaps and delays in needed services and placement options, 2) improve outcomes, and 3) prevent the need for higher-cost interventions. Each county is required to develop and implement a memorandum of understanding (MOU) that sets forth the roles and responsibilities of agencies and other entities that serve children and youth in foster care who have experienced severe trauma. The MOU is required to include the county child welfare agency, probation department, behavioral health department, office of education, the regional center for children and youth with developmental disabilities, and foster care or other child welfare advocacy groups. The Secretary of the California Health and Human Services Agency and the Superintendent of Public Instruction are also required to establish a joint interagency resolution team to develop guidance, and provide support and technical assistance to counties and local entities in developing and implementing the MOU and identifying and securing the appropriate level of services to meet the needs of children and youth in foster care who have experienced severe trauma. The team is also required to review the availability of county placement and service options and submit recommendations to the Legislature and develop a multi-year plan for increasing the capacity and delivery of trauma-informed care to children and youth in foster care served by STRTPs and other foster care and behavioral health providers.

AB 2083 imposes the following responsibilities on DHCS:

- **Joint Interagency Resolution Team** – DHCS is required to participate in the joint interagency resolution team to provide technical assistance for implementation of MOUs and identifying and securing appropriate levels of services for foster children and youth.
- **Recommendations to the Legislature** – DHCS is required to assist with the review of available placement and service options and develop recommendations to the Legislature to address any gaps in placement types or needed services.
- **Multi-Year Plan** – DHCS is required to assist with the development of a multi-year plan to address capacity issues and delivery of trauma-informed care to children and youth in foster care.
- **Information Sharing and Privacy Provisions** – DHCS reports it will need to develop a process to share confidential information with other agencies consistent with federal law and the requirements of AB 2083.

DHCS requests three positions and expenditure authority of $438,000 ($219,000 General Fund and $219,000 federal funds) in 2019-20 and $411,000 ($206,000 General Fund and $205,000 federal funds) annually thereafter. Specifically, DHCS requests the following:

- **One Health Program Specialist II** position would provide subject matter expertise and be the lead staff member representing DHCS on the joint interagency resolution team.
- **One Health Program Specialist I** position would provide analytical and program support, develop tracking mechanisms to monitor county implementations of MOUs, manage technical assistance and remediation calls, research case-specific mental health plan requirements related to the provision of mental health services for foster children and youth with complex needs, and provide appropriate recommendations on quality assurance and improvement activities.
- **One Associate Governmental Program Analyst** would assist with program planning and development, oversight and monitoring of mental health plan compliance with AB 2083, respond to mental health plan inquiries, develop and maintain tracking systems to ensure timely receipt and follow-up of mental health plan requests for technical assistance, and assist in compilation of data and related reporting requirements.

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.

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

SUBCOMMITTEE NO. 3 Agenda

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

Thursday, April 4, 2019
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

PART B

Consultant: Scott Ogus

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PUBLIC COMMENT

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

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Community Mental Health - Overview

Community Mental Health – *Three Year Funding Summary*			
Fund Source	**2017-18**	**2018-19**	**2019-20**
1991 Realignment (base and growth):			
Mental Health Subaccount	$129,296,000	$129,415,000	$213,846,000
2011 Realignment (base and growth):			
Mental Health Subaccount	$1,129,234,000	$1,133,218,000	$1,132,142,000
Behavioral Health Subaccount	$1,415,447,000	$1,542,119,000	$1,658,031,000
Realignment Total	**$ 2,673,977,000**	**$2,804,752,000**	**$3,004,019,000**
Medi-Cal SMHS Federal Funds	**$2,954,125,000**	**$2,960,284,000**	**$3,149,401,000**
Medi-Cal SMHS General Fund	**$ 167,177,000**	**$263,550,000**	**$285,941,000**
MHSA Local Expenditures	**$2,009,301,000**	**$2,009,301,000**	**$2,009,301,000**
Total Funds	**$7,804,580,000**	**$8,037,887,000**	**$8,448,662,000**

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. SB 1 X1 (Hernandez), Chapter 4, Statutes of 2013, First Extraordinary Session, 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 –** SB 1 X1 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 local Three-Year Plans with Annual Updates approved by DHCS 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).

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 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 questions:

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

Issue 2: Unusual Occurrences-Complaint Investigations and Disaster Response

Budget Issue. DHCS requests eight positions and expenditure authority of $1.6 million ($858,000 General Fund and $719,000 federal funds) in 2019-20, $1.5 million ($809,000 General Fund and $678,000 federal funds) in 2020-21, and $1.1 million ($595,000 General Fund and $464,000 federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to manage investigations of violations and unusual occurrences in licensed facilities, as well as supporting behavioral health resources during natural disasters or other emergencies.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$858,000	$809,000
0890 – Federal Trust Fund	$719,000	$678,000
Total Funding Request:	**$1,577,000**	**$1,487,000**
Total Requested Positions:	**8.0**	**8.0**

* Additional resources requested – 2021-22 and ongoing: $1,059,000 ($595,000 General Fund and $464,000 federal funds).

Background. The DHCS Mental Health Services Division (MHSD), Licensing and Certification Branch (LCB) is responsible for the licensing, certification and oversight of 285 residential mental health programs ranging from acute care to long-term programs. LCB is responsible for implementing and maintaining a system for compliance with licensing and certification requirements. DHCS is currently the sole licensing authority for 55 facilities, including 30 psychiatric health facilities (PHFs) and 25 mental health rehabilitation centers (MHRCs). In addition, DHCS certifies 230 mental health programs within facilities that are licensed by either the Department of Public Health or the Department of Social Services.

DHCS is currently responsible for the investigation of unusual occurrences reported by facilities and complaints filed by the public, as well as the implementation of civil and monetary sanctions for violations. Unusual occurrences is defined by California regulations as any condition or event which has jeopardized or could jeopardize the health, safety, security or well-being of any patient, employee or any other person while in the facility. Unusual occurrences include epidemic outbreaks of disease, poisonings, fires, physical injury, death, non-consenting sexual acts, physical assaults, patient abuse, or actual or threatened walkout or other curtailment or interruption of services. Unusual occurrence reports (UORs) are required to be reported to DHCS within 24 hours of occurrence.

According to DHCS, the number of UORs and complaints reported to LCB has increased by 68.3 percent between 2016 and 2017. The primary driver of the increase in workload was a sharp increase in UORs from community treatment facilities, which rose from 486 in 2016 to 1,134 in 2017. DHCS reports that a rise in acuity levels for individuals in DHCS licensed and certified facilities has contributed to more active reporting of unusual occurrences. As a result, as of June 2018, DHCS reported a total UOR and complaint investigation backlog of 1,303.

DHCS also supports state-level response activities under the State of California Emergency Plan related to behavioral health needs. During natural disasters or other emergencies, DHCS provides support to counties including providing resource materials, collecting status updates of impacted mental health

facilities, and developing application for federal funding. According to DHCS, it does not have any staff dedicated solely to supporting disaster behavioral health response and must redirect existing staff and re-prioritize workload to respond.

DHCS requests eight positions and expenditure authority of $1.6 million ($858,000 General Fund and $719,000 federal funds) in 2019-20, $1.5 million ($809,000 General Fund and $678,000 federal funds) in 2020-21, and $1.1 million ($595,000 General Fund and $464,000 federal funds) annually thereafter. If approved, these positions and resources would support the following additional staff:

- **One Staff Services Manager I** position and **six Associate Governmental Program Analysts** would be responsible for conducting desk and field investigations of complaints and reportable unusual occurrences, as well as receiving, logging, and tracking progress and resolution.

- Limited-term resources equivalent to **two Attorney III** positions for two years would support the investigative workload at all stages, including providing legal advice, determining specific violations and whether they are supported by evidence, assisting with drafting sanctions documents, and providing legal support for sanctions appeals. DHCS indicates the legal workload may be higher than projected in this request and, if it is higher, may request additional resources in the future.

- **One Associate Governmental Program Analyst** would support workload needed to respond to behavioral health needs during a disaster, unusual event, or emergency. This workload would include serving as a subject matter expert on behavioral health during state- or local-level disaster response, serving as a subject matter expert during emergency preparedness and planning activities, and preparing applications and overseeing implementation of the federally funded Crisis Counseling Assistance and Training 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 3: Drug Medi-Cal Estimate

Budget Issue. The budget includes $593.4 million ($59.7 million General Fund, $403.2 million federal funds, and $130.5 million county funds) in 2018-19 and $687.1 million ($70.3 million General Fund, $489.9 million federal funds, and $126.9 million county funds) in 2019-20 for Drug Medi-Cal.

2018-19 Drug Medi-Cal Program Funding Summary (dollars in thousands)					
Service Description	**Total Funds**	**General Fund**	**Federal Funds**	**County Funds**	**Case-load**
Narcotic Treatment Program	$174,360	$5,334	$122,889	$46,137	9,164
Outpatient Drug Free Treatment Services	$18,712	$711	$14,309	$3,692	3,186
Intensive Outpatient Treatment Services	$7,176	$1,961	$4,814	$401	412
Residential Treatment Services	$2,882	$35	$1,638	$1,209	26
Organized Delivery System Waiver	$308,297	$50,627	$216,330	$41,340	-
Drug Medi-Cal Cost Settlement	($818)	($105)	($713)	$0	-
Drug Medi-Cal Annual Rate Adjustment	$5,781	$166	$4,009	$1,606	-
Drug Medi-Cal County Administration	$69,592	$992	$34,796	$33,804	-
County Util. Review/Quality Assurance	$7,417	$0	$5,099	$2,318	-
TOTAL	**$593,399**	**$59,721**	**$403,171**	**$130,507**	**12,788**
Regular Total	$508,445	$59,388	$358,916	$90,141	12,666
Perinatal Total	$8,763	$107	$5,073	$3,583	122
Other Total	$76,191	$226	$39,182	$36,783	-

2019-20 Drug Medi-Cal Program Funding Summary (dollars in thousands)					
Service Description	**Total Funds**	**General Fund**	**Federal Funds**	**County Funds**	**Case-load**
Narcotic Treatment Program	$174,676	$5,364	$123,246	$46,066	9,144
Outpatient Drug Free Treatment Services	$19,165	$731	$14,633	$3,801	3,266
Intensive Outpatient Treatment Services	$7,377	$2,089	$4,872	$416	427
Residential Treatment Services	$1,467	$20	$831	$616	28
Organized Delivery System Waiver	$425,215	$60,840	$314,022	$50,353	-
Drug Medi-Cal Cost Settlement	$0	$0	$0	$0	-
Drug Medi-Cal Annual Rate Adjustment	$7,229	$431	$4,932	$1,866	-
Drug Medi-Cal County Administration	$44,908	$858	$22,454	$21,596	-
County Util. Review/Quality Assurance	$7,104	$0	$4,884	$2,220	-
TOTAL	**$687,141**	**$70,333**	**$489,874**	**$126,934**	**12,865**
Regular Total	$629,385	$69,383	$459,184	$100,818	12,752
Perinatal Total	$5,744	$92	$3,352	$2,300	113
Other Total	$52,012	$858	$27,338	$23,816	-

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 expansion of Medi-Cal. 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.

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 $174.4 million ($5.3 million General Fund, $122.9 million federal funds, and $46.1 million county funds) in 2018-19 and $174.7 million ($5.4 million General Fund, $123.2 million federal funds, and $46.1 million county funds) in 2019-20 for NTP services. In 2018-19, NTP caseload is expected to be 9,164 a decrease of 39,736 (81.3 percent) compared to the 2018 Budget Act. In 2019-20, NTP caseload is expected to be 9,144, a decrease of 20 (0.2 percent) compared to the revised 2018-19 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 $18.7 million ($711,000 General Fund, $14.3 million federal funds, and $3.7 million county funds) in 2018-19 and $19.2 million ($731,000 General Fund, $14.6 million federal funds, and $3.8 million county funds) in 2019-20 for ODF services. In 2018-19, ODF caseload is expected to be 3,186, a decrease of 33,873 (91.4 percent) compared to the 2018 Budget Act. In 2019-20, ODF caseload is expected to be 3,266, an increase of 80 (2.5 percent) compared to the revised 2018-19 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 $7.2 million ($2 million General Fund, $4.8 million federal funds, and $401,000 county funds) in 2018-19 and $7.4 million ($2.1 million General Fund, $4.9 million federal funds, and $416,000 county funds) in 2019-20 for IOT services. In 2018-19, IOT caseload is expected to be 412, a decrease of 5,279 (92.8 percent) compared to the 2018 Budget Act. In 2019-20, IOT caseload is expected to be 427, an increase of 15 (3.6 percent) compared to the revised 2018-19 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 $2.9 million ($35,000 General Fund, $1.6 million federal funds, and $1.2 million county funds) in 2018-19 and $1.5 million ($20,000 General Fund, $831,000 federal funds, and $616,000 county funds) in 2019-20 for RTS. In 2018-19, RTS caseload is expected to be 26, a decrease of 375 (93.5 percent) compared to the 2018 Budget Act. In 2019-20, RTS caseload is expected to be 28, an increase of 2 (7.7 percent) compared to the revised 2018-19 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 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 caseload and expenditure changes in the Drug Medi-Cal estimate.

Issue 4: Drug Medi-Cal – Organized Delivery System Waiver

Budget Issue. The budget includes $308.3 million ($50.6 million General Fund, $215.1 million federal funds, and $41.3 million county funds) in 2018-19 and $425.2 million ($60.8 million General Fund, $312.5 million federal funds, and $50.4 million county funds) in 2019-20 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.

2018-19 DMC-ODS Waiver Program Funding Summary (dollars in thousands)				
	Total Funds	**General Fund**	**Federal Funds**	**County Funds**
Organized Delivery System Waiver Total	**$308,297**	**$50,627**	**$215,057**	**$41,340**
Regular Total	$304,400	$51,233	$212,764	$39,172
Perinatal Total	$3,897	$55	$2,293	$1,507
Claims Error*	$-	($661)	$-	$661

***** Payments for new required and optional services in the ACA expansion population were erroneously paid using General Fund for the non-federal share.

2019-20 DMC-ODS Waiver Program Funding Summary (dollars in thousands)				
	Total Funds	**General Fund**	**Federal Funds**	**County Funds**
Organized Delivery System Waiver Total	**$425,215**	**$60,840**	**$312,452**	**$50,353**
Regular Total	$426,120	$60,787	$311,145	$49,618
Perinatal Total	$2,095	$53	$1,307	$735

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, four counties began providing services under the DMC-ODS Waiver in 2016-17, and seven counties began providing services in 2017-18. In 2018-19, 28 additional counties are expected to begin providing services, with phased-in implementation expected to occur through April 2019. The department reports a total of 39 counties are participating or planning to participate in the DMC-ODS Waiver. 19 counties have elected not 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 5: Drug Medi-Cal Chaptered Legislation (SB 823, SB 1228, AB 2861)

Budget Issue. DHCS requests 16 positions and expenditure authority of $1.9 million ($1.7 million General Fund and $135,000 federal funds) in 2019-20 and $2.2 million ($2 million General Fund and $135,000 federal funds) annually thereafter. If approved, these resources would allow DHCS to implement new requirements for substance use disorder treatment programs regarding clinical assessment and treatment planning, patient brokering, and telehealth. These requirements were implemented pursuant to SB 823 (Hill), Chapter 781, Statutes of 2018, SB 1228 (Lara), Chapter 792, Statutes of 2018, and AB 2861 (Salas), Chapter 500, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$1,723,000	$2,041,000
0890 – Federal Trust Fund	$135,000	$135,000
Total Funding Request:	**$1,858,000**	**$2,176,000**
Total Requested Positions:	**16.0**	**16.0**

* Positions and Resources ongoing after 2020-21.

Background. Established in 1980, the Drug Medi-Cal program provides medically necessary substance use disorder (SUD) treatment services to eligible Medi-Cal beneficiaries through four primary modalities: 1) the Narcotic Treatment Program (NTP), Outpatient Drug Free (ODF) treatment services, Intensive Outpatient Treatment (IOT) services, and Residential Treatment Services (RTS). 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.

SB 823 Requires Adoption of ASAM Criteria for Licensure of Treatment Facilities. In addition to its responsibilities under Drug Medi-Cal, DHCS is responsible for licensing, certification, and monitoring of alcohol and other drug (AOD) residential treatment programs. DHCS reviews initial facility applications and conducts on-site reviews, oversees licensing and certification renewals, conducts on-site monitoring compliance reviews, and investigates complaints of facilities and counselors. SB 823 (Hill), Chapter 781, Statutes of 2018, requires DHCS to adopt the American Society of Addiction Medicine (ASAM) treatment criteria, or an equivalent evidence-based standard, as the minimum standard of care for licensed facilities.

According to DHCS, the ASAM criteria is the result of a collaboration that began in the 1980s to define one national set of criteria for providing outcome-orientated and results-based care in the treatment of addiction. The ASAM criteria utilizes a multi-dimensional patient assessment that is based on the degree of direct medical management provided; the structure, safety and security provided; and the intensity of treatment services provided. Through this strength-based multi-dimensional assessment, the

ASAM criteria addresses the patient's needs, obstacles and liabilities, as well as the patient's strengths, assets, resources and support structure, and provides an evidence-based common standard for assessing a patient's needs by identifying their placement within a full continuum of care.

The ASAM criteria's multi-dimensional assessment is structured around six unique dimensions which represent different life areas that together impact the assessment, service planning, and level of care placement decisions. These dimensions are utilized to provide a common language of holistic, biopsychosocial assessment and treatment across addiction treatment, physical health, and mental health services. The dimensions are:

- Dimension 1: Acute Intoxication and or Withdrawal Potential
- Dimension 2: Biomedical Conditions and Complications
- Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications
- Dimension 4: Readiness to Change
- Dimension 5: Relapse, Continued Use, or Continued Problem Potential
- Dimension 6: Recovery Environment

The ASAM criteria provides setting, staffing, support systems, therapies, assessments, documentation and treatment plan reviews to ensure the clinical needs of the patient are met. Clinical information pertaining specifically to adults and separate ones for youth are clearly identified. Specialized treatment needs for individuals with complex needs, such as co-occurring disorders, are also contained within ASAM.

Programs operating under the Drug Medi-Cal Organized Delivery System (DMC-ODS) provide a continuum of care modeled on the ASAM criteria for substance use disorder treatment services, which allows these programs to offer a consistent standard of care. DHCS developed a designation program to certify that all DMC-ODS providers of adult and adolescent Level 3.1 through 3.5 residential and inpatient services are capable of delivering care consistent with ASAM criteria. DHCS conducts a review of facility self-reported information and conducts a conference call with each program to determine whether the residential treatment facility is provisionally able to support ASAM Levels 3.1 (Clinically Managed Low-Intensity Residential Services for adolescents and adults), 3.3 (Clinically Managed Population-Specific High-Intensity Residential Services for adults only) or 3.5 (Clinically Managed Medium-Intensity Residential Services for adolescents and Clinically Managed High-Intensity Residential Services for adults).

DHCS is requesting **one Staff Services Manager I** position to manage **six Associate Governmental Program Analysts** in its Substance Use Disorder Compliance Division to implement the requirements of SB 823. According to DHCS, prior to the passage of SB 823, clinical assessments of treatment plans have not been a required aspect of residential licensure. DHCS would be required to promulgate regulations, formulate policies and procedures, draft information notices, and make recommendations on administrative and program-related problems. Each analyst would be responsible for managing a caseload of approximately 90 facilities applying for new ASAM designations. Analysts would review specifications related to treatment planning, educational scheduling, client file documentation, licensing requirements, coordination of care policies, quality monitoring, and data reporting.

SB 1228 Limits Patient Brokering in Recovery and Treatment Facilities. According to DHCS, the nationwide rise in the opioid epidemic highlights the need for treatment services, but has also fueled a surge in patient brokering and patient trafficking. Patient brokering occurs in California's SUD facilities and among the SUD workforce, but DHCS did not have the authority to take action against the facility or the workforce, resulting in insurance fraud and overbilling for inappropriate treatment services. Within the last three years, DHCS has started to receive complaints with allegations specific to issues of the illegal practice of patient brokering and trafficking. Complaints include individuals with or without a SUD being paid to enter certain SUD facilities, counselors or staff receiving kick-backs via money, gifts or services for making referrals to particular facilities, telling individuals they will enter one facility and placing them at a different facility in order to make money, facilities purchasing individual referrals from a referral service, and providing illicit drugs to individuals in order to refer them or retain them in the facility.

SB 1228 (Lara), Chapter 792, Statutes of 2018, prohibits the following persons, programs, or entities from giving or receiving compensation for referral to alcohol or drug treatment services:

1) A licensed alcoholism or drug abuse recovery and treatment facility,
2) A person with an interest of more than 10 percent in a licensed alcoholism or drug abuse recovery and treatment facility,
3) An employee of a licensed alcoholism or drug abuse recovery and treatment facility,
4) A certified alcohol or other drug program,
5) A person with an interest of more than 10 percent in a certified alcohol or other drug program, or
6) An employee of a certified alcohol or other drug program.

SB 1228 authorizes DHCS to assess penalties, suspend or revoke licensure, certification, or registration of a facility, program or counselor for a violation of the prohibition on receiving compensation for patient referrals.

DHCS requests **one Staff Services Manager I** position and **five Associate Governmental Program Analysts** in its Substance Use Disorder Compliance Division. Each analyst would be responsible for initial analysis, oversight, and monitoring of patient brokering and trafficking activities. Analysts would conduct monitoring visits, unannounced visits, conduct complaint investigations, and develop and complete provider trainings and outreach on program requirements.

DHCS also requests **one Attorney I** position in its Office of Legal Services. The attorney would provide legal support to program staff for on-site facility visits including evidence training, legal advice on evidence gathering and interviewing, analysis of evidence, legal theories and legal actions, and advice on follow up work to support legal actions. The attorney would also assist with informal conferences, regulatory development and ongoing legal support.

AB 2861 Allows Drug Medi-Cal Counseling Services Through Telehealth. AB 2861 (Salas), Chapter 500, Statutes of 2018, allows a Drug Medi-Cal certified provider to receive reimbursement for individual counseling services provided through telehealth by a licensed practitioner of the healing arts or a registered or certified alcohol or other drug counselor, when medically necessary and in accordance with the Medicaid state plan. AB 2861 also requires DHCS to promulgate regulations to implement the new policy by July 1, 2022.

DHCS requests **one Associate Governmental Program Analyst** in its Substance Use Disorder Program Policy and Fiscal Division to promulgate regulations, bulletins, and information notices related to implementation of telehealth reimbursement for Drug Medi-Cal providers.

DHCS also requests **one Attorney I** position in the Office of Legal Services to develop the required state plan amendment, develop information notices, and develop regulations. The position would also support contract development, legal research, consultation, written legal advice, and advice regarding the legal questions surrounding telehealth's application in the SUD context.

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 6: SAPT Block Grant Compliance and Audit Enhancement

Budget Issue. DHCS requests 14 positions and federal fund expenditure authority of $1.9 million in 2019-20 and $2.1 million ongoing thereafter. If approved, these resources would allow DHCS to correct audit findings and comply with a corrective action plan related to deficiencies in administration of the federal Substance Abuse Prevention and Treatment Block Grant.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0890 – Federal Trust Fund	$1,9165,000	$2,078,000
Total Funding Request:	**$1,916,000**	**$2,078,000**
Total Requested Positions:	**14.0**	**14.0**

* Positions and Resources ongoing after 2020-21.

Background. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) administers the Substance Abuse Prevention and Treatment (SAPT) Block Grant program, which provides funds to states to help plan, implement, and evaluate activities that prevent and treat substance abuse. The SAPT Block Grant program sets aside funds to target specific populations and services including pregnant women and women with dependent children, intravenous drug users, tuberculosis services, persons living with HIV/AIDS, and primary prevention. According to SAMHSA, California received $254.7 million from the SAPT Block Grant in the federal fiscal year ending September 2018.

DHCS is the designated single state agency that administers the SAPT Block Grant in California. Recent audits by the California State Auditor and SAMHSA have found insufficient oversight and reporting of SAPT Block Grant programs, resulting in a mandatory corrective action plan imposed by SAMHSA. The audit and corrective action plan require enhancement of fiscal oversight, programmatic processes, and monitoring and auditing of grant recipients, as well as substance use disorder facilities providing services funded by the SAPT Block Grant.

As a requirement of the SAPT Block Grant, DHCS is required to collect outcomes data and other information in three systems. The California Treatment Outcomes Measurement System – Treatment (CalOMS-Tx) collects outcome data from counties and providers to identify successful interventions to facilitate the improvement of service delivery. The Drug and Alcohol Treatment Access Report (DATAR) is the DHCS system that collects data on substance use disorder treatment capacity and waiting list, which is used to determine the capacity of the overall system to meet the demand for services. The Behavioral Health Services Information System (BHSIS) collects information on the facilities and services available for behavioral health treatment and on the characteristics of clients admitted to such facilities. BHSIS consists of four national datasets: 1) Treatment Episode Data Set, 2) Inventory of Behavioral Health Services, 3) National Survey of Substance Treatment Services, and 4) the Behavioral Health Treatment Services Locator.

In addition to its data collection responsibilities, DHCS is also responsible for fiscal management and auditing of county programs funded by the SAPT Block Grant. DHCS reviews annual county budgets, quarterly reporting, expenses and payments for compliance with program requirements. DHCS also conducts program audits of county programs receiving SAPT Block Grant funding. The California State

Auditor found that DHCS was not conducting an appropriate number of audits to meet the SAPT Block Grant requirements. As a result, DHCS intends to conduct 19 county audits each year, auditing each of the 58 counties over a three year period.

DHCS requests 14 positions and federal fund expenditure authority of $1.9 million in 2019-20 and $2.1 million ongoing thereafter to comply with the audit findings and corrective action plan related to deficiencies in administration of the federal Substance Abuse Prevention and Treatment Block Grant. Specifically, DHCS requests the following positions:

Substance Use Disorder Program, Policy and Fiscal Division (SUD-PPFD) – Three positions

- **One Staff Services Manager I** and **two Associate Governmental Program Analysts** would manage the increased volume of database administration for the CalOMS-Tx, DATAR, and BHSIS systems. These systems were previously managed by the Enterprise Innovation and Technology Services (EITS) Division and will now shift to SUD-PPFD. These positions would be responsible for maintenance of information within the data systems.

SUD-PPFD, Fiscal Management and Accountability Section (FMAS) – One position

- **One Associate Governmental Program Analyst** would manage the fiscal processes of the annual SAPT Block Grant award. This workload includes review and analysis of 57 county budgets, 228 quarterly reports, quarterly accounting of SAPT Block Grant expenses, quarterly payments, and annual determination of redirections by award.

Audits and Investigations, Financial Audits Branch-Drug Medi-Cal Audit Section – Six positions

- **One Health Program Audit Manager I** would manage a team of **one Health Program Auditor IV** position, **three Health Program Auditor III** positions, and **one Office Technician** to manage the additional auditing workload recommended by the California State Auditor and consistent with the corrective action plan.

Office of Legal Services – Two positions

- **One Attorney I** position would perform legal research, provide legal advice, and draft legal opinions to ensure the SAPT Block Grant data reporting meets all state and federal requirements. The attorney would also review investigations and audits of counties and providers, as well as provide legal support for any necessary changes to current processes, documentation requirements, contract management, or oversight.
- **One Attorney IV** position would support and defend SAPT Block Grant appeals of audit findings and adjustments at the Office of Administrative Hearings and Appeals, engage with opposing counsel to assess settlement opportunities, and assist the Attorney General with defense of DHCS if providers challenge final appeal decisions.

Office of Administrative Hearings and Appeals (OAHA) – Two positions

- **One Administrative Law Judge II** position and **one Senior Legal Analyst** would handle increased workload related to appeal of audit findings. DHCS expects an additional 19 informal appeal requests annually, of which 15 will result in formal hearings. This represents 100 percent of annual county audits requesting informal appeals.

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: Proposals for Investment

Stakeholder Proposals for Investment. The subcommittee has received the following proposals for investment.

Substance Use Counselors in Emergency Departments. The California Chapter of the American College of Emergency Physicians (CalACEP) requests General Fund expenditure authority of $30 million to support the hiring of trained substance use disorder peer navigators and behavioral health peer navigators in emergency departments of acute care hospitals. According to CalACEP, brief interventions are successful in a variety of settings, but there is a unique opportunity to provide this intervention in the emergency department (ED). Patients presenting to the ED are more likely to be having a mental health crisis or have a substance use disorder than those presenting to primary care. For patients coming into the ED with a substance use disorder, the visit offers the opportunity for a "teachable moment" due to the crisis that precipitated the ED visit.

The University of California (UC) Davis Medical Center ED applied for a grant through the UC Office of the President over a year ago to employ a certified drug and alcohol counselor to provide interventions in their ED. Over a 12 month period, the Medi-Cal insured patients who received a brief intervention and referral to treatment experienced a 60 percent decline in ED utilization after the intervention. Based on an average cost to Medi-Cal of $861.50 per visit, this one program resulted in savings to the Medi-Cal program of more than $350,000. There are also likely savings associated with reduced hospital admissions, as studies have shown persons who needed substance abuse treatment and did not get it were 81 percent more likely to be admitted to the hospital during their current ED visit and 46 percent more likely to have reported making at least one ED visit in the previous 12 months.

Expansion of SBIRT to Opioids and Other Drugs. The California Behavioral Health Directors Association requests expenditure authority of $8.4 million ($2.6 million General Fund and $5.8 million federal funds) to expand the Medi-Cal benefit for screening, brief intervention, referral and treatment (SBIRT) to include screening for overuse of opioids and other illicit drugs such as heroin and methamphetamine. The U.S. Department of Health and Human Services describes expanding SBIRT for drug use as a promising practice and the U.S. Preventive Services Task Force is re-visiting its recommendations on this topic. A comprehensive, national SBIRT grant program recently reported a 75 percent reduction in illicit drug use, consistent with other evidence linking SBIRT to reduction in the use of cocaine, amphetamine-type stimulants and opioids. Expanding screening to detect use of opioids and other drugs would be an important step in combatting the current crisis and saving lives.

Youth Mental Health First Aid Training for Teachers and Schools. The California Council of Community Behavioral Health Agencies, the California Behavioral Health Directors Association, and the Born This Way Foundation request expenditure authority to pilot Youth Mental Health First Aid training for teachers and school personnel in districts with high rates of suicide or with high populations of at-risk youth. According to the proponents, 30 percent of high school students report experiencing depression symptoms - feeling sad or hopeless almost every day for two or more weeks in a row, so much so that they stopped doing some usual activities. 18 percent of high school students have seriously considered attempting suicide, and eight percent attempted suicide one or more times. Suicide is the second leading cause of death for youth 15 to 24 years old and the third leading cause of death among

youth aged 10 to 14. In addition, marginalized populations, particularly LGBTQ youth, are at even greater risk. Youth Mental Health First Aid USA is an eight hour in-person course that teaches educators, parents, and other adults how to identify, understand, and respond to signs of mental illnesses and substance use disorders in youth. This preventative training teaches the skills needed to reach out and provide initial help and support to someone who may be experiencing a crisis or developing a mental health or substance use issue.

County Suicide Prevention Strategic Plans. The Steinberg Institute requests resources to require all California counties to develop a suicide prevention strategic plan with an emphasis on adolescents. Over a ten year period, California has experienced a constant rise in deaths by suicide. Youth suicide and self-inflicted injury is on the rise and is the second leading cause of death among youth age 15 to 24 nationwide. Studies show prevention and early intervention efforts can help avoid a suicidal crisis. Local governments play a key role in convening stakeholders from diverse sectors like school districts, health care, youth justice, media campaigns, and community education and organizing. When counties implement strategic suicide prevention plans, they result in fewer suicide deaths in their county.

Friday Night Live Partnership at the Tulare County Office of Education. The Friday Night Live Partnership and the California Behavioral Health Directors Association (CBHDA) request General Fund expenditure authority of $6 million annually to provide supplemental funding for the California Friday Night Live Partnership at the Tulare County Office of Education. According to CBHDA, the Friday Night Live program is a key element of the prevention services provided in 50 or more counties. Cumulatively it represents the highest level of prevention activities in the statewide data collection system managed by DHCS. The Friday Night Live program works well in concert with all our efforts to improve the mental health, school connectedness, and health and safety of youth.

Children's Crisis Residential Programs Trailer Bill Proposal. The California Alliance of Child and Family Services requests trailer bill language to explicitly define Children's Crisis Residential Programs (CCRPs) as Psychiatric Residential Treatment Facilities (PRTFs) and funded accordingly. According to the Alliance, AB 501 (Ridley-Thomas), Chapter 704, Statutes of 2017, created a licensing category for children's mental health crisis residential programs, which is a mental health facility designed to treat youth who are not at imminent danger to themselves or others, but are unsafe to remain in the community due to their mental health needs. The model used in the development of AB 501, as well as models throughout the country utilize the Medicaid mental health program category of Psychiatric Residential Treatment Facility (PRTF), an all-inclusive program for Medicaid beneficiaries. Since AB 501 did not explicitly identify the facility as PRTFs, DHCS refuses to recognize CCRPs as PRTFs, and has designed a funding structure that covers only specific specialty mental health services, not the entire cost of providing 24-hour care and treatment.

Funding for Public Administrators, Public Guardians, and Public Conservators. The California Association of Public Administrators, Public Guardians, and Public Conservators (CAPAPGPC), the California State Association of Counties (CSAC), CBHDA, and the Service Employees International Union of California (SEIU CA) request General Fund expenditure authority of $68 million for DHCS to augment county spending for Public Administrator, Public Guardian, and Public Conservator (PA/PG/PC) programs at the county level. According to the proponents, PA/PG/PC programs are the only statewide California safety net programs that do not receive any dedicated state or federal funding even though the majority of the individuals served by these programs qualify for Med-Cal. In total,

California counties are spending approximately $194 million annually to provide critical PA/PG/PC services to California's most defenseless dependent adults and decedent estates. On average county PA/PG/PC programs are understaffed by 20 percent. State funding to annually augment, not supplant, county spending for these programs by 35 percent, or $68 million, would increase direct services to the vulnerable dependent adult population whom PA/PG/PC programs serve.

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 stakeholders to present these proposals for investment.

4260 DEPARTMENT OF HEALTH CARE SERVICES
4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Mental Health Services Act Oversight and Policy Development

Budget Issue. DHCS requests 13 positions and Mental Health Services Fund expenditure authority of $1.9 million in 2019-20 and $1.8 million annually thereafter. If approved, these resources would allow DHCS to provide oversight and monitoring of the use of Mental Health Services Act funds, in response to a series of audits by the California State Auditor and hearings by the Little Hoover Commission.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3085 – Mental Health Services Fund	$1,919,000	$1,802,000
Total Funding Request:	**$1,919,000**	**$1,802,000**
Total Requested Positions:	**13.0**	**13.0**

* Positions and Resources ongoing after 2020-21.

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

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

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

3. *Innovation:* Up to 5 percent of MHSA funds received for CSS and PEI may be used for innovative programs that develop, test and implement promising practices that have not yet demonstrated their effectiveness.

MHSA also required counties to spend a portion of their revenues on two additional components to build the infrastructure to support mental health programs. Since 2008-09, counties have the option of using a portion of their CSS funding in these areas or to build up a prudent reserve:

4. *Workforce Education and Training:* This component aims to train more people to remedy the shortage of qualified individuals who provide services to address severe mental illness. Counties may use funds to promote employment of mental health clients and their family members in the

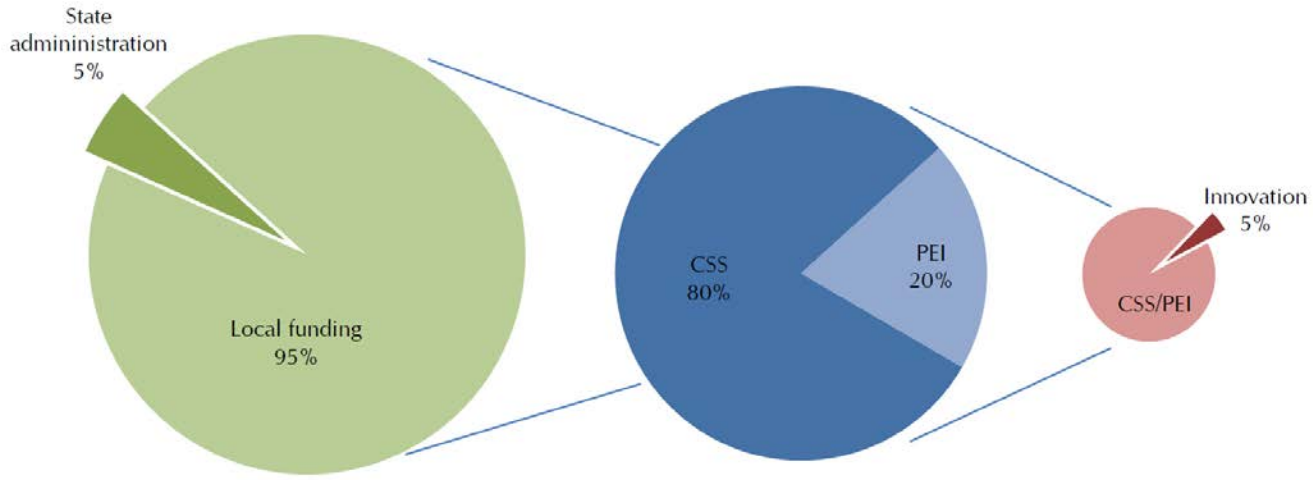
mental health system and increase the cultural competency of staff and workforce development programs.

5. *Capital Facilities and Technological Needs:* This component finances necessary capital and infrastructure to support implementation of other MHSA programs. It includes funding to improve or replace technology systems and other capital projects.

MHSA funds are allocated to counties by the State Controller 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. In its October 2018 report on funds subject to reversion as of July 1, 2017, DHCS identified a total of $391 million subject to reversion that was deemed reverted and reallocated to the expenditure components to which it was first allocated. Of this amount, $5.1 million was allocated for CSS, $128.2 million for PEI, $187.5 million for Innovation, $27 million for Workforce Education and Training, and $43.2 million for Capital Facilities and Technological Needs.

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 a 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 indicated that it agreed 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 would 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.

On March 22, 2019, DHCS released a notice of proposed rulemaking DHCS-16-009, promulgating fiscal regulations for the prospective oversight of MHSA funds subject to reversion after July 1, 2018. According to DHCS, the purpose of the regulations is to provide a clear framework for MHSA recipients to allocate, transfer, expend, and report the use of MHSA funds, and to establish rules and processes for reversion of funds. The regulations provide definitions of key fiscal terminology, address allocation and expenditure requirements of MHSA funds including investment gains, transfer of MHSA funds from the CSS account, funding and transfers from the prudent reserve, maintenance of records for such transactions, reversion of unspent MHSA funds, and an appeals process. The 45 day comment period for the regulations will expire in May 2019.

DHCS indicates its MHSUDS Information Notice 17-059, its pending 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. However, SB 192 (Beall), Chapter 328, Statutes of 2018, approved by the Governor in September 2018, sets the prudent reserve level at no more than 33 percent.

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 in 2019.

In response to Recommendation 7 (Establish process for comprehensive program reviews), the 2018 Budget Act included four staff to begin conducting onsite program reviews beginning September 2018.

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 Innovative project proposals, approvals, and evaluation results. The 2018 Budget Act included resources for MHSOAC 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 began meeting in March 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.

MHSOAC Fiscal Reporting Tool. According to MHSOAC, in 2015 the commission's Financial Oversight Committee requested staff to explore options for providing regular, descriptive information to the public about county MHSA expenditures, revenues, and unspent funds, and authorized staff to negotiate contracts to develop a series of web applications and tools to inventory and display key fiscal information. MHSOAC recently released its Fiscal Reporting Tool, which is based on county annual revenue and expenditure reports (ARER) submitted by the counties to DHCS and publicly reported. However, MHSOAC indicates DHCS has recalculated certain categories of funding certified by counties in ARERs in its estimate of funds subject to reversion, resulting in discrepancies between the fiscal reporting tool and DHCS fiscal reporting.

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.

DHCS Requests Resources to Manage its MHSA Responsibilities. DHCS requests 13 positions and Mental Health Services Fund expenditure authority of $1.9 million in 2019-20 and $1.8 million annually thereafter to provide oversight and monitoring of the use of Mental Health Services Act funds, in response to a series of audits by the California State Auditor and hearings by the Little Hoover Commission. Funding for these positions would be partially offset by termination of a technical assistance and training contract with the California Institute for Behavioral Health Solutions (CIBHS) funded at $4.1 million annually. According to DHCS, this funding is no longer necessary as counties may use local funding to contract with an entity for training and technical assistance to support local needs.

DHCS has responsibility for a range of fiscal and programmatic oversight activities of MHSA-funded programs, including developing and administering ARERs to identify county revenues and expenditures, implementation and triennial review of performance contracts with county mental health plans, referrals of critical performance issues from MHSOAC, and withholding funds and requirements for corrective action plans for county non-compliance with applicable laws and regulations. The requested resources would fund the following activities:

Fiscal Oversight – Three positions

- **One Health Program Specialist I** position, **one Associate Governmental Program Analyst**, and **one Information Technology Associate** would be responsible for reviewing ARERs to determine compliance with applicable laws and regulations, monitoring county program expenditures, providing technical assistance to counties in preparing ARERs, calculating reversion for each MHSA component, communicating with counties regarding reversion, and developing and maintaining databases and fiscal web pages for stakeholder transparency.

Program Oversight – Four positions

- **Two Health Program Specialist I** positions and **two Associate Governmental Program Analysts** would evaluate Three-Year Program and Expenditure Plan or Annual Updates with ARERs prior to each county site review, develop county findings reports with narrative summary of non-compliance findings from on-site reviews, determine if county correction plans are sufficient, identify and participate in performance improvement projects, and monitor ongoing quality improvement.

Policy Development – Five positions

- **One Staff Services Manager I** position, **two Health Program Specialist I** positions and **two Associate Governmental Program Analysts** would update existing fiscal, program, and evaluation policy for each of the five components of the MHSA, develop policies for new requirements or processes necessary due to changes in statute or regulation, or based on findings identified through program oversight reviews.

DHCS also requests conversion of limited-term resources equivalent to **one Staff Services Manager II** to permanent. This position would oversee and manage the MHSA fiscal and program oversight activities of the requested staff positions.

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 and MHSOAC to respond to the following:

1. DHCS: Please provide a brief overview of the request for positions and resources for MHSA Oversight and Policy Development.

2. DHCS: Please describe the activities performed by CIBHS under the training and technical assistance contract proposed for termination. What funding would DHCS expect counties to provide to contract with their own vendor for this purpose?

3. DHCS: Please provide a brief overview of the fiscal regulations for MHSA funding released on March 22, 2019. How will these regulations improve transparency and accountability for MHSA funds provided to counties?

4. MHSOAC: Please describe the fiscal reporting tool developed by the commission and the challenges posed by the recalculation of ARER amounts by DHCS.

Issue 2: Early Psychosis Research and Treatment

Budget Issue. DHCS requests General Fund expenditure authority of $25 million in 2019-20. If approved, these resources would allow DHCS to provide grants to county mental health plans, nonprofit organizations, behavioral health providers, or academic institutions to identify and support appropriate interventions for California youth experiencing signs of early psychosis.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$25,000,000	$-
Total Funding Request:	**$25,000,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

Background. According to the National Institute of Mental Health, psychosis describes a condition that affects the mind, where there has been some loss of contact with reality, or a psychotic episode. During a period of psychosis, a person's thoughts and perceptions are disturbed and the individual may have difficulty understanding what is real and what is not. Symptoms of psychosis may include delusions (false beliefs) and hallucinations (seeing or hearing things that others do not see or hear). Other symptoms include incoherent or nonsense speech, and behavior that is inappropriate for the situation. A person in a psychotic episode may also experience depression, anxiety, sleep problems, social withdrawal, lack of motivation, and difficulty functioning overall. Psychosis often begins when a person is in their late teens to mid-twenties. Three out of 100 people will experience psychosis at some time in their lives and about 100,000 adolescents and young adults nationwide experience their first episode of psychosis each year. According to the National Association of Mental Illness, several factors may contribute to psychosis, including genetics, trauma, substance use, physical illness or injury, or mental health conditions such as schizophrenia, schizoaffective disorder, bipolar disorder, or depression.

The average delay between the onset of symptoms and diagnosis and treatment of psychosis is 18.5 months. Clinical research suggests that early intervention at the first signs of psychosis results in better treatment outcomes. According to DHCS, there are emerging evidence-based strategies to identify, diagnose, and treat individuals with early signs of serious mental illness, including psychotic symptoms and behaviors. Some of these interventions include cognitive and behavioral psychotherapy, low doses of antipsychotic medications, family education and support, educational and vocational rehabilitation and coordinated case management.

DHCS requests one-time General Fund expenditure authority of $25 million in 2019-20 to provide grants to support projects that demonstrate innovative approaches to detect and intervene when young people have had, or are at risk of, psychosis. If approved, DHCS would seek competitive applications from entities, including but not limited to, county mental health plans, nonprofit organizations, behavioral health providers, or academic institutions to identify and support appropriate interventions for California youth experiencing the signs of early psychosis. The grants would not be allowed to supplant existing financial or resource commitments by a county or county mental health plan. Successful applicants may be required to provide a matching contribution to access larger grant awards over $1 million. The requested resources include up to $1 million for administrative resources for implementation of the program.

MHSOAC Early Psychosis Intervention Plus Program. AB 1315 (Mullin), Chapter 414, Statutes of 2017, established the Early Psychosis Intervention Plus (EPI Plus) Program at MHSOAC. The bill established an advisory committee to the commission to: 1) provide advice and guidance on approaches to early psychosis and mood disorder detection and intervention programs from an evidence-based perspective, 2) review and make recommendations on funding awards for early psychosis and mood disorder detection and intervention programs, 3) assist and advise on evaluation of the programs, 4) recommend a core set of standardized clinical and outcome measures programs would be required to collect, and 5) inform funded programs about opportunities to participate in clinical research studies. The bill established the Early Psychosis and Mood Disorder Detection and Intervention Fund to collect private or federal funding, but prohibited allocation of General Fund for this purpose. Once $500,000 is deposited in the fund, MHSOAC is authorized to develop a competitive grant program for counties to accomplish the following goals:

- Expanding the provision of high-quality, evidence based early psychosis and mood disorder detection and intervention services in the state.
- Improving access to effective services for transition-aged youth and young adults at high risk for, or experiencing, psychotic symptoms.
- Measuring more comprehensively and effectively, programmatic effectiveness and enrolled client outcomes of programs receiving awards.
- Improving client experience in accessing services and in working toward recovery and wellness.
- Increasing participation in school attendance, social interactions, personal bonding relationships, and active rehabilitation.
- Reducing unnecessary hospitalizations and inpatient days by using community-based services and improving access to timely assistance to early psychosis and mood disorder detection and intervention services.
- Expanding the use of innovative technologies for mental health information feedback, including technologies for treatment and symptom monitoring.
- Providing local communities with increased financial resources to leverage additional public and private funding sources.

The funding requires counties to provide a contribution of local funds and may not supplant existing county funding for these purposes. MHSOAC is also authorized to set aside up to 10 percent of the funding for clinical research studies.

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 and MHSOAC to respond to the following:

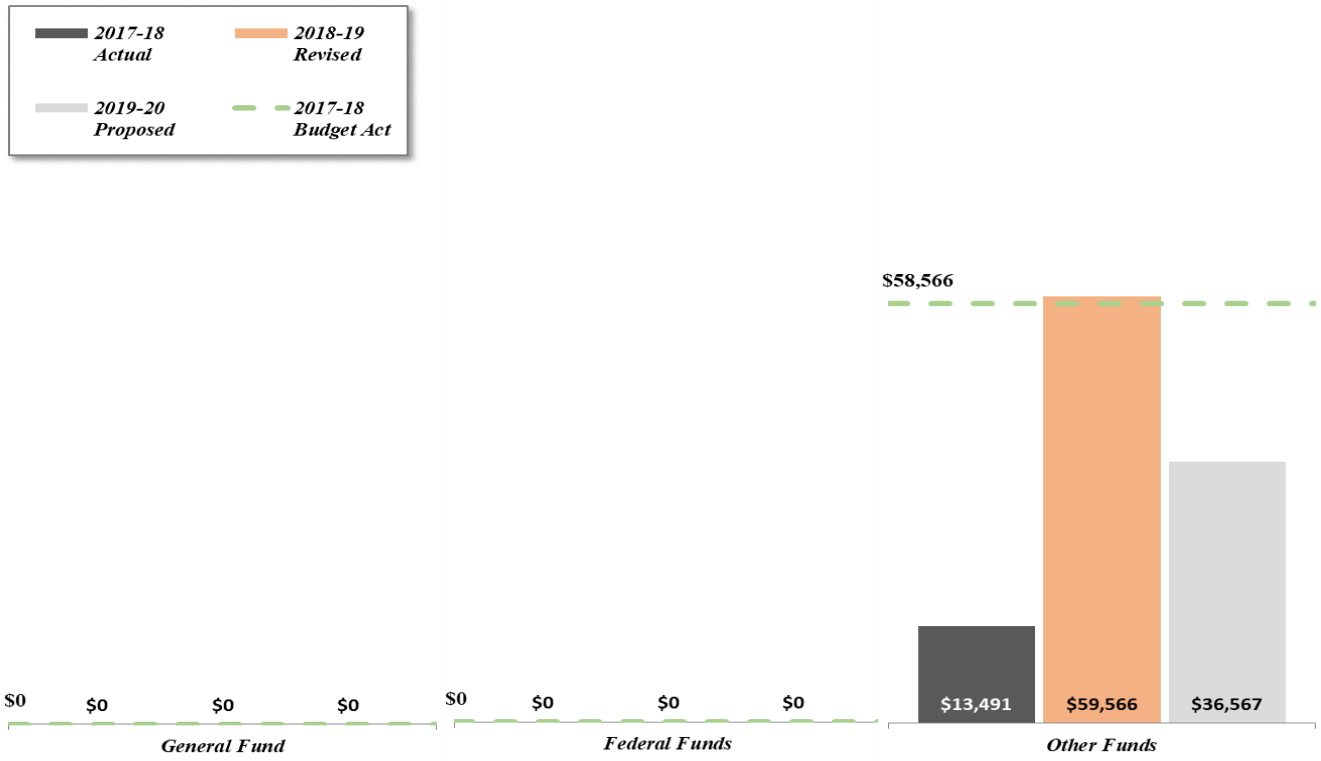
1. DHCS: Please provide a brief overview of this proposal.

2. MHSOAC: Please provide a status update on the EPI Plus program, including establishment of an advisory committee and implementation of a selection process for grant awards upon receipt of sufficient funding.

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	***2018-19 Budget Act***	***2018-19 Revised***	***2019-20 Proposed***
General Fund	$0	$0	$0
Federal Funds	$0	$0	$0
Other Funds	$58,566,000	$59,566,000	$69,896,000
Total Department Funding:	**$58,566,000**	**$59,566,000**	**$69,896,000**
Total Authorized Positions:	**26.6**	**26.6**	**27.6**
Other Funds Detail:			
Reimbursements (0995)	*$22,000,000*	*$-*	*$-*
Mental Health Services Fund (3085)	*$36,566,000*	*$59,566,000*	*$36,567,000*

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 Tempore of the Senate
- Assemblymember selected by the Speaker of the Assembly

12 members appointed by the Governor:

- Two persons with a severe mental illness
- A family member of an adult or senior with a severe mental illness
- A family member of a child who has or has had a severe mental illness
- A physician specializing in alcohol and drug treatment
- A mental health professional
- A county sheriff
- A superintendent of a school district
- A representative of a labor organization
- A representative of an employer with less than 500 employees
- A representative of an employer with more than 500 employees
- A representative of a health care services plan or insurer

In making appointments, the Governor shall seek individuals who have had personal or family experience with mental illness.

MHSOAC's responsibilities are as follows:

- **Review of MHSA Programs -** The MHSOAC oversees the MHSA funded programs and services through the counties' annual updates. Counties submit updates every year to reflect the status of programs and services in their counties.

- **Evaluations -** The MHSOAC has a statutory mandate to evaluate how MHSA funding has been used, what outcomes have resulted, and how to improve services and programs.

- **Research -** The MHSOAC supports collaborative research efforts to develop and implement improved tools and methods for program improvement and evaluation statewide.

- **Triage -** County triage personnel provide linkages and services to what may be the first mental health contact for someone in crisis. Crisis services are provided at shelters, jails, clinics and hospital emergency rooms to help link a person to appropriate services.

- **Stakeholder Contracts -** Statewide stakeholder advocacy contracts are focused on supporting the mental health needs of consumers, children and transition aged youth, veterans, racial and ethnic minority communities and their families through education, advocacy, and outreach efforts.

- **Commission Projects -** The MHSOAC selects special project topics and under the direction of a subcommittee of commissioners, conducts research through discussion, review of academic literature, and interviews with those closely affected by the topic to formulate recommendations for administrative or legislative changes.

- **Technical Assistance & Training -** The MHSOAC offers technical assistance and training to counties, providers, clients and family members, and other stakeholders to support the goals of the MHSA and specific responsibilities of the commission, such as review of counties' MHSA-funded Innovative Program plans.

Subcommittee Staff Comment and Recommendation—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.

Issue 2: Transition Staff from Temporary to Permanent

Budget Issue. MHSOAC requests one position funded by existing expenditure authority from the Mental Health Services Fund. If approved, this position authority would transition a temporary help position to permanent status.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3085 – Mental Health Services Fund	$-	$-
Total Funding Request:	**$-**	**$-**
Total Requested Positions:	**1.0**	**1.0**

* Position ongoing after 2020-21.

Background. According to the Department of Finance, Section 31.00 of the annual Budget Act provides departments the authority to administratively establish and reclassify positions within an existing appropriation, subject to certain criteria. In particular, administratively establishing positions is generally reserved for circumstances that mandate additional, previously unanticipated current year workload. In July 2018, the Department of Finance released Budget Letter 18-16 to provide guidance to departments regarding establishment of position authority for positions funded through the temporary help blanket.

The temporary help blanket provides staffing flexibility to meet operational needs and allows a department to temporarily hire above its total authorized positions. However, frequently workload managed by positions supported by the temporary help blanket initially believed to be temporary becomes permanent. Budget Letter 18-16 instructed departments during the 2019-20 budget development process to work with Department of Finance to analyze the use of blanket positions for permanent workload and submit a net-zero BCP to establish any necessary authorized positions. In addition to providing more transparency, converting blanket positions to authorized positions allows departments to receive accurate funding for employee compensation and retirement adjustments, which is not provided for blanket positions.

According to MHSOAC, its temporary help blanket supports **one Staff Services Analyst** position that provides administrative support to commission members and staff for commission meetings. This employee's current duties include meeting logistics, meeting material preparation, committee meeting support, travel coordination, training coordination, and front desk reception. MHSOAC indicates these duties are ongoing and is requesting to transition this position from temporary to permanent status. MHSOAC would redirect $78,000 from its existing operating expenses and equipment budget to fund the establishment of the requested position.

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

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

1. Please provide a brief overview of this proposal.

Issue 3: Investment in Mental Health Wellness Act Triage Grant Funding

Background. The Investment in Mental Health Wellness Act of 2013 authorized Mental Health Service Fund expenditure authority of $32 million annually to add 600 triage personnel in select rural, urban, and suburban regions. The 2016 Budget Act included an additional $3 million to provide a complete continuum of crisis intervention services and supports for children age 21 and under and their families and caregivers. Triage personnel provide intensive case management and linkage to services for individuals with mental health disorders at various points of access. Targeted case management services may be provided face to face, by telephone, or by telehealth with the individual in need of assistance or his or her significant support person, and may be provided anywhere in the community. These service activities may include, but are not limited to: 1) communication, coordination, and referral; 2) monitoring service delivery to ensure the individual accesses and receives services; 3) monitoring the individual's progress; 4) providing placement service assistance and service plan development.

Between 2013-14 and 2017-18, counties received the following grant funding for triage personnel:

County	Funding	County	Funding
Alameda	$2,666,797	Orange	$10,250,000
Butte	$1,075,070	Placer	$2,509,346
Calaveras	$262,686	Riverside	$7,441,142
Fresno	$3,073,100	Sacramento	$4,474,908
Lake	$184,794	San Bernardino	$8,113,498
Los Angeles	$31,177,000	San Francisco	$14,365,009
Madera	$1,360,596	Santa Barbara	$8,348,529
Marin	$1,099,922	Sonoma	$3,044,363
Mariposa	$699,428	Trinity	$497,713
Merced	$3,003,070	Tuolumne	$478,503
Napa	$1,323,635	Ventura	$7,573,671
Nevada	$2,477,628	Yolo	$1,728,234

The first round of grants, funded in 2014, resulted in more than 70,000 instances of individuals utilizing services provided through the grants. The program resulted in an increase in access and linkage to services and resources, utilization of peers in crisis intervention, a reduction in psychiatric hospitalizations and in stigma associated with mental illness, and improved consumer well-being and coordination of services.

The 2018 Budget Act reduced the Mental Health Service Fund expenditure authority by $12 million for an annual allocation of $20 million. In 2018, MHSOAC also requested to reappropriate unspent funding from the first round of triage grants, but the request was not included in the 2018 Budget Act. According to MHSOAC, the combined reduction in ongoing funding has resulted in a 29 percent reduction in available funding for triage grants to counties. MHSOAC reports the reduction led counties to scale back programs that were granted under a second round of funding prior to the reduction. MHSOAC worked with grantees to ensure the programs were in alignment with the requirements of the

triage program. However, the reduction in program funding ultimately led to reductions in schools served by triage personnel, reductions in personnel hours for crisis intervention and case management, and reductions in mobile treatment personnel.

Request for Restoration of Triage Personnel Funding. MHSOAC requests additional expenditure authority from the Mental Health Services Fund of $15 million to restore the funding reduction included in the 2018 Budget Act and dedicate these funds and an additional $3 million for partnerships between local educational agencies and county mental health plans.

SB 582 (Beall), currently pending in the Legislature, would require MHSOAC, when making grant funds available on and after July 1, 2021, to allocate at least 50 percent of those funds to local educational agency and county mental health plan partnerships. The bill also would provide annual expenditure authority from the Mental Health Services Fund of $15 million for establishment of these partnerships.

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 the triage grant program, the projects funded to date, and adjustments required by the reduction in funding in the 2018 Budget Act.

2. Please present the proposed restoration of triage grant funding, including the intended use of these restored funds.

0977 CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY

Issue 1: Overview and Reappropriation of Investment in Mental Health Wellness Funding

Background. The California Health Facilities Financing Authority (CHFFA) was established in 1979 to help nonprofit and public health facilities reduce their cost of capital and promote health care improvement and cost containment objectives. CHFFA achieves these goals by providing cost-effective tax-exempt bond, low-cost loan, and direct grant programs. The Authority is governed by nine members, including the State Treasurer, the State Controller, the Director of Finance, two members appointed by the Senate Rules Committee, two members appointed by the Speaker of the Assembly, and two members appointed by the Governor subject to confirmation by the Senate. Of the members appointed by the Senate, one member must be a licensed physician and surgeon, and one must be a current or former health facility executive. Of the members appointed by the Assembly, one member must be trained in investment or finance and one member represents the general public. The members appointed by the Governor also represent the general public. Appointed members serve for four years.

California Health Facilities Financing Authority Three-Year Funding Summary			
Fund Source	**2017-18**	**2018-19**	**2019-20**
	Actual	***Revised***	***Proposed***
0001 – General Fund	$1,000	$67,499,000	$-
0904 – CHFFA Fund	$14,480,000	$20,897,000	$9,090,000
0995 – Reimbursements	$-	$2,800,000	$-
3085 – Mental Health Services Fund	$4,253,000	$160,453,000	$144,000,000
6046 – Children's Hospital Fund	$526,000	$40,000,000	$40,362,000
6079 – Children's Hosp. Bond Act Fund	$30,689,000	$100,775,000	$75,775,000
6084 – No Place Like Home Fund	$151,000	$149,000	$-
8073 – CHAMP Acct, CHFFA Fund	$-	$5,600,000	$5,600,000
Total Department Funding:	**$50,100,000**	**$398,173,000**	**$274,827,000**
Total Authorized Positions:	**16.4**	**17.5**	**17.5**

CHFFA was created to be the state's vehicle for providing financial assistance to public and non-profit health care providers in California through loans funded by the issuance of tax-exempt bonds. CHFFA has financed a wide range of providers and programs throughout the state and administers the following six major programs: 1) Children's Hospital Program, 2) Tax-Exempt Bond Program, 3) Clinic Grant Program, 4) Healthcare Expansion Loan Program (HELP II), 5) California Health Access Model Program (CHAMP), and 6) Investment in Mental Health Wellness Act of 2013.

Children's Hospital Program. In 2004, California voters approved Proposition 61, which authorized the issuance of $750 million in general obligation bonds and established the Children's Hospital Program. In 2008, Proposition 3 authorized the issuance of an additional $980 million in general obligation bonds. The purpose of both programs is to improve the health and welfare of California's critically ill children by providing a stable source of funds for capital improvement projects for children's hospitals. Eight private, non-profit children's hospitals are each eligible for $172 million and

five University of California Children's Hospitals are eligible for $69.2 million each through Proposition 61 and Proposition 3 combined. As of December 2018, the following grants have been approved under Proposition 61 and Proposition 3:

- Children's Hospital and Research Center Oakland
  - Prop. 61: $73.9 million (six completed projects)
  - Prop. 3: $97.4 million (four completed projects)
- Valley Children's Health Care (formerly Children's Hospital Central California)
  - Prop. 61: $73.9 million (six completed projects)
  - Prop. 3: $70 million (seven completed projects; one project in progress; $27.4 million remaining to be disbursed)
- Children's Hospital Los Angeles
  - Prop. 61: $72.2 million (one completed project)
  - Prop. 3: $97.4 million (one completed project)
- Children's Hospital Orange County
  - Prop. 61: $73.9 million (five completed projects)
  - Prop. 3: $97.4 million (one completed project)
- Earl and Loraine Miller Children's Hospital Long Beach
  - Prop. 61: $73.9 million (one completed project)
  - Prop. 3: $34.7 million (one completed project; two projects in progress; $62.7 million remaining to be disbursed)
- Loma Linda University Children's Hospital
  - Prop. 61: $26.1 million (two completed projects; one project in progress; $47.9 million remaining to be disbursed)
  - Prop. 3: $- (one project in progress; $97.4 million remaining to be disbursed)
- Lucile Salter Packard Children's Hospital at Stanford
  - Prop. 61: $73.6 million (one completed project)
  - Prop. 3: $97.4 million (one completed project)
- Rady Children's Hospital San Diego
  - Prop. 61: $73.9 million (three completed projects)
  - Prop. 3: $88.9 million (seven completed projects; one project in progress; $8.5 million remaining to be disbursed)
- Mattel Children's Hospital at UCLA
  - Prop. 61: $29.8 million (one completed project)
  - Prop. 3: $24.9 million (one completed project; one project in progress; $14.1 million remaining to be disbursed)
- UC Davis Children's Hospital
  - Prop. 61: $29.8 million (three completed projects)
  - Prop. 3: $18.7 million (two completed projects; one project in progress; $20.3 million remaining to be disbursed)
- University Children's Hospital at UC Irvine
  - Prop. 61: $29.8 million (one completed project)
  - Prop. 3: $- (two projects in progress; $39 million remaining to be disbursed)
- UC San Diego Children's Hospital
  - Prop. 61: $29.8 million (one completed project)

  - Prop. 3: $39 million (one project in progress)
- UC San Francisco Children's Hospital
  - Prop. 61: $29.8 million (one completed project)
  - Prop. 3: $39 million (one completed project)

According to CHFFA, after each children's hospital received its maximum grant award, there was $8.2 million remaining due to accrued interest and lower than expected administration costs. CHFFA developed regulations allowing a third and fourth round of funding to disburse the remaining funds. In the third round of funding, four University of California Children's Hospitals each received an additional $128,121, while eight non-profit children's hospitals each received an additional $944,551.

New Children's Hospital Bond Act Approved in 2018. In November 2018, voters approved Proposition 4, the Children's Hospital Bond Act of 2018, which authorizes $1.5 billion in general obligation bonds to fund a new round of capital improvements at California children's hospitals. Eight non-profit children's hospitals are eligible for up to $135 million each, five University of California Children's Hospitals are eligible for $54 million each, and an estimated 160 hospitals that provide services in the California Children's Services program are eligible for a total of $150 million, or $8 to $15 million each. CHFFA expects the deadline for first round funding applications for the new program will be in March or April 2020.

Tax-Exempt Bond Program. CHFFA established the Tax-Exempt Bond Program to provide health facilities with access to tax-exempt, fixed rate financing for their equipment purchases. A borrower under the program may fund qualifying equipment purchases of $500,000 or more. The maturity of the loan must be related to the useful life of the equipment to be financed. Notes issued through the program are collateralized by the equipment that is purchased. Funds may be used to purchase or reimburse all types of qualifying equipment by an eligible health facility, including but not limited to medical and diagnostic equipment, computers, and telecommunications equipment. Funds may also be used to finance minor equipment installation costs. To qualify for funding, the proposed project must be a health facility, operated by a private nonprofit corporation or association, city, city and county, county, or hospital district.

Clinic Grant Programs. AB 2875 (Cedillo), Chapter 99, Statutes of 2000, established the Cedillo-Alarcon Community Clinic Investment Act of 2000 and allocated $50 million to CHFFA for the purpose of awarding grants to eligible primary care clinics for capital outlay projects. In 2004, as part of the Anthem-Well Point merger, $35 million dollars was allocated to CHFFA for the purpose of awarding grants to eligible health care facilities providing service to underserved communities throughout California. To qualify for funding, the proposed project must be a health facility, operated by a private, non-profit corporation or association, city, city and county, county, or hospital district. Approximately 150 non-profit community clinics received grants for infrastructure improvement.

Healthcare Expansion Loan Program II (HELP II). CHFFA established HELP II in 1995 to assist small and rural health facilities in obtaining financing for their capital needs. Health facilities eligible for financing under HELP II must meet one of the following conditions:

- Receive no more than $30 million in annual gross revenues.

- Located in a rural Medical Service Study Area as defined by the California Workforce Policy Commission.
- A district hospital.

Eligible facilities must be non-profit or publicly operated, have been in existence for at least three years performing the same types of services, and demonstrate evidence of fiscal soundness and ability to meet the terms of the loan. Eligible health facilities may receive loans under the following general terms:

- Two percent fixed interest rate for property acquisition, construction, renovation (maximum 20 year repayment period).
- Two percent fixed interest rate for equipment (maximum five year repayment period).
- Three percent fixed interest for loan refinancing (maximum 15 year repayment period).
- Loan amounts between $25,000 and $1,500,000.

Clinic Lifeline Grant Program. The 2017 Budget Act established the Clinic Lifeline Grant Program, which authorized the expenditure of $20 million of reserves in the HELP II program to assist small and rural health facilities, including community based clinics, that may be adversely affected financially by a reduction or elimination of federal government assistance and that have little to no access to working capital. Clinics are eligible for up to $250,000 each for core operating expenses and must either have less than $10 million in annual operating expenses, be located in a rural medical service study area, or be operated by a district hospital or health care district. In June 2018, 42 clinics received $8.3 million during the first round of funding awards. Applications for funding are accepted on a rolling basis. According to CHFFA, there is approximately $11.2 million remaining to be disbursed under the Lifeline Grant Program.

California Health Access Model Program (CHAMP). AB 1467 (Committee on Budget), Chapter 23, Statutes of 2012, authorized CHAMP, a one-time grant program to support innovative methods of health care service delivery and improve health outcomes for vulnerable populations by bringing services to individuals where they live or congregate. These health care services include medical, mental health, or dental services for the diagnosis, care, prevention, and treatment of illness or individuals with physical, mental, or developmental disabilities. In 2014, CHAMP approved a demonstration project grant for the San Francisco Health Plan (SFHP) for up to $1.5 million. SFHP's proposed project aims to expand and evaluate an existing pilot program for high-risk, high-cost patients to improve their health outcomes and experience of care, as well as to lower costs. CHFFA is reviewing options for additional CHAMP funding rounds. If demonstration projects that receive initial grants are successful at developing new methods of delivering high-quality, cost-effective health care services in community settings that result in: 1) increased access to quality health care and preventive services, 2) improved health care outcomes for vulnerable populations or communities, or both, CHFFA is authorized to implement a second grant program that awards recipients up to an additional $5 million.

Investment in Mental Health Wellness Grant Program. SB 82 (Committee on Budget and Fiscal Review), Chapter 34, Statutes of 2013, provided $142.5 million in one-time General Fund, $4 million in ongoing Mental Health Services Act (MHSA) funding, and $2.8 million in federal matching funds (reimbursements) to provide grants for community-based mental health crisis support. Known as the Investment in Mental Health Wellness Act of 2013, SB 82 authorized CHFFA to disburse funds to California counties or their nonprofit or public agency designees to develop mental health crisis support

programs. The one-time General Fund grants support capital projects to increase capacity for crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and peer respite. The MHSA and federal funds grants support personnel costs associated with operation of mobile crisis support teams. The grants support capital improvement, expansion and limited start-up costs.

CHFFA conducted six funding rounds for competitive grant awards, approving a total of 56 grants for 79 projects (69 capital and 10 personnel) in 41 counties. Approximately $136.5 million of capital funding (General Fund) and $4 million of MHSA funding for mobile crisis support team personnel has been encumbered. As of September 2018, $62.4 million of total funding has been disbursed. Once projects are completed, these grants will add the following mental health crisis support resources:

- 110 mobile crisis vehicles (or equivalent IT equipment)
  - Status (Sept 2018): 110 purchased

- 57.25 mobile crisis personnel
  - Status (Sept 2018): 57.25 individuals hired

- 782 crisis stabilization and crisis residential treatment beds
  - Status (Sept 2018):
    - 152 crisis stabilization beds added; additional 422 have a site secured, are under construction, or awaiting licensing and certification
    - 110 crisis residential treatment beds added; additional 91 have a site secured, are under construction or awaiting licensing and certification

- 12 peer respite beds
  - Status (Sept 2018): eight added; six in the planning stage

CHFFA Proposes Reappropriation to Align Expenditure Authority. The 2016 Budget Act authorized $30 million for children's mental health crisis services, which included $16 million General Fund and $14 million Mental Health Service Fund. The 2017 Budget Act reverted the $16 million General Fund authority and replaced it with $16.4 million from the Mental Health Services Fund. However, the first allocation of $14 million Mental Health Service Fund was made available for encumbrance or expenditure until June 30, 2019, the second allocation of $16.4 million Mental Health Service Fund was made available until June 30, 2020, and the remaining General Fund resources from previous allocations were made available for liquidation of encumbrances until December 31, 2021. CHFFA proposes reappropriation budget bill language to align the encumbrance and expenditure periods for these funds until June 30, 2024, to improve operation of the children's crisis funding under the Investment in Mental Health Wellness program. The language is as follows:

0977-492–Reappropriation, California Health Facilities Financing Authority. Notwithstanding any other provision of law, the balances of the appropriations provided in the following citations are reappropriated to fund crisis residential treatment, crisis stabilization, mobile crisis support teams, and/or family respite care approved by the California Health Facilities Financing Authority and shall be available for encumbrance or expenditure until June 30, 2024:

0001–General Fund

(1) Item 0977-101-0001, Budget Act of 2013 (Chs. 20 and 354, Stats. 2013), as reappropriated by Item 0977-490, Budget Act of 2016 (Ch. 23, Stats. 2016).
(1) 50–Mental Health Wellness Grants

3085–Mental Health Services Fund

(1) $10,815,000 in Item 0977-101-3085, Budget Act of 2016 (Ch. 23, Stats. 2016) appropriated in Program 0890–Mental Health Wellness Grants.

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 CHFFA to respond to the following:

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

2. Please provide a status update on implementation of the Children's Hospital Bond Act of 2018 (Proposition 4).

3. Please provide a status update on implementation and awards for the Clinic Lifeline Grant Program.

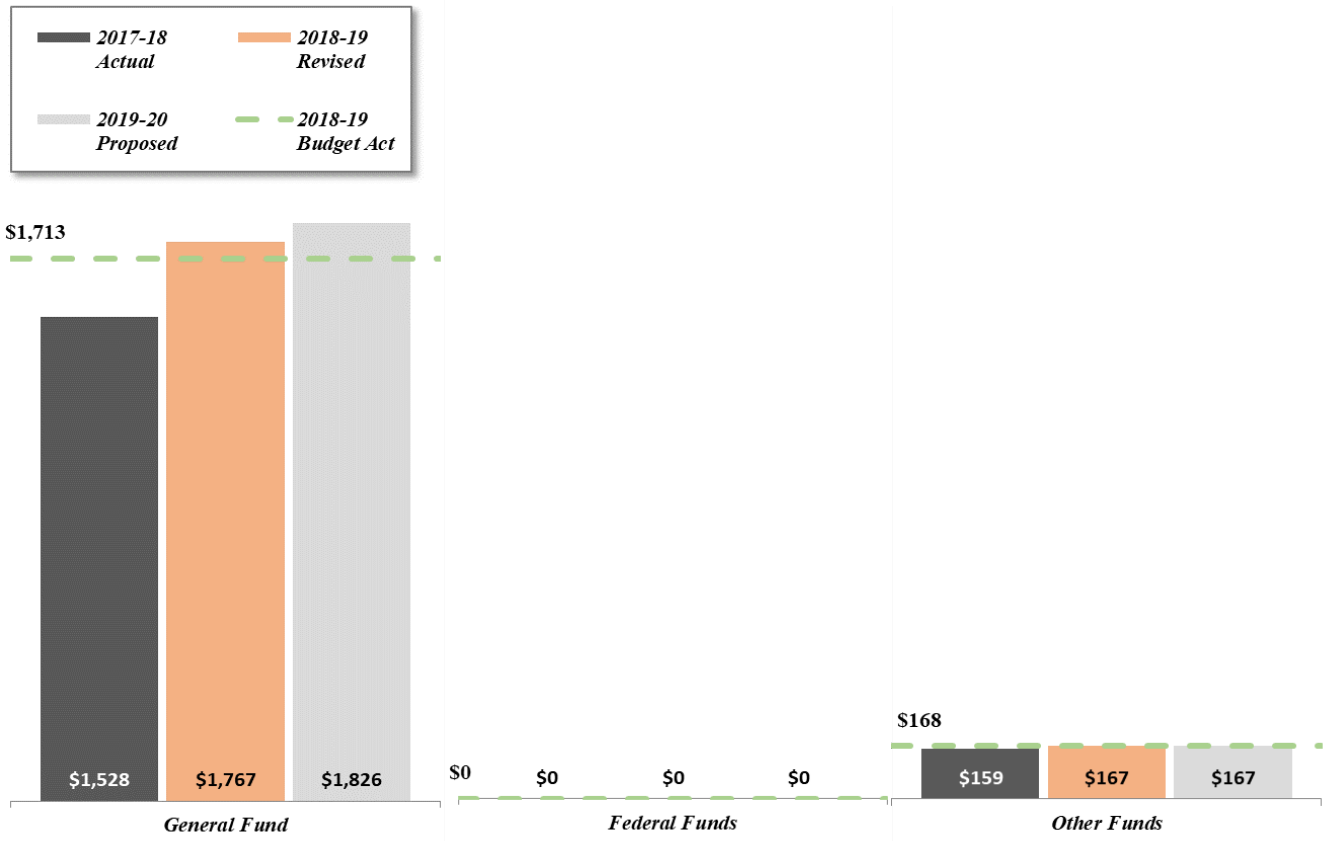
4. Please provide a status update on implementation of the Investment in Mental Health Wellness Grant Program.

5. Please present CHFFA's proposed reappropriation language for the Investment in Mental Health Wellness Grant Program.

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	***2018-19 Budget Act***	***2018-19 Revised***	***2019-20 Proposed***
General Fund	$1,713,168,000	$1,766,643,000	$1,825,789,000
Federal Funds	$0	$0	$0
Other Funds	$167,508,000	$167,499,000	$167,346,000
Total Department Funding:	**$1,880,676,000**	**$1,934,142,000**	**$1,993,135,000**
Total Authorized Positions:	**10088.7**	**10088.7**	**11006.4**
Other Funds Detail:			
CA State Lottery Education Fund (0814)	*$32,000*	*$23,000*	*$23,000*
Reimbursements (0995)	*$167,476,000*	*$167,476,000*	*$167,323,000*

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 88.6 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.

	2018-19	2019-20
Population by Hospital		
Atascadero	1,093	1,106
Coalinga	1,403	1,403
Metropolitan	906	1,046
Napa	1,278	1,278
Patton	1,484	1,494
Population Total	**6,164**	**6,327**
Population by Commitment Type		
Incomptent to Stand Trial (IST)	1,465	1,613
Not Guilty by Reason of Insanity (NGI)	1,393	1,399
Mentally Disordered Offender (MDO)	1,421	1,427
Sexually Violent Predator (SVP)	953	953
Lanterman-Petris-Short Civil Commitments (LPS)	700	703
Coleman Referrals	230	230
Dept. of Juvenile Justice (DJJ)	2	2
Jail-Based Competency Treatment (JBCT) Programs		
Kern Admission, Evaluation, and Stabilization (AES) Center	60	60
Riverside JBCT	22	22
Sacramento JBCT (Male and Female)	42	42
San Bernardino JBCT	123	143
San Diego JBCT	28	28
Sonoma JBCT	11	11
Stansislaus JBCT	11	11
Monterey JBCT	15	15
San Joaquin JBCT	10	10
Solano JBCT	12	12
Mendocino JBCT	TBD	TBD
Mariposa JBCT	TBD	TBD
Butte JBCT	5	5
Southern CA County A JBCT	5	5
Central CA County B JBCT	0	5
Northern CA County C JBCT	0	6
Northern CA County D JBCT	0	48
Southern CA County E JBCT	0	10
Total JBCT Programs	**344**	**433**

Figure 1: State Hospital Population by Hospital, Commitment Type and JBCT Programs
Source: *2019-20 Governor's Budget Proposals and Estimates, Department of State Hospitals, January 2019*

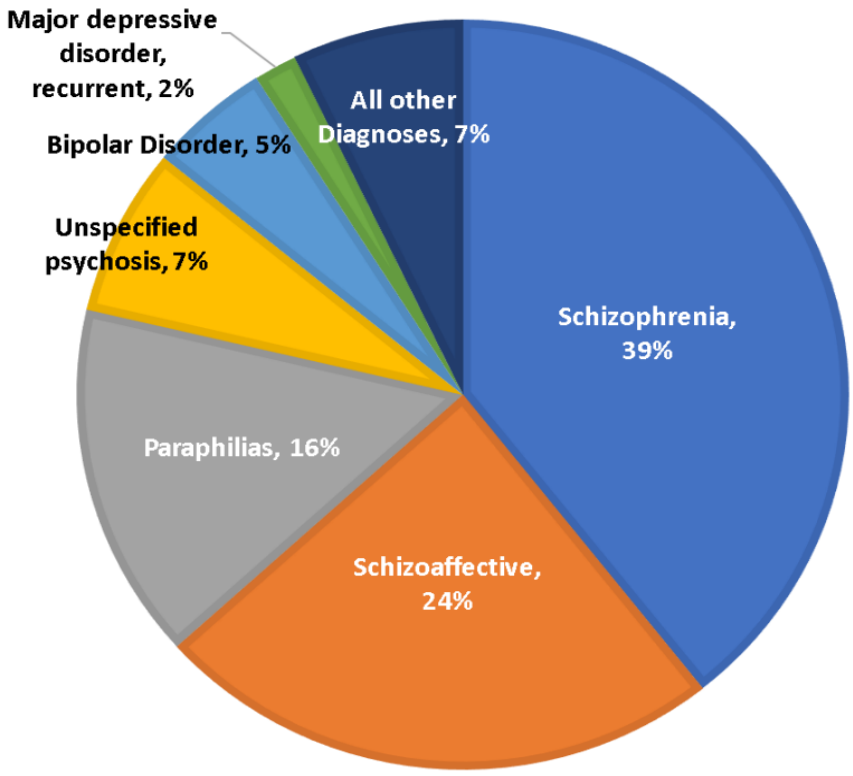


Figure 2: State Hospital Population By Major Diagnosis
Source: *2019-20 Governor's Budget Proposals and Estimates, Department of State Hospitals, January 2019*

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 an operational bed capacity of 1,184.

- **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 an operational bed capacity of 1,286.

- **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 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 an operational bed capacity of 1,255.

- **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 and has 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: State Hospitals Program Updates

Budget Issue. DSH requests resources to support the following program updates in its Governor's Budget Estimate.

Program Update: Metropolitan State Hospital Bed Expansion. DSH requests 119.3 positions and General Fund expenditure authority of $18.6 million in 2019-20 and 130 positions and General Fund expenditure authority of $20.1 million in 2020-21 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.

The 2017 Budget Act included 22.2 positions in 2017-18, and 38.5 positions and $12.4 million in 2018-19 to prepare for the expansion by relocating LPS patients and hiring hospital police officers. The 2018 Budget Act included a reduction of 10.1 positions and savings of $1.1 million in 2017-18 due to delays in activations. The 2018 Budget Act also included 162.8 positions and $24.8 million in 2018-19 and 342.2 positions and $50.6 million in 2019-20 for patient movement and activation of four new forensic units. The current budget request activates and provides staff for approximately 236 forensic beds between March and November 2019 to treat IST patients.

Program Update: Jail-Based Competency Treatment (JBCT) Programs. DSH reports net General Fund savings of $253,000 in 2018-19 composed of one-time cost savings of $1.9 million at San Bernardino and San Joaquin JBCT programs, offset by $1.6 million in increased costs at Sacramento, Sonoma, Mariposa, Solano, Mendocino, and Butte JBCT programs. DSH requests General Fund expenditure authority of $1.1 million in 2019-20, and $1.7 million in 2020-21 and annually thereafter to activate jail-based competency treatment 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. DSH expects these programs to increase bed capacity by 254 in 2018-19 and 274 in 2019-20.

DSH also requests General Fund expenditure authority of $191,000 in 2018-19, $11 million in 2019-20, and $11.4 million in 2020-21 and annually thereafter for the proposed activation of new JBCT programs. DSH proposes: 1) an April 2019 activation of a five-bed JBCT program in a Southern California county; 2) a July 2019 activation of a five-bed JBCT program in a Central California county, a six-bed JBCT program in a Northern California county, and a 48-bed JBCT program in a Northern California county; and 3) an October 2019 activation of a 10-bed JBCT program in a Southern California County. According to DSH, the cost estimate is based on an expected per diem rate of $420 per patient.

DSH is also requesting General Fund expenditure authority of $259,000 annually to support patients' rights advocates. Existing law requires patients' rights advocates to provide advocacy services for, and conduct investigations of alleged or suspected abuse and neglect of, including deaths of, persons with

mental disabilities residing in state hospitals. According to DSH, these requirements include patients in JBCT programs. If approved, these resources would allow for 6.5 patients' rights advocates based on a 60 patient caseload for each advocate.

Program Update: Patient Driven Operating Expenses and Equipment. In a 2015 report, the Legislative Analyst's Office made recommendations for improvement in the DSH budgeting methodology, including the establishment of a standardized per patient operating expenses and equipment cost estimate and an annual budget adjustment based on patient census. According to DSH, the average operating cost per patient is $19,534 across all five state hospitals, which represents an increase of 18 percent over the last six years. This increase is primarily driven by the costs of pharmaceuticals and outside hospitalization.

Over the past five years, DSH reports its patient population has increased by 547 beds, including expansions of 236 secured beds at Metropolitan State Hospital. However, DSH did not budget for operating expenses and equipment for much of these new beds. The 2018 Budget Act included $3.7 million for the operating expenses and equipment for the 236 secured beds at Metropolitan. Due to delays in unit activations, DSH reports 140 of those beds will not be activated as expected, resulting in $2.2 million General Fund savings in 2018-19.

DSH requests General Fund expenditure authority of $10.5 million annually to support the full cost of operating expenses and equipment for the 547 beds activated since 2012-13 in the five state hospitals.

Program Update: Hospital Police Officer Academy. The DSH Office of Protective Services (OPS) provides safety and security to patients, staff, and the community through competent, professional law enforcement services, while facilitating compassionate treatment of patients. OPS is supported by approximately 657 Hospital Police Officers (HPOs) across all five state hospitals. New HPO cadets are required to attend the DSH Police Academy, a 14 week program to ensure proper training on requirements and standards of the HPO classification.

According to DSH, the Hospital Police Academy historically ran two sessions annually of 32 cadets each. The 2017 Budget Act included $7.8 million in 2017-18 and $12.4 million and three limited-term positions in 2018-19 to expand to three academies of 50 cadets each. The academy expansion was necessary to accommodate the need for additional HPOs for the new secured bed space at Metropolitan State Hospital.

DSH requests conversion of three limited-term positions to permanent and General Fund expenditure authority of $5.8 million annually to continue the specialized expanded academy. DSH reports it has 98.7 HPO vacancies as of September 2018, primarily due to an academy failure rate of 8.2 percent, attrition, and a high proportion of law enforcement staff eligible for retirement.

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 an independent patients' 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 began in September 2018 and was completed February 2019, while construction for the second unit was expected to begin February 2019 and be completed June 2019.

The 2018 Budget Act included reversion of General Fund savings of $4.9 million General Fund in 2017-18 and $4.6 million in 2018-19 related to construction delays of the ETP units. For 2019-20, the 2018 Budget Act included 60.3 positions and General Fund expenditure authority of $8.3 million annually thereafter to fund an additional ETP unit at Atascadero, as well as one unit at Patton. According to DSH, construction for the third unit at Atascadero is expected to begin June 2019 and be completed in September 2019, while construction for the unit at Patton is expected to begin September 2019 and be completed in January 2020.

DSH expects General Fund savings in 2019-20 of $1.8 million due to a five month delay for the ETP unit at Patton. The expected construction timelines are as follows:

Units/Hospital	Construction Initiated	Construction Completed
DSH-Atascadero Unit 1	September 24, 2018	February 11, 2019
DSH-Atascadero Unit 2	February 11, 2019	June 3, 2019
DSH-Atascadero Unit 3	June 3, 2019	September 23, 2019
DSH-Patton Unit 1	September 2, 2019	January 27, 2020

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. In 2017-18, DSH had a budgeted LPS capacity of 628. As of July 2018, DSH reported a total LPS census of 690. The 2018 Budget Act included a $20.1 million adjustment in reimbursement authority to account for actual expenditures for LPS patients.

DSH requests additional reimbursement expenditure authority of $606,000 in 2019-20 and annually thereafter. This additional authority would allow DSH to have sufficient authority to accept the expected LPS caseload from county commitments. The amount of this additional authority was calculated based on 2018-19 projected expenditures of $157.4 million, which is $606,000 less than its 2018-19 authority of $156.7 million.

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.

DSH requests General Fund expenditure authority of $1 million in 2019-20 and annually thereafter to fund its contracted CONREP caseload of 666 clients. Due to rising housing costs, DSH was required to reduce its CONREP caseload to 621 clients to remain within its budgeted authority. If approved, these additional resources will allow DSH to cover the cost increases for each of the housing types in the program.

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 there are currently 14 patients residing in a house and two in a motel throughout California within the county of commitment. DSH has established two rate structures for CONREP-SVPs: 1) $310,000 per SVP where a permanent residence has been established, and 2) $653,000 per CONREP-SVP when ordered as a transient release.

DSH requests General Fund expenditure authority of $768,000 in 2018-19 and $2.1 million annually thereafter. If approved, these resources would support an expected caseload increase of four SVPs in 2018-19, including two transient releases, for a total of 21 SVPs conditionally released to the community by June 2019, and an additional two SVPs released by June 2020 for a total caseload of 23.

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 DSH to respond to the following:

1. Please provide a brief overview of each of the program updates referenced in this item.

Issue 3: Incompetent to Stand Trial – Diversion and Community-Based Treatment

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, DSH expects 815 individuals in the IST population will be housed in county jails in 2018-19 because they are awaiting placement into a state hospital bed or jail-based competency treatment program. This backlog, which has grown significantly in recent years, 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.

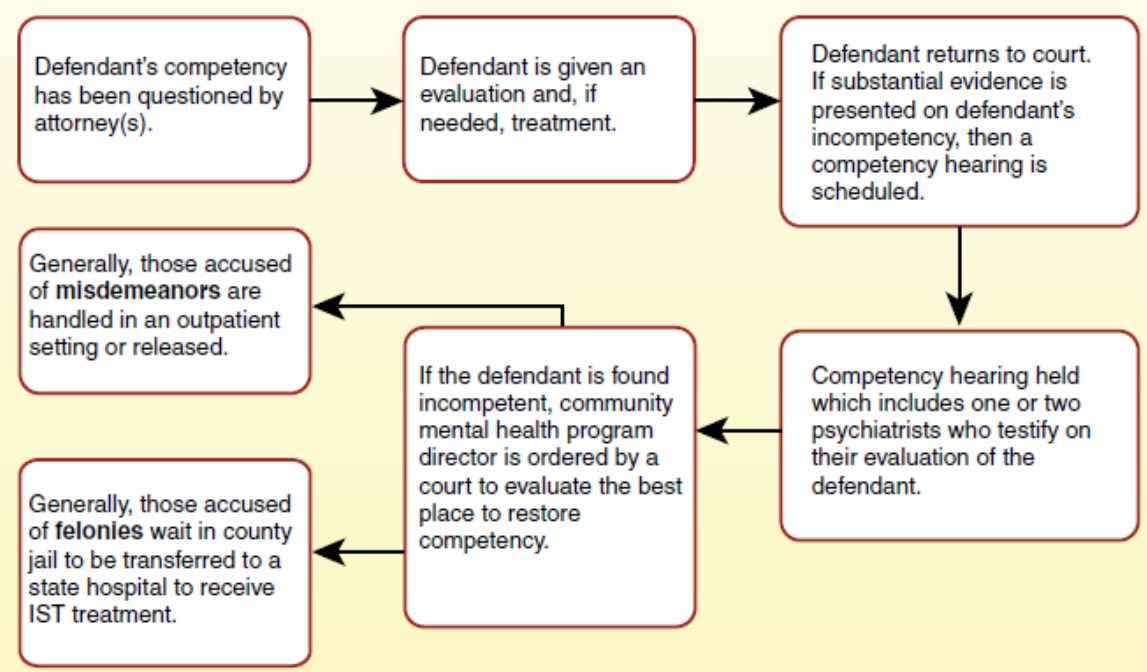


Figure 1: Incompetent to Stand Trial Commitment Process
Source: "*An Alternative Approach:Treating the Incompetent to Stand Trial", Legislative Analyst's Office, Jan 2012*

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 836 as of July 2018. 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.

Incompetent to Stand Trial Diversion Program. In the 2018 Budget Act, the Legislature approved trailer bill language and General Fund expenditure authority of $100 million over three years to promote community mental health treatment and diversion for individuals determined to be, or at risk of being determined to be, incompetent to stand trial. Specifically, the program included the following components:

- Diversion of Individuals with Mental Disorders – Grants pre-trial diversion to defendants, including postponement of prosecution and referral to mental health treatment, under the following conditions:

    1. The court is satisfied the defendant suffers from a qualifying mental disorder including, but not limited to, schizophrenia, schizoaffective disorder, or posttraumatic stress disorder, but excluding antisocial personality disorder, borderline personality disorder, and pedophilia.

2. The court is satisfied the defendant's mental disorder played a significant role in the commission of the charged offense.
3. A qualified mental health expert determines the defendant would respond to mental health treatment.
4. The defendant consents to diversion, waives his or her right to a speedy trial, and agrees to comply with treatment as a condition of diversion.
5. The court is satisfied the defendant will not pose an unreasonable risk of danger to public safety.
6. The court is satisfied the recommended treatment program will meet the specialized mental health needs of the defendant.
7. The period of diversion shall be no longer than two years.

If the court concludes a defendant has substantially complied with the requirements of diversion, has avoided significant new violations of law, and has a plan in place for long-term mental health care, the court shall dismiss the charges that prompted the initial diversion.

- Community-Based Treatment – Provides $100 million over three years to assist counties in providing diversion for individuals with serious mental illnesses who may otherwise be found incompetent to stand trial. These county programs will provide clinically appropriate or evidence-based mental health treatment and wraparound services across a continuum of care to:

  - Individuals diagnosed with schizophrenia, shizoaffective disorder, or bipolar disorder who could potentially be found incompetent to stand trial.
  - Individuals for which there is a significant relationship between the individual's mental disorder and the charged offense or between the individual's conditions of homelessness and the charged offense.
  - Individuals that do not pose an unreasonable risk of danger to public safety if treated 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 DSH to respond to the following:

1. Please provide a status update on the community-based treatment diversion program authorized in the 2018 Budget Act, including counties receiving awards, brief descriptions of program services, and county matching requirements.

2. Please describe how DSH intends to evaluate the outcomes for each of the programs funded by the community-based treatment diversion program.

Issue 4: Atascadero – Potable Water Booster Pump System

Capital Outlay Budget Issue. DSH requests General Fund expenditure authority of $113,000 in 2019-20. If approved, these resources would allow DSH to support preliminary plans for a project to install a potable water booster pump system to serve Atascadero State Hospital's main water system.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$113,000	$-
Total Funding Request:	**$113,000**	**$-**

Background. According to DSH, Atascadero State Hospital's water supply is generated from five underground wells located on the northeast part of the campus. Each well station has a pump that sends water from the wells to an adjacent underground reservoir, from which it is pumped to a one million gallon storage tank on top of a hill. The storage tank then supplies water to the hospital by gravity feed. This gravity line supports the hospital's fire sprinkler system, as well as patient showers, kitchens, and bathrooms.

DSH reports when multiple users draw water, the hospital's main water pressure drops considerably. Water pressure during normal operations averages between 40 and 50 pounds per square inch (psi), which is below the necessary 60 psi required for normal facility operations. According to DSH, the reduced pressure could compromise the hospital's fire sprinkler system in the event of a fire.

DSH requests General Fund expenditure authority of $113,000 in 2019-20 to support preliminary plans for a project to install a potable water booster pump system to serve Atascadero State Hospital's main water system. DSH expects the total project will cost $2.1 million, including $113,000 for preliminary plans, $229,000 for working drawings, and $1.8 million for construction. If approved, this request would only support preliminary plans for the project.

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: Increased Court Appearances and Public Records Act Requests

Budget Issue. DSH requests 5.5 two-year limited-term positions and General Fund expenditure authority of $767,000 in 2019-20 and 2020-21. If approved, these positions and resources would allow DSH to address increases in court hearings at which DSH attorneys are required to appear, as well as increases in requests pursuant to the Public Records Act.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$767,000	$767,000
Total Funding Request:	**$767,000**	**$767,000**
Total Requested Positions:	**5.5**	**5.5**

Background. Since the 2007-08 fiscal year, the backlog of individuals determined incompetent to stand trial (IST) awaiting treatment in state hospitals has grown from between 200 and 300 to 836 as of July 2018. 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.

According to DSH, the ongoing and growing IST waitlist has resulted in a significant amount of related litigation, including:

- County public defenders filing motions seeking Orders to Show Cause (OSCs) why DSH should not be held in contempt for not timely admitting IST patients, and seeking sanctions.
- County public defenders filing motions under Code of Civil Procedure section 177.5 seeking sanctions against DSH for not complying with superior court orders to admit IST patients by a date specified.
- Superior courts issuing OSCs seeking to sanction DSH for not timely admitting IST patients or violating court orders to admit patients.
- Courts setting status conferences, with mandatory appearances by DSH, to explain why the patients have not been transported, or admitted to its hospitals, or considering whether to hold DSH in contempt.
- County public defenders filing motions seeking standing orders requiring that DSH admit IST patients by a specified time-frame.
- County public defenders filing writs of habeas corpus, writs seeking release of IST patients held in jail awaiting admission to DSH, and writs of mandate requiring DSH to comply with various specified time-frames for admission.
- The ACLU and private law-firms filing state and federal civil-rights cases seeking injunctive relief and damages for alleged violations of IST patients' constitutional rights.

DSH attorneys must respond, object, appear, or serve as staff counsel to represent DSH in each of these types of motions, status conferences, OSCs, standing-order requests, writs, and civil-rights litigation. The courts often provide less than one week notice to appear to defend DSH against an OSC and it is not uncommon for DSH to be provided only 24 or 48 hours of notice for a contempt hearing. DSH attorneys are required to constantly be ready to travel on short notice anywhere from two to four hours away to appear on DSH's behalf in county superior courts to advocate against findings of contempt or sanctions.

In addition to increased legal workload, DSH reports the number of Public Records Act requests it receives annually has increased by 220 percent between 2012 and 2018. The Public Records Act (PRA) requires all entities of the state to disclose governmental records to the public, upon request, unless there is an applicable statutory exemption. DSH legal staff receive PRA requests, reach out to relevant divisions, review and catalog records identified for responsiveness or exemption, and provide the responsive records with any necessary redactions.

DSH requests 5.5 two-year limited-term positions and General Fund expenditure authority of $767,000 in 2019-20 and 2020-21. If approved, these positions and resources would support **three Attorney I** positions to handle the increased volume of OSC appearances and other hearing-related work. This workload includes reviewing hospital and patient documentation, reviewing alienist reports and commitment packets, working with the DSH Patient Management Unit and hospital forensic staff to ascertain a patient's status on the waitlist, communicating with courts and public defenders to seek to have OSCs vacated in the event of an imminent patient placement, and appearing in court to defend DSH at hearings against court orders to transport the patient, OSCs to hold DSH in contempt, and any follow-up status conferences.

These positions and resources would also support **one Legal Secretary** to support the three attorneys by coordinating and calendaring OSC hearings; preparing OSC responses, declarations, and requests for representations; and other legal support.

For the PRA workload, this request would support **one Legal Analyst** and **0.5 Staff Services Analyst** to review PRA requests, gather input from hospital divisions and headquarters, review and redact responsive documents, draft and prepare PRA response letters, consult with DSH attorneys regarding PRA legal issues, and advise DSH staff on PRA-related matters.

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: Privacy Protection Program

Budget Issue. DSH requests nine positions and General Fund expenditure authority of $1.3 million annually. If approved, these resources would allow DSH to establish a system-wide Privacy Protection Program in accordance with a recent audit by the California Office of Health Information Integrity.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$1,263,000	$1,254,000
Total Funding Request:	**$1,263,000**	**$1,254,000**
Total Requested Positions:	**9.0**	**9.0**

* Positions and resources ongoing after 2020-21.

Background. According to DSH, federal and state laws and policies, including the Health Insurance Portability and Accountability Act (HIPAA), the Lanterman-Petris-Short Act, the Information Practices Act, the Statewide Health Information Policy Manual, and the State Administrative Manual Chapter 5300, require health care providers to perform privacy and security activities to safeguard health information. The California Office of Health Information Integrity (CalOHII) is responsible for ensuring state departments comply with HIPAA. In May 2018, CalOHII performed an audit of DSH's health information privacy and security activities from both system-wide and hospital-specific perspectives. CalOHII audited four compliance categories related to privacy, security, administration, and patient rights in two hospitals and six system-wide programs. The audit contained 61 findings, of which 34 were high risk, 24 were medium risk, and three were low risk. The most significant finding was that DSH lacks a system-wide privacy program responsible for policies and procedures, training, monitoring and oversight over compliance, incident and breach response, and risk mitigation. CalOHII requires DSH to address all deficiencies by November 2019.

DSH requests nine positions and General Fund expenditure authority of $1.3 million annually to establish a system-wide Privacy Protection Program and a Privacy Office. Specifically, DSH requests the following positions:

- **One Attorney III** would act as a legal subject matter expert on complex privacy issues, draft and review contracts, perform de-identification and data governance, and ensure patient rights are maintined.

- **One Attorney I** would handle the increased volume of privacy and security incidents, act as legal subject matter expert on privacy laws and policies, develop, review and update privacy policies, assist with operationalization and implementation of privacy policies, and develop and present privacy training.

- **Six Associate Governmental Program Analysts,** one located at each of the state hospitals and the state headquarters, would perform investigations, log and track incidents, analyze root causes, coordinate and track corrective action, ensure corrective action has been fully completed, ensure patients have access to health information and can make amendments or corrections, draft and

update hospital-specific procedures to operationalize privacy policies, assist in responding to subpoenas, court orders, and patient requests for the release of their information.

- **One Staff Services Manager I Specialist** would act as a non-attorney subject matter expert in privacy compliance related to HIPAA, the Lanterman-Petris-Short Act, the Information Practices Act, the Public Records Act, the State Administrative Manual, and the Statewide Health Information Policy Manual.

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 7: Contracted Services and Patient Management Support

Budget Issue. DSH requests eight positions and General Fund expenditure authority of $1.1 million annually to manage the development and ongoing support of the expansion of competency restoration programs, an increasing caseload of patients determined incompetent to stand trial (IST), and to provide essential data and analysis for effective and efficient management of DSH patient management programs.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$1,085,000	$1,077,000
Total Funding Request:	**$1,085,000**	**$1,077,000**
Total Requested Positions:	**8.0**	**8.0**

* Positions and resources ongoing after 2020-21.

Background. According to DSH, there continues to be an increase in IST patients referred to DSH by California counties. Since 2016-17, IST referrals have grown by 37.9 percent. Between July 2018 and October 2018, DSH received 1,704 IST referrals and anticipates receiving 5,112 total IST referrals in 2018-19, a 14.6 percent growth from 2017-18. To address the continual increase in IST referrals, DSH has established several jail-based competency treatment (JBCT) programs, the Admission, Evaluation, and Stabilization (AES) Center in Kern, and the Los Angeles Community-Based Restoration program. DSH reports that JBCT and AES capacity has increased by 83 percent since 2016-17.

DSH also reports it has worked to increase efficiency and maximize service to IST patients by reducing the average length of stay and streamlining the referral intake process by way of centralization in DSH under the Patient Management Unit. As a result, 5,813 IST patients were served by DSH in 2017-18, which was a growth of 9.1 percent from 2016-17. With the projected increases in capacity at both state hospitals and JBCT programs, DSH anticipates serving 6,426 IST patients in 2018-19, a 10.5 percent growth from 2017-18.

DSH indicates that, to continue to manage the growth of IST referrals, DSH will need additional staffing resources to manage the referral intake process and the placement of patients at appropriate facilities; to appropriately facilitate and support additional JBCT, AES, and Community Based Restoration (CBR) programs; and to collect, manage, and report on all applicable data related to the new JBCT, AES, and community-based programs.

DSH requests eight positions and General Fund expenditure authority of $1.1 million annually to manage the development and ongoing support of the expansion of competency restoration programs, an increasing caseload of patients determined incompetent to stand trial (IST), and to provide essential data and analysis for effective and efficient management of DSH patient management programs. Specifically, DSH requests the following:

- **One Consulting Psychologist** would assist in monitoring clinical and administrative performance of JBCT and AES programs, conduct site visits, participate in organization and planning of formal program reviews and development and update of policies and procedures, serve as liaison between

the programs and DSH staff and the courts, and gather and use data to support findings of program deficiencies.

- **One Health Program Specialist I** position would serve as the primary contract manager, analyze administrative problems related to the program, recommend actions, review special incident reports, serve as liaison between DSH and program staff, perform independent analysis of fiscal and programmatic data, serve as lead for Public Records Act and media requests, perform quarterly on-site liaison program reviews, and assist in performing formal program reviews.

- **One Research Data Specialist I** position would reconcile data for weekly reporting on patient movement to and from the JBCT waitlist, coordinate with state hospital staff to ensure precision of the weekly Pending Placement Report, collaborate in discussions relating to all DSH IST referrals and waitlist management, develop and produce full annual program reports, develop and produce semiannual program analyses for executive staff and other stakeholders, develop and produce annual reports for the Los Angeles Community-Based Restoration Program, develop and produce semiannual analyses of the Los Angeles Community-Based Restoration program for executive staff and other stakeholders, provide support in litigation and legislation requests, and conduct regular data auditing to ensure data management standards.

- **Four Associate Governmental Program Analysts** would receive and document receipt of referrals for IST patients, review referral packets for completeness, enter referral information into a statewide management database, request any missing information or documentation, communicate the referral to clinical staff for evaluation of appropriate placement, determine the proper placement of the patient and update the database for proper tracking, transfer the records to the appropriate hospital or JBCT, address any JBCT denials, and monitor the JBCT census.

- **One Office Technician** would provide clerical support including scheduling meetings, preparing travel arrangements, assisting with travel claims, time keeping, mail distribution, supply ordering, filing, answering phones, responding to emails, preparing documents, making arrangements for new employees, and data entry.

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

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

1. Please provide a brief overview of this proposal.

Issue 8: Deferred Maintenance

Budget Issue. DSH requests General Fund expenditure authority of $35 million in 2019-20. If approved, these resources would allow DSH to address deferred maintenance projects that represent critical infrastructure deficiencies. These resources would be available for encumbrance or expenditure until June 30, 2022.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$35,000,000	$-
Total Funding Request:	**$35,000,000**	**$-**

Background. According to DSH, state hospital facilities require routine maintenance and repair to keep them in acceptable condition and to preserve and extend their useful lives. The state hospitals were established in 1875 (Napa), 1893 (Patton), 1915 (Metropolitan), 1954 (Atascadero), and 2005 (Coalinga). The majority of the hospitals' buildings were built prior to 1960 and are in constant need of repair.

California Code of Regulations, Title 22, Section 71641(a)(b) states that each "hospital shall be clean, sanitary, and in good repair at all times" and "hospital buildings and grounds shall be maintained free of such environmental pollutants and such nuisances as may adversely affect the health or welfare of patients." Over time, the number of deferred maintenance projects for each state hospital has grown, making it more challenging to make the necessary repairs.

DSH requests General Fund expenditure authority of $35 million in 2019-20 available for encumbrance or expenditure until June 30, 2022. If approved, these resources would allow DSH to address deferred maintenance, primarily road repairs and roof replacement, at its five state hospitals. These projects are as follows:

Deferred Maintenance Projects		
Hospital	Project	Cost
Atascadero	Road Repairs	$ 300,000
Coalinga	Road Repairs	$ 300,000
Metropolitan	Road Repairs	$ 300,000
Metropolitan	Roof and Air Handler Replacement	$ 10,000,000
Napa	Road Repairs	$ 300,000
Napa	Building 168 Roof Replacement	$ 10,000,000
Napa	Building 196 Roof Replacement	$ 4,000,000
Napa	Building 261 Roof Replacement	$ 1,500,000
Patton	Road Repairs	$ 300,000
Patton	G Building Roof Replacement	$ 5,000,000
Patton	T Building Roof Replacement	$ 1,000,000
Patton	Ligature Retrofits	$ 2,000,000

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

Thursday, April 11, 2019
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultants: Renita Polk and Elisa Wynne

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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.

5180 DEPARTMENT OF SOCIAL SERVICES (DSS) – IMMIGRATION SERVICES BRANCH

Issue 1: Overview

Budget Issue. The budget includes $45 million for Immigration Services funding, $10 million for services on behalf of recipients of temporary protected status (TPS), $17 million for other undocumented and immigration services, and $3 million for services for Unaccompanied Undocumented Minors (UUMs) in 2019-20 and annually thereafter for immigration-related services within the Department of Social Services. While the 2018 budget provided $17 million of that funding as one-time, the Governor's budget proposes to maintain 2018 funding levels on an ongoing basis.

Although not included in the department's budget, the Governor's proposed budget includes a one-time augmentation of $5 million General Fund in 2018-19, and $20 million General Fund in 2019-20, for an Immigration Rapid Response program to be set aside in a reserve until needed.

The table below provides an overview of funding for each of the programs within the Immigration Services Branch from 2015-16 to 2018-19.

Funding (in millions)	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19
UUM	$3.0	$3.0	$3.0	$3.0
ISF	$15.0	$30.0	$45.0	$45.0
DACA			$20.0	
TPS/UUM				$10.0
CSU/CCCO				$17.0
Disaster Response			$3.0[3]	
Rapid Response Reserve				$2.2
Total Funding	**$18.0**	**$33.0**	**$71.0**	**$77.2**

Background. DSS funds qualified nonprofit organizations to provide legal services to immigrants who reside in California via the UUMs and Immigration Services Funding programs. Immigration Services Funding programs are divided into the following categories: 1) education and outreach, 2) legal training and technical assistance, and 3) legal services, including naturalization, DACA, removal defense, and other immigration remedies.

Immigration Services Programs (also known as "One California"). In 2018-19, the department provided $55 million for Immigration Services program. A funding history for these programs is provided below.

Table 3. ISF Funding Overview			
Fiscal Year	**ISF Appropriation**	**Organizations Funded**	**Service Categories**
2015-16	$15 million	62	• Naturalization • Deferred Action for Childhood Arrivals (DACA) • Deferred Action for Parents of American Citizens and Residents (DAPA)
2016-17	$30 million	80	• Naturalization • DACA • Other Immigration Remedies • Removal Defense
2017-18	$45 million	92	• Naturalization • Other Immigration Remedies • Removal Defense
2018-19	$55 million[6]	101	• Naturalization • DACA • Other Immigration Remedies (including TPS/UUM) • Removal Defense (including TPS/UUM)

*The total appropriation for 2018-19 includes $45 million for legal services and $10 million to prioritize services to beneficiaries of TPS and minors.

The table below provides the number of cases served under these programs by service type and fiscal year.

	Number of Individuals Served by DSS Immigration Services							
Fiscal Year	DACA Services	Naturalization Services	Other Immigration Remedies	Removal Defense	Education and Outreach	TPS Other Immigration Remedies	TPS Removal Defense	UUM Removal Defense
2015-16	11,369	13,485	N/A	N/A	111,080	N/A	N/A	N/A
2016-17	6,070	31,249	5,399	N/A	163,510	N/A	N/A	N/A
2017-18	N/A	24,308	19,783	7,014	201,095	N/A	N/A	N/A
2018-19	7,469	23,875	20,086	6,021	204,660	2,763	183	889

Unaccompanied Undocumented Minors (UUM). DSS annually oversees $3 million legal services funding for the UUM program. In 2014, the United States experienced a surge of arrivals of UUMs fleeing violence from El Salvador, Guatemala, and Honduras. Since then, the number of arrivals has remained historically high, with 13% to 14% of UUM arrivals being placed in California. 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. 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. Contractors submit quarterly reports to DSS that include information on services provided and case closure. Services began on

December 19, 2014. The UUM fee-per-case is currently $5,000 per case to adequately compensate legal services organizations for the contracted UUM services. As of August 31, 2018, DSS had allocated all $3 million to fund legal services for the 2018-19 fiscal year. As of 2017-18, the program has served a total of 3,045 clients.

Immigration Rapid Response. The Governor's budget includes funding for an Immigration Rapid Response program ($5 million General fund in 2018-19 and $20 million General Fund in 2019-20) to quickly address emergencies affecting immigration and human trafficking victims to protect children, families, and public health. The General Fund will be appropriated to a newly established Rapid Response Reserve. Once the Administration has determined there is a need to use the funds to address immigration or human trafficking emergency situations the Department of Finance (DOF) will adjust the appropriate department's budget authority. This funding will assist qualified community-based organizations and nonprofit entities in providing services during immigration or human trafficking emergency situations when federal funding is not available. These funds will also be available to support the redirection of state-level staff who directly assist in response efforts. Within 30 days of making any adjustments DOF will report the adjustments in writing to the Joint Legislative Budget Committee. The department has indicated that proposed budget language around the program is forthcoming.

$2.2 million of the $5 million provided for 2018-19 has already been authorized to provide shelter and other rapid response services at the California border with Mexico through June 2019. Many of the organizations in San Diego that provide emergency shelter and rapid response services indicate that they are at full capacity and need supplemental resources to continue serving this population.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an update on major accomplishments and challenges the Immigration Services branch has encountered in the last year.

2. Please discuss the effect of federal policy changes on immigration patterns and state responses in California.

3. Please provide an update on Rapid Response efforts and DSS's role in assisting with local efforts.

Issue 2: Human Services Technical BCP – Immigration Initiatives and Legal Services State Support

Each year, the departments within the Health and Human Services (HHS) Agency submit a number of proposals requesting various technical adjustments, largely related to workload adjustments and resources needed to implement new legislation. The proposal discussed in this item is included in that larger Agency BCP.

Governor's Proposal. The Governor's budget includes $885,000 for six positions to support the increase in capacity to provide immigration services and support interdepartmental immigrant integration efforts.

Background. Since program implementation in 2015, the Immigration Services Funding (ISF) has experienced significant program growth. DSS requests an increase in program resources and oversight to ensure the effective and continued development and implementation of programs and funding initiatives necessary to support legal services, outreach, community education, and other immigrant integration efforts in the state. The Immigration Services Unit (ISU) is required to report program outcomes and data to the Legislature annually, which is completed through the manual collection of individual service reports. The ISU expects to award approximately 175 contractors in 2018-19 and 200 in 2019-20. Contractors must report on each funded service category, which creates a high volume of administrative burden for the ISU.

The requested positions will form a new unit responsible for the immigrant integration efforts that require statewide leadership and coordination, increasing access to services, and improving the effectiveness of services. Requested positions include:

- **One Staff Services Manager (SSM) II.**
- **One SSM I.**
- **Three Associate Governmental Program Analysts (AGPA).**
- **One Information Technology Specialist.**

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

Issue 3: TBL - California Newcomer Education & Well-Being Project (CalNEW)

Governor's Proposal. The Governor's budget includes trailer bill language to eliminate administrative barriers for school districts by clarifying the state's intention to provide funding for school programs for refugees and other populations currently served by the Office of Refugee Resettlement, including unaccompanied undocumented minors (UUM).

Background. In 2017, the Budget Act appropriated $10 million to fund school sites to provide supportive services to refugees and other populations currently served by the Office of Refugee Resettlement. The department currently administers a similar federal program known as the Refugee School Impact Grant (RSIG). UUMs are considered refugees and eligible for CalNEW services once they are granted asylum by the U.S. Citizenship and Immigration Services (USCIS). While their case is pending before USCIS, a UUM will not be eligible for CalNEW services.

The state appropriated funding with the intention of augmenting current services, expanding the scope of the services provided, and serving additional populations excluded from the RSIG. Current statute includes references to the existing federal program which limit the department's ability to adequately serve UUMs. The proposed language change would allow the department to serve those populations currently excluded from the RSIG.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposed language.

Issue 4: Proposal for Investment

The Subcommittee has received the following Immigration Services-related proposal.

1. California Immigrant Justice Fellowship

Budget Issue. A coalition of organizations, including the Northern California Rapid Response Network, the Justice and Diversity Center of the Bar Association of San Francisco, and the Northern California Collaborative for Immigrant Justice, request $4.7 million in 2019-20 and 2020-21 for the California Immigrant Justice Fellowship pilot. The program will provide funds for the following purposes:

- $2.3 million to host incubating agencies in rural communities that will house ten legal fellows for a 20-month period and develop a robust removal defense services program.

- $270,000 to Bay Area training agencies that will host ten legal fellows for a four month apprenticeship.

- $565,000 to a coordinating agency that will coordinate the fellowship initiative, recruit and hire legal fellows, provide non-profit training for host incubating agencies, and administer overall program monitoring and evaluation.

- $245,000 to a technical assistance agency to work the attorneys from lead mentor agencies in developing training materials.

- $670,000 to the lead mentor agency to house two expert senior immigration attorneys to provide training during the apprenticeship and fellowship periods.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – MISCELLANEOUS

Issue 1: Proposals for Investment

The Subcommittee has received the following proposals for investment.

1. Youth and Family Civic Engagement Initiative

Budget Issue. The Dolores Huerta Foundation and the Martin Luther King Jr. Freedom Center request a one-time appropriation of $12 million over the next three fiscal years (through 2021-22) to support the Youth and Family Civic Engagement Initiative. The purpose of the initiative is to increase understanding of government and civic institutions, and increase civic participation among low-income, disenfranchised youth and their families in targeted regions throughout the state. The requested funding will allow program expansion in the Los Angeles, San Diego, Stockton, and Sacramento regions, as well as providing 200 students and their family members with meaningful civic engagement, public speaking, and cultural leadership encounters.

Staff Comment and Recommendation. Hold open. The 2018-19 budget appropriated $2 million General Fund (one-time) to support the program.

2. SupplyBank.Org Basic Needs and Disaster Relief Infrastructure

Budget Issue. SupplyBank.org, along with a coalition of partner organizations, request a one-time allocation of $4 million to support the organization's critical infrastructure costs. Mirroring the model of food banks and with a volume of more than $25 million worth of materials to more than 500,000 people, SupplyBank.Org centralizes procured and in-kind materials and distributes them across California through existing partnering agencies' programs. Collectively, this investment will enable SupplyBank.Org to provide hundreds of thousands of additional low-income children and families, and those displaced by natural disasters, with tens of millions of dollars' worth of vital basic need materials. These include toiletries, household items, diapers and wipes, school supplies, home displacement kits, feminine hygiene products and other crucial resources.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES - CALFRESH

Issue 1: Overview

Governor's Proposal. The Governor's budget includes $1.82 billion ($630.1 million General Fund) for CalFresh administration in 2019-20. The CalFresh program is projected to serve 2.1 million households (about four million people) in 2019-20. This is a 10.6 percent increase from 2018-19 projections of 1.9 million households.

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 2019-20 includes $52.9 million General Fund for food benefits. CFAP is projected to serve 39,779 in 2019-20.

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. The current average monthly benefit per household is around $282 ($137 per person).

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 and net incomes of no more than 100 percent of the federal poverty level, after specified adjustments.

Efforts to improve participation. In federal fiscal year 2016, the most recent period for which official measures are available[1], the participation rate for the working low-income population was 75 percent nationally. California's participation rate for the working low-income population was the lowest in the nation at an estimated 61 percent. California's overall participation rate was the fourth lowest in the nation at an estimated 72 percent while the national rate was 85 percent.[2]

Efforts to increase participation include outreach to communities, particularly 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

[1] *Reaching Those in Need: Estimates of State Supplemental Nutrition Assistance Program Participation Rates in 2016*, USDA, March 2019 (https://fns-prod.azureedge.net/sites/default/files/ops/Reaching2016.pdf)

[2] 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 of those individuals who would otherwise be eligible for CalFresh were counted as participating. Beginning June 2019, SSI/SSP recipients will be eligible for CalFresh benefits.

was recognized for these efforts and won a most improved Program Access Index award from the USDA for FFY 2014[3].

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 received a waiver to implement 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. However, there is concern among advocates that the application used for these cases is still cumbersome.

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.

Several recently enacted program changes seek to improve CalFresh program participation. Some of those program changes include:

1. CalFresh Expansion (SSI Cash-out Reversal). The "SSI Cash-out" is a state policy that provides SSI/SSP recipients with an extra $10 payment in lieu of their being eligible to receive federal food benefits through the CalFresh program. AB 1811 (Committee on Budget), Chapter 35, Statutes of 2018, ended this policy. This expansion of CalFresh benefits is effective beginning June 1, 2019. It is estimated that the policy change will increase the CalFresh caseload by approximately 370,000 new households.

2. 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.

3. Semiannual reporting. Evidence suggest 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.

4. 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.

5. 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

[3] 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

Service of the United States Department of Agriculture published new rules on the definition of fleeing felon that allow a majority of previously ineligible adults to become eligible for CalFresh benefits and were implemented in California on December 1, 2015.

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. A county, or an entire state, can be approved for a waiver of the ABAWD time limit if it meets federally established criteria for high unemployment or a lack of sufficient jobs. In 2008, California received a statewide waiver of the ABAWD time limits due to a high statewide unemployment rate. Waiver approvals are reviewed each year. While most of the state is still under the waiver, three counties (San Francisco, San Mateo, and Santa Clara counties) implemented the ABAWD time limit on September 1, 2018, as a result of improved economic conditions. While the statewide waiver is set to expire on August 31, 2019, DSS has submitted a request to the federal Federal Nutrition Services (FNS) that would implement the time-limit in only three additional counties (Alameda, Marin, and Contra Costa counties) in September 2019. However, that request is still pending and the department has indicated it will provide an updated estimate based on approval or denial with the May Revision.

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.

Disaster CalFresh. The Disaster CalFresh Program 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. Over the last year, California has had to implement Disaster CalFresh in five counties in response to wildfires and mudslides. An affected area must have received a Presidential Declaration with Individual Assistance in order to request this.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of recent major accomplishments and challenges within the program.

2. Please discuss the expiration of the federal ABAWD waiver, impacts it may have and efforts the department is making to mitigate any negative effects. What steps is the department taking to prepare in the event the federal FNS denies its submission for a waiver on the time limit?

Issue 2: BCP – CalFresh Employment and Training Program

Governor's Proposal. The Governor's budget includes $928,000 federal funds in 2019-20, and $820,000 federal funds every year thereafter, to form a new Employment and Training (E&T) unit with six new permanent positions.

Background. The CalFresh E&T program provides recipients with opportunities to gain skills, training, and/or experience that will improve their employment prospects and reduce their reliance on CalFresh benefits. DSS provides oversight, technical assistance, and program support to counties and to third-party partners that have opted into implementing an E&T program. The current single E&T Unit was formed in 2016 with 100 percent federal E&T funds. Since 2016, the number of CalFresh recipients it serves on an annual basis has grown from 57,000 to more than 100,000 in 2018. California's E&T program presently operates in 36 counties and with over 65 third-party partners.

The department has indicated that plans for program growth including making connections with other employment programs, the development of an E&T handbook, and diversifying offerings to including community college partnerships and apprenticeships. Federal work requirements for able bodied adults without dependents (ABAWDS) were waived during the recession; but, as of September 1, 2018, these work requirements have been re-imposed, beginning in the Bay Area, and are expected to be re-imposed further across the state each federal fiscal year. The California Workforce Development Board has included E&T as a strongly encouraged partner in regional workforce plans to increase the quantity, quality, and outcomes of E&T programs. E&T program services are intended to increase employment rates and wages among CalFresh recipients with the goal of eventually making households economically self-sufficient.

Current staffing includes one Staff Services Manager (SSM) I and four analysts, but an additional E&T unit would aid in expanding the program as mentioned above. The additional requested positions include:

- **One SSM II.**
- **One SSM I.**
- **Four Associate Governmental Program Analysts (AGPA).**

The requested staff would comprise one unit, with one SSMI and four analysts, along with a new section chief to oversee both the new and existing unit. The new section chief would report to the existing Policy Bureau Chief. The two E&T units would be responsible for County Programs, State Programs, and Managements Evaluations (ME).

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

Issue 3: Human Services Technical BCP – California Fruit and Vegetable EBT Pilot

Each year, the departments within the Health and Human Services (HHS) Agency submit a number of proposals requesting various technical adjustments, largely related to workload adjustments and resources needed to implement new legislation. The proposal discussed in this item is included in that larger Agency BCP.

Governor's Proposal. The Governor's budget includes $311,000 in 2019-20 and 2020-21 for the implementation of the California Fruit and Vegetable EBT pilot. The 2018 Budget Act included $9 million to cover all costs of this pilot, of which $311,000 is being requested in both 2019-20 and 2020-21 to carry out state operations activities.

Background. Evidence indicates that increasing consumption of fruits and vegetables can help improve health outcomes, yet millions of low-income Californians report that they cannot consistently afford to purchase fruits and vegetables. In the past decade, programs providing supplemental benefits to CalFresh recipients piloted by numerous organizations in California and nationwide have demonstrated that when low-income families have additional money for fruits and vegetables, they buy and consume more fruits and vegetables.

AB 1811 (Committee on Budget), Chapter 35, Statutes of 2018, requires the establishment pilot projects aimed at producing an incentive program for CalFresh recipients to increase their consumption of California grown fruits and vegetables. Each of the pilot grantees will design and implement an incentive program that must be tracked and measured to determine its efficacy in producing the desired outcome. The department is requesting two Research Data Analyst (RDA) II positions, who will be responsible for the design and analysis of data produced from each of the pilots. The RDA IIs will also lead in the synthesis of that information, including any programmatic recommendations to be included in a report due to the Legislature no later than January 1, 2022.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

Issue 4: Proposals for Investment

The Subcommittee has received the following proposals for investment.

1. CalFood Funding

Budget Issue. The California Association of Food Banks (CAFB) requests in increase in CalFood funding of $16.5 million General Fund, and an increase in the storage and transportation rate to 15 percent. CAFB emphasizes changes and proposed changes at the federal level, as well as natural disasters, has increased reliance on food banks. Food banks are a critical piece of our safety net, serving 650 million meals to more than two million Californians a year, yet California's missing meal gap is estimated at one billion annually. CalFood strengthens emergency food providers and our agricultural communities by enabling California food banks to purchase only California produced foods, especially expensive, healthy proteins and fresh produce.

Staff Comment and Recommendation. Hold open. The 2019-20 budget includes $8 million for the CalFood program.

2. Simplifying Senior Access to CalFresh

Budget Issue. California Food Policy Advocates and the CAFB, along with local food banks and other partners, request a one-time augmentation of $1 million General Fund for the department to design and automate a user-centered simplified CalFresh application for seniors and people with disabilities. DSS has been participating in a federal demonstration project to simplify access to CalFresh for seniors and people with disabilities since October 2017, when DSS received waivers to implement the CalFresh Elderly Simplified Application Project (ESAP). However, stakeholders state that the existing application for ESAP households that DSS has directed counties to use is a long, cumbersome application with many questions that are not relevant to ESAP cases. The requested funding would allow DSS to create a simpler application.

Staff Comment and Recommendation. Hold open.

3. Disaster CalFresh Automation

Budget Issue. The County Welfare Directors Association of California (CWDA) requests $1.8 million ($900,000 General Fund) to allow DSS to automate disaster CalFresh eligibility determinations, add related forms and notices in CalSAWS. Currently, the Disaster CalFresh process is largely not automated, and counties must manually track applications and outcomes. Automation would eliminate this workload and support faster issuance of mass replacement benefits and provide support for cross-county access to enable other counties to more readily assist those impacted by a disaster. As California has faced numerous recent disasters and will face more in the future, the need for automation improvements has become critical, as manual processes delay and divert county staff who could otherwise be providing direct services to disaster victims.

Staff Comment and Recommendation. Hold open.

4. ABAWDs and Comparable Workfare

Budget Issue. The California Coalition of Welfare Rights Organizations request the Subcommittee consider language that would allow voluntary work performed for employers, other than non-profit agencies, to meet the federal ABAWD work requirements as long as work verification is provided.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES - CALWORKS

Issue 1: Overview

Governor's Proposal. The revised 2018-19 budget includes $4.9 billion in total funds for the program, and estimates an average monthly caseload of 391,161 (a decline of 7.6 percent from the previous year). The 2019-20 budget includes $5.3 billion in total funds for the program, and estimates an average monthly caseload of 371,316. The table below provides a summary of the CalWORKs 2019-20 budget.

CalWORKs Budget Summary
All Funds (Dollars in Millions)

	2018-19 Revised	2019-20 Proposed	Change From 2018-19 Amount	Change From 2018-19 Percent
Number of CalWORKs cases	**391,161**	**371,316**	**-19,845**	**-5%**
Cash Grants	**$2,685**	**$3,068**	**$384**	**14%**
Single Allocation				
Employment services	$841	$809	-$32	-4%
Cal-Learn case management	20	20	—	—
Eligibility determination and administration	602	579	-23	-4
Stage 1 child care	290	272	-17	-6
Subtotals, Single Allocation	**($1,753)**	**($1,680)**	**(-$72)**	**(-4%)**
Home Visiting Initiative	**$29**	**$79**	**$50**	**170%**
Other County Allocations	**383**	**405**	**22**	**6**
Other[a]	**12**	**21**	**—**	**—**
Totals	**$4,862**	**$5,253**	**$391**	**8%**

[a] Primarily includes various state-level contracts.

Of the funds in the 2018-19 revised budget, $2 billion are federal funds, $295 million are General Fund, and $2.6 billion are realignment and other county funds. Of the 2019-20 proposed funds, $3.1 billion are federal funds, $2.1 billion are state funds, and $100 million are county funds.

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.

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. There had been longstanding concerns by counties that the methodology behind the Single Allocation was 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. In 2017, the Legislature directed the department and counties to work together to develop a new methodology. Last year, the Legislature adopted a new methodology for eligibility and administration operations. The Governor's budget provides approximately $1.7 billion in funding the Single Allocation in 2019-20. The 2019-20 budget includes a placeholder funding amount for employment services which will hold funding for employment services at 2018-19 levels ($93.6 million). The department has indicated that it is currently working on a new employment services methodology with counties and that a new methodology will be included in the Governor's May Revision of the budget.

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 to around 390,000 families in 2018-19, a decrease of 7.6 percent from the prior year. For 2019-20, the caseload is projected to decrease by 5.1 percent to 371,316 cases.

Federal Context and Work Participation Rate. Federal funding for CalWORKs is part of the TANF block grant program. TANF currently requires states to meet a work participation rate (WPR) for all aided families, or face a penalty of a portion of their block grant. States can, however, reduce or eliminate penalties by disputing them, demonstrating reasonable cause or extraordinary circumstances, or planning for corrective compliance. It is also important to note that federal formulas for calculating a state's WPR have been the subject of much criticism. For example, the federal government does not give credit for a significant number of families who are partially, but not fully, meeting hourly requirements.

California did not meet the WPR requirements in 2007-2015, and was assessed $1.8 billion in penalties. California has successfully completed corrective compliance plans (CCPs) that address the WPR shortfalls of 2008-2011, eliminating $587.1 million in penalties for those years. 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, which are still in the calculation dispute phase. Currently, through the CCP process, all original penalties have decreased to $780 million. It is predicted that penalties will fall further, to a final penalty for all years through federal fiscal year 2017 of $53.3 million. As of yet, California has not been required to pay these penalties. Since 2015, California has achieved compliance with the overall WPR.

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. For 24 months of aid support participants are given additional flexibility around how to meet work requirements, but after the initial 24 months, stricter work requirements are imposed. The 24-moth clock can be stopped under certain circumstances.

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.

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. In 2017-18, 7,582 new participants entered the program.

- 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. $46.9 million was appropriated for the program in 2018-19.

- 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. Between July 1, 2017 and June 30, 2018, 83,846 appraisals were completed with recommendations for supportive services. Most of these recommendations were for mental health services.

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 and is a significant barrier to self-sufficiency.

- 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. As of July 2019, counties participating in the program will be required to follow a Housing First model. Total funding for the HSP was $70.8 million in 2018-19 and $95.3 million in 2019-20.

- 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 $85 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 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. In 2017-18, 69,174 requests for assistance were received and 63,890 families were approved to receive assistance. Total funding for the program was $9.7 million in 2018-19, and $16.6 million in 2019-20.

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 for former CalWORKs recipients.

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.

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.

Application Hub. DSS 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. SIS released its analysis in November 2018, and recommended a mix of efforts including the development of a statewide client-centered vision of the eligibility experience, refine policy, create governance structures, improve operations and training, and enhance existing systems, to create a new state verification hub in a phased approach.

Monitoring results and outcomes. DSS prioritizes program oversight to strengthen CalWORKs. Currently, the department uses research funds to fund seven different research projects to study effectiveness of the CalWORKs program. SB 1041 requiredCDSS to contract with an independent institution to evaluate changes put into effect by the legislation. 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. A third report published in April 2018 found that understanding of the 24-month time clock has improved over time but some difficulties remain.

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 as 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. CalOAR will begin in July 2019 and continue indefinitely on a three-year cycle.

Safety Net Reserve. Assembly Bill 1830 (Committee on Budget), Chapter 42, Statutes of 2018, created the Safety Net Reserve within the state treasury. The fund includes two subaccounts: one for the CalWORKs program and another for Medi-Cal. These programs are often the most needed and heavily utilized during an economic downturn, yet often face severe cuts during those times. The Safety Net Reserve will provide additional resources in a recession to mitigate this effect and avoid cutting these programs when most needed. The 2019-20 Governor's budget proposes a deposit of $700 million into the Safety Net Reserve, bringing the total funds to $900 million. The proposal also seeks to eliminate the CalWORKs and Medi-Cal subaccounts and the requirement to establish a caseload savings and cost per case contribution methodology.

Policy consideration. The Legislature may wish to examine the following issue related to CalWORKs programs:

- Earned Income Disregard (EID). The EID is the amount of a CalWORKs recipient's gross monthly earnings that is ignored when their grant levels are calculated. This allows recipients to continue to receive benefits while earning income. Currently, the first $225 of monthly earnings is ignored, then 50 percent of the remaining income. The greater the value of the disregard, the more families can earn before losing eligibility. The EID has not been changed in twenty years. A recent report[4] by the California Budget & Policy Center found that had the EID been adjusted for inflation it would have been $399 in 2019-20. As an example, the current monthly income limit for a family of three in a high-cost county is $1,981. Had the EID been adjusted for inflation that monthly income limit would be $2,155. The EID has also not kept pace with the rising minimum wage. In 2019-20, a parent working a minimum wage job year-round and full-time would have annual earnings of $27,040 (or $13/hour), higher than annual income limit of $23,772, and thus, be ineligible for assistance.

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 major accomplishments and challenges within the CalWORKs program, include a discussion of recent legislative and policy changes.

2. What are the reasons behind the declining CalWORKs caseload?

3. Please discuss ongoing conversations with county partners regarding the Single Allocation.

4. If the EID were increased, what does the Administration predict would be the effect on the state's WPR?

5. Please provide an update on the CalOAR process.

6. Please discuss the Application Hub endeavor and next steps.

7. Please provide an overview of the proposed changes to the Safety Net Reserve, and explain why the Administration chose to remove the requirement for a depositing methodology for the reserve.

4 Esi Hutchful, *The Earned-Income Disregard Falls Short of Supporting Working Families in CalWORKs* (California Budget & Policy Center: March 2019)

Issue 2: CalWORKs Stage 1 Participation

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 One is administered by the county welfare departments; Stages Two and Three are administered by Alternative Payment (AP) Program agencies under contract with CDE. The three stages of CalWORKs child care are defined as follows:

- **Stage One** begins with a family's entry into the CalWORKs program. Clients leave Stage One after six months or when their situation is "stable," and when there is a slot available in Stage Two or Three. Former CalWORKs clients are also eligible to receive child care services in Stage One and/or Stage Two for a total of no more than 24 months after they leave cash aid.

- **Stage Two** 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 Two up to two years after they are no longer eligible for cash aid.

- **Stage Three** begins when a funded space is available and when the client has acquired the 24 months of child care after transitioning off of cash aid (for former CalWORKs recipients). Families remain in Stage Three until the family's income exceeds 85 percent of the state median income or until the children are over the eligibility age.

Historically, caseload projections have generally been funded for Stages One, Two, and Three in their entirety –although Stage Three is not technically an entitlement or caseload-driven program.

Funding rates and income eligibility for all stages of CalWORKs child care were reduced in the early part of the past decade as the state struggled to make cuts during the great Recession. As the state built back from the recession, funding has been increasing for the program and along with rate increases; in 2017-18 income eligibility for state subsidized child care programs was increased and families were provided with 12 months of eligibility regardless of change in need or income (for CalWORKs child care this applied to stages two and three).

CalWORKs Stage One Participation. Child care in Stage One 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%
FY 2017-18	55,339	16,618	30%	16,109	59%

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.

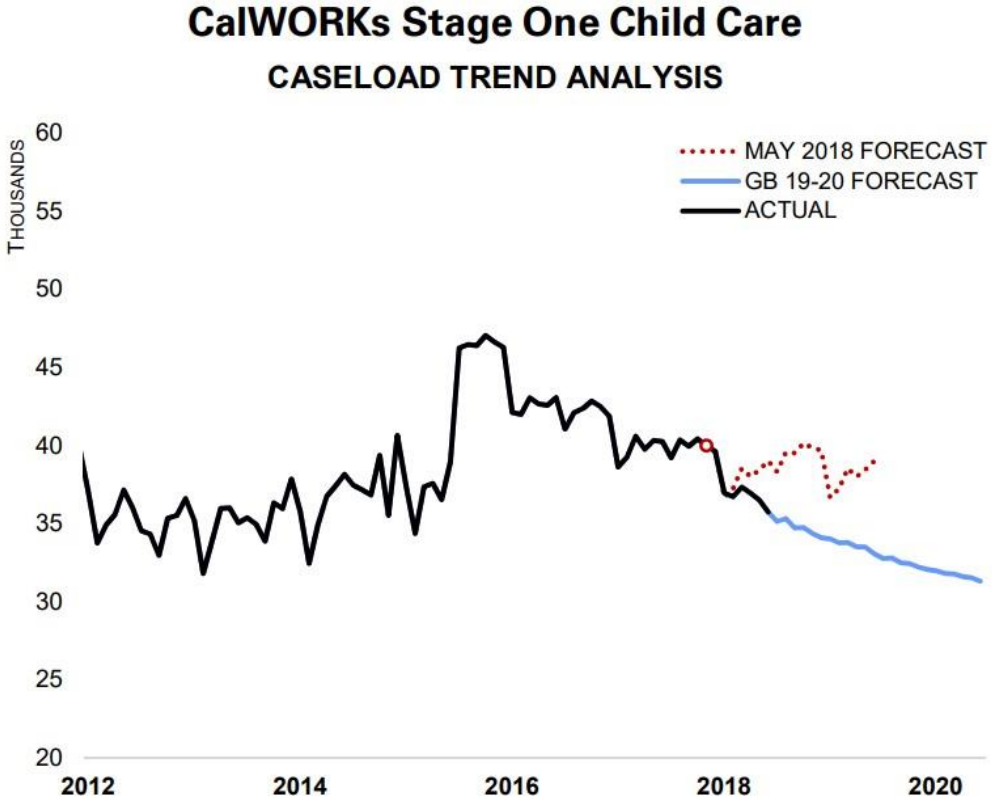
5 Participation Rate was calculated by taking total number of Stage One families and CDE Child Care TANF families, divided by the number of adults participating in a WTW activity with an age eligible child. This is not adjusted for cases who do not need care, for example, school-aged children who do 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 One caseload and the processes of counties as they qualify families for Stage One 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.

At the 2018-19 May Revision, DSS projected the average base monthly caseload for 2017-18 would decrease by 4.9 percent from the previous FY, and the caseload for 2018-19 would decrease by 0.5 percent from 2017-18. The most recent six months of actual data came in 1.6 percent lower than projected in 2018 May Revision. For the 2019-20 Governor's budget, DSS projects the base caseload

for 2018-19 will decrease by 10.8 percent from the previous FY, and the caseload for 2019-20 will decrease by 6.2 percent from 2018-19.

Panel. In addition to DSS, DOF, and the LAO, the Subcommittee has requested the following panel to provide comment on Stage One child care.

- Patti Prunhuber, Senior Policy Attorney, Child Care Law Center
- Parent Representative

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

Questions.

1. Is the reduction in the uptake of Stage One child care (the total numbers) reflective of changes and trends in the CalWORKs program as a whole?
2. What challenges do families face when determining whether to take up Stage One child care benefits?

Issue 3: CalWORKs Grant Increases

Governor's Proposal. The Governor's budget includes $348 million General Fund in 2019-20 for a 13.1 percent across-the-board increase to CalWORKs grants. Full year costs are expected to be $455 million General Fund. The proposed grant increase would go into effect October 1, 2019.

Background. The FPL is an economic measure that is used to decide whether the income level of an individual or family qualifies them for certain benefits and programs. The FPL is the set amount of income that a family needs for food, clothing, transportation, shelter, and other necessities. Each year the U.S. Census Bureau releases a public report on the level of poverty in the county, which provides an estimate of the number of people living in poverty and below the poverty line and the poverty distribution by age, ethnicity, location, and other factors. The U.S. Department of Health and Human Services uses this report to set a poverty guideline. The FPL varies according to family size and location. Generally, families with income below 50 percent of the FPL are considered to be living in deep poverty.

Poverty in California. Nearly one in five Californians live at or near the poverty line – or close to eight million residents[5]. In 2017, the U.S. Census Bureau and the Bureau of Labor Statistics released estimates of poverty based on the Supplemental Poverty Measure (SPM), which takes into account the effects of government programs designed to assist low-income families, including refundable tax credits and other in-kind public benefit programs, necessary expenses that may affect family resources, such as out-of-pocket medical expenses and childcare costs, and geographic differences in housing costs.[6] According to 2017 U.S. Census Bureau figures, California's current official poverty measure is 13.4 percent; under the SPM, its poverty rate over 2015-2017 averaged 19 percent—the highest of any state in the nation except for the District of Columbia. Poverty rates vary significantly across California's counties, due to differences in the cost-of-living. In estimates from 2014-2016, Placer County had the lowest poverty rate (12.9 percent), and Los Angeles had the highest (24.3 percent)[7].

Research has shown evidence that childhood poverty can negatively alter brain development, lead to poor educational outcomes and behavioral challenges, among other negative results. Beyond the timing of poverty, extended exposure to poverty as a child is also associated with worse adolescent and adult outcomes. Poverty has negative consequences not only for those living in poverty but also for the state as a whole. By reducing poverty, safety net programs can also benefit the economy of the state. Children growing up in poverty are much more likely to have low earnings as adults, which negatively effects the workforce.[8] A report by the Center for American Progress found that nationally, each year, childhood poverty: 1) reduces productivity and economic output by about 1.3 percent of gross domestic products (GDP); 2) raises the costs of crime by 1.3 percent of GDP; and 3) raises health expenditures and reduces the value of health by 1.2 percent of GDP. The report emphasizes that these estimates likely underestimate the true costs of poverty to the economy.

5 Public Policy Institute of California. "Just the Facts: Poverty in California." July 2018. https://www.ppic.org/publication/poverty-in-california/

6 Liana Fox. "The Supplemental Poverty Measure: 2017." *U.S. Census Bureau, Economics and Statistics Administration.* September 2015. https://www.census.gov/content/dam/Census/library/publications/2018/demo/p60-265.pdf

7 Public Policy Institute of California. "Just the Facts: Poverty in California." July 2018. http://www.ppic.org/wp-content/uploads/JTF_PovertyJTF.pdf

8 Center for American Progress. "The Economic Costs of Poverty in the United States." January 2007. https://cdn.americanprogress.org/wp-content/uploads/issues/2007/01/pdf/poverty_report.pdf

Legislature's Plan for Grant Increases. The 2018 budget increased the maximum aid payment (MAP) amounts for CalWORKs recipients by 10 percent effective April 1, 2019, and included $90 million in 2018-19 and $360 million annually thereafter for those purposes. Trailer bill language also stated the intent of the Legislature to provide future grant increases in 2019-20 and 2020-21 in order to increase grants to no less than 50 percent of the FPL.

The Legislature's plan for increasing grants to no less than 50 percent of the FPL differs from the Governor's proposal above. The plan consists of several steps – the first of which was included in the 2018 budget, a 10 percent across-the-board increase. The second step, subject to appropriation in the 2019-20 budget, would raise grants by varying amounts based on family size halfway to the final goal of 50 percent of FPL. The last step, also subject to appropriation in the 2020-21 budget, would raise those grants the rest of the way to meet the final goal of 50 percent of the FPL.

While the Governor's plan raises grant increases across-the-board, the Legislature chose to focus on increasing grant levels by family size for the next steps in its plan. The Legislature chose this approach to account for the fact that many AUs contain a family member that is ineligible and therefore not considered part of the AU. Under the Legislature's plan, an AU size of three would receive a maximum grant of 50 percent of the FPL for a family of four. Grants would be raised by varying percentages, since some grant amounts are further away from the target of 50 percent of the FPL. The smallest percentage increase would be 19 percent for an AU of four, and the largest would be 42 percent for an AU of one.

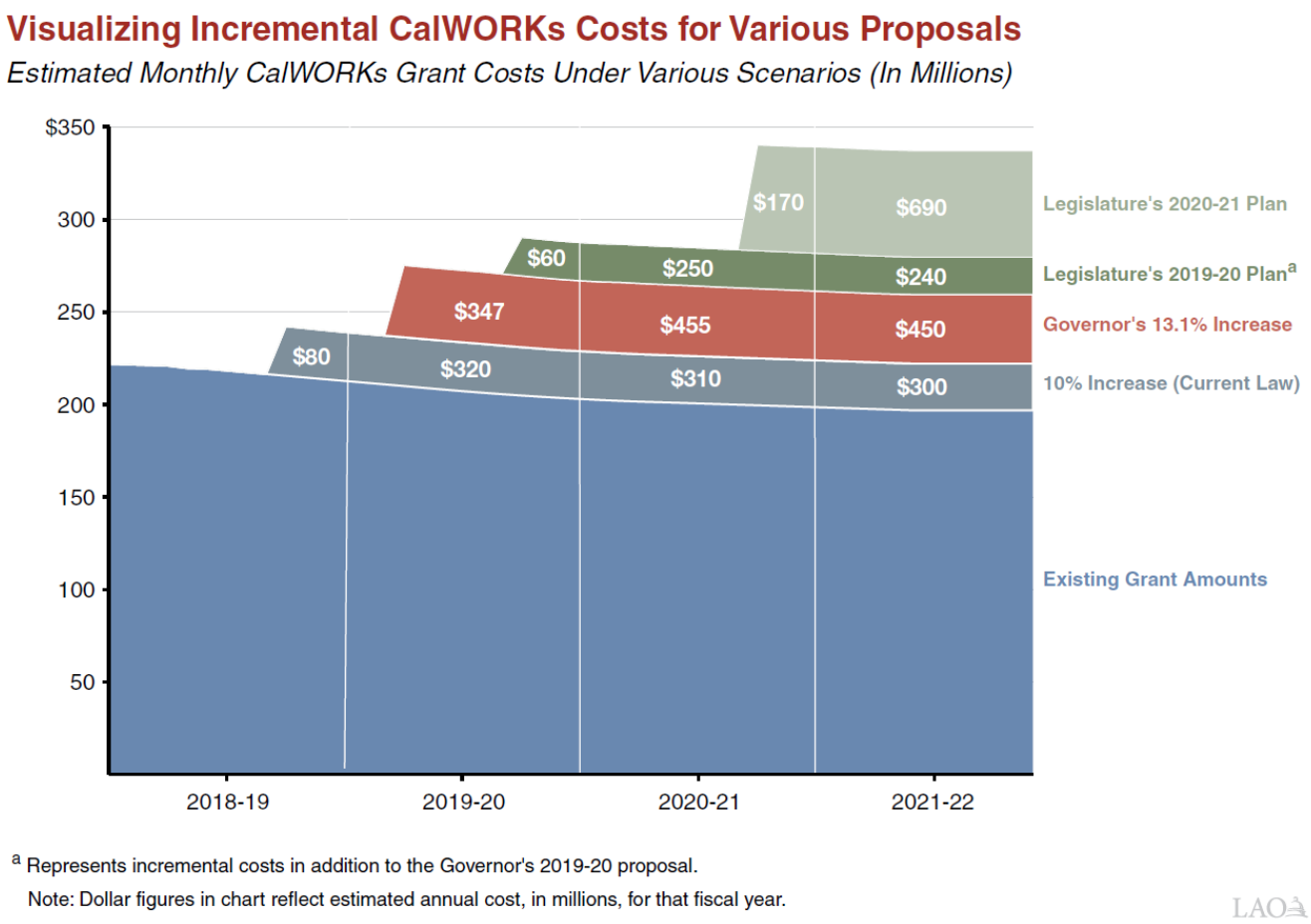
The table below compares current grants (step one of the Legislature's approach to raising grant levels) and the Governor's proposed grant increases to the 2019 federal poverty levels (FPL).

Assistance Unit Size[9]	Current MAP[10] (as of April 1, 2019)	Percent of 2019 FPL	Governor's Proposed MAP	Percent of 2019 FPL
1	$391	38%	$442	42%
2	$635	45%	$718	51%
3	$785	44%	$888	50%
4	$937	44%	$1060	49%
5	$1065	42%	$1205	48%

Note that the table above is only for high-cost counties. MAPs in other counties would be slightly less.

There are significant cost differences between the Legislature's plan and the Governor's plan. The Legislative Analyst's Office (LAO) estimates that the full-year cost under the Legislature's plan would be $250 million higher annually than the Governor's plan. However, note that the Legislature's plan is currently in statute, but subject to appropriation during the annual budget process. The higher cost under the Legislature's plan is mostly a result of the higher grant increases for smaller AUs. The figure below, provided by the LAO, displays the monthly cost of providing CalWORKs grants under current grant levels, the recent ten percent increase that went into effect April 1, 2019, the Governor's proposed 13.1 percent increase, and the next steps of the Legislature's approach. The dollar amounts in the figure show the estimated additional cost of each increase for each fiscal year. The Legislature's approach would require more than $900 million in annual ongoing spending above the Governor's current proposal.

9 Assistance unit – number of family members eligible for CalWORKs
10 MAP – maximum assistance payment



A notable difference between the two plans is the effect on AUs of different sizes. The Governor's plan maintains a difference in FPL percentage between different AU sizes. The Legislature aims to eliminate that difference so that all AU sizes are at 50 percent of the FPL. The Legislature's approach is most noteworthy for the smallest families. The grant amount for the smallest AU size is lower, relative to the FPL, than grants for other AU sizes. Thus, the Legislature's plan would increase grant amounts for those smaller AUs than grant amounts for AUs that are closer to 50 percent of the FPL.

LAO Comments. In its February analysis of the Governor's proposed budget for the Department of Social Services the LAO described some examples of different options the Legislature could choose.

The Legislature could choose to prioritize linking grant levels to the FPL, as it originally intended. The LAO describes two different options related to that approach.

1. Modify the Governor's proposal of an across-the-board increase and distribute that same amount of funding ($347 million in 2019-20) differently across various AU sizes. The largest increases could be given to AU sizes furthest away from that final goal of 50 percent of the FPL, and smaller increases to those AUs closer to that target. The LAO estimates that, with this approach, grant levels for all AU sizes could be raised to 48 percent of the FPL.

2. Reject the Governor's proposal and move ahead with the Legislature's original plan. As mentioned above, this plan includes multiple steps that would ultimately result in all AU sizes being at 50 percent of the FPL, or more.

Alternatively, the Legislature could prioritize an across-the-board increase by first adopting the Governor's proposal and providing other increases in subsequent years to reach the Legislature's final goal. The grant increases provided in later years would need to be of varying percentages. This option is very similar to the Legislature's current plan. Note that all of the options described are examples, and other approaches not described here could be taken.

Panel. The Subcommittee has requested Mike Herald, Director of Policy Advocacy, Western Center on Law and Poverty, in addition to DSS, DOF, and the LAO to provide comment on the proposed grant increases.

Staff Comment and Recommendation. Hold open. As mentioned above, California's poverty rate is the second highest in the nation, behind only Washington, D.C. Research has consistently shown that childhood poverty leads to poor physical, emotional, and behavioral outcomes for children. The Legislature recognizes these connections, and has made a commitment to lift all children out of deep poverty by implementing its plan to raise all CalWORKs AUs to at least 50 percent of the FPL in last year's budget. While the Governor's plan aligns with the Legislature's intent to raise all children out of deep poverty there are some differences between the two approaches. The Legislature may want to weigh the many different options, and how it can best meet its goal of raising all children out of deep poverty within those options. The Subcommittee may want to consider using the same funding amount provided in the Governor's budget but instead focus on providing larger grant increases to AUs with the greatest need.

Questions.

For DSS:

1. Please describe the Governor's proposal for raising CalWORKs grants.

2. What percentage of AUs include an ineligible or unaided family member?

3. What operational considerations should be kept in mind when considering the options provided by the LAO?

For LAO:

1. Please describe the different options the Legislature could consider in regards to this proposal.

Issue 4: BCP and Overview - CalWORKs Home Visiting Initiative (HVI)

Governor's Proposal. The Governor's budget includes $861,000 General Fund for six positions to ensure the timely and appropriate implementation of the CalWORKs HVI.

Additionally, the Governor's budget proposes ongoing funding for the program. A Home Visiting Reserve of $158.4 million was set aside to fund the HVI, from 2019 through 2021. In 2019-20, the budget provides a total of $79 million for the program. After implementation in 2018-19 and 2019-20, there will be $50.3 million remaining in the reserve. After 2020-21, funding for the program will be subject to annual appropriation during the budget process.

Background. Home visiting is an evidence-based, voluntary program model that pairs new parents with a nurse or other trained professional who makes regular visits to the participant's home to provide guidance, coaching, access to prenatal and postnatal care, and other health and social services.

Initial funding for the program was provided in the 2018 budget. DSS released a request for county plans on July 31, 2018. 44 counties submitted applications, and all 44 will receive funding for some or all of their proposed models. Many counties proposed using more than one home visiting model. Total funding awarded in 2018-19 is $26.9 million. The amount allocated to each county is based on the distribution of eligible cases per county with a minimum of $10,000 for counties with smaller caseloads.

Assembly Bill 1811 (Committee on Budget), Chapter 35, Statutes of 2018, laid out the requirements for the HVI. DSS is responsible for oversight in participating counties. This includes creating an allocation methodology, analyzing county plans, distributing funds, monitoring compliance, providing technical assistance, and legal support. AB 1811 also requires DSS to establish curriculum to train on cultural competence and implicit bias, work with a research-based institution on evaluation of the program, and to convene a stakeholder group to ensure quality improvement. An evaluation of program efficacy should be presented to the Legislature no later than January 10, 2022.

The department requests the following positions to aid in carrying out these responsibilities:

- **One Staff Services Manager I.** The manager will supervise the work of the analysts and convene with stakeholders to improve services strategies and outcomes.

- **Three Associate Governmental Program Analysts.** The analysts will serve as points of contact and subject matter experts for implementation and operation of the HVI. They will perform contract monitoring, and provide oversight of program implementation, research, and design.

- **One Research Analyst II.** The analyst will assist with analysis of caseload characteristics, as well as monitor and oversee county expenditures.

- **One Research Data Specialist I.** The data specialist will create a case management tracking system, develop data sharing agreements with other departments, and prepare research methodologies for responding to mandated reporting requirements.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide a brief overview of the BCP and an update on the HVI.

2. Please discuss the different metrics that will be tracked in the monitoring and evaluation of the program.

Issue 5: TBL – Application Fee Reimbursement for Child Care Providers in the Emergency Child Care Bridge Program

Governor's Proposal. The Governor's budget proposes language to allow for the reimbursement of the fees associated with registering as a Trustline child care provider in the Bridge Program. Currently, only license-exempt child care providers working with families in CalWORKs stages one, two, and three and Alternative Payment Programs can have their Trustline fees paid for at no cost to the provider. Total processing fees range from about $135 to $170.

Background. Existing law, provides that non-relative, prospective license-exempt child care providers who are planning to provide child care to families receiving child care subsidies, are required to become Trustline registered. Trustline is California's registry of in-home child care providers who have been cleared through a fingerprint check of records and criminal background screening. This process includes a search of the California Criminal History system, the Child Abuse Central Index and conducting a Federal Bureau of Investigation background check.

Beginning January 1, 2018, counties participating in the Bridge Program may provide a time limited six-month child care voucher or payment to help pay for child care costs for foster children birth through age 12. Currently, Trustline fees can be paid at no cost to prospective license-exempt child care providers who plan to provide child care to families in CalWORKs stages one, two, and three and Alternative Payment Programs. However, prospective license-exempt child care providers caring for children in the Bridge Program do not have access to these resources. The proposed language would allow for child care providers in the Bridge Program to also have their Trustline fees be paid at no cost to them.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

Issue 6: TBL - Work Incentive Nutritional Supplement (WINS) Two-parent Population

Governor's Proposal. The Governor's budget includes trailer bill language to align state law with current practice and the budget in regards to the payment of the two-parent portion of WINS benefits.

Background. WINS is a $10 food benefit for CalFresh recipients who are not on CalWORKs, but are working enough hours to meet Temporary Assistance for Needy Families (TANF) work requirements and count positively toward California's Work Participation Rate (WPR). By funding the $10 with MOE, this CalFresh population counts towards the WPR. As of October 1, 2017, WINS two-parent cases are funded with non-MOE General Fund, which conflicts with existing state law requiring funding to be claimed as MOE. DSS began funding this population with non-MOE General Fund to remove this population from WPR calculation and mitigate the risk of federal penalty exposure. California has failed to meet the 90 percent for the two-parent WPR from 2012 through 2015, with continued noncompliance expected. Fiscal analysis showed that funding the two-parent WINS population outside of the TANF program reduces the state's potential penalty exposure, while maintaining compliance with the All Families WPR requirement.

In order to include the two-parent population with the non-MOE California Food Assistance Program (CFAP) population, a change in statutory language is needed to provide less specificity with regard to the WINS funding source. This change will allow administrative flexibility to use appropriate funding to mitigate or avoid federal fiscal penalties.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposed language.

Issue 7: Proposals for Investment

The Subcommittee has received the following CalWORKs related proposals for investment.

1. Strengthen the Earned Income Disregard (EID)

Budget Issue. The California Welfare Director's Association (CWDA) requests the 2019-20 budget strengthen the EID. The EID is the amount subtracted from a CalWORKs recipient's income to determine initial eligibility for assistance and monthly grant amounts. By allowing a certain amount of income to be excluded, the EID is intended to facilitate and encourage paid employment. However, the EID has not been changed since it was first established in 1997.

Staff Comment and Recommendation. Hold open. Advocates are currently working with the department to determine a cost estimate. Full year costs will likely range from $80 - $120 million.

2. CalWORKs 2.0 Automation

Budget Issue. CWDA requests $5.1 million to support the automation of the CalWORKs 2.0 tools in the California Statewide Automated Welfare System (SAWS) and make them available to CalWORKs participants. Currently, the CalWORKs 2.0 tools are primarily paper based and there is no way to store the information they capture in the SAWS.

Staff Comment and Recommendation. Hold open.

3. Additional Funding for the Home Visiting Initiative

Budget Issue. The Western Center on Law and Poverty, Parents as Teachers, Head Start California, Children NOW, and the GOOD+ Foundation request an additional $25 million to extend the reach of the CalWORKs Home Visiting Initiative (HVI) to more CalWORKs families who are expecting or parenting a child under the age of two, regardless of whether they are a first-time parent or not.

Staff Comment and Recommendation. Hold open. The 2019-20 budget includes a total of $78.9 million for the CalWORKs HVI. The Administration expects 15,000 cases to be served on an annual basis beginning in 2020-21.

4. Restoration of 60-Month Time Clock

Budget Issue. The Western Center on Law and Poverty (WCL&P) and the Coalition of California Welfare Rights Organizations (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. The organizations also propose to repeal the two 24-month periods but retain county flexibility to design welfare to work programs that fit the needs of families.

Staff Comment and Recommendation. Hold open.

5. Cal-OAR and CalWORKs 2.0 TBL

Budget Issue. The WCL&P and the CCWRO request the Legislature consider trailer bill language concerning both CalOAR and CalWORKs 2.0. As can be expected, during beginning conversations around CalOAR there were some differences on which performance measures to include in CalOAR. Based on these conversations the department increased the number of measurements beyond what was initially envisioned. However, stakeholders request that the Legislature provide continued oversight of CalOAR and the inclusion of additional performance measures as needed. In addition, advocates request the Legislature consider language to formally recognize CalWORKs 2.0 in statute, and consider impacts of CalWORKs 2.0 on various aspects of the CalWORKs program, including child care, housing assistance, barrier removal services, and welfare to work requirements.

Staff Comment and Recommendation. Hold open.

6. Homeless Assistance Program

Budget Issue. The WCL&P and the CCWRO request a change in statute so that a single time limited use of homeless assistance does not result in a family losing all 16 days of temporary shelter. Further, the organizations request that the limit on the use of homeless assistance payments to once a year be repealed. The organizations state that this provision is inconsistent with the realities of many families and it also makes it more difficult for counties to assist families struggling with housing.

Staff Comment and Recommendation. Hold open.

7. Repeal CalWORKs Asset Test

Budget Issue. The WCL&P, Prosperity Now, EARN, the California Association of Food Banks, the California Asset Building Coalition, and the California Coalition of Welfare Rights Advocates request the repeal of the CalWORKs Asset Test in the 2019-20 budget. Currently, families with total assets exceeding $2,250 or with a vehicle assessed at more than $9,500 cannot qualify for CalWORKs. Removing the asset test would allow more families to qualify for the CalWORKs program.

Staff Comment and Recommendation. Hold open.

8. Emergency Child Care Bridge Program for Foster Children

Budget Issue. A coalition of advocates, including the Alliance for Children's Rights, the California Alliance of Caregivers, the California Alternative Payment Program, CWDA, the Child Care Resource Center, and the SEIU California, request $47 million General Fund to ensure additional access to early care and education services for children in foster care. This program helps to immediately stabilize traumatized children in the most appropriate foster care placement, and provides them with a bridge to long-term, high-quality early education programs to promote their educational success. Stakeholders estimate that the requested funding would draw down an additional $34.3 million in federal funds.

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 Melissa Hurtado
Senator Jeff Stone

Thursday, April 25, 2019
9:30 a.m. or upon adjournment of session
State Capitol - Room 4203

Consultant: Scott Ogus

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PUBLIC COMMENT

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

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Medi-Cal Dental Services - Overview

Dental Services for Medi-Cal Beneficiaries. The budget includes $485.9 million ($200.2 million General Fund and $285.8 million federal funds) in 2018-19 and $993.3 million ($377.8 million General Fund and $615.5 million federal funds) in 2019-20 for base fee-for-service expenditures for dental services in the Medi-Cal program. The 2018-19 figures are net of a one-time underwriting savings adjustment of $514.2 million ($167.3 million General Fund and $346.9 million federal funds) from the program's contract with Delta Dental.

The budget also includes $80.9 million ($30.6 million General Fund and $50.3 million federal funds) in 2018-19 and $67.3 million ($26 million General Fund and $41.3 million federal funds) in 2019-20 for base dental services provided through dental managed care plans.

Dental Services Funding Summary			
Fiscal Year:	**2018-19**	**2019-20**	**CY to BY**
Dental Fee-for-Service			
Fund Source	***Revised***	***Proposed***	***Change***
0001 – General Fund	$200,174,510	$377,767,700	$177,593,190
0890 – Federal Trust Fund	$285,754,490	$615,544,300	$329,789,810
Total Expenditures	**$485,929,000**	**$993,312,000**	**$507,383,000**
Dental Managed Care			
Fund Source	***Revised***	***Proposed***	***Change***
0001 – General Fund	$30,619,010	$25,961,960	($4,657,050)
0890 – Federal Trust Fund	$50,307,990	$41,311,040	($8,996,950)
Total Expenditures	**$80,927,000**	**$67,273,000**	**($13,654,000)**

Background. Medi-Cal provides an array of dental benefits 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. With some restrictions, Medi-Cal covers the following dental benefits for beneficiaries with full-scope, restricted-scope, or pregnancy related coverage, and those residing in a skilled nursing facility (SNF) or an intermediate care facility (ICF):

MEDI-CAL DENTAL BENEFITS BY ELIGIBILITY CATEGORY				
PROCEDURE	**Full Scope**	**Restricted Scope**	**Pregnancy Related**	**Residing in a Facility (SNF/ICF)**
Oral Evaluation (Under age 3)	**YES**	**NO**	**NO**	**YES**
Initial Exam (Age 3 and above)	**YES**	**NO**	**YES**	**YES**
Periodic Exam (Age 3 and above)	**YES**	**NO**	**YES**	**YES**
Prophylaxis	**YES**	**NO**	**YES**	**YES**
Fluoride	**YES**	**NO**	**YES**	**YES**
Restorative Services: Amalgams, Composites, Pre-fabricated Crowns	**YES**	**NO**	**YES**	**YES**
Laboratory Processed Crowns	**YES**	**NO**	**YES**	**YES**
Scaling and Root Planing	**YES**	**NO**	**YES**	**YES**
Full Mouth Debridement	**NO**	**NO**	**NO**	**YES**
Periodontal Maintenance	**YES**	**NO**	**YES**	**YES**
Anterior Root Canals	**YES**	**NO**	**YES**	**YES**
Posterior Root Canals	**YES**	**NO**	**YES**	**YES**
Partial Dentures	**YES**	**NO**	**YES**	**YES**
Full Dentures	**YES**	**NO**	**YES**	**YES**
Extractions/Oral and Maxillofacial Surgery	**YES**	**YES**	**YES**	**YES**
Emergency Services	**YES**	**YES**	**YES**	**YES**

Source: *California Medi-Cal Dental Services – 2018 Beneficiary Handbook (May 2018)*

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

1. Fee-for-Service – Most Medi-Cal beneficiaries receive dental benefits through the fee-for-service delivery system. The department contracts with an administrative services organization (ASO), Delta Dental, to provide administrative services for the Medi-Cal Dental Program including adjudication of claims, treatment authorization requests, and customer service for both providers and beneficiaries. The department also contracts with a fiscal intermediary (FI), DXC Technology, which manages the California Dental Medicaid Management Information System (CD-MMIS), which processes dental services claims.

2. Dental Managed Care - The department contracts with six dental managed care plans that provide dental care to approximately 832,000 Medi-Cal beneficiaries in Sacramento and Los Angeles counties. These plans are regulated by the Department of Managed Health Care and licensed under the Knox-Keene Act. The department contracts with Access Health Plan, Health Net and Liberty Health Plan to provide dental benefits in both Sacramento and Los Angeles. In Sacramento, approximately 418,000 beneficiaries are mandatorily enrolled in one of three geographic managed care plans, while in Los Angeles approximately 414,000 beneficiaries voluntarily enroll in one of three prepaid health plans.

2014 Audit Found Low Children's Dental Utilization and Provider Reimbursement. In 2014, the California State Auditor performed an audit of Medi-Cal dental services 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, 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.

Annual Dental Reimbursement Rate Review. After the 2014 audit, DHCS resumed its annual review of dental reimbursement rates in Medi-Cal. The most recent report was released in August 2018 for the 2015-16 and 2016-17 fiscal years. The report found that in 2015-16, for the 25 most frequent utilized procedure codes, Medi-Cal paid an average of 105.3, 99.2, 76.5, and 62.9 percent of Illinois, Florida, New York, and Texas Medicaid Program's dental fee schedules, respectively. For 2016-17 the overall averages were 109, 91.5, 78.7, and 64.3 percent of Illinois, Florida, New York, and Texas Medicaid Program's dental fee schedule, respectively. The report also found a decrease in providers rendering Medi-Cal dental services, from 9,527 in calendar year 2008 to 8,270 in calendar year 2016, a decrease of 13.2 percent.

Dental Outreach. The audit also recommended the department enforce and enhance its contract with Delta Dental to conduct outreach to Medi-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 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 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), 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 20 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 offers 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 $60.2 million ($30.1 million General Fund and $30.1 million federal funds) in 2018-19 and $76.9 million ($38.5 million General Fund and $38.5 million federal funds) in 2019-20.

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.

   According to DHCS, Domain 2 costs for caries risk assessment and disease management will be $3.7 million ($1.8 million General Fund and $1.8 million federal funds) in 2018-19 and $4.1 million ($2 million General Fund and $2 million federal funds) in 2019-20.

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 receive an incentive payment for maintaining continuity of care for enrolled child beneficiaries for two, three, four, five, and six year continuous periods. Incentive payments are made annually.

   According to DHCS, Domain 3 costs for incentive payments for continuity of care will be $11.9 million ($5.9 million General Fund and $5.9 million federal funds) in 2018-19 and $18.1 million ($9 million General Fund and $9 million federal funds) in 2019-20.

4. Local Dental Pilot Programs (LDPPs) –15 LDPPs were approved, although two have been withdrawn, 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 requires 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 is allocated to this domain.

   According to DHCS, Domain 4 costs for LDPPs will be $39.5 million ($19.7 million General Fund and $19.7 million federal funds) in 2018-19 and $50.1 million ($25 million General Fund and $25 million federal funds) in 2019-20.

Restoration of Adult Dental Benefits. AB 5 X3 (Evans), Chapter 20, Statutes of 2009, Third Extraordinary Session, 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 include 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.

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 2018 Budget Act included up to $210 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 to 60 percent of the dental Schedule of Maximum Allowances (SMA), or fixed supplemental payment amounts, for certain dental services. According to DHCS, the services included the following claiming (CDT) codes in the following procedural categories:

Type of Procedure	# of Specific CDT codes	Supplemental Payment Amount or Percent of SMA
Restorative	35 CDT codes	40 percent
Endodontic	18 CDT codes	40 percent
Prosthetic	76 CDT codes	40 percent
Oral and Maxillofacial Surgery	111 CDT codes	40 percent
Adjunctives	15 CDT codes	40 percent
	2 CDT codes	60 percent
	1 CDT Code (D9220)	$148.65
	1 CDT Code (D9221)	$110.99
Visits and Diagnostics	5 CDT codes	20 percent
	1 CDT Code (D0120)	$30.00
	1 CDT Code (D0145)	$39.00
	1 CDT Code (D0150)	$41.00
	1 CDT Code (D0350)	$3.60
	1 CDT Code (D0230)	$1.05
Preventive	1 CDT Code (D1110)	$50.00
	1 CDT Code (D1206)	$12.00
	1 CDT Code (D1208)	$9.00
Orthodontics	10 CDT codes	40 percent
Periodontics	3 CDT codes	40 percent

The budget includes $510.1 million ($194.4 million Proposition 56 funds and $315.7 million federal funds) in 2018-19 and $546.6 million ($216.6 million Proposition 56 funds and $330 million federal funds) in 2019-20.

Current Status of Provider Participation and Dental Utilization. According to data provided by DHCS in its two most recent quarterly reports for the 1115 Waiver, which includes DTI, children's preventive utilization was 45.2 percent as of July 2018 and had increased slightly to 45.4 percent as of November 2018. Between July 2018 and December 2018, the number of rendering dental providers in fee-for-service grew from 10,270 to 10,479 and service offices grew from 5,780 to 5,815. Between July

2018 and November 2018, the number of rendering providers in Geographic Managed Care dental plans grew from 268 to 399 and service offices grew from 118 to 158. During the same period, the number of rendering providers in the Prepaid Health Plans in Los Angeles grew from 1,930 to 2,112 and service offices grew from 874 to 1,043. Also during the same period, the number of safety net clinics decreased from 565 to 556.

According to DHCS' most recent fee-for-service performance measures report, 22.8 percent of adults 21 and over had an annual dental visit between July 2017 and June 2018. 13.7 percent of adults 21 and over used a preventive service during that period. 48.7 percent of continuously covered adults 21 and over utilized a dental service in the prior three years. These data include the first six months of the restoration of full adult dental benefits and the implementation of Proposition 56 supplemental provider payments for dental services approved in the 2017 Budget Act.

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

Trailer Bill Language Clarifying Establishment of Patients for Clinics – The Children's Partnership and a coalition of ten other organizations request trailer bill language to clarify the provisions of AB 1174 (Bocanegra), Chapter 662, Statutes of 2014, that states that federally qualified health centers (FQHCs) and rural health clinics (RHCs) are allowed to establish a patient through store-and-forward teledentistry for the purposes of billing so that a virtual dental home (VDH) can operate as intended, as efficiently as possible in community settings. FQHCs and RHCs are a critical source of care for underserved communities and have been extremely successful at implementing the VDH. However, FQHCs and RHCs must establish an individual as a patient before they can bill for services. This simple budget language clarification request would allow the provision of safe and quality dental care to children and adults in community settings through the Virtual Dental Home.

Silver Diamine Fluoride Coverage in Denti-Cal – The California Dental Association (CDA) requests resources to add silver diamine fluoride as a Medi-Cal dental benefit. According to CDA, dental caries remain 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 dental benefit covered by Medi-Cal. It is a painless topical medication that can provide enormous benefit and eliminate the need for more extensive restorative procedures. Modernizing the dental benefits offered under Medi-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 dental services for both children and adults in the Medi-Cal program.

2. Please describe current outreach efforts by DHCS and the ASO to improve children's utilization of preventive dental services.

3. Please describe current outreach efforts by DHCS and the ASO to improve adult utilization of preventive dental services since the restoration of the full dental benefit.

Issue 2: Medi-Cal Pharmacy Services

Governor's Executive Order on Prescription Drug Purchasing. On January 7, 2019, the Governor issued Executive Order N-01-19, ordering state departments to implement several directives intended to reduce the cost of prescription drugs for both public and private purchasers.

1. *Transition of Medi-Cal Prescription Drug Benefits to Fee-For-Service.* The Executive Order directs the Department of Health Care Services (DHCS) to take all necessary steps to transition all pharmacy services currently provided by Medi-Cal managed care plans into the Medi-Cal fee-for-service delivery system. The transition, which would be completed by January 2021, is intended to create additional negotiating leverage on behalf of the state's 13.2 million Medi-Cal beneficiaries. According to the Administration, this transition would standardize the Medi-Cal drug benefit, reduce confusion among beneficiaries without sacrificing quality or outcomes, and result in hundreds of millions of dollars in additional savings beginning in the 2021-22 fiscal year. There are no savings or transition costs for this purpose reflected in the Governor's January budget for the 2019-20 fiscal year.

2. *Statewide Review of Drug Purchasing Initiatives.* The Executive Order directs DHCS, in consultation with the California Pharmaceutical Collaborative (CPC), to review all state purchasing initiatives and consider additional options to maximize the state's bargaining power, including the Medi-Cal program. The review, which may include recommended changes to state law or other procurement or reimbursement processes, will be completed by July 12, 2019.

3. *Prioritization of Drugs and Implementation of Bulk Purchasing Arrangements.* The Executive Order directs the Department of General Services (DGS), in collaboration with the CPC, to develop a prioritized list of prescription drugs for future bulk purchasing initiatives or for renegotiation of existing purchasing arrangements with manufacturers. The prioritization would be based on the level of competition for the drug in the marketplace and consideration of the 25 highest-cost drugs. The department will provide a written report to the Governor's Office by March 15, 2019.

   Once DGS and the CPC have developed a prioritized list, these two entities will develop and implement bulk purchasing arrangements for high-priority drugs. The department will encourage local governments to participate in the bulk purchasing arrangement through proactive outreach and will provide a written status report to the Governor's Office by April 12, 2019. The Executive Order also directs DGS and the CPC to develop a framework for private purchasers, such as small businesses, health plans, and the self-insured to opt into the state bulk purchasing program. DGS will provide a written report recommending any necessary legislative changes to the Governor's Office by May 17, 2019.

Prescription Drug Coverage in California. While recent health reform efforts have led to significant expansions of health insurance coverage in California and across the United States, a complementary goal of these health reform efforts has also been to reduce the growth of health care costs. One of the primary drivers of rising health care costs has been the growth in the price of prescription drugs, which in 2017 accounted for approximately one out of every ten dollars in national health care expenditures.[1] Employer-based health plans experience even higher expenditures for prescription drugs, which make up 19 percent of employer-based health spending.[2]

According to the federal Centers for Medicare and Medicaid Services (CMS), California has experienced average annual growth in prescription drug expenditures of seven percent between 1991 and 2014, with total expenditures rising from $7.7 billion in 1991 to $36.9 billion in 2014.[3]

Medi-Cal, which covers 13.2 million low-income Californians, is one of the largest purchasers of prescription drugs in the state. The Governor's January budget estimates that Medi-Cal will spend $1.4 billion in 2018-19 and $2 billion in 2019-20 on prescription drugs in the fee-for-service delivery system. These figures are net of rebates provided by manufacturers under state and federal drug rebate programs (see *Prescription Drug Rebates in Medi-Cal*) and do not include drugs purchased on behalf of Medi-Cal beneficiaries by managed care plans.

Many other California state entities are impacted by high prescription drug spending. Total prescription drug costs for state employees and retirees covered by the California Public Employee Retirement System (CalPERS) were $1.25 billion for Basic Plans and $880.1 million for Medicare plans in 2017.[4] Other state entities prescription drug expenditures in the 2015-16 fiscal year were as follows:

Prescription Drug Expenditures by Various State Departments, 2015-16[5]	
Department	Expenditures
CA Dept. of Corrections Rehabilitation: California Correctional Health Care Services	$239,454,095
Department of State Hospitals	$34,895,455
Department of Developmental Services	$8,539,096
California State Universities	$3,569,905
CA Dept. of Corrections and Rehabilitation: Division of Juvenile Justice	$275,695

[1] Centers for Medicare and Medicaid Services. "National Health Expenditures 2017 Highlights". https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf. Accessed February 9, 2019.

[2] Peterson-Kaiser Health System Tracker. "Retail drugs as a share of national health spending and as a share of employer health benefits, 2017".

[3] Centers for Medicare and Medicaid Services. "Health expenditures by state of residence: summary tables, 1991-2014. Table 8: Total All Payers State Estimates by State of Residence (1991 - 2014) - Drugs and Other Non-durable Products".

[4] CalPERS Pension and Health Benefits Committee. "Board Agenda Item 5c: Prescription Drugs Utilization and Cost Trends". September 25, 2018.

[5] Legislative Analyst's Office. "Department of General Services' Efforts to Control State Prescription Drug Spending". (Handout - Assembly Health Committee. February 14, 2017).

High-Cost Specialty Drugs Dramatically Increase Costs for Public Health Care Programs. One of the primary drivers in the growth of overall prescription drug expenditures is the high cost of specialty drugs. According to a Health Affairs Blog post from May 2016, specialty drugs account for a disproportionate share of overall drug spending and have a corresponding effect on spending growth. In fact, spending on specialty medicines was responsible for 73 percent of overall medicine spending growth over the past five years. Approval of these drugs by the federal Food and Drug Administration, along with the requirement of public health care programs to cover approved, medically necessary prescription drugs have placed enormous fiscal and programmatic pressures on these programs in recent years. In particular, the emergence of Sovaldi and Harvoni, specialty drugs developed by Gilead Sciences, which effectively cure individuals infected with hepatitis C, illustrate the potential for unexpected skyrocketing costs to public health programs. In response to these costs, the 2015-16 Governor's January budget reserved $300 million for the combined impact of hepatitis C treatment on California's public health programs including Medi-Cal, the Department of State Hospitals, and the California Department of Corrections and Rehabilitations. Medi-Cal implemented a supplemental capitation payment for hepatitis C treatment for Medi-Cal managed care beneficiaries. The Governor's January budget estimates Medi-Cal will spend a total of $400.9 million in 2018-19 and $359.3 million in 2019-20 for hepatitis C treatment for managed care beneficiaries.

While hepatitis C treatment is one of the more well-known instances of high-cost specialty drugs that impact public health care programs, the population with hepatitis C is relatively small. Several other specialty drugs have been approved, or are nearing approval that could target much larger populations. Specialty drugs treating high cholesterol or other common conditions could result in increased expenditures dramatically higher than those experienced for hepatitis C treatments. The prices of specialty drugs are also growing dramatically. For example, the Memorial Sloan Kettering Cancer Center reported that the median launch price of new cancer agents doubled in the last decade, from $4,500 per month to more than $10,000 per month. Similarly, the launch prices of new multiple sclerosis drugs increased from $8,000 to $12,000 per year in the 1990s to $50,000 to $65,000 per year today. Specialty drugs also often experience substantial price growth every year they are on the market. For example, the AARP Public Policy Institute's December 2016 Rx Price Watch report found that the retail prices of specialty drugs widely used by older Americans increased by almost 11 percent in 2013.

Generic Drugs Also Subject to Sharp Price Increases. Significant price increases are not limited to specialty drugs. Prices for drugs that have been on the market for decades have also seen inexplicable increases. For example, over the past 20 years, the price of human insulin produced by two major manufacturers – Eli Lilly and Novo Nordisk – rose 450 percent after accounting for inflation, according to a 2016 Washington Post analysis of data from Truven Health Analytics. A single 10-milliliter vial of Eli Lilly's Humalog insulin, which is less than a month's supply for many adults, was listed at $254.80 in 2016, compared with $20.82 in 1996.

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. However, managed care drug utilization is not eligible for state supplemental rebates.

The Governor's January budget includes General Fund savings from drug rebates of approximately $1.6 billion in 2018-19 and $1.4 billion in 2019-20 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).

Medi-Cal Drug Rebates, 2019-20 Governor's January Budget		
Rebate Program	**2018-19**	**2019-20***
Managed Care (Fed only)	$(549,832,000)	$(639,218,000)
Federal Rebate Program	$(953,904,000)	$(727,582,000)
State Supplemental	$(65,385,000)	$(67,262,000)
Family PACT	$(3,067,000)	$(3,213,000)
BCCTP	$(3,166,000)	$(3,251,000)
TOTAL	**$(1,575,354,000)**	**$(1,440,526,000)**

* 2019-20 rebates deposited in the Medi-Cal Rebate Fund, which will offset General Fund expenditures

Federal 340B Drug Pricing Program Supports Safety Net Providers. 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 (ADAP), Medicare/Medicaid Disproportionate Share Hospitals, children's hospitals, and other safety net providers.

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. 340B- covered entities are also required to provide drugs purchased under the 340B program to Medi-Cal beneficiaries in the fee-for-service delivery system at the 340B price. It is unclear the extent to which Medi-Cal managed care plans, in an effort to maintain an adequate network of pharmacy providers, reimburse 340B entities at a higher rate than the 340B price. However, it is likely 340B entities receive a significant amount of revenue from the incremental difference between costs and managed care reimbursement, as this feature is the primary method utilized by the 340B program to assist safety net clinics and providers to stretch scarce funding resources to care for underserved populations.

Stakeholder Proposals Related to Pharmacy Services. Stakeholders have proposed the following proposals related to Medi-Cal pharmacy benefits.

Trailer Bill Language to Add Hemlibra to Carved-Out Products Similar to Blood Factors – Genentech requests trailer bill language to expand the definition of "blood factor" to ensure parity in access for all hemophilia products. Hemlibra was approved in November 2017 for routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adults and children with Hemophilia A. Hemlibra is the only prophylactic treatment for Hemophilia A patients without factor VIII inhibitors that can be administered subcutaneously and at multiple dosing options. Hemlibra is a high-cost specialty drug and, despite the long-term savings that can ensue from the use of Hemlibra, the short-term costs are a significant deterrent to managed care organizations approving utilization. The proposed trailer bill language would treat Hemlibra similar to blood factors by carving it out of managed care.

Carve-Out of High Cost Drugs From Hospital Reimbursement – The California Children's Hospital Association requests trailer bill language to require DHCS to reimburse hospitals for newly-approved, high-cost, inpatient-administered drugs based on the acquisition cost of the drug, rather than as part of a diagnosis-related group (DRG) payment. When a Medi-Cal patient is administered a prescription drug on an inpatient basis, the hospital is reimbursed with a bundled payment called a DRG, which is meant to cover all the costs associated with treating someone with that condition, including the cost of any necessary medications. When a high-cost prescription drug is administered to a patient on an inpatient basis, and particularly when a high-cost drug first hits the market, the DRG payment does not adequately incorporate the cost of the medication. As such, hospitals experience significant financial losses if they administer these drugs, and have a disincentive to provide these treatments to 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 the department's proposal to transition pharmacy benefits to fee-for-service.

2. How does the department intend to address concerns from Medi-Cal managed care plans that inability to access or manage the pharmacy benefit would be detrimental to effective clinical management?

3. Has the department conducted or does it intend to conduct an analysis of safety net clinics that are also 340B entities to determine if loss of rebate revenue from the department's transition of the pharmacy benefit would result in a reduction in access to care for Medi-Cal beneficiaries?

4. When will the department be able to provide a fiscal estimate of the savings to the Medi-Cal program from the pharmacy benefit transition?

Issue 3: California 1115 Waiver - Medi-Cal 2020

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 ($843.9 million intergovernmental transfers and $843.9 million federal funds) in 2018-19 and $1.3 billion ($666 million intergovernmental transfers and $666 million federal funds) in 2019-20 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 $2.4 billion ($1.2 billion intergovernmental transfers and $1.2 billion federal funds) in 2018-19 and $2.4 billion ($1.2 billion intergovernmental transfers and $1.2 billion federal funds) in 2019-20 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	15,600	$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	625	$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	600	$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	287	$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

The budget includes $839.7 million ($419.9 million intergovernmental transfers and $419.9 million federal funds) in 2018-19 and $646.7 million ($323.4 million intergovernmental transfers and $323.4 million federal funds) in 2019-20 for funding WPC Pilots. The budget also includes a one-time General Fund augmentation of $100 million to provide funding for supportive housing services for individuals who are homeless or are at risk of becoming homeless, with a focus on individuals with mental illness.

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 offers 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 $60.2 million ($30.1 million General Fund and $30.1 million federal funds) in 2018-19 and $76.9 million ($38.5 million General Fund and $38.5 million federal funds) in 2019-20.

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.

   According to DHCS, Domain 2 costs for caries risk assessment and disease management will be $3.7 million ($1.8 million General Fund and $1.8 million federal funds) in 2018-19 and $4.1 million ($2 million General Fund and $2 million federal funds) in 2019-20.

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 receive an incentive payment for maintaining continuity of care for enrolled child beneficiaries for two, three, four, five, and six year continuous periods. Incentive payments are made annually.

   According to DHCS, Domain 3 costs for incentive payments for continuity of care will be $11.9 million ($5.9 million General Fund and $5.9 million federal funds) in 2018-19 and $18.1 million ($9 million General Fund and $9 million federal funds) in 2019-20.

4. Local Dental Pilot Programs (LDPPs) –15 LDPPs were approved, although two have been withdrawn, 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 requires 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 is allocated to this domain.

   According to DHCS, Domain 4 costs for LDPPs will be $39.5 million ($19.7 million General Fund and $19.7 million federal funds) in 2018-19 and $50.1 million ($25 million General Fund and $25 million federal funds) in 2019-20.

The budget includes total funding of $115.2 million ($7.6 million General Fund and $57.6 million federal funds) in 2018-19 and $149.1 million ($74.5 million General Fund and $74.5 million federal funds) in 2019-20 for all four domains of the DTI.

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.

Issue 4: Whole Person Care Housing Services

Budget Issue. DHCS requests General Fund expenditure authority of $100 million in 2019-20 to provide funding for supportive housing services for individuals who are homeless or are at risk of becoming homeless, with a focus on individuals with mental illness. The expenditure authority would be available until June 30, 2025.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$100,000,000	$-
Total Funding Request:	**$100,000,000**	**$-**

Background. The Medi-Cal 2020 Waiver includes Whole Person Care (WPC) pilot projects 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. The 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: 1) with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement; 2) with two or more chronic conditions; 3) with mental health and/or substance use disorders; 4) who are currently experiencing homelessness; or 5) 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. However, federal funding is not available to cover the cost of room and board, monthly rental or mortgage expense, food, regular utility charges, or household appliances. Direct funding for housing or housing-related goods and services must be provided by the state or county.

DHCS requests General Fund expenditure authority of $100 million in 2019-20 to provide multi-year funding for supportive housing services for individuals who are homeless or are at risk of becoming homeless, with a focus on individuals with mental illness. The funds would be provided to active WPC pilot programs that provide housing services and would be available for the costs of long-term and short-term housing, such as hotel vouchers, rental subsidies, and capital investment for housing projects for Medi-Cal beneficiaries who are mentally ill and are experiencing homelessness, or are at risk of homelessness. The funds may not supplant existing funds for this purpose.

The proposed allocation methodology for these funds would take into account the prevalence of homelessness and individuals who are mentally ill, the cost of living, and the performance of the pilot to which the funding would be allocated.

- Prevalence of Homelessness: 50 percent of the funds would be allocated in proportion to the total number of people experiencing homelessness in the county compared to the total for all WPC counties. Each county would receive a minimum allocation of $500,000.

- Cost of Living: 25 percent of the funding would be allocated in proportion to the cost of living in the pilot county, based on the federal Housing and Urban Development (HUD) Fair Market Rent Efficiency amounts for each pilot area.
- Prevalence of Individuals Who Are Mentall Ill and Are Experiencing Homelessness: 25 percent of the funding would be allocated in proportion to the total number of individuals who are mentally ill and are experiencing homelessness in the county compared to the total for all WPC counties, based on the HUD count of the Severely Mentally Ill subpopulation for each county.
- Performance: WPC pilots that have demonstrated unacceptable performance regarding their pilot housing supportive services for the homeless target population would not be eligible for funding.

According to DHCS, the funding is proposed to be allocated as follows:

Pilot	Allocation	Pilot	Allocation
Alameda	$4,647,160	Sacramento (City)	$3,059,351
Contra Costa	$2,058,505	San Benito	$1,600,251
Kern	$1,213,868	San Bernardino	$1,646,280
Kings	$1,166,795	San Diego	$5,327,990
Los Angeles	$36,139,682	San Francisco	$8,130,059
Marin	$2,522,163	San Joaquin	$1,366,775
Mariposa	$1,033,636	San Mateo	$2,340,849
Mendocino	$1,137,159	Santa Clara	$5,680,408
Monterey	$2,407,787	Santa Cruz	$2,642,337
Napa	$1,491,767	Shasta	$1,198,356
Orange	$3,413,987	Solano	$1,603,827
Placer	$1,318,476	Sonoma	$3,284,476
Riverside	$1,999,856	Ventura	$1,568,200
		TOTAL	$100,000,000

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 5: Private Hospital Directed Payment and Quality Incentive Pool

Budget Issue. DHCS requests four positions and expenditure authority of $1.7 million ($595,000 General Fund, $864,000 federal funds, and $270,000 Hospital Quality Assurance Revenue Fund) in 2019-20 and $1.6 million ($568,000 General Fund, $819,000 federal funds, and $252,000 Hospital Quality Assurance Revenue Fund) annually thereafter. If approved, these positions and resources would allow DHCS to implement the Private Hospital Directed Payment program, and support the Quality Incentive Pool program.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$595,000	$568,000
0890 – Federal Trust Fund	$864,000	$819,000
3158 – Hospital Quality Assurance Revenue Fund	$270,000	$252,000
Total Funding Request:	**$1,729,000**	**$1,639,000**
Total Positions Requested:	**4.0**	**4.0**

***** Positions and resources ongoing after 2020-21.

Private Hospital Directed Payment Program. The Hospital Quality Assurance Fee (HQAF) program collects fees from private hospitals to draw down additional federal funds, which provide supplemental payments for hospital services and funding for health care coverage for children in the Medi-Cal program. The program supports hospital services for Medi-Cal beneficiaries by providing Medi-Cal managed care supplemental payments of approximately $4 billion annually for Medi-Cal hospitals. In 2016, the federal Centers for Medicare and Medicaid Services (CMS) issued a final rule that defined existing HQAF program payments in managed care as an unallowable direction of payment which must be discontinued, phased down over a 10-year period, or converted into an allowable directed payment model. To continue providing critical funding for hospital services and minimize risks related to CMS approval of future capitation rates, including HQAF program payments, and in consultation with CMS and the private hospital stakeholder community, DHCS is converting the majority of HQAF program payments into an allowable directed payment model, the private hospital directed payment (PHDP) program.

The PHDP program implements a uniform dollar increase in reimbursement to private hospitals that provide designated services under their contracts with plans. To comply with CMS regulations, DHCS must seek annual approval to continue the PHDP program and develop interim adjustments to the Medi-Cal managed care capitation rates to reflect the anticipated amount of PHDP program payments for each combination of plan, county or rating region, aid category, and rating period. Final PHDP program payment amounts are calculated by reweighting the interim adjustments based on the actual utilization of inpatient and outpatient hospital services. Payments are structured utilizing a pool approach that caps statewide payments to a maximum amount each year.

Quality Incentive Pool. DHCS has also developed several managed care directed payment programs to align, augment, and support the quality improvement initiatives promulgated through the managed care delivery systems and the Medi-Cal 2020 Demonstration. CMS approved California's Quality Incentive Pool (QIP) proposal for Designated Public Hospital (DPH) systems for delivery system and provider

payment initiatives under Medi-Cal managed care plan contracts. Implementation of this directed payment program will allow the state to continue the progress made through the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program and other programs of the 1115 waiver, Medi-Cal 2020. DHCS will direct plans to make QIP payments tied to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization.

DHCS requests four positions and expenditure authority of $1.7 million ($595,000 General Fund, $864,000 federal funds, and $270,000 Hospital Quality Assurance Revenue Fund) in 2019-20 and $1.6 million ($568,000 General Fund, $819,000 federal funds, and $252,000 Hospital Quality Assurance Revenue Fund) annually thereafter to implement the PHDP and QIP programs. Specifically, this funding would support the following positions and limited-term resources for each of these programs:

PHDP Resources
Capitated Rates Development Division – Four positions (permanent)

- **Four Associate Governmental Program Analysts** would collect private hospital utilization data from each plan, analyze the data, produce reports to inform actuarial expectations for hospital services utilization, develop interim adjustment amounts within the capitation rates that account for anticipated directed payment model payments, compile managed care encounter data for each private hospital, segment and analyze each hospital's encounter data by plan, produce reports of actual utilization of contracted hospital services at every private hospital that is a network provider with each plan, and develop final adjustment amounts within the capitation rates that reflect the final distribution of payments to private hospitals based on actual patterns of inpatient utilization and outpatient hospital services.

QIP Resources
Office of the Medical Director – Limited-term resources equivalent to seven positions

- **One Nurse Consultant III** position would support the Medical Director and DHCS clinical team to perform clinical and quality improvement oversight on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization.
- **One Staff Services Manger I** position would oversee incentive claims and payment for the QIP program, complete more complex policy and projects, and convene and engage with other DHCS divisions on payment and programmatic activities.
- **One Health Program Specialist II** position would act as a subject matter expert on 26 measures under QIP, work with DHCS partners to create and maintain the metric specification manual and establish and maintain metric benchmarks, provide technical assistance to the 17 designated public hospital (DPH) systems, and develop program monitoring protocols.
- **One Health Program Specialist I** position would be in charge of the QIP online reporting platform, work collaboratively with the Enterprise Innovation & Technology Services Division to conduct any necessary technical updates to meet reporting deadlines, and provide technical assistance to the 17 DPH systems.
- **Two Associate Governmental Program Analysts** would perform day-to-day programmatic support for the 17 DPH systems, conduct completeness and comprehensive reviews on semi-annual and

annual reports, monitor and assess the implementation of program policy and protocols, and propose recommendations and programmatic solutions based on the analysis.

- **One Associate Governmental Program Analyst** would perform day-to-day administrative and analytical duties for the QIP team, conduct research related to emerging health care policy issues, and engage and maintain effective flow of communication among DHCS divisions and external partners.

Capitated Rates Development Division – Limited-term resources equivalent to one position

- **One Research Program Specialist I** would assist in developing and submitting annual proposals to CMS for approval to implement and continue the QIP in future years' rate setting, formulate and propose responses to CMS questions, perform calculations and analyses of rate adjustments by county and population for each affected plan, coordinate with DPH systems and plans related to calculations of payment amounts and rate adjustments, and develop exhibits required by CMS to obtain approval of rate adjustments related to QIP.

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 6: 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 received 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, the waiver 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 $16.4 million ($7.4 million General Fund and $7.4 million federal funds) in 2018-19 and $42.7 million ($21.3 million General Fund and $21.3 million federal funds) in 2019-20

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 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. CMS recently approved renewal of the DD Waiver until December 31, 2022, with an approved capacity of unduplicated recipients of 130,000 in 2018, 135,000 in 2019, 140,000 in 2020, 145,000 in 2021, and 150,000 in 2022. As of March 29, 2017, behavioral health treatment services for waiver participants under the age of 21 is covered as 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.

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. According to DHCS, after discussion with CMS regarding service delivery issues, the department decided to end the waiver and transition current waiver participants to other systems of care beginning January 1, 2019.

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

Continuation of California Community Transitions Services. Disability Rights California (DRC) and East Bay Innovations request General Fund authority of $19.1 million to continue the California Community Transitions (CCT) program. According to DRC, CCT has successfully helped more than 3,600 people move out of nursing homes and into their own homes or other community settings. Federal funding was scheduled to end last year, but a recent extension, passed on a bipartisan vote in Congress and signed by the President, has provided temporary support. The House of Representatives recently approved funding anticipated to last through the end of the federal fiscal year and a five-year extension bill is pending.

Caregiver Resource Center Funding. The Association of California Caregiver Resource Centers requests one-time General Fund expenditure authority of $30 million over three years to expand services and capabilities to meet the challenges of a changing family caregiver population. California is set to see a rapid increase in older adults over the next decade when 20 percent of the population will be over age 65. This population and their family caregivers will be more diverse than in any other time in CA history. The estimated 4.5 million unpaid family caregivers are the largest long-term workforce caring

for older and disabled adults. The state needs to expand support to family caregivers so adults needing assistance can remain in the community and family caregivers can get the services they need to work, care and thrive.

Feasibility Study and Actuarial Analysis for Long-Term Services and Supports Benefit. The California Aging and Disability Alliance, requests General Fund expenditure authority of $1 million to fund a feasibility study and actuarial analysis of long-term services and supports (LTSS) financing and benefit options to meet the growing need for these services in California. This study and analysis are an essential first step toward the ultimate goal of creating a new, independent, and sustainably funded LTSS benefit for all Californians regardless of income or zip code.

This study and analysis would provide critical guidance on the following: the scope of services for such a benefit; eligibility criteria; projected cost estimates and financing options; and projected savings to state funded programs and services associated with each option, including, but not limited to, Medi-Cal and the In-Home Supportive Services (IHSS) 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 update on the status of renewal and expansion of the Assisted Living Waiver.

Issue 7: Statewide Transition Plan Extension

Budget Issue. DHCS requests expenditure authority of $575,000 ($288,000 General Fund and $287,000 federal funds) annually until 2021-22. If approved, these resources would support implementation, ongoing monitoring, and oversight of the Statewide Transition Plan for Home- and Community-Based Services.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$288,000	$288,000
0890 – Federal Trust Fund	$287,000	$287,000
Total Funding Request:	**$575,000**	**$575,000**

***** Additional fiscal year resources requested – 2021-22: $575,000.

Background. Federal Centers for Medicare and Medicaid Services (CMS) regulations require DHCS to develop, implement, and monitor characteristics of home- and community-based services (HCBS) settings. In May 2017, the requirements under these regulations was extended to March 16, 2022, and require revisions to statutes and regulations, administering and evaluating provider self-surveys for thousands of providers, performing extensive validation of provider self-surveys through on-site assessments, beneficiary-self surveys, and a robust heightened examination process.

Currently, there are eight HCBS 1915(c) waivers, one 1915(i), one 1915(k) State Plan program, one 1115 Demonstration waiver benefit, and one Community-Based Adult Services (CBAS) in California. HCBS programs differ significantly from each other in the following areas: the population they serve, provider types and network, size and complexities, structure of delivery system and operations, as well as statutory and regulatory authorities. Due to the complexity of each program, being in compliance with the federal regulations while serving over 500,000 beneficiaries, will pose a challenge without additional resources.

The 2016 Budget Act included limited-term resources equivalent to five positions, expiring June 30, 2019. These resources were approved as part of a budget change proposal, "Statewide Transitions Plan – Long Term Care Waivers". DHCS requests expenditure authority of $575,000 ($288,000 General Fund and $287,000 federal funds) annually until 2021-22 to support implementation, ongoing monitoring, and oversight of the Statewide Transition Plan for Home- and Community-Based Services. These resources are an extension of the previously requested resources and would support the following:

Integrated Systems of Care Division – Limited-term resources equivalent to five positions

- **Four Associate Governmental Program Analysts** would manage consultant contracts for the compliance determination process, as well as statutory and regulatory revisions, update HCBS provider enrollment processes, analyze assessment results and issue corrective action plans, and provide technical assistance to agencies and stakeholders.
- **One Office Technician** would coordinate and document meetings, and respond to inquiries from stakeholders and other agencies.

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 8: Proposition 56: Medi-Cal Provider Reimbursement Rates

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 $531.9 million ($181.3 million General Fund and $350.6 million federal funds) in 2018-19 and $531.9 million ($185.5 million General Fund and $346.4 million federal funds) in 2019-20 for the provider rate reductions imposed pursuant to AB 97.

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.

Figure HHS-03

Proposition 56 Expenditures

(Dollars in Millions)

Investment Category	Department	Program	2019-20 Governor's Budget
Enforcement	Department of Justice	Local Law Enforcement Grants	$26.0
	Department of Justice	Distribution and Retail Sale Enforcement	$6.9
	Department of Tax & Fee Administration	Distribution and Retail Sales Tax Enforcement	$4.5
	Department of Public Health	Law Enforcement	$5.3
Education, Prevention, and Research	University of California	Cigarette and Tobacco Products Surtax Medical Research Program	$58.6
	University of California	Graduate Medical Education	$36.5
	Department of Public Health	State Dental Program	$28.8
	Department of Public Health	Tobacco Prevention and Control	$137.0
	State Department of Education	School Programs	$24.2
Health Care	Department of Health Care Services	Health Care Treatment	$1,053.5
Administration and Oversight	State Auditor	Financial Audits	$0.4
	Department of Tax & Fee Administration	Sales and Use Tax	$1.0
Revenue Backfills	Proposition 99, Breast Cancer Research Fund, Proposition 10, and General Fund		$69.7
Total			**$1,452.5**

Figure 1: Proposition 56 Expenditures, 2019-20 Governor's Budget
Source: *2019-20 Governor's Budget Summary – Health and Human Services, January 2019*

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".

The 2017 Budget Act allocated Medi-Cal funding for supplemental payments for certain physician services, dental services, women's health, intermediate care facilities for individuals with developmental disabilities (ICF-DDs), and provider serving beneficiaries of the AIDS Waiver. The 2018 Budget Act increased the allocation for physician and dental services by expanding eligible preventive service codes

and the level of reimbursement for each code, as well as funding for home health services, pediatric day health centers, free-standing pediatric subacute facilities, and certain qualified community-based adult services programs,

The budget includes $2.1 billion ($711.9 million Proposition 56 and $1.4 billion federal funds) in 2018-19 and $2.2 billion ($769.5 million Proposition 56 and $1.4 billion federal funds) in 2019-20 for supplemental provider payments in Medi-Cal. The supplemental payments by category are as follows:

Category	2018-19	2019-20	Category	2018-19	2019-20
Physician Services			***PDHCs***		
Total Fund	$1,299,439	$1,387,169	Total Fund	$11,753	$14,246
Proposition 56	$409,156	$455,549	Proposition 56	$5,620	$6,880
Federal Funds	$890,283	$931,620	Federal Funds	$6,133	$7,366
Dental Services			***Ped Subacute***		
Total Fund	$510,070	$546,633	Total Fund	$6,189	$1,811
Proposition 56	$194,391	$216,624	Proposition 56	$2,993	$876
Federal Funds	$315,679	$330,009	Federal Funds	$3,196	$935
Women's Health			***CBAS***		
Total Fund	$203,057	$159,614	Total Fund	$1,913	$-
Proposition 56	$54,198	$41,943	Proposition 56	$1,327	$-
Federal Funds	$148,859	$117,671	Federal Funds	$586	$-
ICF-DDs			***Home Health***		
Total Fund	$29,377	$27,819	Total Fund	$56,600	$64,834
Proposition 56	$13,744	$13,041	Proposition 56	$27,042	$31,205
Federal Funds	$15,633	$14,778	Federal Funds	$29,558	$33,629
AIDS Waiver			***TOTAL***		
Total Fund	$6,800	$6,800	Total Fund	$2,125,198	$2,208,926
Proposition 56	$3,400	$3,400	Proposition 56	$711,872	$769,518
Federal Funds	$3,400	$3,400	Federal Funds	$1,413,326	$1,439,408

Additional Augmentations Funded by Proposition 56. The budget includes $965 million ($282.5 million Proposition 56 funds and $682.5 million federal funds) in 2019-20 for three augmentations:

- Value-Based Payments Program – The budget includes $360 million ($180 million Proposition 56 funds and $180 million federal funds) to fund a value-based payments program to encourage Medi-Cal managed care providers to meet goals in critical areas such as chronic disease management and behavioral health integration.
- Developmental and Trauma Screening – The budget includes $105 million ($52.5 million Proposition 56 funds and $52.5 million federal funds) to provide early developmental screenings for children and adverse childhood experiences (ACEs) screenings for children and adults in Medi-Cal.
- Family Planning Services – The budget includes $500 million ($50 million Proposition 56 funds and $450 million federal funds) for family planning services in the Medi-Cal program.

Proposals for Investment to Improve Provider Reimbursement and Access to Care in Medi-Cal. Various stakeholders have proposed the following investments to improve provider reimbursement and access to care in Medi-Cal.

Proposition 56 Supplemental Payments Timing. The California Medical Association (CMA) requests language to direct DHCS to submit a three-year federal State Plan Amendment (versus the current single year approval) to smooth and make more certain the Proposition 56 revenue stream supporting increased access to health care for Medi-Cal beneficiaries. According to CMA, approving this budget committee action will return clinical time back to physicians (versus spending administrative time reconciling supplemental payments), allowing them to spend more time with acute patients, coordinating care and improving health outcomes. The net boost to a physician's practice of the Proposition 56 supplemental payments is lessened by unexpected administrative tasks - tracking down payments and patient level data from the plans or matching up multiple supplemental payments based on various funding timelines. Providers will be able to reclaim clinical time to spend with beneficiaries if the administrative burden of the payments are lessened. The supplemental payments provided through Proposition 56 are effectively increasing access to care, and physicians are more likely to see more Medi-Cal beneficiaries if they can count on the funding without delays or lags in payments. In addition, the administrative burden for DHCS of obtaining approval by CMS each year will be lessened, giving them more capacity to monitor the Medi-Cal managed care plans and enforce accurate and timely distribution of the supplemental payments to providers. Once federal approval is received for the three-year State Plan Amendment, CMA believes continued oversight and transparency of the program is necessary to ensure that the benefit of Proposition 56 dollars continue to flow from Medi-Cal managed care plans to providers and beneficiaries as intended.

Breast Pump Rate Increase. The California WIC Association requests $7 million ($3.5 million General Fund and $3.5 million federal funds) to increase reimbursements for breast pumps for Medi-Cal beneficiaries. According to the California WIC Association, science proves that when infants are breastfed, their risk for obesity is reduced. Breastfeeding is also responsible for the reduction in many childhood illnesses including ear infections, digestive and lower respiratory infections and other serious illnesses. Studies also show that breastfeeding leads to reduced risk of both breast and ovarian cancer in mothers. Rates for breast pumps have not been raised since 1998. Low quality breast pumps may yield little or no milk, preventing mothers from establishing or maintaining breastfeeding, which impacts their baby's feeding and ultimately overall health. Lack of quality breast pumps through Medi-Cal has forced new mothers to search for alternative providers, such as WIC, to cover gaps in breast pumps and related supplies.

Air Ambulance Provider Rate Increase. The California Association of Air Medical Services (Cal-AAMS) requests General Fund resources of $25 to $35 million to increase air ambulance provider reimbursements commensurate with rural Medicare rates. According to Cal-AAMS, emergency air ambulance services are an essential part of the statewide EMS system and provide a critical link between rural areas and urban tertiary care hospitals (trauma centers, heart/stroke centers, burn units, children's hospitals and neonatal centers, etc.). They also play a key role in homeland security and disaster response, including the evacuating hospitals in the path of wildfires. The vast majority of the emergency air ambulance services throughout CA are provided by private entities that do not receive local tax support. These critical service providers transport all emergency patients without knowing if the patient has any form of medical insurance or ability to pay for the service. A significant number of emergency

patients transported by air ambulances have no insurance, and have no ability to pay for the service, yet these patients are given the same high level of care as those with medical insurance. Medi-Cal payment rates for air ambulance services have not increased in more than twenty five years. Without this proposed rebasing, Medi-Cal payments will revert back to 1993 levels of payment, less the 10 percent reduction applied in 2011.

Rate Increase for Stand-Alone Pediatric Sub-Acute Facilities. Sun Valley Specialty Healthcare requests General Fund expenditure authority of $10 million to increase reimbursement rates for stand-alone pediatric sub-acute facilities and trailer bill language to remove the statutory rate freeze applicable to these 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.

Eliminate 10 Percent Reduction for Community-Based Adult Services Programs. The California Association for Adult Day Services (CAADS) requests restoration of the 10 percent reduction for Community-Based Adult Services (CBAS) programs pursuant to AB 97 (Committee on Budget), Chapter 3, Statutes of 2011, as well as a 15 percent cost-of-living increase. According to CAADS, local CBAS centers have been straining to cover the costs of doing business. There has been no increase to the CBAS Medi-Cal fee-for-service published rate for the past 10 years, threatening center closures and access to this valuable community based care for eligible program participants. CBAS providers deliver essential nursing, clinical, occupational and other supports to adults with complex medical, cognitive and psychological conditions. As evidence mounts that use of CBAS results in decreased use of more costly interventions including emergency room visits, hospital admissions and re-admissions and skilled nursing care, it makes fiscal sense to invest in the viability of this program so it can continue to meet the growing needs of California's aging population and other adults with complex medical, cognitive and psychological conditions.

Clinical Laboratory Reimbursement Methodology. The California Clinical Laboratory Association (CCLA) requests revision of the statutory clinical laboratory services rate methodology in Medi-Cal. According to CCLA, the historical statutory rate methodology in California has also included a provision capping Medi-Cal laboratory rates at no more than 80 percent of the Medicare rate. In 2018, the federal government implemented the Protecting Access to Medicare Act (PAMA). As a part of PAMA, Congress directed the Centers for Medicare and Medicaid Services (CMS) to establish new Medicare rates for clinical lab services based on commercial market rates calculated by CMS. This has resulted in a reduction for most Medicare clinical lab rates. As a result, now (for the first time) when DHCS applies California's existing 80 percent of Medicare cap, the resulting Medi-Cal rates are often lower than the California market-based rates that DHCS has painstakingly developed to serve the California market. This entirely undermines the purpose behind developing Medi-Cal's market-based rates, and often results in Medi-Cal rates that are well below market. This unintended and inequitable result can be remedied simply by eliminating the current statutory "80 percent of Medicare" cap for Medi-Cal clinical lab rates. CCLA requests elimination of the cap on Medi-Cal's clinical laboratory rates of 80 percent of the new Medicare rates, and the AB 97 10 percent reduction as applied to clinical laboratories.

Eliminate Rate Freeze and Increase Reimbursement for Intermediate Care Facilities. Developmental Services Network (DSN) requests resources to eliminate the 2008 Medi-Cal rate freeze and adjust rates by 15 percent for intermediate care facilities for individuals with developmental disabilities (ICF-DDs). According to DSN, the Great Recession was hard on California and in 2008 ICF-DD Medi-Cal rates were frozen. Other than small adjustments for complying with certain state and federal mandates, and a Quality Assurance Fee adjustment, rates remain frozen at the 2008 level. The recent supplemental payment funded through Proposition 56 revenues has served as a lifeline and kept homes afloat, but a core baseline rate increase is absolutely necessary to continue their existence.

Proposition 55 Allocations. The California Hospital Association requests recalculation of the Proposition 55 formula allocating revenue to Medi-Cal to fund the following investments:

- Address the workforce shortage - Allocate $250 million to bolster the state's physician workforce by expanding the number of primary care and psychiatrists trained and supporting efforts to retain them.
- Improve the state's behavioral health infrastructure - Direct $100 million in grants to improve infrastructure and care systems for individuals in crisis with behavioral health needs.
- Expand access to care in rural communities - **.** Allocate $100 million to hospitals in rural, remote, or low-population density areas to support greater access to medical services, particularly telepsychiatry and regional crisis stabilization services.
- Disproportionate share hospitals - Allocate $250 million to enhance payments for providers that serve a disproportionate number of Medi-Cal and uninsured patients, given recent payment cuts at the federal level.

Restoration of 10 Percent Reduction for Certified Nurse Midwives and Alternative Birth Centers. The California Birth Center Association requests restoration of the 10 percent reduction in Medi-Cal payments for certified nurse-midwives and alternative birth centers imposed pursuant to AB 97 (Committee on Budget), Chapter 3, Statutes of 2011. While the reduction has been restored for physicians and hospitals, it has not been restored for these providers.

Durable Medical Equipment Rates. The California Association of Medical Products Suppliers (CAMPS) requests expenditure authority of approximately $7 million for the following changes to reimbursement for durable medical equipment in Medi-Cal: 1) establish that all categories of DME be reimbursed at 100 percent of the lowest maximum allowance for California for Medicare, and 2) require Medi-Cal, when reimbursing for custom rehabilitation equipment when reimbursing using 100 percent of the Medicare rate to recognize the KU modifier and increase reimbursement according to the applicable Medicare rate.

Complex Rehabilitation Technology Reimbursement. The National Coalition for Assistive and Rehab Technology (NCART) requests the following changes to Medi-Cal reimbursement for complex rehabilitation technology (CRT): 1) repeal AB 97 ten percent reduction to CRT providers, and 2) revise the upper billing limit to include labor costs. According to NCART, the CRT industry provides critical and essential products to some of California's most vulnerable patients with the most severe conditions. Medi-Cal reimbursement reductions and pending additional cuts through the SPA, the payment levels will be well below the actual cost of providing the service.

Restoration of 10 Percent Reduction for Non-Emergency Medical Transportation. The California Medical Transportation Association (CMTA) requests General Fund expenditure authority of $4.8

million annually to restore the ten percent Medi-Cal reimbursement cut for non-emergency medical transportation (NEMT) provider, and an additional fifteen percent increase in reimbursement to address an access to care problem that is preventing Medi-Cal beneficiaries from receiving life sustaining care on an outpatient basis. Without reliable and timely access to NEMT (wheelchair and litter vans), sick and frail Medi-Cal beneficiaries' conditions worsen until they need emergency care at a far higher cost to the state, and the healthcare delivery system. Since a vast majority of NEMT transports involve dialysis patients, it cannot be overemphasized that timely delivery and return of these frail dialysis patients is essential for their having full four-hour treatments to diminish the need for hospital emergency room care and inpatient stays due to missing or shortened dialysis treatments.

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 DHCS to respond to the following:

1. Please provide an update on supplemental provider payments funded by Proposition 56 revenue.

2. Is DHCS gathering data to evaluate the impact of the supplemental provider payments program on access to care for Medi-Cal beneficiaries?

Issue 9: Proposition 56: Physician and Dentist Loan Repayment Program

Background. The 2018 Budget Act included a one-time allocation of $220 million of Proposition 56 tobacco tax revenue for a loan repayment program to increase access to care for Medi-Cal beneficiaries. $190 million was allocated for recent graduate physicians and $30 million was allocated to recent graduate dentists. The funding was made available until June 30, 2025.

DHCS contracted with Physicians for a Healthy California (PHC) to administer the loan repayment program, known as CalHealthCares. Eligible physicians may apply for a loan repayment up to $300,000 in exchange for a five-year service obligation. Eligible dentists may apply for either a loan repayment up to $300,000 in exchange for a five-year services obligation or a practice support grant up to $300,000 in exchange for a ten-year service obligation. All medical and dental specialties are eligible. In this cycle, CalHealthCares expects to award approximately 125 physicians and 20 dentists. All awardees are required to maintain a patient caseload of 30 percent or more Medi-Cal beneficiaries.

Eligibility Requirements. According to CalHealthCares, eligibility requirements for the loan repayment program are as follows:

To be considered for an award, the applicant must be a current licensed healthcare provider (physician or dentist) or current dental student, as well as, a physician or dental resident, intern, or fellow.

For physicians, the applicant must:

- Have an unrestricted license and currently be in good standing with the Medical Board of California or the Osteopathic Medical Board of California
- Be an active enrolled Medi-Cal provider without existing suspensions, disbarments or revocations, or have submitted an application to become a Medi-Cal provider
- Have graduated from an ACGME-approved residency program and/or completed a fellowship within the last five years (on or after January 1, 2014)
- Have existing educational loan debt incurred while pursuing a medical degree
- Not currently participating in another loan repayment program
- Practice in California
- If awarded, maintain a patient caseload of 30 percent or more Medi-Cal beneficiaries

For current dental students, medical or dental residents, or fellows, the following must be true as of July 1, 2019:

- Have an unrestricted license and currently be in good standing with the Medical Board of California, the Osteopathic Medical Board of California, or the Dental Board of California
- Be an active enrolled Medi-Cal provider without existing suspensions, disbarments or revocations, or have submitted an application to become a Medi-Cal provider
- Have graduated from a dental school, as well as, a physician or dental residency program, and/or completed a fellowship
- Have existing educational loan debt incurred while pursuing a medical or dental degree
- Not currently participating in another loan repayment program

- Practice in California
- If awarded, maintain a patient caseload of 30 percent or more Medi-Cal beneficiaries
- One letter of recommendation

The application process for the loan repayment program opened on April 1, 2019 and the deadline to submit applications is April 26, 2019.

Subcommittee Staff Comment – This is an informational item.

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

1. Please provide a brief update on the Physician and Dentist Loan Repayment Program.

2. How many physicians and dentists does the department expect to receive loan repayment under this program? How many have applied?

Issue 10: Proposition 56: Value-Based Payment Program

Budget Issue and Trailer Bill Language. DHCS requests $360 million ($180 million Healthcare Treatment Fund and $180 million federal funds) to establish a Value-Based Payment program to provide incentive payments to providers for meeting specific metrics aimed at improving care for high-cost or high-need populations. DHCS also requests trailer bill language to implement the program.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0890 – Federal Trust Fund	$180,000,000	$180,000,000
3305 – Healthcare Treatment Fund	$180,000,000	$180,000,000
Total Funding Request:	**$360,000,000**	**$360,000,000**

Background. The Governor's January budget proposes to implement a Value-Based Payment (VBP) program in the Medi-Cal managed care delivery system. The VBP would provide risk-based incentive payments to providers for meeting specific measures aimed at improving care for certain high-cost or high-need populations. The payments would be targeted at physicians that meet specific achievement on metrics targeting areas such as behavioral health integration, chronic disease management, prenatal and post-partum care, and early childhood prevention. DHCS released its preliminary measures for payments under the VBP program for public comment until March 22, 2019. The preliminary measures in each category are as follows:

Pre-Natal/Post-Partum Care

Proposed Measure	Measure Payment Method	Measure Purpose
Prenatal Pertussis Vaccine	Incentive payment to the provider for every pertussis vaccination for women between 27 and 36 weeks of pregnancy.	Improve the content and quality of prenatal care. Pertussis vaccination prevents pertussis or whooping cough, a potentially severe illness in young infants, but must be given during pregnancy to be effective.
Prenatal Care Visit	Incentive payment to the provider for ensuring that the woman comes in for her initial, first trimester prenatal visit.	Improve prenatal care by incentivizing it to start early in pregnancy.

Postpartum Care Visits	Incentive payment for completion of recommended postpartum care visits after a woman gives birth. Partial incentive payment if complete only one of the visits, full incentive payment for completing both visits.	Given the importance of the postpartum period to the health of mothers and infants, improve postpartum care by incentivizing providers to provide two postpartum visits
Postpartum Depression Screening	Incentive payment for each screening for clinical depression using a standardized screening tool of postpartum women within 12 weeks after delivery.	Improve the content and quality of postpartum care. Depression screening is one of the recommended key components of postpartum care per the American College of Obstetricians and Gynecologists (ACOG).
Postpartum Birth Control	Incentive payment to provider when the provide either a moderately or more effective form of birth control (birth control pills, shot, patch, ring, diaphragm, intrauterine device, implant or sterilization) for postpartum women between 3 and 60 days after delivery	Improve the content and quality of postpartum care. Birth control and birth spacing are one of the recommended key components of postpartum care per ACOG.

Early Childhood

Proposed Measure	Measure Payment Method	Measure Purpose
Well Child Visits in first 15 months	Incentive payment to a provider for successfully completing the last three well child visits out of eight total - 6th, 7th, and 8th visits.	Increase the number of well child visits that infants and toddlers receive, as well as the preventive services ssociated with those visits, by incentivizing the latter visits in the series of well child visits recommended by the American Academy of Pediatrics (AAP) between birth and 15 months of life.
Well Child Visits 3-6 years old	Incentive payment to provider for successfully completing all four well child visits during the 3rd to 6th years of life. Full incentive payment for all four visits, partial incentive payments if complete some but	Increase the number of well child visits that young children receive, as well as the preventive services associated with those visits, by incentivizing the AAP recommended well child visits

	not all.	in the young childhood years.
All childhood vaccines for 2 year olds	For two year old children, pay an incentive payment to a provider when the last dose in any of the multiple dose vaccine series is given (e.g., the last dose of the diphtheria, tetanus and pertussis four vaccine series; the last dose of the three vaccine polio series; the 2nd flu vaccine, etc.).	Improve vaccination rates in young children by incentivizing the last doses in the multi-dose vaccine series required by AAP to ensure that children two years of age are fully immunized.
Blood Lead Screening	Incentive payment to a provider for completing a blood lead screening in children up to two years of age.	Improve the rate of identification and treatment of elevated blood lead levels among young children.
Dental Fluoride Varnish	Incentive payment to provider if provides oral fluoride varnish application for children 6 months to 5 years.	Promote and improve on preventive dental care, specifically the prevention of dental caries (tooth decay) in young children by incentivizing a preventive dental service that managed care primary care providers perform.

Chronic Disease Management

Proposed Measure	Measure Payment Method	Measure Purpose
Controlling High Blood Pressure	Incentive payment to provider for each event of adequately controlled blood pressure for members 18 to 85 years being seen by the provider for their diagnosis of high blood pressure.	Improve the management and outcome of members with high blood pressure, a chronic disease that affects numerous adult managed care members.
Diabetes Care	Incentive payment to provider for each event of diabetes (HbA1c) testing that shows better than poor control (a result of less than 9%) for members 18 to 75 years with a diagnosis of diabetes.	Improve the management and outcome of members with diabetes, a chronic disease that affects numerous adult managed care members.

Control of Persistent Asthma	Incentive payment to provider for each beneficiary between the ages of 5 and 64 years with a diagnosis of persistent asthma who has more controller medications prescribed than those for the treatment of acute asthma.	Improve the management of persistent asthma for both children and adults by incentivizing better asthma control and the prevention of acute asthma attacks.
Tobacco Use Screening	Incentive payment to provider for tobacco use screening provided to members 18 years and older.	Improve tobacco screening, and ultimately tobacco cessation efforts, by incentivizing providers to identify their members who are current smokers.
Adult Influenza Vaccine	Incentive payment to a provider for ensuring influenza vaccine administered to members 19 years and older for individuals with a chronic disease diagnosis (e.g., high blood pressure, atherosclerotic coronary artery disease, stroke, chronic obstructive pulmonary disease, asthma, chronic kidney disease, chronic liver disease, diabetes, and dementia)	Increase the provision of the flu vaccine to adults with a chronic disease diagnosis in order to prevent flu-related complications from these chronic conditions.

Behavioral Health Integration

Proposed Measure	Measure Payment Method	Measure Purpose
Screening for Clinical Depression	Incentive payment for provider for conducting screening for clinical depression (with a standardized screening tool) for beneficiaries 12 years and older	Increase screening for clinical depression which will lead to better identification and treatment of members suffering from depression, as well as promote the integration of behavioral health and primary care.

Management of Depression Medication	Incentive payment for provider if beneficiary 18 years and old with a diagnosis of major depression and treated with an antidepressant medication has remained on the anti-depressant medication for at least 12 weeks.	Improve on the management and outcome of members who have been diagnosed with clinical depression.
Screening for Unhealthy Alcohol Use	Incentive payment for provider for screening for unhealthy alcohol use using a standardized screening tool for beneficiaries 18 years and older	Increase screening for unhealthy alcohol use which will lead to better identification and treatment of members with alcohol use disorders, as well as promote the integration of behavioral health and primary care.
Colocation of primary care and behavioral health services	Health plan to attest to co-location of the provider and the direct payments to those providers. Payment per visit at the provider level.	Incentivize an arrangement that promotes the most seamless integration of behavioral health and primary care.

Stakeholder Proposal – Include Metrics in VBP to Reduce Health Disparities. The California Pan-Ethnic Health Network requests to include a requirement that the Value-Based Payment program prioritizes metrics that reduce health disparities and that DHCS consult with stakeholders on the mechanics of the proposal.

Stakeholder Proposal – Allow Clinics to Receive VBP Incentive Payments. The California Primary Care Association requests the Value-Based Payment program include federally qualified health centers and rural health clinics as eligible providers for incentive payments.

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. When will DHCS complete its review of submitted comments for this proposal? Is the proposal likely to change significantly based on submitted comments?

Issue 11: Proposition 56: Developmental and Trauma Screening

Budget Issue. DHCS requests $105 million ($52.5 million Healthcare Treatment Fund and $52.5 million federal funds) annually to provide developmental and trauma screening for Medi-Cal beneficiaries.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0890 – Federal Trust Fund	$52,500,000	$52,500,000
3305 – Healthcare Treatment Fund	$52,500,000	$52,500,000
Total Funding Request:	**$105,000,000**	**$105,000,000**

Developmental Screening – Background. According to DHCS, developmental screening is the use of a standardized set of questions to see if a child's motor, language, cognitive, social, and emotional development are on track for their age. The American Academy of Pediatrics' Bright Futures periodicity schedule recommends developmental screening for all children at 9 months, 18 months, and 30 months of age, and as medically necessary when risk is identified on developmental surveillance. All children enrolled in Medi-Cal are entitled to receive developmental screening under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, which follows the Bright Futures schedule.

DHCS requests $60 million ($30 million Healthcare Treatment Fund and $30 million federal funds) annually to provide early developmental screening for children. According to DHCS, the screening would be provided through both the managed care and fee-for-service delivery systems and the supplemental payments to providers would be in addition to the amounts paid for the office visit during which the screening occurs. DHCS expects 25,000 children age 9 months, 29,000 children age 18 months, and 29,000 children age 30 months would receive developmental screenings every month. The screenings would use a tool that meets criteria set forth by both the American Academy of Pediatrics and the federal Centers for Medicare and Medicaid Services. The additional reimbursement to providers for developmental screenings would be $59.90 per screen.

Trauma Screening – Background. According to DHCS, trauma-informed care is a model of care intended to promote healing and reduce risk for re-traumatization. Early identification of trauma and providing the appropriate treatment are critical tools for reducing long-term health care costs for both children and adults. Individuals who experienced trauma in childhood are at significantly increased risk of heart disease and diabetes compared to those who did not experience traumatic events. Research has shown that individuals who experienced several traumatic childhood events are likely to die 20 years sooner than those without these experiences. These physical health costs are in addition to the mental health and substance use disorders that often follow childhood trauma.

DHCS requests $45 million ($22.5 million Healthcare Treatment Fund and $22.5 million federal funds) annually to support trauma screenings for all children and adults in Medi-Cal. According to DHCS, the trauma screening would also be provided through both the managed care and fee-for-service delivery systems and the supplemental payments to providers would also be in addition to the amounts paid for the office visit during which the screening occurs. The screenings for children would use a tool recommended by the AB 340 Trauma Screening Advisory Workgroup, known as PEARLS and

developed by the Bay Area Research Consortium on Toxic Stress and Health (BARC). According to DHCS, there are two versions of the tool. One version is for ages one through 12 and the other for teens ages 13 through 19. For adults, DHCS intends to use the Adverse Childhood Experiences (ACEs) assessment or a similar tool. The additional reimbursement to providers for developmental screenings would be $29 per screen.

Stakeholder Proposal – Provider Training and Data Collection on Trauma Screenings. Californians for Safety and Justice and the County Welfare Directors Association request one-time expenditure authority of $15 million in 2019-20 for provider training and data collection. $10 million would fund training for primary care providers and others who will administer the PEARLS trauma screening. $5 million would fund data collection and the creation of new screening codes to allow the Administration and the Legislature to monitor the progress of trauma screening implementation and track the improvement in children's health and well-being.

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 these proposals.

Issue 12: Proposition 56: Family Planning Supplemental Payment

Budget Issue. DHCS requests $500 million ($50 million Healthcare Treatment Fund and $450 million federal funds) to provide supplemental payments for family planning services in Medi-Cal fee-for-service and Medi-Cal managed care.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0890 – Federal Trust Fund	$450,000,000	$450,000,000
3305 – Healthcare Treatment Fund	$50,000,000	$50,000,000
Total Funding Request:	**$500,000,000**	**$500,000,000**

Background. The 2017 Budget Act allocated up to $40 million of Proposition 56 revenue to fund supplemental payments for women's health services provided under the Family Planning, Access, Care, Treatment (Family PACT) program for the evaluation and management (E&M) portion of office visits and up to $10 million to fund supplemental payments for medical pregnancy termination. The payments for E&M services were set at a rate equal to 150 percent of the existing Family PACT reimbursement rates. These payments were continued in the 2018 Budget Act and DHCS proposes to extend these payments indefinitely. The budget includes $203.1 million ($54.2 million Healthcare Treatment Fund and $148.9 million federal funds) in 2018-19 and $159.6 million ($41.9 million Healthcare Treatment Fund and $117.7 million federal funds) in 2019-20 for supplemental payments for women's health services.

DHCS requests $500 million ($50 million Healthcare Treatment Fund and $450 million federal funds) to provide supplemental payments for family planning services in Medi-Cal fee-for-service and Medi-Cal managed care. According to DHCS, these payments are intended to help support the larger Medi-Cal population accessing and using family planning services, as well as the providers delivering such services in Medi-Cal. DHCS intends to provide a fixed $20 supplemental payment in fee-for-service and managed care for family planning office visits under new patient claim codes (99201, 99202, 99203, and 99204) and established patient claim codes (99211, 99212, 99213, and 99214).

Stakeholder Proposal – Alternative Investments to Support Reproductive Health. Planned Parenthood Affiliates of California has proposed several alternative priority investments for the Administration's allocation of Proposition 56 funding for family planning. These alternative investments are as follows:

- Supplemental payments for an expanded list of Family PACT codes that would receive a 150 percent supplement, including education and preventive counseling, as well as various reproductive health services.
- Supplemental payments for Medi-Cal E&M codes to achieve 150 percent rate parity
- Supplemental payments for Medi-Cal family planning services to achieve 150 percent rate parity
- Allow family planning providers to offer and be reimbursed for a broader range of services by adding claim codes
- Create encounter rates or global fees for family planning providers that offer select public health promoting interventions on a single date of service

- Permit family planning providers to be reimbursed for care management, care connection, patient navigation, or patient follow-up and referral
- Make capital investments to support infrastructure and workforce to increase access to sexual and reproductive health care in areas of need and to pilot new health care delivery technologies or models.

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: Proposition 56 Staffing

Budget Issue. DHCS requests 18 positions and expenditure authority of $3 million ($1.5 million Healthcare Treatment Fund and $1.5 million federal funds) annually. If approved, these positions and resources would allow DHCS to support implementation of the new Value-Based Payments program.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0890 – Federal Trust Fund	$1,500,000	$1,500,000
3305 – Healthcare Treatment Fund	$1,500,000	$1,500,000
Total Funding Request:	**$3,000,000**	**$3,000,000**

***** Positions and resources ongoing after 2020-21.

Background. The Governor's January budget proposes to implement a Value-Based Payment (VBP) program in the Medi-Cal managed care delivery system. The VBP program would provide risk-based incentive payments to providers for meeting specific measures aimed at improving care for certain high-cost or high-need populations. The payments would be targeted at physicians that meet specific achievement on metrics targeting areas such as behavioral health integration, chronic disease management, prenatal and post-partum care, and early childhood prevention.

DHCS requests 18 positions and expenditure authority of $3 million ($1.5 million Healthcare Treatment Fund and $1.5 million federal funds) annually to support implementation of the new Value-Based Payments program including designing program elements, developing and calculating performance metrics, coordinating with stakeholders, developing capitation rates and supplemental payment amounts, and preparing payment systems. Specifically, the funding would support the following positions:

Managed Care Quality Management Division – Eight positions

- **One Staff Services Manager III** position would provide critical oversight and direction for the development of the Medi-Cal managed care performance metric, take the lead role in all managerial aspects of performance measure development and maintenance, and act as the primary point of contact for the division when coordinating efforts with other state and federal agencies, internal and external stakeholders, and other divisions within DHCS.
- **Two Health Program Specialist II** positions would provide analytic support for the VBP program, receive, manage, and calculate encounter data to be used for performance metrics, and take the lead in programmatic aspects of performance management.
- **Two Health Program Specialist II** positions would provide policy support for the VBP program, develop and implement policies for the program, assist with compliance measurements and quality improvement activities, and prepare warning letters, corrective action plans, and sanctions for noncompliance.
- **Two Health Program Specialist I** positions would support the development of performance metrics and measurement, coordinate on program design, analyze feedback from stakeholders on metrics and reporting, calculate metric results, and produce reports and dashboards.
- **One Office Services Supervisor I** position would provide clerical support, develop correspondence, schedule meetings, track projects, and organize relevant documents.

Information Management Division – Two positions

- **One Staff Services Manager II** position would plan, organize, and direct analysis and research required to calculate the performance measures, work with other parts of DHCS that are supporting the VBP program to assess data quality, evaluate results, and communicate findings to internal and external partners.
- **One Health Program Specialist I** position would plan, organize, and carry out data preparation, assessment, and reporting for the VBP program measures, serve as a team member and act as a technical consultant to inform program and policy implications of the results of the performance measures.

Capitated Rates Development Division – Six positions

- **One Staff Services Manager I** position would plan, organize, and direct the activities of staff responsible for implementing the VBP program, assume a lead role on the financial policy related to each VBP program, work closely with actuaries to assist in rate-setting activities for the VBP program, perform management review of all applicable rate exhibits, financial calculations, and written correspondence, and coordinate with other divisions regarding the financial aspects of the VBP program.
- **One Health Program Specialist I** position would perform more complex programmatic and financial analysis related to the VBP program, contribute to the development and implementation of related financial policy, complete all documents required to obtain federal approval of the directed payments, and respond to complex or non-routine inquiries affecting the VBP program.
- **Four Associate Governmental Program Analysts** would perform less complex programmatic and financial analysis related to the VBP program, collect historical cost and utilization data, prepare and populate rate exhibits for CMS and managed care plans as well as payment exhibits for the Managed Care Oversight Division, write All Plan Letters, memoranda, and other guidance documents, and respond to routine inquiries affecting the VBP program.

Managed Care Operations Division – Two positions

- **One Health Program Specialist I** position would serve as subject matter expert on the VBP program, conduct research and analysis, develop project plans, policies, guidance materials, issue papers and reports, and communicate with stakeholders.
- **One Associate Governmental Program Analyst** would assist with analysis, documentation, and implementation of changes to the Capitation Payment Management System, evaluate system-related impacts, provide guidance and procedural documentation for improvement to the system, conduct ongoing quality control activities to proactively address system changes, and create trend analyses, pivot charts, and dashboard reports for reporting of system modifications, improvements, or changes.

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: Program for All-Inclusive Care for the Elderly Expansion

Budget Issue. DHCS requests two positions and expenditure authority of $279,000 ($140,000 General Fund and $139,000 federal funds) in 2019-20 and $261,000 ($131,000 General Fund and $131,000 federal funds) annually thereafter. If approved, these resources would allow DHCS to manage the expansion of Programs of All-Inclusive Care for the Elderly operating in California.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$140,000	$131,000
0890 – Federal Trust Fund	$139,000	$130,000
Total Funding Request:	**$279,000**	**$261,000**
Total Positions Requested:	**2.0**	**2.0**

***** Positions and resources ongoing after 2020-21.

Background. Programs for All-Inclusive Care for the Elderly (PACE) provide care to California's frail population as an alternative to institutionalization by coordinating and integrating medical, dental, mental health, substance use treatment services, and long-term care services. These services are provided to beneficiaries while still residing in a home- or community-based setting, rather than a skilled nursing facility or other institutional setting. Eligible PACE participants must be at least 55 years old, live in the PACE organization's designated service area, be certified as eligible for nursing home level of care by DHCS, and be able to live safely in their home or community at the time of enrollment. PACE programs are the sole provider of Medicare and Medi-Cal services for participants.

The 2016 Budget Act included trailer bill language, the PACE Modernization Act, that implemented new flexibilities and growth of the PACE program. The provisions included removal of the cap on the total number of PACE organizations in the state (previously limited to 15), implementation of an experience-based rate methodology, and allowing for-profit entities to participate. The PACE Modernization Act has resulted in significant growth in the number of PACE programs providing services to Medi-Cal beneficiaries.

DHCS requests two positions and expenditure authority of $279,000 ($140,000 General Fund and $139,000 federal funds) in 2019-20 and $261,000 ($131,000 General Fund and $131,000 federal funds) annually thereafter to manage contracting and compliance workload related to the expansion of PACE programs under the PACE Modernization Act. Specifically, DHCS is requesting the following positions in the Integrated Systems of Care Division:

- **One Associate Governmental Program Analyst** would be added to the Contract Management Unit to prepare, review, track, monitor, and process all contracts and contract amendments for assigned PACE organizations. This position would serve as the point of contact for all applicants, would collaborate with the PACE Policy Unit to verify policies and procedures are aligned with contract deliverables and requirements, and would serve as subject matter expert for contract needs and deliverables.
- **One Associate Governmental Program Analyst** would be added to the Compliance and Oversight Unit to provide technical assistance and guidance to PACE organizations regarding corrective action

plans, deficiencies, and audit findings. This position would also conduct monitoring and oversight through review of policies and procedures, contract requirements, development of audit tools and guidance documents, review of sub-contractor compliance, collaboration with CMS on current PACE program policies and procedures, ongoing tracking and monitoring of federal and state laws and regulations, and training for PACE programs for proper submission of documents for DHCS review and approval.

Stakeholder Proposal – Amendments to the PACE Modernization Act. The California Association of Programs of All-Inclusive Care for the Elderly (CalPACE) requests adoption of trailer bill language to make changes to the Medi-Cal rate methodology for PACE. According to CalPACE, the current PACE rate methodology, which was adopted as part of the budget in 2016, moved the payment methodology from a fee-for-service based methodology to an experience-based rate methodology, under which payments are more closely tied to each organization's costs, similar to the methodology used for Medi-Cal managed care plans.

DHCS has pointed to the capital intensive nature of PACE as a factor that is limiting more rapid PACE expansion. The proposed changes would better align the rate methodology with this inherent feature of PACE. The relatively small average enrollment in PACE (approximately 700 enrollees versus several thousand in traditional managed care plans) severely limits the ability of PACE organizations to manage the risks and volatility in costs associated with their highest cost enrollees by spreading them across their overall enrollment. The proposed changes would enable PACE organizations to create reasonable reserves to manage this increased risk and volatility.

The proposed trailer bill language would ensure that PACE continues to be a viable program for older adults and seniors with higher care needs while continuing to be cost-effective for the state by establishing a floor for rates that is linked to the amount that would otherwise be paid for comparable 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.

Issue 15: Provider Enrollment Workload Increase

Spring Finance Letter. DHCS requests expenditure authority of $3.1 million ($795,000 General Fund and $2.4 million federal funds) in 2019-20 and $3 million ($744,000 General Fund and $2.2 million federal funds) in 2020-21. If approved, these resources would allow DHCS to process an increase in provider enrollment applications from Drug Medi-Cal and Medi-Cal managed care plans resulting from new federal requirements.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$795,000	$744,000
0890 – Federal Trust Fund	$2,386,000	$2,230,000
Total Funding Request:	**$3,181,000**	**$2,974,000**

Background. DHCS' Provider Enrollment Division (PED) is responsible for enrollment and renewal of medical providers and applicants pursuant to state and federal laws and regulations. PED is required to complete application review for new physicians or physician groups, which comprise the majority of PED applications, within 90 days. Applications for other providers, including psychologists, licensed clinical social workers, licensed midwives, nurse practitioners, physician assistants, and podiatrists must be completed within 180 days.

Federal Provider Enrollment Requirements. The federal Patient Protection and Affordable Care Act requires providers to be revalidated every five years and monitored monthly to ensure they continue to meet state and federal requirements. In addition, the federal 21st Century Cures Act and CMS Final Rule CMS-2390-F requires the state to screen, enroll, and periodically revalidate health plan network providers by implementing a plan-specific enrollment process, or by directing providers to enroll as Medi-Cal fee-for-service providers. According to DHCS, nearly all Medi-Cal managed care plans opted to direct their network providers to enroll in Medi-Cal fee-for-service rather than implementing their own enrollment process.

DHCS reports these new provider enrollment requirements have led to a significant increase in provider applications and a backlog of approximately 19,000 applications. PED expects to receive approximately 33,600 applications in 2018-19 and 2019-20, and 53,600 applications annually beginning in 2020-21. In September 2018, PED deployed the Provider Application and Validation for Enrollment (PAVE) enrollment portal and associated business process applications with electronic provider management activities. PED staff currently are able to process 800 paper applications per person annually. Once PED is able to reduce its paper-based application backlog, it expects to be able to process 1,500 PAVE applications per person annually. According to DHCS, PED became fully automated with PAVE functionality on March 5, 2019.

DHCS requests expenditure authority of $3.1 million ($795,000 General Fund and $2.4 million federal funds) in 2019-20 and $3 million ($744,000 General Fund and $2.2 million federal funds) in 2020-21, equivalent to 21 positions, to clear the application backlog and process the additional provider enrollment applications. Specifically, DHCS requests the following two-year, limited-term resources in the following divisions:

Provider Enrollment Division – Two-year funding equivalent to 21 positions

- **One Staff Services Manager II** would supervise and direct activities in the section, provide leadership to staff and managers, develop and monitor goals and objectives, establish and maintain workload priorities and reporting processes, respond to calls from legislative and executive staff and providers regarding provider issues or problems, recruit and train staff, evaluate performance, and prepare probationary and performance reports.
- **Three Staff Services Manager I** positions would supervise the unit, assign work and manage workflows, direct staff in conducting enrollment activities, oversee review of all provider enrollments, recruit and train staff, evaluate performance and prepare probationary and performance reports, consult with DHCS management, contractors and other state and federal agencies to improve fraud prevention, and meet with providers and provider organizations about enrollment issues.
- **16 Associate Governmental Program Analysts** would review enrollment provider applications and supporting materials, communicate with providers regarding deficiencies, verify licensure and permit status, evaluate applications for fraud risk factors and compliance with state and federal requirements, generate and analyze workload reports, and track workflow.
- **One Associate Governmental Program Analyst** would also perform secondary review of provider applications and supporting materials, and perform quality control reviews.

Office of Administrative Hearings and Appeals – Two-year funding equivalent to two positions

- **One Health Program Audit Manager I** would manage increased workload related to appeals of denied provider enrollment applications. DHCS expects approximately 3,520 applications will be denied annually and 5 percent, or 176, will be appealed to the Office of Administrative Hearings and Appeals.
- **One Legal Secretary** would perform necessary clerical functions associated with processing appeals and transmitting the increased number of appeal decisions within required timeframes.

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: Office of Civil Rights Increased Workload

Spring Finance Letter. DHCS requests two positions and expenditure authority of $296,000 ($148,000 General Fund and $148,000 federal funds) in 2019-20 and $278,000 ($139,000 General Fund and $139,000 federal funds) annually thereafter. If approved, these resources would allow DHCS to address workload increases in its equal employment opportunity, reasonable accommodations, and civil rights compliance programs.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$148,000	$139,000
0890 – Federal Trust Fund	$148,000	$139,000
Total Funding Request:	**$296,000**	**$278,000**
Total Positions Requested:	**2.0**	**2.0**

* Positions and resources ongoing after 2020-21.

Background. DHCS' Office of Civil Rights is responsible for three main program areas: Equal Employment Opportunity (EEO), Reasonable Accommodations (RA), and Civil Rights Compliance (CRC). The Office protects the employment rights of its employees through the EEO and RA programs, while the Office, through the CRC program, is responsible for preventing and correcting civil rights violations in the delivery of services administered by the department.

Equal Employment Opportunity Responsibilities. According to the California Department of Human Resources (CalHR), all state agencies have an affirmative duty to take reasonable steps to prevent and promptly address discrimination and harassment in the workplace. Agencies are responsible for integrating equal employment opportunity into every aspect of human resource management policies and practices in the recruitment, examination, selection, training and advancement of employees. Under the California Fair Employment and Housing Act, equal employment opportunity is afforded to all applicants and employees without regard to age, ancestry, color, disability (mental or physical), engaging in a protected activity, gender, gender identity or expression, genetic information, marital status, medical condition, military veteran status, national origin, political affiliation, pregnancy, race, religion, sex, and sexual orientation. State agencies' EEO programs are responsible for preventing employment harassment and discrimination by monitoring recruitment, examination, hiring, and retention policies, investigating complaints in a timely manner, and overseeing curriculum and learning objectives for employee training regarding their rights and responsibilities to maintain a harassment-free work environment.

Reasonable Accommodations Responsibilities. California state agencies are also required by state and federal laws to provide Reasonable Accommodation (RA) to applicants and employees with disabilities. An RA may be a modification or adjustment to a job, or to the work environment, that enables an individual with a disability to have the same employment opportunities and benefits as those without a disability. When a request for a disability accommodation is made employers are required to enter an interactive process with the employee to make an individualized assessment of the essential job functions and the specific limitations of the person with a disability. The Fair Employment and Housing Act also prohibits employment discrimination based on religion. This discrimination includes refusing to accommodate an applicant's or employee's sincerely held religious beliefs or practices. Applicants and

employees may obtain exceptions to rules or policies in order to fulfill their essential job functions within the constraints of their religious beliefs or practices.

Civil Rights Compliance Responsibilities. Section 1557 of the federal Patient Protection and Affordable Care Act prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities, extending federal nondiscrimination protections to individuals participating in any health program or activity receiving funding from the federal Department of Health and Human Services (HHS), any health program or activity administered by HHS, health insurance marketplaces, and all plans offered by issuers that participate in those marketplaces. These requirements extend to all programs administered by DHCS that receive federal funding including Medi-Cal, community behavioral health programs, family planning programs, and many others. The Office of Civil Rights is responsible for preventing and correcting civil rights violations in the delivery of services administered by DHCS.

DHCS Reports Increased Office of Civil Rights Workload. According to DHCS, the Office's workload related to EEO, RA, and civil rights compliance has experienced a steady increase in recent years. The Office has received a steady increase in complaints that established a bona fide allegation of discrimination or harassment requiring an investigation. DHCS indicates this increased workload may be due to the increase in awareness of rights and remedies for incidents of discrimination or harassment, as well as the department's efforts to make employees aware of the availability of the Office of Civil Rights.

DHCS also has experienced an increase in RA requests, as the department has begun taking a more active role in facilitating accommodation discussions with employees. In addition, many of the requests are more complex, involving developmental disabilities or mental health issues. The complexity of these requests require additional work to make the necessary accommodation.

DHCS also reports a steady increase in volume and complexity of its civil rights compliance workload, particularly over the past three years. During that period, the number of complaints requiring investigation has increased from one to ten cases. DHCS is also increasing enforcement of managed care plan contract requirements related to civil rights compliance and directing counties to report civil rights complaints by Medi-Cal beneficiaries in a timely manner. DHCS is attempting to address the increase in workload by standardizing and streamlining the process for civil rights complaints.

DHCS requests two positions and expenditure authority of $296,000 ($148,000 General Fund and $148,000 federal funds) in 2019-20 and $278,000 ($139,000 General Fund and $139,000 federal funds) annually thereafter to address the workload increases in its EEO, RA, and civil rights compliance programs. These resources would fund the following positions in the Office of Civil Rights:

- **One Staff Services Manager I** position would act as a subject matter expert in civil rights compliance, provide additional resources for more complex and sensitive workload, and develop policies and procedures to improve responsiveness and reduce liability risks.
- **One Associate Governmental Program Analyst** would provide additional responsiveness to workload increases in EEO, RA, and civil rights compliance, and would provide training to DHCS management and staff at all work locations throughout 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 DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 17: Federally Qualified Health Centers Drug Medi-Cal Providers

Spring Finance Letter. DHCS requests one position and expenditure authority of $139,000 ($70,000 General Fund and $69,000 federal funds) in 2019-20 and $130,000 ($65,000 General Fund and $65,000 federal funds) annually thereafter. If approved, this position and resources would allow DHCS to support workload to allow federally qualified health centers and rural health clinics to participate in the Drug Medi-Cal program, pursuant to the requirements of SB 323 (Mitchell), Chapter 540, Statutes of 2017.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$70,000	$65,000
0890 – Federal Trust Fund	$69,000	$65,000
Total Funding Request:	**$139,000**	**$130,000**
Total Positions Requested:	**1.0**	**1.0**

* Position and resources ongoing after 2020-21.

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 (DMC-ODS) Waiver, if the county is participating, or under direct contract with the county or DHCS if the county is not participating. 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.

2018 Budget Act Resources for Provider Enrollment and Rate Audits. The 2018 Budget Act included 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 positions included two permanent program staff to provide technical assistance to clinics for enrollment and claims payment for Drug Medi-Cal services and limited-term resources equivalent to 15 auditors to process reimbursement rate audits to remove the Drug Medi-Cal and SMHS components from clinics' per-visit rates.

DHCS reports that ten clinics have enrolled as Drug Medi-Cal providers since passage of SB 323, but this number is expected to increase as waiver counties attempt to meet federal network adequacy requirements. DHCS estimates approximately 180 new clinics will ultimately be enrolled as Drug Medi-Cal providers. While the two positions approved in the 2018 Budget Act are responsible for managing the provider enrollment and claims payment workload, DHCS indicates it needs an additional position to maintain program integrity and avoid duplicate billing.

DHCS requests one position and expenditure authority of $139,000 ($70,000 General Fund and $69,000 federal funds) in 2019-20 and $130,000 ($65,000 General Fund and $65,000 federal funds) annually thereafter to support workload to allow federally qualified health centers and rural health clinics to participate in the Drug Medi-Cal program.

One Associate Governmental Program Analyst in the Performance Integrity Branch of the Substance Use Disorder Program, Policy, and Fiscal Division would conduct on-site technical assistance and compliance reviews of Drug Medi-Cal certified clinics, oversee clinic compliance with applicable state and federal laws and regulations, evaluate beneficiary and program records, compare paid claims to beneficiary service documentation, perform peer reviews of utilization review and technical assistance draft reports, and participate in meetings and workgroups regarding Drug Medi-Cal policy and 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.

2. How will the workload of this new position differ from the two positions approved in the same division in the 2018 Budget Act?

Issue 18: Reappropriation: Behavioral Health Modernization Resources

Spring Finance Letter. DHCS requests reappropriation of expenditure authority of $2.1 million ($808,000 General Fund and $1.2 million federal funds) in 2019-20. If approved, these reappropriated resources would cover planning costs of the department's Comprehensive Behavioral Health Data Systems Modernization Project.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$808,000	$-
0890 – Federal Trust Fund	$1,245,000	$-
Total Funding Request:	**$2,053,000**	**$-**

Background. DHCS administers several behavioral health programs in California that receive federal support, including Medi-Cal Specialty Mental Health Services (SMHS), Drug Medi-Cal (DMC), the Substance Abuse Prevention and Treatment (SAPT) Block Grant, the Community Mental Health Block Grant, the Mental Health Services Act (MHSA), and the Bronzon-McCorquodale Act (1991 Realignment). Most mental health and substance use disorder services are provided by county behavioral health departments. DHCS is responsible for oversight of claims for federal matching funds, distribution of MHSA funds, distribution of block grant funds, and behavioral health programs funded by 1991 Realignment. State and federal requirements related to these funding sources require DHCS to monitor delivery of behavioral health services and collect data for reporting, evaluation, and monitoring for compliance with the conditions of each of the funding sources. According to DHCS, the data for this purpose is currently collected through multiple data systems in an extremely labor-intensive process.

The 2018 Budget Act included expenditure authority to fund planning costs to develop a Comprehensive Behavioral Health Data Systems Modernization (CBHDSM) project. DHCS completed the Stage 1 Business Analysis, as part of the Project Approval Lifecycle (PAL) process at the California Department of Technology (CDT), in October 2016. In December 2017, DHCS submitted a Planning Advanced Planning Document (PAPD) to the federal Centers for Medicare and Medicaid Services (CMS) to request an enhanced federal match of 90 percent for the project. In February 2018, CMS approved the PAPD funding request for federal fiscal years 2018 and 2019. Total funding in the 2018 Budget Act was $2.1 million ($808,000 General Fund and $1.2 million federal funds). DHCS indicates the second phase of planning work will occur in 2020-21 upon CMS approval of additional documentation and CDT approval of the department's Stage 2 Alternatives Analysis under the PAL process.

According to DHCS, the funding included in the 2018 Budget Act was not spent, and the project delayed for the following reasons:

- Because the request for offer (RFO) contract amount was over DHCS' purchasing authority, the department was directed to work with Statewide Technology Procurement.
- The development and approval of the RFO was delayed. DHCS indicates the contractor is estimated to start October 2019.

DHCS requests reappropriation of expenditure authority of $2.1 million ($808,000 General Fund and $1.2 million federal funds) in 2019-20 to cover planning costs of the CBHDSM project funded, but unexpended, in the 2018 Budget Act. The requested reappropriation language is as follows:

4260-491 – Reappropriation. Department of Health Care Services. The balances of the appropriations provided in the following citations are reappropriated for the purposes provided for those appropriations and shall be available for encumbrance or expenditure until June 30, 2020:

0001 – General Fund
(1) Item 4260-001-0001, Budget Act of 2018 (Chs 29 and 30, Statutes of 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 DHCS to respond to the following:

1. Please provide a brief overview of this proposal.

Issue 19: Strengthening Preventive Services for Children in Medi-Cal

Spring Finance Letter. DHCS requests 12 positions and expenditure authority of $22.7 million ($11.1 million General Fund and $11.6 million federal funds) in 2019-20, $7.5 million ($3.5 million General Fund and $4 million federal funds) in 2020-21 through 2022-23, and $6 million ($2.8 million General Fund and $3.1 million federal funds) annually thereafter. If approved, these resources would allow DHCS to improve delivery of preventive services for children in Medi-Cal in response to findings of a state audit.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$11,079,000	$3,495,000
0890 – Federal Trust Fund	$11,603,000	$3,998,000
Total Funding Request:	**$22,682,000**	**$7,493,000**
Total Positions Requested:	**12.0**	**12.0**

* Additional fiscal year resources requested – 2021-22 through 2022-23: $7,493,000; 2023-24 and ongoing: $5,996,000.

Background. Medi-Cal offers an array of preventive diagnostic and treatment services for individuals under age 21 as part of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. The EPSDT benefit covers all medically necessary services, including those to correct or ameliorate defects and physical and mental illnesses or conditions. EPSDT ensures that children receive age appropriate preventive services, including screening for medical, dental, vision, hearing, mental health, and substance use disorders. Services provided under EPSDT include, but are not limited to, physician services, nurse practitioner services, hospital services, physical therapy, speech and language therapy, occupational therapy, home health services, medical equipment, supplies and appliances, treatment for mental health and substance use disorders, and treatment for vision, hearing, and dental diseases and disorders.

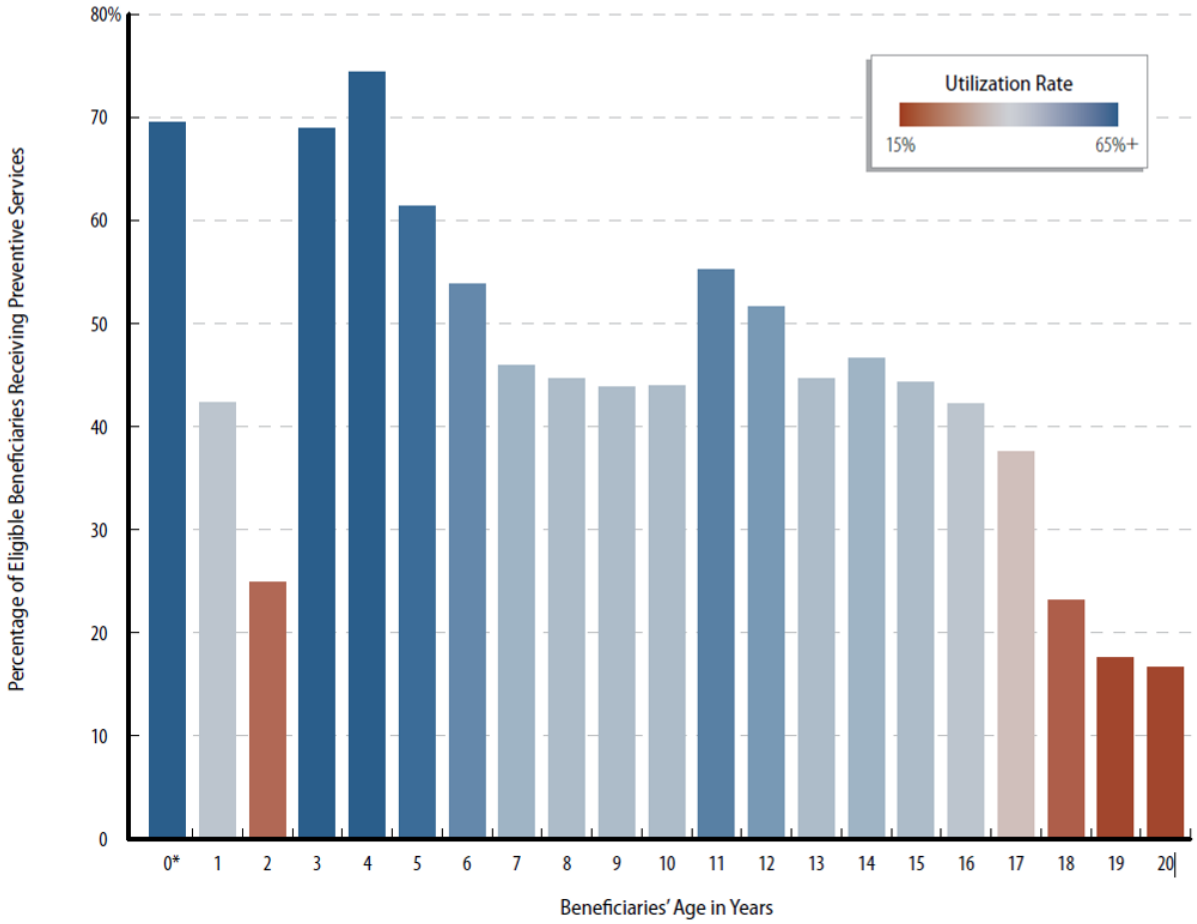
Medi-Cal uses the American Academy of Pediatrics' Bright Futures periodicity schedule to achieve the goal of age-appropriate periodic screenings. The Bright Futures periodicity schedule outlines the appropriate timing for various screenings performed by health care providers including medical history, body measurements (e.g. length, height, weight, head circumference, body-mass index, etc.), sensory screening (e.g. vision and hearing), developmental and behavioral health screening (e.g. for autism spectrum disorder, tobacco or substance use, depression, etc.), physical examination, regular testing and monitoring (e.g. testing for blood lead, tuberculosis, dyslipidemia, sexually transmitted diseases, cervical dysplasia, etc.), immunizations, and oral health (e.g. fluoride varnish or supplementation).

Medi-Cal managed care plans, which cover more than 80 percent of Medi-Cal beneficiaries are required under terms of their contracts with the state to adhere to the Bright Futures periodicity schedule for children's preventive services. According to DHCS, All Plan Letter 18-007 outlines plans requirements for delivering the EPSDT benefit and references federal requirements that children receive services according to Bright Futures.

State Audit Finds Children Not Receiving All Preventive Services in Medi-Cal. In March 2019, the California State Auditor released the results of its audit of DHCS, "Department of Health Care Services, Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services" (Report 2018-111),

which found that an annual average of 2.4 million children in Medi-Cal, or more than 50 percent, do not receive all required preventive services. The audit found most of the lowest rates of preventive utilization for children were in 15 rural counties in the eastern part of California, with the lowest usage in Alpine, Plumas, Mariposa, and Sierra counties. The audit also found significantly lower utilization rates for children ages two and under, when many important developmental and other screenings are expected under the Bright Futures periodicity schedule.

Utilization Rates Were Low for Some of the Youngest Children in Medi-Cal
Fiscal Years 2013–14 Through 2017–18



Source: California State Auditor. "Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services" (March 2019)

DHCS requests 12 positions and expenditure authority of $22.7 million ($11.1 million General Fund and $11.6 million federal funds) in 2019-20, $7.5 million ($3.5 million General Fund and $4 million federal funds) in 2020-21 through 2022-23, and $6 million ($2.8 million General Fund and $3.1 million federal funds) annually thereafter to make the following changes to improve children's preventive utilization in response to the audit findings:

- **Managed Care Performance Measures** – DHCS is expanding the scope of performance measures for Medi-Cal managed care plans to include measures from the Centers for Medicare and Medicaid

Services (CMS) Child Core Set and Adult Core Set. Plans are currently required to report yearly on certain measures from the Healthcare Effectiveness Data and Information Set (HEDIS), a set of performance measured developed by the National Committee for Quality Assurance. DHCS is also planning to issue a follow-up All Plan Letter specifically highlighting the requirements for plans to deliver services according to the Bright Futures periodicity schedule.

- **Minimum Performance Level** – DHCS is updating its requirements for managed care plan performance on the new core sets from the 25th percentile to the 50th percentile of Medicaid plans in the United States. If data is not available to determine nationwide percentile rankings, DHCS may establish alternative benchmarks. When plans do not meet the minimum performance level, sanctions and corrective action plans will be imposed and quality improvement work required.
- **Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey** – DHCS contracts with an external quality review organization (EQRO) to administer the CAHPS survey triennially, which assesses beneficiary experience and satisfaction with health care services for managed care beneficiaries by county and plan. The EQRO conducts the survey annually for children on a statewide level. DHCS is planning to conduct the CAHPS survey every two years instead of every three years to better monitor plan performance.
- **Beneficiary Outreach Activities** – DHCS intends to conduct a beneficiary outreach campaign, including a mail and phone survey, to inform parents and caregivers about the need to schedule preventive services for their children and the availability of these services under Medi-Cal. According to DHCS, this outreach campaign would be similar to a campaign it conducted recently which successfully improved dental utilization among children in Medi-Cal.

Specifically, DHCS is requesting the following positions and contract resources in the following divisions:

Managed Care Quality Monitoring Division (MCQMD)

MCQMD requests 12 positions, four-year limited-term funding equivalent to six positions, and $18.5 million contract funding, as follows:

- **One Staff Services Manager III** position would oversee a new branch within the division for development of the outreach campaign and methodologies for reporting. This position would manage quality monitoring including directing programmatic staff on quality strategy, monitoring, oversight, and act as the primary point of contact when coordinating efforts with state and federal agencies, internal and external stakeholders, and other DHCS divisions.
- **One Staff Services Manager II** position would oversee and direct program staff relating to utilization reporting for preventive services for children, quality improvement efforts, and health equity. This position would also manage programmatic aspects of the beneficiary outreach campaign including second-level review and quality assurance of program staff work, and serve as primary point of contact for the campaign.
- **Four Nurse Consultant III** positions (two permanent, two limited-term) would work with the EQRO and managed care plans on quality improvement plans and other monitoring such as performance on quality indicators, comparison of plan performance to the minimum performance level, establishing and monitoring corrective action plans, providing technical assistance to plans, identifying and reviewing quality improvement goals for plans, analyzing EQRO findings, and collaborate with other staff to support efforts to reduce health disparities.

- **One Nurse Consultant III** position would analyze quality improvement and health disparity interventions, determine if interventions were successful, identify promising practices, and support addition of Child and Adult Core Set measures to plan performance metrics.
- **Four Health Program Specialist II** positions would work with the EQRO and plans on corrective action plans and other improvement activities, develop and implement policies and strategies for improving preventive services for children, support procedures for tracking corrective action plans and calculate potential sanctions for non-compliance.
- **One Health Program Specialist II** position (limited-term) would serve as the lead on facility site review policy, data collection, monitoring reporting, and compliance. This position would provide plans with technical assistance, maintain documentation of promising improvement practices, and develop strategy for dissemination and implementation of promising improvement practices.
- **One Health Program Specialist I** position would develop an annual compliance report issued publicly to outline health plan quality interventions and results.
- **One Associate Governmental Program Analyst** (limited-term) would collaborate with DHCS consultants and the Department of Public Health to assist in development of the beneficiary outreach campaign including development and design of an outreach website, engaging in focus groups for messaging purposes, development of beneficiary notices, and creating outreach campaign policies and procedures for plans.
- **One Associate Governmental Program Analyst** would be the lead on corrective action plans and sanctions including monitoring and tracking plan performance, drafting corrective action plan and sanction correspondence with plans, documenting actions taken by plans and plan progress, providing guidance to plans during the corrective action plan process, publicly posting results, and answering stakeholder inquiries.
- **One Research Scientist III** position would lead the development of methodologies for evaluations and studies on utilization and disparities for preventive services for children in Medi-Cal including workgroup facilitation for methodology development, validation of methodology, presentation of research methodologies to DHCS leadership, peer review of EQRO deliverables, and serve as the lead on reviewing and making recommendations with results from EQRO findings.
- **One Research Data Specialist II** (limited-term) would provide technical analytic support to MCQMD staff, carry out research projects and develop monitoring reports using managed care encounter and provider network data.
- **One Research Data Specialist II** (limited-term) would lead maintenance and development of DHCS' Enterprise Performance Measurement system to expand its oversight specifically to children's preventive services.
- **Contract Resources – EQRO Activities -** $4 million ($2 million General Fund and $2 million federal funds) annually to fund additions to the EQRO contract to expand health disparities report, create a utilization report and analysis, continue and expand encounter data validation reports, expand performance metrics, expand timely access surveys, expand HEDIS auditing, and conduct CAHPS survey every two years.
- **Contract Resources – FSR Process** - $500,000 ($250,000 General Fund and $250,000 federal funds) annually for a contract to automate the facility site review (FSR) process, in which DHCS and plans send nurses to provider offices to gather data by surveying medical records. This contract would allow plans to submit data electronically rather than requiring an on-site visit.
- **Contract Resources – Initial Beneficiary Outreach Campaign -** $4 million ($2 million General Fund and $2 million federal funds) in 2019-20 to conduct an initial mailing and phone campaign by

January 1, 2020. The campaign would include consultation with stakeholders on development of letters and call scrips. Managed care plans would be responsible for calling beneficiaries.

- **Contract Resources – Beneficiary Outreach Campaign** - $10 million ($5 million General Fund and $5 million federal funds) in 2019-20 for a contract with an independent consultant to conduct surveys of beneficiaries, design outreach materials, engage with stakeholders, and create an outreach campaign recommendations report.

Office of Legal Services (OLS)

- OLS requests four-year limited term funding equivalent to **one Attorney IV** position to provide comprehensive legal support and services for improving preventive services to children including reviewing sanction letters, corrective action plans, and sanction appeals. This position would also provide litigation legal support in the event that sanctions are appealed.

Managed Care Operations Division (MCOD)

MCOD requests four-year limited-term funding equivalent to two positions and $500,000 contract funding, as follows:

- **Two Associate Governmental Program Analysts** would assist in reviewing health plan provider directories to ensure accuracy is at least at an 81 percent confidence level. These positions would also work with plans to initiate, develop, and deliver corrective action plans and provide resolution to deficiencies, review and analyze reports and performance data, and make recommendations regarding plan performance.
- **Contract Resources – Provider Directory Tool and Document Storage** - $500,000 ($250,000 General Fund and $250,000 federal funds) in 2019-20 for a contract to automate the oversight process for provider directory accuracy. The contract would also help build a document storage system for plan deliverables.

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 impact does DHCS expect the beneficiary outreach campaign to have on increasing utilization of preventive services by children in Medi-Cal.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Alzheimer's Grant Awards & Governor's Task Force on Alz. Prevention & Preparedness

Spring Finance Letter. DPH requests a shift of General Fund expenditure authority of $300,000 from local assistance to state operations in 2019-20. If approved, this shift of resources would support contracts needed to administer the Governor's Task Force on Alzheimer's Prevention and Preparedness and would reduce research grant funding in 2019-20 related to the incidence of Alzheimer's disease among women and communities of color.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund		
State Operations	$300,000	$-
Local Assistance	($300,000)	$-
Total Funding Request:	**$-**	**$-**

Background. In the Governor's January budget, DPH requests two positions and General Fund expenditure authority of $3 million annually to expand research grants in the Alzheimer's Disease Program focused on the prevalence of the disease among women and communities of color. These resources would also support creation and implementation of the Governor's Task Force on Alzheimer's Prevention and Preparedness (previously known as the Governor's Task Force on Brain Health). The task force, chaired by Maria Shriver, will be co-chaired by the Governor, will hold listening sessions in different parts of the state and develop guidelines on brain health that can be shared with partners in the public, private, and non-profit sectors. The task force will also look at the effects of Alzheimer's disease and policies that can point the way for brain-healthy families, workplaces, and communities.

According to the Administration, the task force will need to rely on contract resources to manage and coordinate its activities. The shift in General Fund resources from research purposes on a one-time basis would fund a contractor to provide project management, meeting facilitation, act as an author for task force documents, and provide event management services for listening sessions and other meetings. The Administration indicates the California Health and Human Services Agency's Let's Get Healthy California project relied on similar contract resources for its activities.

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, Licensing and Certification Program

Budget Issue. The budget includes expenditure authority for the Center for Healthcare Quality of $291.4 million ($3.7 million General Fund, $104.5 million federal funds, and $183.1 million special funds and reimbursements) in 2018-19, an increase of $10.2 million or 3.6 percent compared to the 2018 Budget Act, and $309.6 million ($3.7 million General Fund, $99.3 million federal funds, and $206.5 million special funds and reimbursements) in 2019-20, an increase of $20.1 million or 6.9 percent compared to the revised 2018-19 budget. According to DPH, the increase in 2018-19 is attributable to adjustments for employee compensation, retirement, and federal approval of a Certified Nurse Assistant (CNA) Kickstarter program. For 2019-20, the increase in expenditures is attributed to increased costs for the department's contract with Los Angeles County, implementation of a centralized program flexibility unit, and legislatively mandated hospital licensing timelines and implementation of online and distance learning opportunities for CNA training.

CHCQ Funding Summary, November 2018 Estimate		
Fund Source	**2018-19**	**2019-20**
0001 – General Fund	$3,700,000	$3,700,000
0890 – Federal Trust Fund	$104,534,000	$99,349,000
0942 – Special Deposit Fund		
Internal Departmental Quality Improvement Account	$2,600,000	$2,600,000
State Health Facilities Citation Penalty Account	$2,144,000	$2,144,000
Federal Health Facilities Citation Penalty Account	$2,166,000	$2,201,000
0995 – Reimbursements	$12,265,000	$12,187,000
3098 – Licensing and Certification Program Fund	$163,942,000	$189,248,000
Total CHCQ Funding	**$291,351,000**	**$311,429,000**
Total CHCQ Positions	**1304.3**	**1346.3**

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 and entity-reported incidents to ensure health care facilities comply with state and federal laws and regulations, conducting more than 30,000 complaint and entity-reported incident investigations of long-term care facilities 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 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.

2018 Budget Act – The 2018 Budget Act included*:*

- $2.6 million from the Licensing and Certification Program Fund to fund a one-year extension of the Los Angeles County contract for licensing and certification activities and to account for adjustments to the indirect cost rate, employee benefits rate, personnel costs, and lease costs.
- Budget bill language to authorize DPH to increase funding for the Los Angeles County contract as needed based on actual cost information that becomes available during 2018-19.
- Trailer bill language to authorize a supplemental license fee on facilities located in Los Angeles County to offset additional costs necessary to regulate facilities in the county.
- 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 allow DPH to improve core operations and effectiveness, foster quality improvement projects, and address workforce needs, particularly in the licensing of certified nurse assistants.

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 an 8.2 percent vacancy rate for all positions reported as of the fourth quarter of 2017-18, compared to 14.64 percent in the fourth quarter of 2016-17. The vacancy rate for the HFEN classification, the primary classification conducting health facility oversight and investigation, was 4.8 percent in the fourth quarter of 2017-18, compared to 15.2 percent in the fourth quarter of 2016-17. L&C vacancies, particularly in the HFEN classification, have been a persistent concern for the program, the Legislature, and stakeholders, about the program's ability to manage its licensing and certification and complaint and entity-reported incident investigation workload. While publicly available vacancy data is only available through the fourth quarter of 2017-18, DPH reports its current HFEN vacancy rate is 4.2 percent.

DPH indicates its successful reduction in its vacancy rate is due to recent implementation of recruitment and retention strategies. The program hired two contractors to help remedy the high vacancy rates for HFENs in the L&C program: 1) an onboarding and retention contractor assists hiring candidates to navigate the state civil service process and helps improve retention of hired staff, and 2) a recruitment contractor seeks candidates for HFEN 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 also represent two of the recommendations from the Hubbert assessment.

Persistent Complaint Investigation Backlog. While the program has significantly reduced its position vacancy rate, data released to date on timeliness of complaint and entity-reported incident investigations has not shown a significant impact. Beginning in 2014, L&C has produced quarterly reports on the number, investigation, completion and other details about health care facility complaints and entity-reported incidents. According to the program's Complaints and Entity-Reported Incidents Dashboard, since the first quarter of 2014-15, the number of open complaints has grown from 4,312 to 5,184 in the fourth quarter of 2017-18, while the number of entity-reported incidents has grown from 7,568 to 10,705 during the same period. The backlog of open complaints and entity-reported incidents continues to grow despite the approval of significant staff resources for the division and contract resources for the Los Angeles County contract, although it has remained level or decreased slightly during the four quarters of 2017-18. 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 entity-reported incident investigation workload. DPH also reports it will release metrics for the first and second quarter of 2018-19 shortly, which will provide additional data to determine if the program's attempts to improve its investigation timeliness, including its recent reduction in position vacancy rates, are having a measurable effect.

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. Please provide an update on the L&C Program's vacancy rate, particularly for the HFEN classification.

3. Please provide an update on the most current timeliness metrics for investigation of complaints and entity-reported incidents. In what activities is the program currently engaged to help reduce the persistent backlog of investigations and high average age of open cases?

Issue 3: L&C – Los Angeles County Contract

Budget Issue. DPH requests expenditure authority from the Licensing and Certification Program Fund of $17.2 million in 2019-20, $38.2 million in 2020-21, and $57.3 million annually thereafter. If approved, these resources would allow DPH to implement a new three-year contract with the Los Angeles County Department of Public Health to transition workload related to federal certification, state licensing, and investigation of complaints and reported incidents in facilities located in Los Angeles County effective July 1, 2019.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3098 – Licensing and Certification Program Fund	$17,158,000	$38,219,000
Total Funding Request:	**$17,158,000**	**$38,219,000**

* Additional fiscal year resources requested: 2021-22 and ongoing: $57,326,000

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 2,900 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 20 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.

The department's contract with LA County 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.

The 2018 Budget Act included resources to allow DPH to extend the LA County contract for an additional year until June 30, 2019. The Legislature also approved trailer bill language to assess a supplemental license fee on facilities located in LA County to offset additional costs necessary to regulate entities in the county. The supplemental fee is intended to prevent the need to increase license fees on health care facilities statewide to absorb increasing contract costs and to allow health care facilities in LA County to receive services comparable to other health care facilities statewide.

The department and LA County are completing negotiations on the terms of a new three-year contract beginning July 1, 2019, that emphasizes pay for performance with defined quality, quantity, and service metrics. According to DPH, the new contract reflects a gradual increase for LA County workload and

resources to hire necessary staff over three years to complete 100 percent of the mandated workload, including its existing tier 1 and tier 2 federal workload, complaint and incident investigations, as well as new tier 3 and tier 4 federal workload, state licensure activities, and responsibility for all complaints and entity-reported incidents in the county. DPH has expenditure authority for the existing contract of $48.4 million. According to DPH, the new contract would require an additional $17.2 million in 2019-20, $38.2 million in 2020-21, and $57.3 million annually thereafter. Once fully phased in, the LA County contract would result in annual expenditures of $105.6 million beginning in 2021-22 and would be sufficient for LA County to hire an additional 172 health facility evaluator nurse (HFEN) positions and associated support and supervisory staff, for a total of 491 staff including 317 HFENs.

New Contract Includes Performance Metrics, Penalties and Additional Oversight Tools. According to DPH, while final details are still being negotiated, the department and LA County have agreed the contract would include financial penalties in the event the county does not achieve defined quantity metrics. These quantity metrics would likely include the percent of complaints and licensing and certification surveys completed within required timeframes.

The contract would also require LA County to provide and implement a corrective action plan if the county does not meet quality or customer service metrics. These metrics would likely include regular State Observation Survey Analysis (SOSA) surveys for skilled nursing facilities and intermediate care facilities, yearly review of closed complaints and entity-recorded files, average rating of 75 percent or higher on Provider Evaluation Surveys, timely scheduling and completion of initial and final letter to complainants, and timely scheduling and completion of informal conferences and dispute resolutions.

The contract would also include provisional language to allow for a reduction of the budget in 2021-22 if the actual workload of the county does not align with the workload projections upon which the third-year budget is based. DPH also intends to increase the supplemental license fee in LA County to account for the expanded costs of the new contract.

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. How would the department manage budgetary changes related to using the proposed contract provisional language to reduce the LA County budget in 2021-22 if actual workload is below projections? Would budgetary provisional language be necessary?

3. If LA County were assessed a financial penalty under the new contract for failure to meet quantity metrics, where would the financial penalty revenue be deposited and for what purpose would it be used?

Issue 4: L&C – Creation of a Centralized Program Flex Unit

Budget Issue. DPH requests six positions and expenditure authority from the Licensing and Certification Program Fund of $973,000 annually. If approved, these positions and resources would allow DPH to shift health facility program flexibility application workload from district offices to a new centralized headquarters unit.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3098 – Licensing and Certification Program Fund	$973,000	$973,000
Total Funding Request:	**$973,000**	**$973,000**
Total Positions Requested:	**6.0**	**6.0**

* Positions and resources ongoing after 2020-21.

Background. Health and Safety Code section 1276 requires DPH to grant facilities certain flexibility from regulatory requirements by using alternate concepts, methods, procedures, techniques, equipment, personnel qualifications, bulk purchasing of pharmaceuticals, or conducting pilot projects as long as the facility meets statutory requirements and the program flexibility is approved by DPH with specified terms and conditions. Applications for program flexibility must include justification for the request and adequate supporting documentation that the alternative does not compromise patient care. DPH is required to approve, approve with conditions or modifications, or deny the application within 60 days.

According to DPH, each of the thirteen district offices of the Licensing and Certification Division reviews program flexibility requests submitted by facilities in their areas of oversight. Between 2013-14 and 2017-18 facilities submitted more than 1,600 program flexibility requests. DPH indicates the 60 day review timeline is not being met consistently, with only 50 percent completed on time in 2017-18. Because each district office handles program flexibility requests differently, there is no consistency in review and approval.

DPH requests six positions and expenditure authority from the Licensing and Certification Program Fund of $973,000 annually to shift health facility program flexibility application workload from district offices to a new centralized headquarters unit. According to DPH, the new unit would provide program-wide efficiency and consistency, promote development of subject matter expertise and promote consistency in evaluation of the requests. Centralizing these functions would also allow for analysis of data, identification of trends, and more informed decisions on the need for future policy or regulatory changes. The requested resources would support the following positions within the new unit:

- **One Health Program Manager II** would oversee the centralized program flexibility unit, supervise the unit's multidisciplinary team, consult with subject matter experts and state and federal staff to assess and evaluate alternative methods of compliance with licensing and certification requirements, monitor trends in requests to assess and make recommendations on the need for policy or regulatory changes, and perform personnel and administrative responsibilities.
- **Three Nurse Consultant II** positions would evaluate program flexibility requests and supporting documentation, assess alternatives proposed by facilities, research clinical standards of practice applicable to various care settings for consideration of program flexibility applications, and evaluate whether proposed alternative meet relevant regulatory requirements and program standards.

- **One Associate Governmental Program Analyst** would review program flexibility applications, prepare monthly summary reports, maintain electronic logs of all aspects of work for tracking purposes, and prepare outcome letters for facilities.
- **One Office Technician** would process program flexibility applications, update electronic databases with request information, and process mail.

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: L&C – Increased IT Customer Support

Budget Issue. DPH requests six positions and expenditure authority from the Licensing and Certification Program Fund of $911,000 annually. If approved, these positions and resources would allow DPH to increase information technology services associated with a new federally required health facility survey automation system.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3098 – Licensing and Certification Program Fund	$911,000	$911,000
Total Funding Request:	**$911,000**	**$911,000**
Total Positions Requested:	**6.0**	**6.0**

* Positions and resources ongoing after 2020-21.

Background. The federal Centers for Medicare and Medicaid Services (CMS) approved a new Long Term Care Survey Process (LTCSP), a resident-centered, outcome-oriented inspection that supports identification of quality of care and quality of life problems in health facilities. The LTCSP was intended to combine two existing survey processes into one efficient and comprehensive survey that includes various existing requirements and new requirements contained in long-term care reform regulations. According to DPH, CMS requires use of a single, software-based nationwide survey process and requires surveyors to complete in-depth on-site surveys and share information in the field. CMS implemented LTCSP for skilled nursing facilities in November 2017 and expects to add one to two facility types annually over the next several years to the new process.

DPH requests six positions and expenditure authority from the Licensing and Certification Program Fund of $911,000 annually to increase information technology services associated with implementation and transitioning staff to the new LTCSP. DPH reports its Information Technology Services Division has experienced an increase in information technology (IT) support tickets and slower response times for resolving those support tickets. The division is responsible for addressing software and hardware issues for 800 surveyors and 2,000 total users. The requested resources will support two teams, as follows:

- **Three Information Technology Specialist I** positions would focus on resolving IT support tickets within three days, serve as subject matter experts and provide problem resolution, respond to phone calls and other communications, and monitor helpdesk ticket requests.
- **Three Information Technology Specialist I** positions would support surveyors with updating technologies, setting up workstations, and completing configuration and desktop 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 6: L&C – Timelines for Hospital Licensing Applications (AB 2798)

Budget Issue and Trailer Bill Language. DPH requests 21 positions and expenditure authority from the Licensing and Certification Program Fund of $3.4 million annually. If approved, these positions and resources would allow DPH to comply with new health facility licensing application processing timelines, pursuant to the requirements of AB 2798 (Maienschein), Chapter 922, Statutes of 2018. DPH also requests trailer bill language to amend a provision of AB 2798 to allow the Licensing and Certification Program Fund to support the required workload.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3098 – Licensing and Certification Program Fund	$3,386,000	$3,386,000
Total Funding Request:	**$3,386,000**	**$3,386,000**
Total Positions Requested:	**21.0**	**21.0**

* Positions and resources ongoing after 2020-21.

Background. The Centralized Applications Branch (CAB) in the Licensing and Certification (L&C) Division processes health care facility applications including initial facility licensure, changes to existing licensure, and licensure renewals. This workload was previously distributed to the L&C Division's district offices, but was centralized at the state level in 2015-16 to provide a standardized application process and create consistent application processing timelines. CAB is responsible for licensing of the following facility types:

Acute Psychiatric Hospitals	District Hospitals (<100 beds)	ICF-DD Nursing
Adult Day Health Centers	General Acute Care Hospitals	Pediatric Day Health and Respite Care Facility
Alternative Birthing Centers	Home Health Agencies	Psychology Clinics
Chemical Dependency Recovery Hospitals	Hospices	Referral Agencies
Chronic Dialysis Clinics	Hospice Facilities	Rehabilitation Clinics
Primary Care Clinics – Community Clinics/Free Clinics	Intermediate Care Facilities (ICF)	Skilled Nursing Facilities
Congregate Living Health Facilities	ICF/Developmentally Disabled (ICF-DD)	Special Hospitals
Correctional Treatment Centers	ICF-DD Habilitative	Surgical Clinics

According to DPH, CAB processes licensing applications in the order in which they are received. The most recent data released by DPH on processing timeliness indicates a median age of open applications of 211 days as of the last quarter of 2017-18. The median age is down somewhat from the 221 days in the third quarter of 2017-18, but higher than the 130 day median age of open applications for the entire

2016-17 fiscal year. DPH indicates CAB has increased staffing from 25 to 95 staff members and implemented new training and procedures to reduce application backlogs.

AB 2798 Mandates Expedited Review of Certain Hospital Licensure Applications. AB 2798 requires DPH to evaluate and approve or deny an application from a general acute care hospital or an acute psychiatric hospital within 100 days of receipt. Upon approval, DPH is also required to complete any additional review of the application within 30 days. In addition, DPH is required to review and approve applications for expansions of existing services in general acute care hospitals or acute psychiatric hospitals within 30 days of receipt. If DPH does not complete its review within 30 days, the application is automatically approved. In addition to the accelerated processing timelines for these facility applications, AB 2798 requires the department to develop an automated application system on or before December 31, 2019, and establish an advice program to assist applicants to complete their applications.

DPH requests 21 positions and expenditure authority from the Licensing and Certification Program Fund of $3.4 million annually to comply with the new general acute care hospital and acute psychiatric hospital licensing application processing timelines required by AB 2798. These resources would fund the following staff:

- **Three Associate Governmental Program Analysts** would review incoming applications for completeness and accuracy, notify applicants of missing documentation, monitor survey reports, assist in the development of the automated application system, and assist in the establishment of an advice program to assist applicants to complete their applications.
- **14 Health Facilities Evaluation Nurses**, as well as $199,000 to support the equivalent of two nurses in the Los Angeles County contract, would survey hospitals to assess compliance with regulations, prepare written analyses of findings, and provide technical assistance to facility administrators.
- **Four Associate Governmental Program Analysts** would perform licensing functions, monitor compliance with processing timelines, and perform survey workload.

DPH also requests trailer bill language to authorize expenditures from the Licensing and Certification Program Fund to support the new licensing application processing timelines. A provision of AB 2798 required resources to support implementation to be appropriated from the Internal Departmental Quality Improvement Account. Because this account typically funds time-limited quality improvement projects, DPH believes implementation of the provisions of AB 2798 would be more appropriately funded from the Licensing and Certification Program Fund on an annual basis. The proposed trailer bill language deletes the specific funding requirements included in AB 2798.

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 7: L&C – Online and Distance-Learning Nurse Assistant Training Programs (AB 2850)

Budget Issue. DPH requests nine positions and expenditure authority from the Licensing and Certification Program Fund of $1.2 million annually. If approved, these positions and resources would allow DPH to review, approve, and monitor applications from new online and distance learning nurse assistant training programs and instructors, pursuant to the provisions of AB 2850 (Rubio), Chapter 769, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3098 – Licensing and Certification Program Fund	$1,243,000	$1,243,000
Total Funding Request:	**$1,243,000**	**$1,243,000**
Total Positions Requested:	**9.0**	**9.0**

* Positions and resources ongoing after 2020-21.

Background. Certified nurse assistants (CNAs) provide basic patient care services directed at the safety, comfort, personal hygiene, and protection of patients under the supervision of a registered nurse or licensed vocational nurse. The Professional Certification Branch (PCB) within the Licensing and Certification Division at DPH is responsible for the certification of CNAs. To become a CNA, an individual must be 16 years of age or older, complete a background check, complete an approved nurse assistant training program (NATP) consisting of 60 hours of classroom training, and pass the required examination.

In addition to issuing CNA certification, PCB is also responsible for review and approval of proposed NATP curriculum prior to operation to verify inclusion of all required components and consistency with relevant laws and regulations. PCB enforcement includes monitoring classes, assessing enrollment, and evaluating examination pass rates. Facilities must maintain a 60 percent pass rate to maintain approval.

2017 Budget Act Increased Minimum Staffing Ratios for CNAs in Skilled Nursing Facilities. The 2017 Budget Act included trailer bill language to require free-standing skilled nursing facilities (SNFs) to 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 CNAs, beginning July 1, 2018. In addition to the new direct care service hour requirements, the trailer bill language required 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. The workforce shortage waivers were developed to provide flexibility to SNFs if insufficient staff are available to fulfill the direct care service hour requirements. Waivers require SNFs to provide evidence of efforts to address the workforce shortage and a detailed plan for maintaining high quality resident care despite the shortage. Waivers may be renewed annually, but no facility may receive more than two consecutive renewals. According to DPH, 117 facilities were granted workforce waivers for the required minimum 2.4 direct care service hours for CNAs. As a result of the need for a more robust CNA workforce, DPH has engaged in several initiatives to increase opportunities to train and be certified as a CNA.

AB 2850 Allows Online or Distance-Learning for Classroom Component of CNA Training. AB 2850 allows SNFs or other health facilities, educational institutions, or local agencies to conduct the 60 hours of classroom training required to be certified as a CNA in an online or distance learning course

format. The program may be provided by a registered nurse or licensed vocational nurse with at least two years of nursing experience, one year of which must be providing care and services to chronically ill or elderly patients in an acute care hospital, SNF, or other health facility. The online or distance learning programs must comply with specific requirements including: 1) online instruction in real-time with instructors and trainees, 2) use of personal identification methods to confirm identities of instructors and trainees, 3) protection of personal information, 4) policies and procedures to insure instructor accessibility outside of normal instruction times, 5) policies and procedures for equipment failures, student absences, and completing assignments past original deadlines, 6) provide clear explanation of all technology requirements to complete the program, and 7) provide DPH statistics about performance of trainees in the program.

DPH requests nine positions and expenditure authority from the Licensing and Certification Program Fund of $1.2 million annually to review, approve, and monitor applications from new online and distance learning nurse assistant training programs and instructors, pursuant to the provisions of AB 2850. Eight positions would comprise a new Nurse Assistance Training Program Unit within the Aide and Technician Certification Section in PCB. The unit would include the following positions:

- **One Health Facilities Evaluator Manager I** position would oversee the program including supervising and coordinating staff activities to provide oversight and monitoring of program and instructor applications.
- **Three Health Facilities Evaluator Nurses** would review clinical training components of online training programs, conduct complaint investigations for programs, develop and maintain standards for course and quality control reviews, and consult with and provide technical assistance to entities offering programs.
- **Three Associate Governmental Program Analysts** would review initial program and entity applications for accuracy and completeness, correspond with applicants to correct application deficiencies, assist with training and outreach to applicants and entities, and develop reporting and other communications related to the program.
- **One Program Technician II** position would provide clerical support and perform general office tasks.

One Information Technology Specialist I position in the Information Technology Services Division would serve as the subject matter expert for online CNA training program compliance, provide oversight and enforcement of training course requirements, provide technical assistance and other guidance to DPH staff to support compliance monitoring, and participate in joint application development sessions.

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: L&C – Soliciting and Implementation of Projects to Benefit Nursing Home Residents

Spring Finance Letter and Budget Bill Language. DPH requests one position and expenditure authority from the Federal Health Facilities Citation Penalties Account of $680,000 in 2019-20, $431,000 in 2020-21, and $149,000 annually thereafter. If approved, this position and resources would allow DPH to implement a federally approved Nurse Leadership project and solicit future projects to benefit skilled nursing facility residents. In addition, DPH requests budget bill language to augment expenditure authority from the Federal Health Facilities Citation Penalties Account upon federal approval of project planning funded by the account and after legislative notification.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0942 – Special Deposit Fund**	$680,000	$431,000
Total Funding Request:	**$680,000**	**$431,000**
Total Positions Requested:	**1.0**	**1.0**

* Additional fiscal year resources requested: 2021-22 and ongoing: $149,000.
** Special Deposit Fund - Federal Health Facilities Citation Penalties Account

Background. DPH's Licensing and Certification (L&C) Division regulates more than 10,000 health care facilities in California for compliance with state and federal laws and regulations. For violations of federal laws and regulations, the federal Centers for Medicare and Medicaid Services (CMS) may impose monetary penalties against skilled nursing facilities and other facilities based on the number of days or for each instance of non-compliance. These penalties are returned by CMS to the state and may be reinvested to support CMS-approved activities that benefit nursing home residents that protect or improve their quality of life.

In California, federal penalties are deposited in the state's Federal Health Facilities Citation Penalties Account, a Special Deposit Fund. According to DPH, states must submit an annual plan for use of penalty funds including fund balances, current obligations, and plans for solicitation and review of future projects. Previous projects funded by federal penalty revenue include the following:

1. 2013-14 – Three-year project to reduce antipsychotic medication in skilled nursing facilities, in collaboration with the California Culture Change Coalition.
2. 2015-16 – Three-year project for a Music and Memory program to improve dementia care, in collaboration with the California Association of Health Facilities (CAHF).
3. 2017-18 – Four-year project to improve dietary services in skilled nursing facilities, in collaboration with CAHF.
4. 2018-19 – Three-year project for a Volunteer Engagement Project, in collaboration with CAHF.
5. 2018-19 – Two-year project for the Certified Nursing Assistant Training Kickstarter Project, in collaboration with the Quality Care Health Foundation.

DPH requests one position and expenditure authority from the Federal Health Facilities Citation Penalties Account of $680,000 in 2019-20, $431,000 in 2020-21, and $149,000 annually thereafter. DPH reports CMS has approved a grant funded by federal citation penalties for a Nurse Leadership Project, which would concentrate on development of nurse leaders, focusing on leadership abilities, effective communication, managing expectations, accountability, delegation, and mentorship. The goal

of the project would be to reduce turnover rates of direct care staff to improve resident care and satisfaction. The project is approved for $1.7 million of funding for three years ($567,000 in 2019-20, $579,000 in 2020-21, and $592,000 in 2021-22). DPH indicates a portion of the funding is available under its existing expenditure authority for the account, but will need additional expenditure authority of $531,000 in 2019-20 and $282,000 in 2020-21 to implement the project.

The request also includes establishment of **one Staff Services Manager I** position to solicit and monitor implementation of projects to benefit skilled nursing facility residents using federal citation penalty funds. This position would monitor expenditures under the federally approved plan for citation penalty expenditures, solicit new projects at quarterly conference meetings and in All Facilities Letters, and review and evaluate project applications.

Provisional Language to Augment Expenditure Authority Upon Federal Approval. DPH also requests budget bill language to augment expenditure authority from the Federal Health Facilities Citation Penalties Account upon federal approval of project planning funded by the account and after legislative notification. According to DPH, CMS recently released guidance requesting states to obtain sufficient expenditure authority to timely and efficiently expend federal penalty funds. Without sufficient expenditure authority, projects may be delayed by up to one year and such delays may discourage entities from submitting project applications. The requested budget bill language is as follows:

Item 4265-115-0942

1. The Department of Finance may augment this item, after review of a request submitted by the State Department of Public Health reflecting federal approval to use this account. Any augmentation shall be authorized not sooner than 30 days after notification in writing to the Chairperson of the Joint Legislative Budget Committee, or not 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 9: Center for Infectious Diseases

Background. DPH's Center for Infectious Diseases (CID) protects the people in California from the threat of preventable infectious diseases and assists those living with an infectious disease in securing prompt and appropriate access to healthcare, medications and associated support services. CID is composed of four primary entities: the Division of Communicable Disease Control, the Office of AIDS, the Office of Binational Border Health, and the Office of Refugee Health.

Division of Communicable Disease Control. 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.

Office of AIDS. DPH's Office of AIDS (OA) has lead responsibility for coordinating state programs, services, and activities relating to HIV/AIDS. OA's mission is to: 1) assess, prevent, and interrupt the transmission of HIV and provide for the needs of infected Californians by identifying the scope and extent of HIV infection and the needs which it creates, and by disseminating timely and complete information; 2) assure high-quality preventive, early intervention, and care services that are appropriate, accessible, and cost effective; 3) promote the effective use of available resources through research, planning, coordination, and evaluation; and 4) provide leadership through a collaborative process of policy and program development, implementation and evaluation.

OA oversees four primary program branches:

1) The Surveillance, Research & Evaluation Branch conducts a variety of epidemiologic studies, evaluates the efficiency and effectiveness of publicly funded HIV/AIDS prevention and care programs, and maintains California's HIV/AIDS Case Registry.
2) The HIV Care Branch has responsibility for programs related to the delivery of care, treatment, and support services for people living with HIV/AIDS. Programs are designed to provide an effective and comprehensive continuum of care to underserved individuals.
3) The HIV Prevention Branch funds initiatives to assist local health departments and other HIV service providers to implement effective HIV detection and prevention programs.
4) The AIDS Drug Assistance Program (ADAP) helps ensure that people living with HIV and AIDS who are uninsured and under-insured have access to medication. OA works closely with the pharmacy benefits manager (PBM), to administer and manage ADAP for the clients served.

Office of Binational Border Health. The mission of the Office of Binational Border Health (OBBH) is to facilitate communication, coordination, and collaboration among California and Mexico health officials, health professionals, and communities in order to optimize binational and border health. The OBBH also publishes the Annual Border Health Status Report to the Legislature to provide a general overview of the health status of border communities in the California-Mexico border region.

Established in 1983, the La Paz Agreement defined a binationally agreed upon border region, the area within 62 miles (100 km) on either side of the border, an area that encompasses approximately 250,000 square miles. Of the 1,952-mile boundary between the United States and Mexico, California's border region spans 140 miles, including San Diego and Imperial Counties, the state's southernmost counties. This area is remarkable because of its assorted geography, highly mobile, culturally and linguistically diverse population.

Recognizing the distinctiveness of the border region, AB 63 (Ducheny) Chapter 765, Statutes of 1999, established a permanent Office of Binational Border Health within the California Department of Public Health "to facilitate cooperation between health officials and health professionals in California and Mexico, to reduce the risk of disease in the California border region and in those areas directly affected by border health conditions". The Office of Binational Border Health began operating in January 2000.

Office of Refugee Health. The Federal Refugee Act of 1980 created the Office of Refugee Resettlement (ORR) to fund and coordinate post-arrival health assessments, time-limited medical services and cash assistance, and other benefits to newly arrived refugees, asylees, and other eligible entrants to help them achieve economic self-sufficiency as quickly as possible after their arrival to the United States. In California, the Office of Refugee Health (ORH) coordinates the following programs supported with ORR funds:

Refugee Health Assessment Program (RHAP) - Impacted local health jurisdictions provide culturally and linguistically-appropriate comprehensive health assessments to newly arrived refugees, asylees, federally-certified victims of severe forms of trafficking, and other eligible entrants. The RHAP focuses on screening of and prevention of communicable diseases; early identification and diagnosis of chronic diseases and other important conditions; assessment of immunization status for children and adults; mental health screening; and referral to health providers for further medical evaluation, treatment, and follow-up.

Refugee Medical Assistance Program (RMA) – In coordination with the Department of Health Care Services, Medi-Cal Eligibility Division, the ORH provides time-limited RMA-based Medi-Cal benefits to refugees, asylees, federally-certified victims of human trafficking, and other entrants who are not eligible to receive Medi-Cal benefits. This benefit is available only for the first eight months from the date admitted to the U.S. or from the date of certification.

Stakeholder Proposals in the Center for Infectious Diseases. Stakeholders have proposed the following investments in programs overseen by CID.

Communicable Disease Infrastructure for Local Health Departments – The County Health Executives Association of California (CHEAC) and the Health Officers Association of California (HOAC) request annual General Fund expenditure authority of $50 million to improve infrastructure to prevent and control the spread of infectious disease in California using strategies that best meet the needs of local jurisdictions. Examples of these strategies include disease surveillance, contact tracing, staff development and training, education and outreach to the general public and health care providers, clinical services, and laboratory testing. According to CHEAC and HOAC, local health departments do not have adequate funding to fulfill their unique mandate to prevent and control infectious diseases within their jurisdictions. State and federal funding for communicable disease control activities have considerably declined over time and are primarily siloed based on disease. This has led to significant challenges in addressing the rising rates of ever-present diseases such as sexually transmitted diseases and tuberculosis, and addressing outbreaks experienced in California such as Hepatitis A, influenza, Zika and measles, posing a health and safety risk to residents throughout the state.

According to statistics from DPH:

1) Nearly 360,000 cases of communicable diseases were reported in 2016
2) In 2016, an estimated 5.8 million cases of foodborne illness occurred in California, leading to nearly 400 deaths
3) An estimated 1.1 million to 4.3 million cases of influenza occurred in 2016, leading to an estimated 1,400 to 6,800 deaths
4) California has experienced a 45 percent increase in chlamydia, gonorrhea and early syphilis since 2012
5) Early syphilis has increased by 600 percent since 2012, 283 children were born with syphilis, and 30 stillbirths occurred due to syphilis
6) The 2017 Hepatitis A outbreak resulted in 704 cases, 461 hospitalizations, and 21 deaths

Communicable disease risks are further exacerbated by key issues facing Californians, such as the alarming number of Californians living in unsanitary or congregate settings due to homelessness or natural disasters.

Funding for California Immunization Registry – The California Immunization Coalition requests expenditure authority of $2.4 million annually to provide full funding for the California Immunization Registry (CAIR). According to the Coalition, state funding for CAIR was eliminated during budget reductions in 2010. Since then, the program has been primarily federally funded and subject to the uncertain availability of those funds. Full funding of the program would require approximately $7.4 million per year, $1.1 million more than its current funding level of $6 million. In addition, the program would need $1.3 million annually for system enhancements and software upgrades to modernize and integrate the registry.

End the Epidemics: Funding to Prevent HIV, Hepatitis C, and STDs – A coalition of 20 organizations including the California HIV Alliance, Essential Access Health, and the California Hepatitis Alliance request a total General Fund expenditure authority of $62 million to fund efforts to end the epidemics of HIV, Hepatitis C and sexually transmitted diseases (STDs) in California. The specific requests are as follows:

- Comprehensive HIV Prevention Services - $20 million would provide grants to local health jurisdictions and community-based organizations for outreach and education, HIV testing, linkage to care, increased access to PrEP, and services for people who use drugs.
- Hepatitis C Prevention, Testing, and Linkage to Care - $20 million would fund two Hepatitis C microelimination projects. $15 million would fund the first project to focus on Hepatitis C in people who use drugs, supporting 25 to 30 programs to serve over 166,000 Californians with evidence-based Hepatitis C outreach, screening, and linkage to and retention in care services. $5 million would fund the second project to focus on Hepatitis C in people coinfected with HIV.
- STD Prevention, Testing, and Treatment Services - $20 million would support a comprehensive, evidence-informed approach to STD prevention. The funding would provide STD screening, testing, and treatment, conduct surveillance activities to trach and share data, support culturally appropriate and responsive outreach and health promotion efforts, and implement innovative community-based projects to effectively reduce local STD rates.

- End the Epidemics Task Force - $2 million would fund an End the Epidemics Task Force to develop a statewide strategy to address HIV, Hepatitis C, and STDs, set targets for ending the epidemics, and identify recommended programs, policies, strategies, and funding for achieving these targets.

Treatment Navigators in Harm Reduction Programs – The Drug Policy Alliance requests one-time General Fund expenditure authority of $15.2 million for grants to harm reduction programs, including syringe access programs, to add staff to reach people who use drugs who are not in treatment and assist them with linkage to health care services, increasing the number of people who are able to benefit from medication assisted treatment such as methadone and buprenorphine. These funds would be available over four years and the programs would be required to report on how many people were linked to and enrolled into treatment and how many acquired health insurance to provide them with improved on-going health care access.

HIV Prevention Clearinghouse and Syringe Access Program Amendments – The Drug Policy Alliance requests annual General Fund expenditure authority of $3 million to the OA Clearinghouse to provide materials, such as sterile syringes, sharps containers, and fentanyl test strips, to authorized syringe exchange programs statewide for distribution to high-risk drug users. According to the Drug Policy Alliance, due to the increased number of programs and the increased number of clients per program, the current annual allocation of $3 million is no longer adequate. Drug Policy Alliance also requests trailer bill language updating requirements for the syringe access 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 DPH and the invited panelists to respond to the following:

1. Please provide an overview of the programs and activities of the department's Center for Infectious Diseases.

Issue 10: 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 2018 ADAP Local Assistance Estimate reflects revised 2018-19 expenditures of $407.9 million, which is a decrease of $26.2 million or six percent compared to the 2018 Budget Act. According to DPH, this decrease is primarily due to reduction in expenditures for medication-only clients due to transitions to private insurance or Medi-Cal. For 2019-20, DPH estimates ADAP expenditures of $449.8 million, an increase of $41.9 million or 10.3 percent compared to revised expenditures for 2018-19. According to DPH, this increase is primarily due to an increase in medication expenditures per client, an increase in insurance premium expenditures for private insurance clients, and overall caseload growth.

ADAP Local Assistance Funding Summary		
Fund Source	**2018-19**	**2019-20**
0890 – Federal Trust Fund	$129,143,000	$135,138,000
3080 – AIDS Drug Assistance Program Rebate Fund	$278,735,000	$314,650,000
Total ADAP Local Assistance Funding	**$407,878,000**	**$449,789,000**

ADAP tracks caseload and expenditures by client group. DPH estimates ADAP caseload and expenditures for 2018-19 and 2019-20 will be as follows:

Caseload by Client Group	**2018-19**	**2019-20**
Medication-Only	12,882	12,653
Medi-Cal Share of Cost	134	134
Private Insurance	9,807	10,752
Medicare Part D	7,712	7,712
PrEP Assistance Program	1,007	2,207

Expenditures by Client Group	**2018-19**	**2019-20**
Medication-Only	$308,019,032	$321,101,989
Medi-Cal Share of Cost	$1,093,904	$1,276,211
Private Insurance	$62,184,844	$83,228,041
Medicare Part D	$23,776,501	$27,114,211
PrEP Assistance Program	$4,101,355	$5,958,138

In addition, enrollment costs are estimated to be $6.9 million in 2018-19 and $7.5 million in 2019-20. Beginning in 2017-18, ADAP introduced a new reimbursement methodology for enrollment sites which includes a payment floor and variable payments dependent on new client medication enrollment, client bi-annual self-verification, client annual re-enrollment, client insurance assistance enrollment and re-enrollment, and PrEP client enrollment and re-enrollment.

ADAP Enrollment System. DPH requests expenditure authority from the ADAP Rebate Fund of $3.3 million in 2019-20. If approved, these resources would allow DPH to support implementation of the ADAP Enrollment System (AES). DPH previously terminated its enrollment vendor contract due to material breaches related to protection of confidential client information. To prevent disruption of client services and care, DPH implemented an interim AES solution in March 2017 to replace the functionality of the terminated vendor contract. Since that time, DPH has been engaging in the California Department of Technology's Project Lifecycle Approval (PAL) process to implement a permanent AES solution. According to DPH, the project received approval for the Stage 2 Alternatives Analysis portion of the PAL process, which determined that enhancements to the existing interim AES offered the highest benefit to the program. The increased funding request in 2019-20 of $3.3 million includes $233,000 for system enhancements, $2.8 million to support maintenance and operations, and $228,000 for costs related to the PAL process.

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.

2. Please provide a brief overview of the resource request for implementation of the ADAP Enrollment System.

Issue 11: Sexually Transmitted Disease Prevention

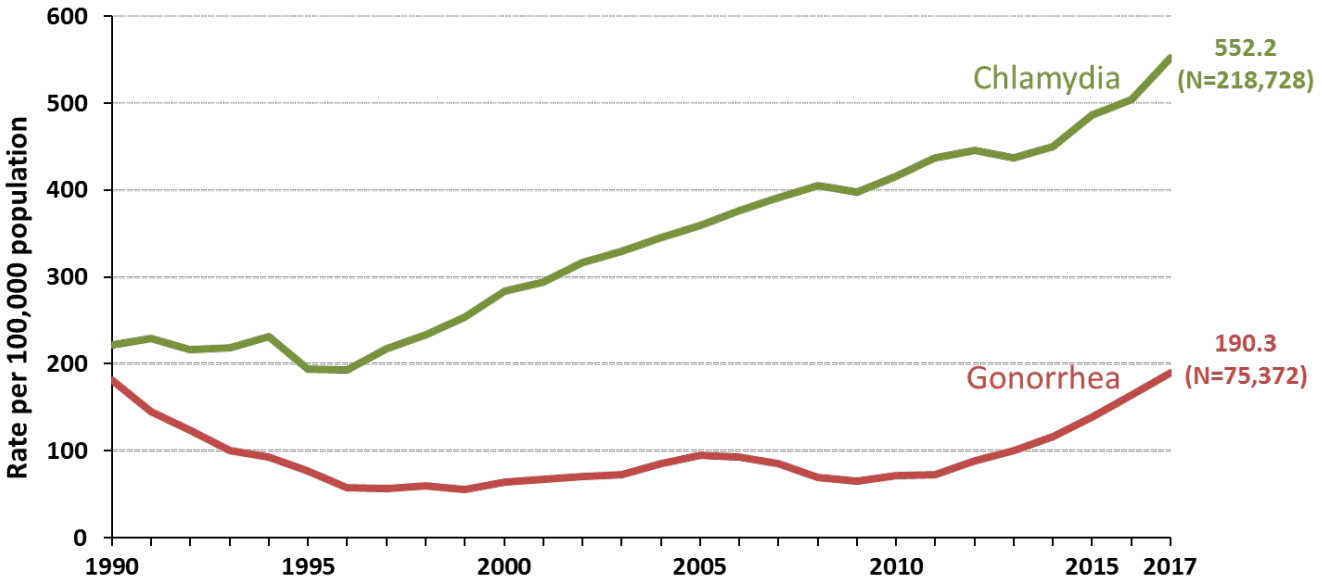
Budget Issue. DPH requests General Fund expenditure authority of $2 million annually. If approved, these resources would allow DPH to provide additional funding to local health jurisdictions for the prevention of sexually transmitted diseases.

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

* Resources ongoing after 2020-21.

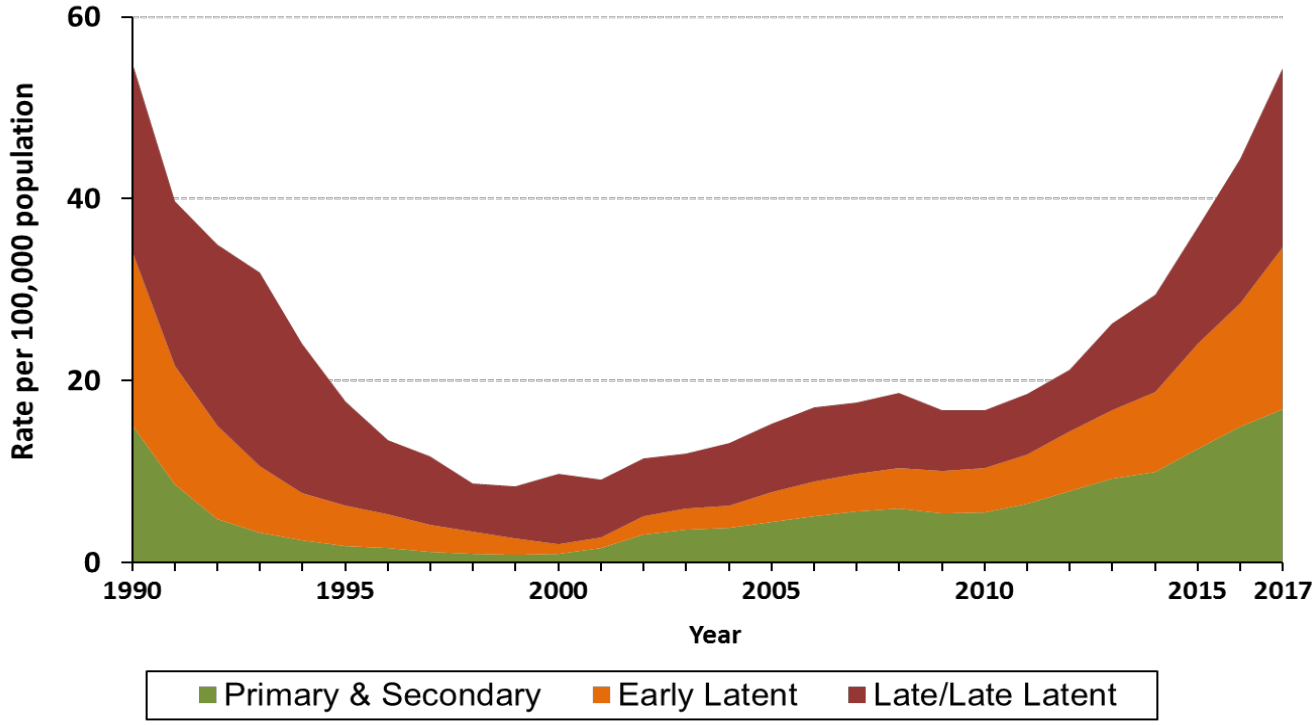
Background. California has experienced a significant multi-year increase in incidence of sexually transmitted diseases (STDs), such as chlamydia, gonorrhea, and syphilis. According to the 2017 California STD Annual Report prepared by DPH, chlamydia is the most common reportable disease in California and is at the highest level since mandated reporting began in 1990. In 2017 there were 552.2 chlamydia cases per 100,000 population, a 10 percent increase in cases compared to 2016 and a 30 percent increase since 2013. The report also indicates gonorrhea cases have increased sharply to 190.3 cases per 100,000 population, a 17 percent increase compared to 2016 and two times higher than in 2013. Early syphilis cases have also increased significantly to 34.6 cases per 100,000 population, a 22 percent increase compared to 2016 and two times higher than in 2013. Of particular concern is an increase in the number of infants born with congenital syphilis, which increased for the fifth consecutive year to 58.2 cases per 100,000 live births, a 32 percent increase since 2016 and five times higher than in 2013. Syphilitic stillbirths also increased from seven cases in 2013 to 30 cases in 2017.

Chlamydia and Gonorrhea – California Incidence Rates 1990-2017



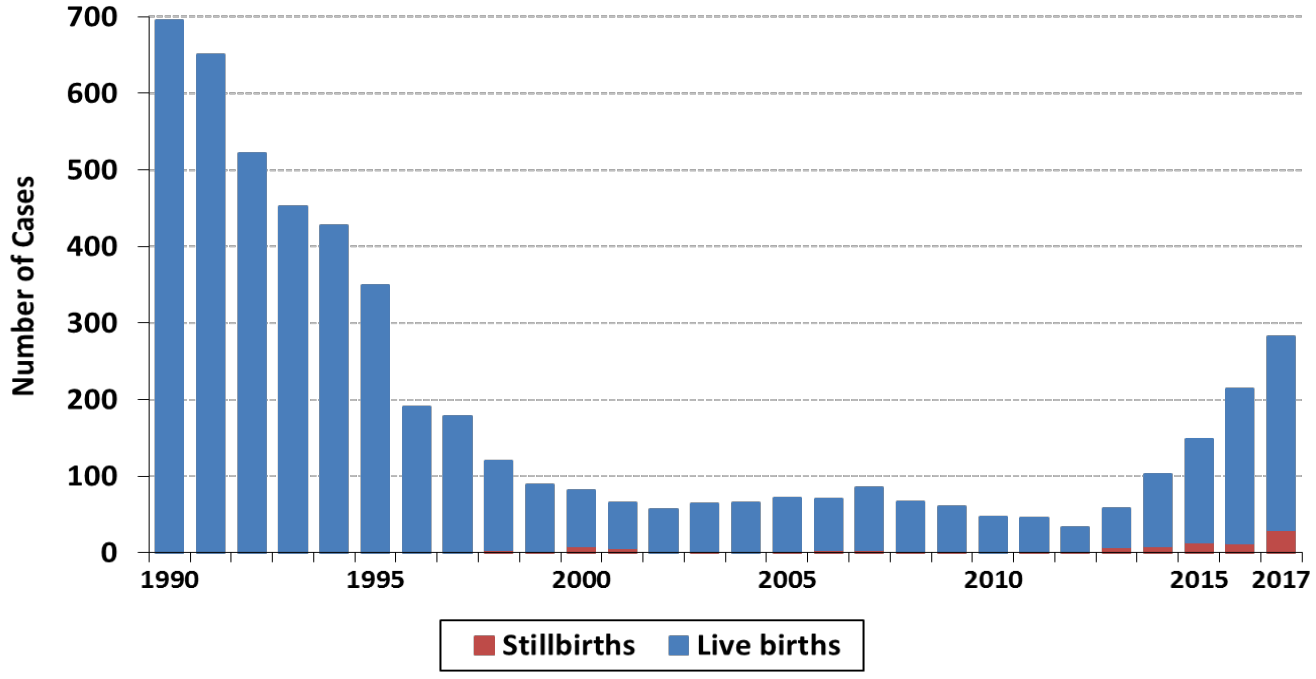
Source: California Department of Public Health. "California STD Surveillance – 2017 Data Graph Set" (2017)

Syphilis – California Incidence Rates by Stage 1990-2017



Source: California Department of Public Health. "California STD Surveillance – 2017 Data Graph Set" (2017)

Congenital Syphilis and Stillbirths – California Number of Cases 1990-2017



Source: California Department of Public Health. "California STD Surveillance – 2017 Data Graph Set" (2017)

According to DPH, STDs disproportionately affect populations that are vulnerable and living in poverty and are associated with significant health disparities, particularly African-Americans and men who have sex with men. African-American women have a disproportionately high rate of syphilis, which can lead to congenital syphilis, potentially resulting in deformities or still births. In addition, the largest proportion of congenital syphilis cases in California are born to Latina women. Importantly, these diseases are preventable and there are new opportunities to protect California residents from these diseases

One-Time Resources for STD Prevention. The 2016 Budget Act included one-time General Fund expenditure authority of $5 million for STD prevention grants to targeted local health jurisdictions with high incidence of STDs. The 2018 Budget Act included additional one-time General Fund expenditure authority of $2 million for STD prevention grants. The 2018 allocation also targeted counties based on population and STD incidence, as well as awards to authorize innovative and impactful outreach, screening, and other core services. The funds were required to enhance services already provided and not replace existing local services.

Budget Proposes Annual STD Prevention Funding. DPH requests General Fund expenditure authority of $2 million annually to provide additional funding to local health jurisdictions for the prevention of sexually transmitted diseases. According to DPH, this funding would enable local health jurisdictions to collaborate with health care providers serving vulnerable populations to provide an optimal level of STD prevention services and help reduce disparities. The funding would be prioritized for counties with the largest incidence of STDs, particularly syphilis, congenital syphilis and gonorrhea. The funding allocations would also place a particular focus on syphilis infections passed from mother to newborn.

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 local health jurisdictions have utilized previous budget allocations for STD prevention and how DPH expects annual funding would be utilized to decrease incidence of STDs in California.

Issue 12: Richmond Lab: Viral Rickettsial Disease Lab Enhanced Upgrade

Capital Outlay Spring Finance Letter. DPH requests additional General Fund expenditure authority of $1.1 million for its project 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	**2019-20**	**2020-21**
0001 – General Fund	$1,080,000	$-
Total Funding Request:	**$1,080,000**	**$-**

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.

According to DPH, in August 2017 the Department of General Services (DGS) received only one bid for the construction contract for the lab, which 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. The 2018 Budget Act included additional resources to account for the higher costs for the contract, as well as funding to rebid the contract. In October 2018, DGS rebid the project and again received only one bid, which also exceeded expenditure authority by $1 million. According to DPH, this bid will be accepted.

DPH expects the contract to be awarded in August 2019, and expects to complete the project in August 2020. The total expected cost for the project is $7 million and would be fully funded by the requested 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 13: Infant Botulism Treatment and Prevention – Compliance Costs for BabyBIG

Budget Issue. DPH requests expenditure authority from the Infant Botulism Treatment and Prevention Fund of $7.8 million in 2019-20, $3.9 million in 2020-21, and $2.6 million in 2021-22 to support contract costs for the next production cycle of Human Botulism Immune Globulin (BabyBIG).

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0272 – Infant Botulism Treatment and Prevention Fund	$7,833,000	$3,917,000
Total Funding Request:	**$7,833,000**	**$3,917,000**

* Additional fiscal year resources requested: 2021-22: $2,564,000.

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. Prior to the production of BabyBIG, botulism was treated with a horse-derived (equine) botulism antitoxin. However, treatment with the equine antitoxin was accompanied by substantial serious adverse effects including allergic reactions, serum sickness and anaphylaxis. Beginning in the 1970s, the California Department of Health Services (DHS), the precursor to DPH, attempted to facilitate commercial production of a human botulism immune globulin (BIG) for the treatment of infant botulism, but was unsuccessful. With approval and assistance from the federal Office of Orphan Products Development, DHS organized a randomized clinical trial to test effectiveness of BIG in treating infant botulism. In May 1997, the drug received approval from the Food and Drug Administration (FDA).[6] DPH is currently the only producer of BabyBIG in the world, with only one contracted facility, Shire Biotechnology in Los Angeles, FDA-approved to produce the drug.

According to DPH, production of BabyBIG is difficult to schedule. BabyBIG is produced in a multi-year, multi-stage process that involves plasma collection, validation, production, and regulatory filings. BabyBIG is produced every five years in lots sufficient to treat the expected 500 to 750 patients with infant botulism in the United States each year. The current lot of BabyBIG, Lot 6, was completed in 2016. According to DPH, the next lot, Lot 7, must be completed by 2021 to ensure an uninterrupted supply of BabyBIG.

The 2018 Budget Act assumed a production timeline for BabyBIG in the 2019-20 fiscal year, but also included flexibility regarding the program's budget authority due to the uncertain timing for manufacturing. According to DPH, production on Lot 7 began in 2018-19 and is currently underway. The production of BabyBIG is funded by fees received by DPH for use of the drug. According to DPH, effective January 1, 2019, the fee for BabyBIG was increased by $12,000 from $45,300 to $57,300, which is the first fee increase since 2004.

DPH requests expenditure authority from the Infant Botulism Treatment and Prevention Fund of $7.8 million in 2019-20, $3.9 million in 2020-21, and $2.6 million in 2021-22 to support contract costs for production of Lot 7 of BabyBIG over the next three years.

[6] Stephen S. Arnon, MD. "Creation and Development of the Public Service Orphan Drug Human Botulism Immune Globulin". *Pediatrics*, Volume 119, Number 4, April 2007

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 14: 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 department's status on the "Approved-But-Unfunded" list was set to expire on January 31, 2019. However, the department received confirmation from CDC that it will continue to be placed on the list until August 1, 2020. The proposed provisional language would provide flexibility in the department's federal fund appropriation to allow the department to meet the requirements of the "Approved-But-Unfunded" grant in response to a public health emergency.

Provisional Language. DPH requests the following provisional language:

Item 4265-001-0890

1. Notwithstanding any other law, the Department of Finance may augment this item in excess of the amount appropriated upon notice by the State Department of Public Health that additional funds are available funds pursuant to a United States Department of Health and Human Services, Centers for Disease Control and Prevention Cooperative Agreement for Emergency Response: Public Health Crisis Response grant. Within 10 working days of authorizing that 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 law, the Department of Finance may augment this item in excess of the amount appropriated upon notice by the State Department of Public Health that additional funds are available funds pursuant to a United States Department of Health and Human Services, Centers for Disease Control and Prevention Cooperative Agreement for Emergency Response: Public Health Crisis Response grant. Within 10 working days of authorizing that 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.

Issue 15: Additional Proposals for Investment

Stakeholder Proposals for Investment. Stakeholders have proposed the following additional investments in DPH programs.

Farmworker Health Study. The California Rural Legal Assistance Fund (CRLAF) requests expenditure authority of $1.5 million over three years to provide funding for a comprehensive study to improve farmworker health. According to CRLAF, the last and only comprehensive assessment of agricultural workers, the California Agricultural Workers Survey, was conducted in 1999. The study's publication as "Suffering in Silence" by The California Endowment and California Institute for Rural Studies found that nearly one in five male California agricultural workers had at least two or three risk factors for chronic disease: high serum cholesterol, high blood pressure and/or obesity. Nearly 70 percent lacked any form of health insurance, and one third of males said that they had never been to a doctor or clinic in their lives (half had never been to a dentist). To develop effective policy interventions, we need up to date comprehensive data on access to care and coverage, as well as prevalence data on health status.

Office of Healthy and Safe Communities. The RYSE Center requests expenditure authority of $6 million for the creation of an Office of Healthy and Safe Communities. According to the RYSE Center, this investment would support approximately eight core staff to carry out the functions of the office. The Governor and the Surgeon General would appoint a Director of the office to carry out the following responsibilities: 1) Assemble a staff team and an advisory committee, 2) Develop, implement, and monitor a California vision and plan for violence prevention, safety, and healing, 3) Establish and manage a statewide community of practice for leaders working on these issues throughout California, 4) Strengthen and professionalize community violence intervention and prevention as a licensed occupation, and 5) Steward alignment, coordination, and synergy across statewide departments and agencies.

Little by Little Early Literacy Program. Heluna Health requests expenditure authority of $36.4 million to support statewide expansion of the Little by Little School Readiness Program, a Los Angeles-based early literacy pilot project delivered at service sites for the Women, Infants, and Children (WIC) program, and that creates a stimulating home environment, fosters literacy, and improves school readiness for underserved and low-income children. According to Heluna Health, the program begins in the third trimester of pregnancy and continues until the child's fifth birthday. Families receive information about the importance of strengthening literacy practices within the home, each child is able to choose a new age-appropriate book at each visit, and parents are given informational handouts which provide parental guidance tied to their children's developmental milestones.

Sickle Cell Disease Center Funding. The Sickle Cell Disease Foundation of California (SCDFC) and the Center for Inherited Blood Disorders (CIBD) request one-time General Fund expenditure authority of $15 million, available over three years, to create an integrated network of primary and specialty care providers to improve the quality of care for individuals with sickle cell disease. According to SCDFC and CIBD, Californians with sickle cell disease (SCD) suffer poor health, die at younger ages and at higher rates, and have higher emergency room visits and hospitalizations compared to people SCD who live in other states. Currently, the average life expectancy for Californians with sickle cell disease is

about 43, and under 40 in Los Angeles. Compare that to 63 years, the life expectancy for people with SCD in the rest of the United States. Despite that, adults with SCD in California suffer from inattention and inadequate resources, resulting in terrible personal and social costs that are tragically invisible to most because SCD is a rare disorder. This proposal would create a "hub and spoke" model of care and would:

- Build the regional infrastructure needed to develop six new comprehensive adult clinics.
- Foster outreach and education to affected individuals and families as well as healthcare providers.
- Develop initiatives to build the medical workforce of clinicians who are knowledgeable about evidence informed diagnosis and treatment.
- Enhance statewide surveillance to track outcomes, utilization, and costs.
- Support oversight.
- Scale up our award-winning primary-specialty care healthcare delivery model, recognized by the Centers for Disease Control and Prevention (CDC), the National Association of Counties, and Health Resources and Services Administration (HRSA).
- Expand into SCD the nation's successful regional hemophilia network model supported by HRSA and CDC.

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.

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

SUBCOMMITTEE NO. 3 Agenda

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

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

Part A

Consultant: Renita Polk

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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 (DOR)

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 2019-20 budget of $476.1 million ($72.5 million General Fund) and 1,882 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 82 percent of the department's total funding. The table below provides an overview of the department's funding.

Fund Source	2017-18	2018-19	2019-20
General Fund	**$ 64,604**	**$66,301**	**$72,475**
Traumatic Brain Injury Fund	$1,114	$856	-$6
Vending Stand Fund	$2,361	$3,361	$3,361
Federal Trust Fund	$374,049	$390,575	$390,209
Reimbursements	$7,349	$10,080	$10,080
Total Expenditures	**$449,477**	**$471,173**	**$476,119**

* Dollars in thousands.

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. As of March 31, 2019, there were 37 consumers on the DOR waiting list.

Consumers. In 2017-18, DOR handled a total of 101,750 cases. That same year consumers received services for 26 months, on average. The average cost per plan was $5,100, and 10,470 consumers gained and kept employment for at least 90 days.

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. The federal VR grant, which cover approximately 78 percent of DOR's VR program, requires a maintenance-of-effort (MOE) from the state, meaning that the state match in a given federal fiscal year must be at least the actual state match from two years before. If the MOE requirement is not met, the federal VR grant award is reduced by the deficit. In 2017-18, the state match equaled $90.9 million ($63.9 million General Fund).

- 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. ILCs receive government funding from both Title VII(c) funds from the federal Administration for Community Living (ACL) and Title VII (b) funds through DOR.

- 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. 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.

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. The Rehabilitation Services Administration (RSA) issued final WIOA regulations in September 2016 and provided technical assistance in late 2017. 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. DOR's programs have changed in two primary ways due to WIOA implementation:

- Available resources have been reduced for 'traditional Vocational Rehabilitation' requiring DOR to set aside at 15 percent (about $45 Million) of the VR grant to better prepare potentially eligible participants as well as eligible students between the ages 16-21 for post-secondary employment.

- With the provision of the new services to youth, DOR anticipates serving more students than ever. Over time, the numbers of adults served will decrease reflecting the shift in funding allocation.

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.

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 collaborates with five other state departments[1] and 21 Local Educational Agencies (LEAs) to coordinate services, direct outreach, recruitment, and involvement of participants.

The grant is currently in its fifth year. 1,646 participants were recruited for the program. As of March 31, 2018, 1,403 youth continued to participate. Services are received from the 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 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.

Competitive Integrated Employment (CIE) Blueprint. DOR has entered into an agreement with both the Department of Education and the Department of Developmental Services (DDS) consistent with the state's "Employment First" strategy. The purpose of the agreement is to increase the opportunities for those with disabilities to work in an integrated setting at a competitive wage, and improving collaboration and coordination between the departments. Year one of implementation (May 2017 – June

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

2018) saw an increase in the number of individuals with disabilities working in CIE increased from 780 to 1,152.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide a brief update on the various accomplishments and challenges the department has encountered in the past year.

2. Please describe the strategies for serving adults who qualify for the VR program with the increasing emphasis on students and young adults entering the workforce.

Issue 2: BCP – Mission-Based Review for Vocational Rehabilitation and TBI Programs

The following proposals were identified as a result of a Mission Based review of DOR. The DOR was identified and chosen by the Department of Finance (DOF), in collaboration with the Health and Human Services Agency. In recent years there have been several different budgetary pressure points facing the department that made it suitable to review holistically. These included a shift of some existing federal funding toward youth services as a result of the reauthorization of WIOA, the continued decline of the State Penalty Fund and its impact on the Traumatic Brain Injury program, and concerns from community partners and consumer advocates about provider rates. The department decided to take a more holistic look at the funding structure and mission of the department, which is reflected in the multifaceted nature of the proposal. Furthermore, DOF budget staff availability and capacity combined with the relatively smaller size of DOR also made it a good candidate for a Mission Based Review. The overarching goal of the Mission Based Review of the DOR was a review of the requirements, operations, and resources for the entire department.

Governor's Proposal. The Governor's budget includes additional resources for the department's VR and TBI programs, separated into the following three components:

- $3.4 million General Fund annually for a ten percent increase to Community Rehabilitation Program provider rates.

- $1.6 million General Fund for improvements to the department's information technology (IT) infrastructure.

- $1.2 million General Fund annually until 2023-24 to fund the department's TBI program.

As mentioned earlier in the agenda, the VR grant has a MOE requirement, which requires a state match equal to or more than the state match from two years before. Due to the MOE, DOR does not spend more than the required state match for the VR grant award. While the MOE can protect the VR program from disproportionate state budget cuts when state budgets are flat or decreasing. The MOE can function as a disincentive for states to provide additional funds to the VR program during periods when state budgets are increasing because it commits the state to increased spending in future years. Although the federal VR grant has increased each year by roughly two percent, the grant does not keep pace with state employee compensation increases and inflation, which increases expenditures by an average of about five percent per year. With expenditures growing faster than funding, VR programs face challenges in continuing to meet the needs of their consumers.

The proposals below address the VR program funding limitations discussed here.

Issue 2A: Community Rehabilitation Program Rates

The Governor's Budget includes $3.4 million General Fund annually for a ten percent increase to Community Rehabilitation Program provider rates

Background. Through its Community Rehabilitation Program (CRP), DOR delivers VR services to consumers using a uniform fee structure. Currently, there are approximately 245 CRP providers delivering services across the state at over 445 locations. CRP providers deliver services to consumers that fall into the following four categories: 1) assessment, 2) training, 3) job related, and 3) support services.

In 2009, DOR implemented a uniform fee-for-service rate structure, which provides the same rate to all providers without taking into account potential cost differences for different providers. This was implemented as part of statewide efforts to achieve savings in administrative and program areas due to the ongoing budget challenges at the time. Before that time, DOR determined rates individually based on the actual cost to deliver the services. The new uniform fee for service rates implemented in 2009 were based on the average of the rates that providers had been receiving. Because of this change, some CRP providers saw significant decreases in their rates while others saw significant increases. With exceptions for American Sign Language interpreting rates and job coaching rates, the fee-for-service rates have not been adjusted since 2009.

Without any increase in the fee-for-service rates since 2009, many CRP providers find it increasingly difficult to support rising operating expenses under the current rates. Additionally, the department has lost a number of CRP providers and is faced with service gaps in many geographic areas. The department states there has been a decline of approximately 19 percent in total CRP providers, and a 15 percent net loss in provider facility locations between 2008-09 and 2017-18.

Social Security Administration (SSA) Reimbursements. The SSA provides an incentive payment to DOR that recognizes shared savings that results when a VR consumer achieves gainful employment and no longer needs Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) benefits. In 2018, the SSA defined substantial gainful activity as earning more than $1,180 a month for non-blind disabled individuals and $1,970 a month for statutorily blind individuals. If a VR consumer achieves earnings at or above these monthly earnings levels, the SSA will reimburse the VR agency for the direct and administrative costs incurred to provide the services. Currently, SSA reimbursements are used to fund Independent Living Centers (ILCs) and the VR program.

The table below, provided by the department, provides a detailed breakdown of SSA reimbursements and associated expenditures over the last ten federal fiscal years.

Table 1: SSI/SSDI Reimbursements Received and Expenditures by Federal Fiscal Year

Source: DOR Accounting

Federal Fiscal Year	Program Income Received from the SSA	VR Program	Ind. Living (AB204 - WIC section 19806)	Ind. Living (Other)	Work Incentive Planners	Older Individuals Who Are Blind Program	Client Asst. Program	Total Expenditures
2008	$16,894,193		$16,722,755				$171,438	$16,894,193
2009	$13,745,881		$13,745,881					$13,745,881
2010	$14,879,802		$14,721,005				$158,797	$14,879,802
2011	$9,046,392		$9,046,392					$9,046,392
2012	$7,845,583		$7,845,583					$7,845,583
2013	$10,548,625		$10,441,296	$10,096			$97,233	$10,548,625
2014	$19,888,031		$19,718,654	$169,377				$19,888,031
2015	$28,916,254	$5,548,142	$11,834,038	$4,713,287	$3,565,378	$3,255,410		$28,916,254
2016	$22,101,879	$5,322,567	$12,018,305		$4,729,210	$31,797		$22,101,879
2017	$35,355,480[2]	$16,112,360	$11,248,058	$3,275,021	$4,720,041			$35,355,480
2018	$40,317,972	$26,992,663	$13,325,309					$40,317,972
2019[1]	$7,999,777							$7,999,777

[1] As of December 2018

[2] Included $6,756,263 received from prior years.

Proposed Funding. The requested resources would provide a ten percent increase in rates for CRP providers that have not seen an increase since 2009. Using state funds to directly provide an increase in the uniform fee-for-service rates for CRP providers would potentially impact DOR'S MOE levels. Essentially, it could lock in a higher level of state expenditures on the VR program going forward. To avoid this, the budget proposes to shift SSA reimbursements that are currently being used to fund ILCs. SSA reimbursement income can be used to fund CRP rate increases since this income does not count toward the MOE calculations. The General Fund would be used to backfill the SSA reimbursements that would no longer be going to the ILCs to ensure ILC funding is maintained at current levels.

The proposed funding would not only fund a ten percent rate increase for CRP providers, but it would also fund the cost of minimum wage increases to CRP providers. CRP providers that provide situational assessment or work adjustment services pay a minimum wage to VR consumers as part of their services. This proposal increases the rates for those services to account for increases in the state's minimum wage.

Questions.

1. Please provide an overview of the proposal to increase CRP provider rates.

2. Why did the department propose to increase rates across-the-board, instead of providing increases based on the cost to provide services, as was done prior to 2009?

3. How did the department determine that rates should be increased by ten percent?

4. As SSA reimbursements are not a stable funding source, how will the DOR plan for possible future revenue fluctuations?

Issue 2B: IT Infrastructure

The Governor's budget includes $1.6 million General Fund for improvements to the department's information technology (IT) infrastructure

Background. The funding limitations outlined above have also limited the VR program's ability to modernize its IT infrastructure. Most of DOR's branch and district offices have low Internet bandwidth for the number of employees in each office, diminishing staff productivity. The majority of offices have ten or more users, yet many of these offices have internet bandwidth that is not sufficient to support these services for that many users concurrently. For example, at 70 offices, bandwidth supporting all staff at that location is equal to the bandwidth of a smartphone on a 4G LTE network.

Funding limitations have also limited the VR program's ability to modernize business processes and the way DOR staff interact with and exchange data and information with consumers and service providers. Manual, paper-driven processes hamper the DOR employees providing VR services. Additionally, limited funding has impacted DOR's ability to migrate network infrastructure and services to the cloud. Moving aging enterprise hardware, document repositories, authentication, web, and database workloads to the cloud would reduce administrative tasks, such as procuring and managing network hardware and software, backing up systems, and supporting complex networking and storage infrastructure. It would also move DOR from a capital expenditure model to a subscription-based operational expenditure model, allowing for more consistent and reliable cost forecasting, as well as providing technical flexibility to adapt to meet future business needs.

The table below provides a further breakdown of the proposed IT infrastructure cost.

Cost Area	Year 1	Year 2	Year 3
Adding Wi-Fi and increasing bandwidth in district and branch offices	$680,000	$575,000	$575,000
Cloud services and infrastructure	$200,000	$280,000	$430,000
Public-facing portal, electronic workflow, and electronic signature implementation	$750,000	$775,000	$625,000
Total:	**$1,630,000**	**$1,630,000**	**$1,630,000**

DOR will work with the Department of Technology (CDT) on technical logistics as it migrates to the department's cloud service offerings. DOR is currently working with CDT to test and pilot a new service that will help meet DOR's need for increased internet speeds.

Questions.

1. Please provide an overview of the proposal related to IT infrastructure funding.

Issue 2C: TBI Program

The Governor's budget includes $1.2 million General Fund until 2023-24 for the TBI program.

Background. The TBI program serves those who have suffered a traumatic brain injury by providing post-acute care and support. Participants must have a TBI diagnosis and be able to benefit from a coordinated service approach. The most common challenges that TBI survivors face include short-term and long-term memory, cognition, organizational skills, time management, impulse control, interpersonal interactions, and mental health issues. Treatment of TBI happens in the hospital and in rehabilitation programs, with limited services available in the community. Programs that provide services to those with a TBI often use specialists familiar with TBI, such as certified brain injury specialists. The skills and experience of TBI specialists are distinct because TBI survivors must often relearn basic brain functions. DOR currently funds seven TBI program sites that serve approximately 900 consumers in 20 counties. Each site provides supported living, community reintegration, vocational support, information and referral, and public and professional education services.

TBI Program Funding. When California established the TBI program in 1988, the program was a pilot of four sites that received a total of $500,000 in grant funding. At the time, statute directed the transfer of 0.66 percent of all funds in the State Penalty Fund to the TBI Fund. 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.

Historically, the seven TBI sites have received annual funding of $150,000 from the State Penalty Fund. However, the State Penalty Fund has experienced a dramatic decline in revenues over the past decade. Between 2007-08 and 2017-18, the fund has seen more than a 40 percent decrease in funds. In response, DOR has explored other options to fund the TBI program. TBI program sites contribute a 20 percent match to the state funds they receive, which translates to an additional $30,000 per year. DOR also attempted to leverage federal VR dollars for the TBI program through new contractual agreements with TBI program sites. However, this effort failed because the needs and outcomes of the TBI population did not meet the federal government's conditions, primarily due to the extended timeframe and pre-vocational nature of TBI services.

Recent Budget Actions and Legislation. Due to the State Penalty Fund's declining revenues, trailer bill language in the 2017 budget eliminated the formula-based distribution of revenues. The Budget Act of 2017 allocated $800,000 in one-time revenues from the State Penalty Fund to the TBI Fund. The Budget Act of 2018 included the same one-time transfer of $800,000. 2018-19 funding for TBI sites is $115,000, less than the traditional $150,000. SB 398 (Monning), Chapter 402, Statutes of 2018, extended the sunset date of the program to July 2, 2024, but did not identify a funding source. The requested resources would provide support until the sunset date.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal related to funding for the TBI program.
2. Please describe the caseload trends for the TBI program over the past 12 months and discuss any gaps in services or unmet services needs for this population.

Issue 3: Spring Letter/BCP – CalFresh Outreach via ILCs

Governor's Proposal. The Administration requests an increase of $2.5 million in reimbursement authority for 2019-20 to assist with implementation and oversight of the state's CalFresh program outreach plan. The Department of Social Services (DSS) will reimburse DOR for costs in communicating new eligibility requirements for the Supplemental Nutrition Assistance Program (SNAP).

Background. The "SSI Cash-out" is a state policy that provides Supplemental Security Income/State Supplementary Payment (SSI/SSP) recipients with an extra $10 payment in lieu of their being eligible to receive federal food benefits through the CalFresh program, California's version of the federal SNAP. AB 1811 (Committee on Budget), Chapter 35, Statutes of 2018, ended this policy. This expansion of benefits is effective beginning June 1, 2019. It is estimated that the policy change will increase the CalFresh caseload by approximately 370,000 new households, or 20 percent.

DSS is responsible for oversight and implementation of the CalFresh program. Through the use of focus groups DSS identified the ILCs as organizations likely to reach the potential new recipients of CalFresh and requested DOR and ILCs to help inform Californians with disabilities of their new eligibility for CalFresh. To carry out these duties DOR will enter into an interagency agreement with DSS and redirect one temporary help staff to work in collaboration with DSS to collect data on the number of potential applicants' pre-screenings, completed applications, demographic descriptions of the population served, and applications approved. DOR will also provide regular reports to DSS. The temporary help staff will manage the ILC contracts.

ILCs will contract specifically to provide application assistance and will contact consumers on SSI/SSP to prescreen them for CalFresh eligibility. DOR anticipates that an additional 20,000 individuals will be reached through the ILCs.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS)

Issue 1: Overview

Governor's Proposal. The department's budget proposes expenditures of $7.8 billion ($4.8 billion General Fund) in 2019-20, an increase of $435.2 million ($332.4 million General Fund) compared to the updated 2018-19 budget. The increase over the updated 2018-19 budget includes $462.5 million ($333.3 million General Fund) in Purchase-of-Services (POS) and $43.7 million in operations. The table below provides more detail. Growth in the number of people served in the community services program and growing costs associated with implementing state minimum wage increases are the primary drivers of these year-over-year increases.

Department of Developmental Services Funding Summary
(Dollars in Thousands)

	Updated 2018-19	Proposed 2019-20	Difference	Percent Change
Community Services	$6,892,600	$7,398,803	$506,203	7.3%
State Operated Residential and Community Facilities	394,383	309,462	-84,921	-21.5%
Headquarters Support	70,895	84,793	13,898	19.6%
Total	**$7,357,878**	**$7,793,058**	**$435,180**	**5.9%**
General Fund				
Community Services	$4,087,869	$4,450,177	$362,308	8.9%
State Operated Residential and Community Facilities	306,682	265,834	-40,848	-13.3%
Headquarters Support	42,314	53,217	10,903	25.8%
Total	**$4,436,865**	**$4,769,228**	**$332,363**	**7.5%**

Background. The Department of Developmental Services (DDS) oversees the provision of services and supports to over 340,000 persons with developmental disabilities and their families, pursuant to the provisions of the Lanterman Developmental Disabilities Services Act, also known as the Lanterman Act, (Division 4.5 of the California Welfare and Institutions (W&I) Code). The Lanterman Act establishes an entitlement to services and supports for Californians with developmental disabilities. The Early Start Program provides for the delivery of appropriate services to infants and toddlers at risk of having developmental disabilities.

For the majority of eligible recipients, services and supports are coordinated through 21 private, non-profit corporations, known as regional centers. The remaining recipients are served in two state-operated institutions, known as developmental centers, one state-leased and state-operated community-based facility, and four Stabilization, Training, Assistance and Reintegration (STAR) homes.

Eligibility. To be eligible for services and supports through a regional center or in a state-operated facility, regardless of income, a person must have a disability that originates before their 18th birthday, is expected to continue indefinitely, and presents a substantial disability. As defined in Section 4512 of the

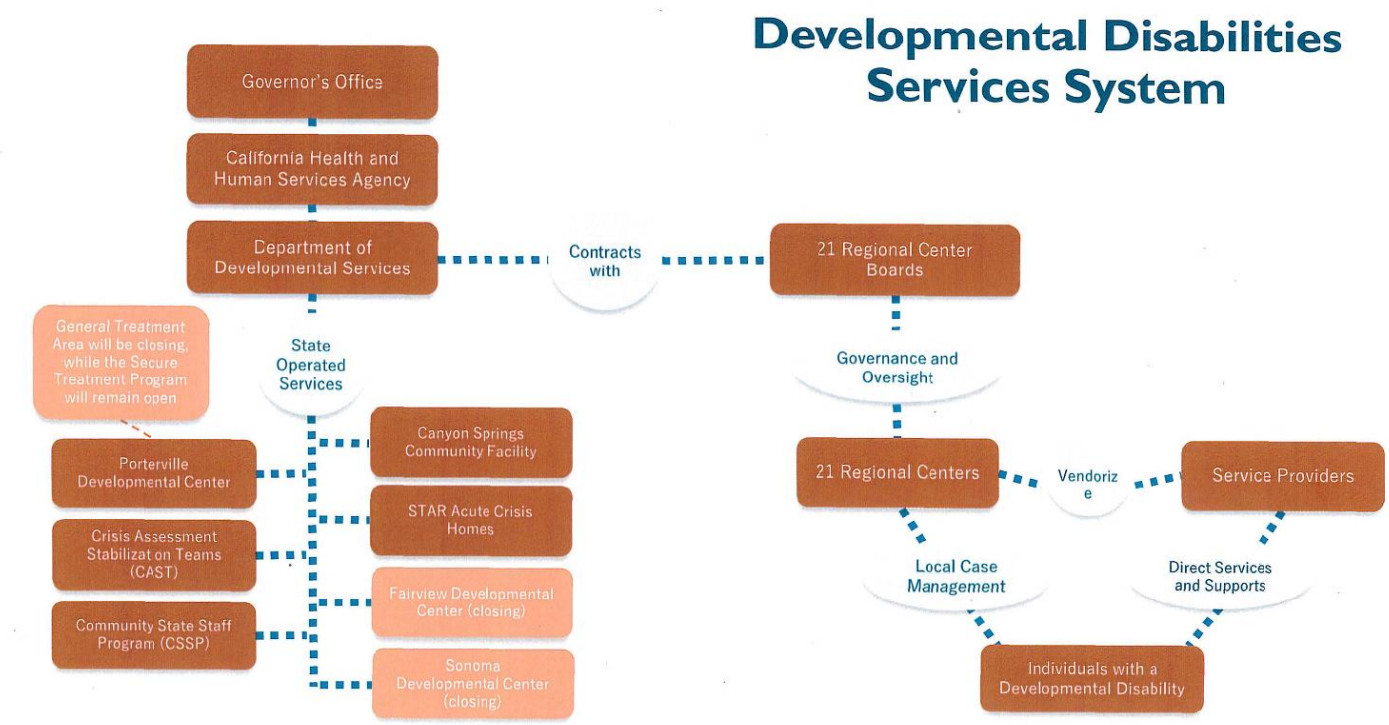
W&I Code, this includes an intellectual disability, cerebral palsy, epilepsy, and autism, as well as conditions found to be closely related to intellectual disability or that require treatment similar to that required for individuals with an intellectual disability. A person with a disability that is solely physical in nature is not eligible. Infants and toddlers (age 0 to 36 months), who are at risk of having a developmental disability or who have a developmental delay, may also qualify for services and supports. Eligibility is established through diagnosis and assessment performed by regional centers.

Caseload. The Governor's budget expects the number of individuals served to increase to 349,606 in 2019-20, a net increase of 16,512 consumers (five percent increase), compared to the updated 2018-19 budget. This includes 4,095 Early Start consumers.

Regional Center (RC) System. RCs coordinate community-based services in community settings through service coordinators who are case managers for consumers. A locally established board of directors directs the policies and decisions of each RC. However, the department provides necessary oversight through its contractual relationship with each regional center. It is the responsibility of the department to ensure that services and supports are provided in the most effective and efficient means possible, and that the tenets of the Lanterman Act and other relevant state and federal requirements are met.

Developmental Centers (DCs). The budget for the 2015-16 fiscal year announced the planned closure of the remaining DCs. These remaining DCs included Sonoma Developmental Center, Fairview Developmental Center, and the Porterville Developmental Center – General Treatment Area (Porterville GTA). The secure treatment program at Porterville will remain open. The plan projected the closure of Sonoma by the end of the 2018 calendar year. The last resident moved out of Sonoma on December 17, 2018. Both Fairview DC and Porterville GTA are scheduled to close by the end of 2021; however, the department and RCs predict a much earlier closure date and there were fewer than 100 consumers left to be moved as of April 2019.

The graphic below, provided by the department, gives a helpful overview of DDS, its responsibilities, and its relationship with the 21 regional centers.



Recent Policy Changes. The following budget adjustments are due to recent policy changes statewide and within the department.

- Specialized Home Monitoring. An increase of $5.5 million ($3.9 million General Fund) to provide required monitoring of specialized homes by regional center licensed nurse/behavior specialist-to-home ratio of 1:4. The department plans to have 93 operational Adult Residential Facilities for Persons with Special Healthcare Needs (ARFPSHN) and 84 Enhanced Behavioral Supports Homes (EBSH) and Community Crisis Homes (CCH) in 2019-20.

- Bridge Funding. A decrease of $42 million ($25 million General Fund) for the one-time appropriation provided in the 2018-19 budget for service provider rate increases.

Policy considerations. The Subcommittee may wish to ask the department about the status of implementation of the following policy initiatives, and discuss the fiscal impact of implementation delays.

- Self-Determination. SB 468 (Emmerson), Chapter 683, Statutes of 2013, requires the department to implement a statewide Self-Determination Program, subject to approval of federal funding. The program will enable consumers and their families more freedom and control in choosing services, supports, and providers. The department received federal approval for federal funding of the program on June 7, 2018.

- Electronic Visit Verification (EVV). The 21st Century CURES Act requires all states set up an EVV system to verify services for all Medicaid-funded personal care and home health care services occurred. All states must implement EVV for personal care services by January 2020 and home health care services by January 2023. Through its regional centers, the department

provides EVV-monitored services including supported living, respite, and personal assistance services. However, the department does not currently have an EVV system. In 2018, the department and other agencies continued stakeholder meetings to inform the design and implementation of the EVV system. The state is also working with CMS to request a one-year extension. If an extension is not approved, the department estimates a penalty of $1.8 million General Fund in 2019-20. The Department of Finance (DOF) released a finance letter in April 2019 requesting $1.5 million in one-time resources to support planning activities to comply with federal EVV requirements for DDS and other state departments.

- Minimum Wage Issues. Currently, the state minimum wage is $11 per hour for businesses with five or fewer employees and $12 per hour for businesses with 26 or more employees. The state minimum wage is statutorily scheduled to increase each year until it reaches $15 per hour—in 2022 for the larger businesses and in 2023 for the smaller businesses. Currently, statute allows DDS to adjust the rates paid to vendors when the adjustment is needed to bring their lowest wage staff up to the state minimum wage. Some cities and counties have enacted minimum wages that exceed the state's minimum wage. In these areas, DDS vendors must pay at least the local minimum wage. In each of the past two January budget proposals, DDS has had to revise downward the current-year POS estimates, in part because the actual prior-year costs to cover state minimum wage increases had come in lower than expected. The updated 2018-19 budget contains a decrease of $54.6 million ($33.1 million General Fund). The downward revision in minimum wage-related spending is likely due in large part to a quirk in the implementation of the statutory policy that guides rate adjustments. Specifically, vendors in areas with a local minimum wage that is higher than the state minimum wage are unable to benefit from the rate adjustments for state minimum wage increases that vendors in lower-cost areas benefit from. The 2019-20 budget includes an increase of $76 million ($38.4 million General Fund) to reflect full-year costs of minimum wage increases from $11 to $12 per hour, and an increase of $83 million ($41.7 million General Fund) to reflect half-year costs of minimum wage increasing from $12 to $13 per hour. This figure assumes that all areas of the state are at the state minimum wage.

LAO Comment and Recommendation. The Legislature has increased the state minimum wage several times over the past decade. Currently, statute allows DDS to adjust the rates paid to vendors when the adjustment is needed to bring their lowest wage staff up to the state minimum wage. Some cities and counties have enacted minimum wages that exceed the state's minimum wage. Nearly 40 percent of the state's population lives in areas with these higher local minimum wages. In these areas, DDS vendors must pay at least the local minimum wage. These vendors must do so, however, without any adjustment to their rate because statute generally does not provide for vendor rate adjustments in response to local minimum wage increases. In each of the past two January budget proposals, DDS has had to revise downward the current-year POS estimates, in part because the actual prior-year costs to cover state minimum wage increases had come in lower than expected. While it is not certain, the LAO believes the downward revision in minimum wage-related spending is likely due in large part to a quirk in implementation of the statutory policy. Specifically, vendors in areas with a local minimum wage that is higher than the state minimum wage are unable to benefit from the rate adjustments for state minimum wage increases that vendors in lower-cost areas benefit from. They are considered ineligible for the state increases because they already pay their minimum wage workers a wage that is higher than the state minimum wage (even though they received no rate adjustment to pay these higher wages).

The LAO recommends that the Legislature clarify what it intended when it authorized DDS vendors to seek rate adjustments. The LAO also recommends that the Legislature request DDS to report the

estimated 2019-20 General Fund cost to allow all vendors to seek an adjustment related to the January 1, 2020 minimum wage increase.

Staff Comment and Recommendation. Hold open

Questions.

1. Please discuss the major accomplishments and challenges the department has experienced in the last year.

2. Please provide an update on the rollout of the Self-Determination program.

3. Please provide an update on the development of an EVV system for the department.

4. Please explain the decrease for minimum wage costs in the updated 2018-19 budget. What would be the estimated 2019-20 cost to allow all vendors to seek an adjustment related to the January 1, 2020 minimum wage increase?

Issue 2: Uniform Holiday Schedule and Half Day Billing

A host of advocacy organizations opposes the reinstatement of the uniform holiday schedule and the elimination of half-day billing policy.

Panel. The Subcommittee has requested the following panelists provide comment on the implementation of the Uniform Holiday Schedule and half day billing policy:

- Jordan Lindsey, Executive Director, The ARC California
- Nancy Chance, Executive Director, Choices Person Centered Services

Budget Issue. The budget proposes enforcement of the "14-day uniform holiday schedule." One-time funding was provided in 2018-19 to delay implementation of the Uniform Holiday Schedule. The 2019-20 budget includes a decrease of $47.8 million ($28.7 million General Fund). The department proposes to implement the policy, effective July 1, 2019.

The department estimates that costs to repeal the 14-day schedule for 2019-20 is $50.3 million ($30.1 Million General Fund). To eliminate half-day billing for 2019-20, it is estimated to cost $2.7 million ($1.6 million GF).

Uniform Holiday Schedule. As part of a package of budget solutions passed in 2009 in response to the significant state budget deficit, the state enacted a policy prohibiting RCs from paying service providers on 14 set holidays per year. This meant that service providers either did not provide services on those days or absorbed the cost without payment. The policy also required that the 14 holidays be uniform statewide (in other words, it could not be any 14 days throughout the year). The policy has not been enforced since 2015, because of litigation. The 2018 Governor's budget proposed implementation of the policy but the final budget agreement delayed enforcement until 2019-20.

Half-Day Billing. The half-day billing policy is also rooted in recessionary budget cuts. The policy states that activity centers, adult development centers, behavior management programs, and other look-alike day programs with a daily rate shall bill regional centers for services provided to consumers in terms of half days of service and full days of service. The definition of "half day of service" is set at any day in which a consumer's attendance does not meet the criteria of at least 65 percent of the declared and approved program day, or what qualifies for billing for a "full day of service." Statute directs each vendor to bill at one-half of its existing rate for any consumer who attended the program for less than 65 percent of the program day. The policy had not been enforced until July 1, 2018, when it was brought back into effect.

Legislative Analyst's Office (LAO) Comments. Typically, most RCs and vendors observe a certain number of holidays each year regardless of state policy—often about ten days. The LAO notes that California state government observes 11 holidays each year and the federal government observes 10. The 14-day schedule would therefore exceed both state and federal government practices. One option is to statutorily establish a 10- or 11-day schedule, rather than 14. However, this option would not result in the estimated savings.

Whether the schedule should be uniform is another question. On the one hand, it ensures that services are up and running on the same days facilitating coordination between, for example, transportation and

day program providers. On the other hand, consumers may have particular needs on certain holidays—for example; they may need day program job support on the day after Thanksgiving if they work in retail.

Staff Comment and Recommendation. Hold open. The Subcommittee may wish to revisit these policies due to the state's improved economic condition, as implementation was a recessionary budget cut.

Issue 3: Social Recreation and Camp Services

A host of advocacy organizations, including Disability Voices United and the California Disability-Senior Community Action Network (CDCAN), propose the reinstatement of social recreation and camp services. CDCAN also proposes one-time funding be allocated to help those providers who need assistance in restoring those services.

Budget Issue. The department estimates that the restoration of these services will cost $23.2 million ($14.8 million General Fund) in 2019-20. Full year costs would be $42.9 million ($27.3 million General Fund).

Panel. The Subcommittee has requested the following panelists provide comment on the restoration of social recreation and camp services:

- Carolyn Tellalian, Board Member, Disability Voices United and parent
- Beth Burt, Executive Director, Autism Society of California, and family member

Background. As part of a package of budget solutions passed in 2009 in response to the significant state budget deficit, the state enacted a policy that suspended social recreation and camp services. Both the Senate and Assembly approved funding to restore these services in the 2018 budget, but the funding was not included in the final budget.

Proponents of the proposal state that it will provide extraordinary benefits for individuals with developmental disabilities. These services will encourage physical activity and participation in cultural events, among many other benefits. Proponents also state that these services have been used at higher rates by underserved Latino, Africa-American.

Staff Comment and Recommendation. Hold open**.**

Issue 4: BCP - Headquarters Restructure and Reorganization

Governor's Proposal. The Governor's budget includes $8.1 million ($6.5 million General Fund) for 54 permanent positions to restructure the organization and realign resources for safety net services, program modernization, risk management, federal and state compliance, and fiscal accountability. Of the requested amount, $400,000 is for 3-year limited-term funding for three positions for oversight of the HCBS provider assessment process.

Panel. In addition to DDS, the DOF, and the Legislative Analyst's Office (LAO), the Subcommittee has requested the following panelists to provide comment on the headquarters restructuring:

- Amy Westling, Executive Director, Association of Regional Center Agencies
- Judy Mark, Board Member, Disability Voices United, and parent
- Catherine Blakemore, Executive Director, Disability Rights California

Background. Currently, DDS is divided into two main divisions. One handles community services, including oversight of regional centers (RCs). The other handles developmental centers (DCs) and other state-operated facilities. The DCs division includes the positions that work at the DCs and other state-operated facilities, providing direct services to consumers or maintaining facilities. At its Sacramento headquarters, DDS also has an administration division, an IT division, and five different offices handling legal affairs, human rights and advocacy, legislation, communications, and emergency preparedness. In addition to the department director, DDS has traditionally had one chief deputy director. Before his departure from office, Governor Brown appointed a second chief deputy director in December 2018 who will play a key role in the newly proposed departmental structure, overseeing Program Services.

Proposed Reorganization. With the impending closure of the remaining DCs, this proposal shifts to a more community-based focus within the department. The proposal consolidates the functions of the department into two main areas – Program Services and Operations. The graphic below depicts the two main areas, each of which would be overseen by a chief deputy director.

Figure 3

Proposed Reorganization and Restructuring of the Department of Developmental Services

Program Services

Community Services Division
- Office of Community Operations
- Appeals and Complaints
- Office of Community Development
- Disparities/Service Equity Section

Office of Statewide Clinical Services and Monitoring[a]

Federal Programs Division[a]
- Self Determination and Home- and Community-Based Services
- Monitoring and Family Services
- Program Operations

State-Operated Facilities Division
- Porterville Developmental Center
- Fairview Developmental Center
- Canyon Springs Community Facility
- STAR Homes and CAST
- Support Services
- Community State Staff
- Quality Assessment and Risk Management
- Regional Resource Development Projects, Transition and Support Services

Operations

Office of Quality Assurance and Risk Management[a]

Office of Legal Affairs

Office of Legislation, Regulations and Public Affairs[a]

Emergency Preparedness and Coordination

Office of Human Rights and Advocacy Services

Office of Protective Services

Administration Division
- Financial Services Branch
- Fiscal Forecasting Branch
- Human Resources and Support Services Branch
- Research, Audits and Evaluation Branch

Information Technology Division
- IT Operations Branch
- Technology Business Management Offices
- Information Security Office
- Enterprise Data Operations Office

[a] New office or division.

STAR = Stabilization, Training, Assistance, and Reintegration; CAST = Crisis, Assessment, Stabilization Teams; and IT = information technology.

LAO

Program Services would include the personnel that manage, and activities that concern, all of the services and supports delivered to consumers. This would include divisions for community services, state-run facilities, and federal programs (a new division). It would also include an office for statewide clinical services and monitoring (a new office). Operations would cover what could be considered primarily administrative functions for all DDS programs. It would include offices for quality assurance and risk management (a new office), legal affairs, human rights and advocacy, and protective services. It would consolidate several functions into a new office of legislation, regulations, and public affairs. It would include an administration division and a restructured IT division, and it includes emergency preparedness/coordination functions.

While the proposal contains many changes, some notable highlights are listed below:

- Increased oversight of Early Start programs. Proposed additional staff will allow programs to be reviewed every year, instead of the current three-year cycle.

- Increased focus on risk management and quality assurance. The proposal includes the creation of a new office focused on quality assurance and risk management to provide additional staff to re-evaluate the department's risk management system. The proposed additional staff will increase incident monitoring and analysis, incorporate additional quality assurance initiatives, work with RCs to analyze their Risk Management and Mitigation plan, and revise the department's Risk Management Training Manual.

- An increased departmental presence at the local level to provide heightened oversight of RC operations. The proposal includes additional positions to act as liaisons with RCs. The additional staff would respond to complaints, attend RC board meetings and train board members, and ensure compliance with statutory, regulatory, and contractual obligations. The proposal also includes opening a new office in Southern California to house the additional staff overseeing the Southern California RCs.

The proposal requests 54 new positions to implement this restructuring. Some positions would augment current functions, and others would perform new functions. Specifically, the department requests the following:

- Twenty-five positions in the Office of Community Operations. Of note, the proposal includes seven teams of three positions each, described as RC Liaison/Monitoring Teams, to provide increased oversight of RCs. Three teams would be located in northern California, and the other four would be based out of a new proposed southern California office.

- Five positions in the Office of Statewide Clinical Services and Monitoring. This new office centralizes community living and clinical services, program and policy, along with monitoring functions to address statewide issues and needs that arise regarding medical, dental, autism spectrum disorders, and new models of residential living. The office would consist of 32 positions total, 27 of which would be redirected from other divisions.

- Nine positions in the Federal Programs Division. Six new permanent positions and three 3-year limited-term positions are requested to provide the resources needed for all activities required by the Home and Community Based Services (HCBS) Statewide Transition Plan, additional monitoring of community service providers to ensure compliance with the new HCBS rules, implementation of the Self-Determination Program, and additional monitoring of Early Start providers. The three 3-year limited-term positions are requested for HCBS Waiver activities to focus on oversight and management of the provider assessment process. This process is discussed in more detail in issue seven. Two positions would be for implementation of the Self-Determination Program, and four positions would provide increased oversight and monitoring of RC Early Start programs.

- One position in the State Operated Facilities Division. This new division will primarily consist of existing positions and staff who are either redirected within DDS for continuing work related to the remaining DCs and state operated community facility, engaged in transition services, or involved with the new state operated facilities and other new models of care. One SSM I is requested to provide coordination and oversight for the DC and state operated facility adult education requirements.

- Five positions in the Research Section of the Administration Division. DDS proposes to increase the number of Research staff by five positions and to separate the section into two units: Research and Data Analytics Unit and the Data and Policy Support Unit. The proposed new staff include one Research Data Supervisor I, one Research Data Specialist II, and three Research Data Analyst IIs.

- One position in the Audit Section of the Administration Division. To enhance monitoring of RCs and community service providers, one new General Auditor III position is requested to improve the timeliness and quality of audit reports.

- Six positions in the Office of Quality Assurance and Risk Management. The office will consist of 16 positions for expanded statewide and enhanced quality assurance and data driven risk management. DDS believes a revamping of the risk management of mitigation system is necessary to address the changing dynamics of the service system overall, including the demographics of the population, specialized service needs, and the application of new models and approaches to risk management.

- Four positions in the Office of Legislation, Regulations, and Public Affairs. A new Office of Legislation, Regulations and Public Affairs is proposed with staff resources to support stakeholder engagement and effective communication with consumers. This office will report to the Chief Deputy, Operations and employ nine staff, including four new positions. Notably, a new Regulations Coordinator position is added to work with executive staff, managers, control agencies, and stakeholders to manage all aspects of the regulation process.

LAO Comment. While the cost of this proposal is relatively small, compared to the total DDS budget, it does represent a shift in policy and thinking for the department. The LAO believes the proposal warrants legislative consideration because it more logically reflects DDS' current responsibilities (and those that are on the horizon) and it attempts to respond to some of its current limitations, such as an inadequate number of staff to conduct timely and comprehensive risk management and quality assurance. However, the LAO notes that the proposal misses some opportunities to more fully consider how the system could better deliver services from a consumer perspective. For example, although some changes could have a positive impact on consumers (such as the proposal to increase DDS oversight of RCs, which should lead to more timely response to complaints and reported incidents), it is unclear how the reorganization will lead more directly, and broadly, to improved outcomes for consumers and what specifically those improvements might be. While the proposal includes increased data analysis and reporting, it does not appear to make significant changes to current data collection methods and types of data available. It is unclear to the LAO whether and how DDS would take disparate pieces of information collected and provided from these various units and use them collectively to strategically plan for the future.

The LAO recommends the Legislature request additional information on the departments near and long-term goals from the consumer perspective, and additional information on how the proposed southern California office would operate and how DDS would consolidate findings from multiple units.

Stakeholder Proposals.

Disability Rights California (DRC), California's statutorily identified consumer protection and advocacy agency, proposes the following related to the department's proposed reorganization and increased transparency and accountability:

- **List of Agreed Upon Services.** DRC proposes amending statute to require RCs to provide a list of agreed upon services and supports at the conclusion of an IPP meeting. RCs should provide a written copy of the IPP, which must be signed to provide consent for services and supports, within 45 days IPP. However, many RCs are experiencing delays due to staff shortages, resulting

in a delay in starting services, or clients and family members being made to sign a blank IPP document.

- **Posting of Guidelines, Protocols, and Assessment Tools.** DRC proposes amending statute to require RCs to post all guidelines, protocols, and assessment tools used to determine consumer's service needs with the relevant purchase of service policy. Currently, each RC must post DDS-approved purchase of service policy, internal guidelines, protocols and assessment tools for respite services. However, most RCs do not publicly post other guidelines, protocols, or assessment tools.

Disability Voices United recommends the department annually report on how their restructuring has provided greater transparency and increased oversight of the RC system.

Staff Comment and Recommendation. Hold open. Staff notes that the proposal does represent a significant change for the department. While staff has no specific concerns with the proposal and recognizes its merit, it is unclear how the proposed restructuring will improve service delivery for consumers, and aid in addressing consumer concerns. The department intends to seek stakeholder input and update its online "dashboard" keep the community informed of system progress in meeting outcomes. However, the proposal does not detail how it will improve consumer outcomes or how/if the department plans to track service delivery and consumer outcomes. Staff recommends the Subcommittee consider requiring the department and RCs to identify and report on key oversight indicators to improve consumer outcomes and track service delivery.

One of the recommendations of the DS Task Force in the department's 2015 plan for the future of the DCs was to increase access to and availability of mental health, medical, crisis, housing, employment, transportation, and social recreational services for individuals in the community. While the department and regional centers have worked to increase crisis services and housing options for individuals in the community, as can be seen with the Safety Net Plan, advocates have voiced concerns that the other services identified by the task force remain difficult to obtain. However, there is little data on the need for and utilization of these specialized services.

Questions.

1. Please provide an overview of the proposal.

2. Will the additional research section staff allow the department to collect more comprehensive data on consumers and services? Will the additional staff allow the department to better understand and address unmet service needs across the state?

3. Please provide specific examples of how the proposed changes will improve service delivery and individual consumer outcomes.

4. Please discuss the current process to establish and inform the public of new regulations, the backlog of regulations to be issued, and how this proposal will affect that backlog and process.

5. Please discuss the additional activities that will be undertaken by the expanded Quality Assurance and Risk Management Unit and how that will affect the experiences of consumers in the regional center system.

Issue 5: BCP – Federal Claims Reimbursement System Project

Governor's Proposal. The Governor's budget includes $3.2 million ($3 million General Fund) in 2019-20, and $12 million ($11.8 million General Fund) in both 2020-21 and 2021-22 for the planning and implementation of the Federal Reimbursement System Project. The request also includes three-year limited-term funding for five positions.

A further breakdown of the requested funds is provided below.

Category	Planning (Year 1)	Implementation (Years 2 & 3)
Position Funding	**$782,000**	**$1,564,000**
Consulting Services and Equipment	**$2,410,000**	**$22,340,000**
Consulting and Professional Services - Interdepartmental	$175,000	$183,000
Consulting and Professional Services - External	$1,962,000	$21,707,000
Office Equipment	$16,000	$0
Data Center Expenses	$125,000	$316,000
Other Items (such as software licensing)	$132,000	$134,000
Total	**$3,192,000**	**$23,904,000**

Background. The Community Services Division, Federal Programs Operations Section, administers and pursues federal reimbursements for Federal Financial Participation (FFP) programs approved by the CMS through waivers or state plan amendments (SPAs). Federal funds recovered under these reimbursements offset state General Fund for services provided to Medi-Cal eligible consumers. In 2018-19, federal reimbursements are budgeted at $2.8 billion. The FFP programs are:

- Medicaid Waiver
- Targeted Case Management (TCM)
- Nursing Home Reform
- State Plan Amendment (1915i)
- Intermediate Care Facility SPA
- Self-Determination program
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Federal Programs Operation Section relies on a 36-year old legacy system to process and claim federal reimbursement for FFP programs. Originally developed to support the Medicaid Waiver and 3,360 consumers, the system now supports four additional programs and processes claims for nearly 330,000 consumers, of which approximately 260,000 are Medi-Cal eligible.

The legacy system does not have maintenance or end-of-life support outside of the department's Information Technology Division. Industry-wide, there is a shortage of staff who can maintain and program older systems like the legacy system because colleges and universities no longer provide instruction on older programming languages. Compounding this issue, the workforce who knows the older programming language is at or past retirement age, making it difficult to recruit and hire new staff as others retire. Consequently, the department contracts for consultant resources to maintain the system. In 2018-19, the department estimates it will spend $400,000 on these contracted resources. Over the last eight years DDS has spent $1.3 million on consulting services for the support and maintenance of the existing reimbursement system.

The department initiated an effort in 2016 to analyze and assess a long-term solution. Following the 4-Stage Project Approval Lifecycle (PAL) process, the department prepared and submitted a stage one business analysis for the project. This analysis identified the problems and challenges with the legacy billing system, established the business need to develop a long-term solution, and assessed the department's readiness to undertake a large project. On April 17, 2017, the California Health and Human Services Agency approved the project to proceed. On August 8, 2018, the department received PAL stage two approval from the California Department of Technology, which authorizes the department to proceed with PAL stages three and four to plan and procure a solution. The department began stage three, which is the procurement development phase for the prime solution vendor, in July 2018. The final stage is project readiness and approval. DDS estimates it will have a modernized and functioning IT system two years following the prime vendor contract execution and kick-off meeting.

LAO Comments. Given that federal reimbursements account for $2.8 billion in annual DDS funding the LAO agrees that there is a need to modernize the department’s federal claims reimbursement system. However, the LAO states that it is unclear that DDS needs to request the full three-year amount of funding. Departments should complete all four stages of CDT’s IT project proposal planning and approval process before the fiscal year in which they are requesting design, development, and implementation funds. This allows the department to solicit bids from external consultants and provide the Legislature with more precise estimates of total project cost, schedule, and scope before the Legislature approves project funding. DDS is in stage three of the process and claims that waiting to seek the remaining funding until after stage four is complete would delay the project by a year. DDS does not plan to award a contract to an external consultant until the fall of 2020, and could request funding in next year’s budget process. By waiting to approve the remaining funding, the Legislature would have additional cost, schedule, and scope information from stages three and four.

The LAO recommends approving only the request for $3.2 million ($3 million General Fund) in planning dollars for 2019-20 and rejecting the current request for design, development, and implementation funding in both 2020-21 and 2021-22.

Staff Comment and Recommendation. Hold open. Staff notes that it does seem that the department would have additional information that would inform cost estimates after completion of stage four of the PAL process.

Questions.

1. Please provide an overview of the proposal.

2. Please describe the additional steps required during stages three and four of the PAL process that may affect project costs.

3. Does the department anticipate that the information that is gathered during stage four of the PAL process will affect project costs?

Issue 6: Developmental Centers Closure – Overview

Background. In 2015, consistent with the recommendations of the Health and Human Services Agency report entitled "Plan for the Future of Developmental Centers in California," and the call for the transformation of developmental center services, the May Revision proposed to initiate the closure planning process for the remaining developmental centers. In response to Senate Bill 82 (Committee on Budget and Fiscal Review), Chapter 23, Statutes of 2015, which required the department to submit a plan or plans to close one or more developmental center(s) to the Legislature by October 1, 2015, the department submitted a plan to close Sonoma Developmental Center (SDC) by December 31, 2018. On April 1, 2016, the department submitted to the Legislature a plan for the closure of the Fairview Developmental Center (FDC) and the Porterville Developmental Center (PDC) – General Treatment Area by the end of December 2021. The department will continue to operate a secure treatment program (STP) at PDC, which can serve up to 211 people.

As mentioned previously in this agenda, the last resident moved out of Sonoma DC on December 17, 2018.

Population. Total population for closing facilities declined by 26 people from December 31, 2018 through March 31, 2019. Population for non-closure facilities declined by two for a net decrease in total population of 28. For the developmental centers, three state-run crisis units on developmental center grounds, and the state-leased and operated community facility (Canyon Springs), the following tables show the populations remaining, movement in and out, and transition activities occurring for residents, as of March 31, 2019.

POPULATION			Q3 FY 18/19	
			12/31/18	3/31/19
CLOSURE	Fairview (FDC)	NF	39	25
		ICF	47	40
	Porterville (PDC) GTA	NF	16	16
		ICF	30	25
	Sonoma (SDC)	NF	0	0
		ICF	0	0
	All Facilities	NF	55	41
		ICF	77	65
		Subtotal	**132**	**106**
NON-CLOSURE	Canyon Springs (CS)	ICF	47	46
	CS	Desert STAR	1	2
	FDC	Southern STAR	5	4
	PDC STP	ICF	210	210
	SDC	Northern STAR	5	4
	All Facilities	**Subtotal**	**268**	**266**
TOTAL			**400**	**372**

Movement and Transition Activity. 43 community placements occurred between December 31, 2018 and March 31, 2019. 23 of those placements were from facilities slated for closure. The tables below show movement activity and where individuals residing at the DCs are in the transition process.

MOVEMENT Jan-Feb-Mar 2019		OUT			IN		
		Placements	Deaths	Transfers to DC/CF	New Admissions	Transfers In	Returns from Placement
CLOSURE	FDC	19	1	1		0	0
	PDC GTA	4	0	1		0	0
	SDC	0	0	0		0	0
	Subtotal	**23**	**1**	**2**		**0**	**0**
NON-CLOSURE	CS	2	0	0	0	1	0
	CS STAR	0	0	0	1	0	0
	FDC Southern STAR	1	0		0	0	
	PDC STP	16	0	0	15	1	0
	SDC Northern STAR	1	0	0	0		
	Subtotal	**20**	**0**	**0**	**16**	**2**	**0**
TOTAL		**43**	**1**	**2**	**16**	**2**	**0**

TRANSITION ACTIVITY AS OF 3/31/19	Level of Care	Population 3/31/19	Exploring Community Options	Meet & Greets	Successful Meet & Greets	Transition Planning Meetings	Transition Review Meetings/ Move Date
FDC (5)*	NF	25	0	0	0	9	16
	ICF	40	1	7	0	19	13
PDC GTA (39)*	NF	16	0	0	0	13	3
	ICF	25	0	4	0	20	1
SDC	NF	0	0	0	0	0	0
	ICF	0	0	0	0	0	0
All Facilities Closing	NF	41	0	0	0	22	19
	ICF	65	1	11	0	39	14
	Total	**106**	**1**	**11**	**0**	**61**	**33**

Residential Capacity for DC Movers. As of March 31, 2019, there are a total of 90 active projects (with a total capacity to serve 376 individuals) that have been approved for consumers transitioning from both Fairview and Porterville DCs. Of those 90 homes, 60 are completed and currently serving or able to serve consumers. The completed homes are able to serve a total of 257 consumers.

DC Properties. The Legislature will soon be faced with the decision of what to do with the state-owned properties that house the closing DCs. The department has indicated that it will not declare Sonoma DC as surplus property (meaning it will not go through the typical Department of General Services (DGS) process of disposing of state properties). The Administration recently released a budget proposal that would transfer authority of Sonoma DC from DDS to DGS. Sonoma County will be heavily involved in the land use planning activities.

DDS has also indicated that the Fairview DC property would not be declared surplus until at least 2020-21. The Fairview property includes two DDS-run crisis homes, an apartment development called Harbor Village (which includes some residences for DDS consumers), and will include a second apartment development, Shannon's Mountain, (which will also include some units for DDS consumers). None of these developments or the crisis homes will be affected by the disposition of the property. There are fewer options for the future of the general treatment area at Porterville DC given its shared infrastructure with, and proximity to, the secure treatment program.

Stakeholder Proposal. Several stakeholder and advocacy organizations, as well as consumers,-advocate have requested that savings that result from the closure of DCs be reinvested into the intellectual and developmental disability community. In January 2018, the LAO issued a report on sequestering savings from the closure of the DCs. In the report, the LAO estimates that net operational savings after the DC closures could reach $100 million annually.

Staff Comment and Recommendation. This item is informational only, and no action is necessary.

Questions.

1. Please provide an update on the disposition of the DC properties.

2. Please provide an update on the planned development of Shannon's Mountain.

Issue 7: Safety Net Facilities and Crisis Services

Governor's Proposal. The Governor's budget includes a total of $11.7 million ($7.3 million General Fund) to enhance the system of crisis and safety net services. Specifically, the budget includes the following:

- $4.5 million ($4.2 million General Fund) to develop two DDS-operated crisis homes and 60 positions in the Central Valley.
- $800,000 ($600,000 General Fund) for a third mobile crisis team in the Central Valley comprised of five state positions.
- $3.2 million ($2.6 million General Fund) ongoing for 27 new positions to staff a third DDS-operated crisis home in Vacaville scheduled to open in fall 2019.
- $3.2 million ($2.6 million General Fund) ongoing for nine positions to provide oversight and support to DDS-operated safety net homes and mobile crisis services.

Panel. In addition to DDS, DOF, and the LAO, the Subcommittee has requested the following panelists provide comment on the department's safety net plan and crisis services:

- Heather Flores, Executive Director, Central Valley Regional Center
- Ann Grubaugh, family member
- Catherine Blakemore, Executive Director, Disability Rights California

Background. The department released its Plan for Crisis and Other Safety Net Services in the California Developmental Services System, otherwise known as the "safety net plan," on May 13, 2017. As part of the May Revision, the Administration proposed, and the Legislature approved, a total of $21.2 million ($7.5 million in new, one-time General Fund and $13.7 million from existing funds). The Safety Net Plan includes the expansion of state-operated and vendor-operated services. Specifically, the development of state-operated Stabilization, training, Assistance, and Reintegration (STAR) acute crisis residences. The Safety Net Plan also proposed state-operated mobile crisis services. These services are provided by the Crisis Assessment Stabilization Teams (CAST), housed at both North and South STAR. The CAST teams are designed to provide partnerships, assessments, training, and support to individuals continuing to experience crises after RCs have exhausted all other available crisis services in order to avoid placement in a locked psychiatric facility.

Additionally, the department has begun an expansion of vendor-operated services including the development of step-down homes and intensive transition services for individuals transitioning into the community from the Porterville Secure Treatment Program (PDC STP) as well as from Institutions for Mental Diseases (IMD). The step-down homes are expected to serve individuals who have been in highly restrictive settings and would benefit from more structure and continued skill development before transitioning back to their home community. With the addition of the proposed resources, there will be a statewide safety net and crisis home capacity of 386. The table below provides further detail on safety net and crisis home capacity.

Figure 4

Safety Net and Crisis Home Capacity

For Individuals With Developmental Disabilities

Consumer Need	Operated by	Already Open		In Development		Proposed In 2019-20		Total When Complete[a]	
		Homes	Beds	Homes	Beds	Homes	Beds	Homes	Beds
Adult									
Needs intensive behavioral supports	Vendor	18	66	39	141	—	—	57	207
In crisis	Vendor	4	16	13	54	—	—	17	70
	DDS	3[b]	20[b]	4	20	2	10	7[c]	40[c]
Transitioning from PDC-STP	Vendor	—	—	3	12	—	—	3	12
Transitioning from IMD	Vendor	—	—	4	16	—	—	4	16
Child/Adolescent									
Needs intensive behavioral supports	Vendor	2	6	5	19	—	—	7	25
In crisis	Vendor	—	—	—	—	3	12	3	12
	DDS	—	—	1	4	—	—	1	4
Totals		**27**	**108**	**69**	**266**	**5**	**22**	**99**	**386**

[a] There are six additional homes with 34 total beds for which it is unclear the target population.

[b] Two of the three crisis facilities currently run by DDS are based at developmental centers and will be replaced by homes currently in development. The third refers to the ten beds available at Canyon Springs Community Facility.

[c] Per 2018 statute, DDS now dedicates ten of Canyon Springs Community Facility's 63 beds for crisis services.

PDC-STP = Porterville Developmental Center-Secure Treatment Program; IMD = Institution for Mental Disease; and DDS = Department of Developmental Services.

Safety Net Plan Update. The department and RCs are continually working to expand access to crisis services. Further details on 2017-18 and 2018-19 projects are provided below.

- **Acute Crisis Services – North STAR.** Two state-operated Community Crisis Homes (CCH) for adults, and one state-operated Enhanced Behavioral Support Home (EBSH) for children and adolescents in the Vacaville region are either in development or operation. Construction on one CCH was completed on April 5, 2019, and service is projected to begin soon. Service in the other CCH is projected to begin in summer 2019. Service in the EBSH is projected to begin in fall 2019.

- **Acute Crisis Services – South STAR.** Two state-operated CCHs for adults in Costa Mesa are in development. Sites have been identified and demolition of existing homes is complete. Construction is scheduled to begin next month.

- **STAR CAST.** CAST begin accepting referrals on January 8, 2018. There have been a total of 44 CAST referrals. The North STAR currently services North Bay RC and RC of the East Bay. The South STAR services RC of Orange County, San Diego RC, and San Gabriel Pomona RC.

- **Porterville DC Secure Treatment Program (STP) Step Down Homes.** Three vendor-operated CCHs with delayed egress are in development to support individuals transitioning into the community from Porterville DC STP. Two homes have been identified and are in escrow. A property search is underway for the third home. Central Valley RC is developing all three homes.

- **Porterville DC STP Intensive Individualized Transition Support Services.** These services will support individuals before, during, and after transition from STP into the community home. Liberty Healthcare has been contracted to provide pre-transition risk assessments, assistance with in-depth person centered planning, environmental assessments of the community home, and consultation and/or direct services before, during, and after transition to residential providers. Currently, there are nine active cases with the first community placement anticipated to occur in May 2019. Services began in November 2018. The department expects to serve 25-35 individuals within the first year. Services will be provided statewide.

- **Institution for Mental Diseases (IMD) Step Down Homes.** Seven vendor-operated homes are in development. These homes will serve areas covered by Alta California RC and Far Northern RC in Northern California, and San Gabriel Pomona RC in Southern California. All homes are at various stages in the development process with expected service dates from spring to winter 2019.

- **IMD Intensive Individualized Transition Services.** These services will support individuals before, during, and after transition from an IMD, as well as those at risk of being placed in an IMD. Services provided will be similar to those provided for individuals transitioning from Porterville DC STP. Merakey has been selected as the statewide provider, with a start date of October 2018. As of April 25, 2019, there were eight active cases in Northern California and eleven active cases in Southern California.

Stakeholder Proposals. Disability Rights California (DRC), California's statutorily identified consumer protection and advocacy agency, proposes the following related to safety net facilities and acute crisis services:

- Authorization of an additional $5 million and trailer bill language to allow up to seven RC pilot programs to more effectively serve consumers with serious mental health disabilities who are at risk of placement in or remaining in an institution. The projects would expand crisis services, develop new community-based models of care, or coordinate with county mental health agencies to serve RC consumers with mental health disabilities.

- Trailer bill language to align admission criteria, post-admission oversight, and process for judicial review for Institutions for Mental Disease (IMD) with the laws governing placements in state-operated acute crisis settings. DRC estimates that these changes will result in a net savings for the department.

- Notification to the clients' rights advocate (CRA) when an individual is placed in a restrictive setting. DRC requests that CRAs receive notice when a consumer is placed on psychiatric hold or conservatorship, or when a 6500 proceeding is initiated.

LAO Comments. While there is likely need for additional safety net services to justify a budget augmentation for this purpose, the LAO states that there is a lack of data to comprehensively assess the demand for these services. Beyond the current proposal, the LAO recommends the Legislature require DDS to submit a revised safety net plan with the 2020-21 budget proposal that provides more detailed information on the determination of future safety net expansion, based on information about consumer needs and demand.

Staff Comment and Recommendation. Hold open. However, the Subcommittee may want to consider requiring the department to update its Safety Net Plan.

Questions.

1. Please provide an update on the safety net plan.

2. Please provide an overview of the proposals for expansion of Safety Net services.

3. With the proposed resources, will Safety Net services be available to all statewide? If not, what geographic locations are not being served?

4. Does the department plan to continually update its Safety Net plan?

5. What additional data did the department use to determine where and how to expand Safety Net service?

Issue 8: Overview and BCP – HCBS Compliance and Final Rule Site Assessments

Governor's Proposal. The Governor's budget includes a one-time augmentation of $3 million ($1.8 million General Fund) to contract for the coordination and completion of on-site visits and assessments of providers and programs as required by the HCBS final federal rules. A further breakdown of the requested funding is provided below.

- $250,000 for preparation activities including infrastructure readiness and outreach
- $2.4 million for on-site assessments
- $300,000 for post-assessment support and closure report

Panel. The Subcommittee has requested the following panelists to provide comment on the overall progress of HCBS compliance among service providers for consumers.

- Marty Omoto, Executive Director, California Disability-Senior Community Action Network (CDCAN), and family member
- Jami Davis, Executive Director, Marin Ventures

Background. In January 2014, CMS issued final regulations for HCBS. The rules require that HCBS programs funded through Medicaid provide individuals with disabilities full access to the benefits of community living and offer services and supports in settings that are integrated in the community. This includes, but is not limited to, opportunities to seek employment in competitive and integrated settings, control personal resources, and engage in the community to the same degree as individuals who do not receive regional center services. The HCBS rules focus on the nature and quality of individuals' experiences and not just the settings where the services are delivered. Originally, CMS required states to comply with these regulations by March 17, 2019, in order to maintain funding. However, CMS has extended that deadline to March 17, 2022.

The federally funded programs that provide HCBS include the Medicaid Waiver, the State Plan Amendment 1915(i), and the Self-Determination program. These waivers enable the state to receive federal funding for services provided to approximately 208,000 consumers. CMS granted initial approval of California's transition plan in February 2018. Included in the department's budget are federal reimbursements for programs that provide HCBS approved by CMS. Federal funds recovered under these programs offset state General Fund for services provided to Medi-Cal eligible consumers. Department funding for these waivers is estimated at $2.3 billion in 2018-19.

The new rules require the state to assess settings to determine if they are in compliance with new settings rules, and if not, determine what actions will be taken to meet them. Providers who indicate that they do not fully meet the criteria will be categorized by the type and level of remediation needed to achieve compliance. Those needing corrective action through technical assistance (e.g. documenting procedures, staff training on the new requirements, reiterating rights and responsibilities to consumers and/or their representatives, etc.) will implement corrective action, monitored by regional centers. While all providers will complete a self-assessment, additional on-site visits must be conducted for a random sample of providers to validate the providers' assessments. At minimum, this will require 1,100 on-site visits.

Previous Budget Actions. In anticipation of the impact these rules will have for some service providers, the 2016, 2017, and 2018 budgets appropriated $15 million General Fund to the department to provide resources to providers to make modifications to programs to achieve compliance with the HCBS final rules. In addition, the budgets included $1.4 million ($700,000 General Fund) for the department to provide regional centers with funds to perform initial and ongoing provider evaluation activities. The prior two years of funding primarily focused on supporting providers to:

- Offer person-centered planning (PCP) training and integrate PCP practices into their program;
- Hire staff to assist individuals in locating and obtaining competitive integrated employment opportunities, and
- Increase transportation resources to better access volunteer, work or leisure activities in the community based on individual choices of the people they serve.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.
2. Please provide an update on the activities performed because of the funding provided in the 2018 budget for providers to meet HCBS standards. Please include an update of the regional center provider evaluation activities that were funded and the statewide status of these activities.
3. How many providers are currently in compliance with the HCBS final rules?
4. Please explain the process to identify those settings that will be identified as needing heightened review, and the impact on providers, consumers, regional centers, and DDS. How many facilities or unique settings does DDS estimate will require heightened review?

Issue 9: Disparities Funding

Panel. In addition to DDS, DOF, and the LAO, the Subcommittee has requested the following panelists provide comment on the department's disparities funding:

- Amy Westling, Executive Director, Association for Regional Center Agencies
- Fernando Gomez, Board Member, Disability Voices United, and parent
- Marty Omoto, Executive Director, California Disability-Senior Community Action Network (CDCAN), and family member

Background. The department and regional centers are statutorily required to annually collaborate to compile data in a uniform manner relating to POS authorization, utilization and expenditure by regional center and by specified demographics including: age, race, ethnicity, primary language spoken by consumer, disability, and other data. This information is also to include data on individuals eligible for, but not receiving, regional center services. Regional centers are required to hold public hearings on this data and the department is required to provide oversight, through their contract agreements with the regional centers, by requiring specified activities and establishing annual performance objectives.

Numerous legislative hearings and press accounts have discussed a significant level of disparities in service delivery among racial and ethnic groups and between regional centers. Multiple bills have been signed into law to address these disparities through multiple strategies including, governing board training; data collection and sharing; improved departmental oversight of regional centers; and requirements that regional centers communicate and provide written materials in multiple languages.

Assembly Bill 1 X2 (Thurmond), Chapter 3, Statutes of 2016, Second Extraordinary Session, provided $11 million General Fund to assist regional centers in the implementation of strategies to reduce POS disparities. On July 26, 2016, the department sent guidelines to regional centers regarding the submission of proposals to obtain funding to address identified areas of disparity. Subsequently, in August 2016, the department held four stakeholder meetings throughout the state to discuss and gather information on disparity issues. Additionally, each regional center was required to consult with stakeholders regarding activities that may be effective in addressing disparities in the receipt of regional center services and the regional center's proposed requests for the above-mentioned funding.

Tracking Progress. In March 2017, the Senate Human Services Committee requested the department identify ways to track progress in reducing disparities in service access in the regional center system. The committee also asked the department to set short- and long-term improvement targets for those measures. After analyzing various datasets and consultation with stakeholders the department developed a set of measures that may serve as bellwethers for system change. The measures and improvement targets to track progress in reducing disparities are listed below:

- High-level comparison of purchase of service (POS) expenditures by age, ethnicity and language
- Timely eligibility determination
- Access to early start services

- Early start utilization rate
- POS equity, focused on youth
- Equity in adaptive skills training, focused on youth
- Respite and personal assistance equity, focused on youth
- Personal Assistance Services equity
- Equity for language diversity
- Equity in support living and independent living services, focused on adults
- Equity in supported work programs, focusing on working age adults

The department approved proposals from all 21 regional centers for activities to promote equity and reduce purchase of services disparities. The first batch of funding for projects was allocated in March 2017. In reviewing proposals, the department took into account statewide needs and available resources, as well as information gathered during the department's statewide stakeholder meetings. In addition, proposals were analyzed for compliance with applicable statute and regulations, and the department's guidelines. Activities funded include: electronic interpreter systems, translation of written materials, cultural training, group trainings in native languages, reduced caseloads, cultural competency staff training, cultural brokers and parent mentors, and outreach activities. In September 2017, the department issued guidelines to solicit community-based organizations (CBOs) and regional centers to utilize AB 1 X2 funds to address disparities in regional center purchase of services.

A list of approved projects, their summaries, and the amount of allocated funding can be found at: www.dds.ca.gov/RC/disparities.cfm.

Project Evaluation. Each organization with approved funding will be required to submit quarterly status reports, throughout the life of the project. The department will evaluate status reports to ensure funding is being used in accordance with state rules, sufficient data is being collected to measure the project's effectiveness, and the project's goals and objectives are being achieved. Grantees were required to submit a comprehensive evaluation report that details the effectiveness of the project in reducing disparities in POS expenditures in April 2019. The department has indicated that it intends to initiate discussions with organizations that are not meeting project goals and objectives, and may determine if continued project funding is appropriate.

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

Questions.

For DDS:

1. Please provide an update on activities performed by the department to address significant disparities and barriers to equitable access to services and supports.

2. When does the department expect to begin to see a change in the overall disparities data?

3. Will the department provide technical assistance to organizations that do not meet project goals? What measures will the department use to determine if the organizations are meeting project goals?

Issue 10: Spring Letter/BCP – Foster Youth Trauma-Informed Systems of Care (AB 2083)

Governor's Proposal. The Governor's budget includes $158,000 ($134,000 million General Fund) in 2019-20 and annually thereafter; and $1.6 million ($1.1 million General Fund) in both 2019-20 and 2020-21 for statewide positions to implement AB 2083 (Cooley), Chapter 815, Statues of 2018.

Background. AB 403 (Stone), Chapter 773, Statutes of 2015, known as Continuum of Care Reform (CCR), is designed to improve California's child welfare system by using comprehensive initial child assessments, increasing the use and support of home-based family care, reducing the use of congregate care placement settings, and creating faster paths to permanency to shorten the duration of a child's involvement in the child welfare and juvenile justice systems. AB 2083 (Cooley), Chapter 815, Statutes of 2018, builds on the framework of CCR to better serve the needs of foster children and youth who have experienced severe trauma. AB 2083 is intended to develop a coordinated, timely, and trauma-informed system of care approach by: 1) identifying and addressing gaps and delays in needed services and placement options, 2) improve outcomes, and 3) prevent the need for higher-cost interventions.

Each county is required to develop and implement a memorandum of understanding (MOU) that sets forth the roles and responsibilities of agencies and other entities that serve children and youth in foster care who have experienced severe trauma. The MOU is required to include the county child welfare agency, probation department, behavioral health department, office of education, the regional center for children and youth with developmental disabilities, and foster care or other child welfare advocacy groups.

The Secretary of the California Health and Human Services Agency and the Superintendent of Public Instruction are required to establish a joint interagency resolution team to develop guidance, and provide support and technical assistance to counties and local entities in developing and implementing the MOU and identifying and securing the appropriate level of services to meet the needs of children and youth in foster care who have experienced severe trauma. The team is also required to review the availability of county placement and service options and submit recommendations to the Legislature and develop a multi-year plan for increasing the capacity and delivery of trauma-informed care to children and youth in foster care.

AB 2083 is premised on the notion of promoting coordination among entities that serve a particular county. The regional center system does not conform neatly to this model. There are 21 regional centers, each serving individuals residing within a designated "catchment" area. There are seven regional centers that serve Los Angeles County, and 13 regional centers that serve multiple counties – some serving as many as ten. Thus, eight regional centers will be involved in developing a single MOU, while 13 others will be required to participate in the development of multiple MOUs. The department states that this unique system will result in a significant workload increase for the department. In addition to providing input on MOUs the department is required to participate in the development of technical assistance for partner agencies, collaborate on recommendations to address identified gaps in placement and service options for foster youth, and collaborate on a multi-year plan to increase systems capacity.

The department requests the following to meet this workload:

- **One Staff Services Manager (SSM) II** position would provide subject matter expertise and be the lead staff member representing DDS on the joint interagency resolution team.

- **Fifteen Senior/Supervising Service Coordinator** positions would be lead regional center staff responsible for coordinating activities to implement AB 2083. Duties would include participating on interagency leadership teams, working with counties to develop and implement MOUs, and providing guidance to regional center service coordinators on case management for foster children and youth. These positions would be for a limited-term of two years. DDS has requested 15 positions based on the number of counties served by each regional center and distribution of foster children by regional center. The seven Los Angeles county regional centers will receive a combined 5.0 full time equivalent positions. Non-Los Angeles county regional centers with more than 3% of the total population of court dependent minors will receive 1.0 position (6 regional centers). Non-Los Angeles county regional centers with less than 3% of the total population of court dependent minors will receive 0.5 position (8 regional centers).

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal, including a description of the need for heightened coordination.

2. How will the department and RCs handle collaboration in instances where multiple RCs are involved in developing one MOU, or one RC is involved in the development of multiple MOUs?

Issue 11: TBL - Crisis Homes for Children

Governor's Proposal. The Governor's budget includes a one-time augmentation of $4.5 million General Fund for the development of three community crisis homes for children. Additionally, the department proposes trailer bill language (TBL) to amend statute to allow children in crisis to be placed into community crisis homes.

Background. Although many children with developmental disabilities live in the family home, some children have more extensive behavioral needs that cannot be met in the family home or other existing settings. The Health and Safety Code and Welfare and Institutions Code were amended in 2014-15 to include emergency regulations for community crisis homes. However, current statute only allows adults in acute crisis to be admitted into community crisis homes. Currently, RCs must sometimes rely on locked psychiatric settings for children and struggle to provide needed services in a child's home in response to acute crisis.

The requested resources would allow for the development of three community crisis homes for children, and the proposed TBL would allow children to be placed in these homes. The homes will provide RCs with immediate access to short-term crisis stabilization, with a limited duration of stay. The homes will be certified by DDS, and licensed by the Department of Social Services. The homes will be developed by RCs through the "Buy-it-Once" model to ensure the homes are used in perpetuity to provide crisis services to children.

Staff Comment and Recommendation. Hold open.

Questions.

1. Provide an overview of the proposal.

2. Where will these homes be located? How did the department decide where the homes will be located?

Issue 12: TBL - Specialized Caseload Ratios for Regional Centers

Governor's Proposal. The Governor's budget includes $3.8 million ($2.6 million General Fund), and TBL to establish a 1:25 service coordinator-to-consumer caseload ratio for consumers with complex needs.

Background. Under current law, there are several service coordinator-to-consumer ratios with which RCs must comply, such as 1:62 for consumers receiving Medicaid waiver funding. For purposes of the proposed caseload ratio, consumers with complex needs may include individuals who reside or are at risk of residing in IMDs, community crisis homes, state-operated acute crisis homes or out-of-state placements; have been admitted to a psychiatric hospital several times within the preceding six months; and individuals who transitioned from any such setting within the preceding 12 months. Due to the complexity and uniqueness of each consumer, intensive case management and service coordination is needed for stabilization in the least restrictive setting.

The requested funding would allow an additional 50 Service Coordinators to provide case management to an estimated 1,231 consumers. The requested ratio is a time limited need to enable service coordinators to assist in identifying and/or stabilizing services to support individuals with the most complex needs. The intensive service coordination would be provided for no more than 12 months, until a consumer is stabilized, after which the consumer would resume working with their regular service coordinator.

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the language.

Issue 13: Proposals for Investment

The Subcommittee has received the following proposals for investment related to the DDS.

1. Increased Funding for Regional Center Operations

Budget Issue. The Association of Regional Center Agencies (ARCA) requests additional resources to address the following issues related to RC operations:

- Operations Down Payment. ARCA requests $39.2 million General Fund for additional staffing and other operations expenses at RCs. Since 2016, there has been an eight percent increase in the Consumer Price Index and a twelve percent increase in California's wage index. While there are efforts underway to identify strategies for adjusting regional centers' funding model to ensure its long-term sustainability, current fiscal pressures are leading to high rates of staff turnover and position vacancies, which get in the way of long-term, effective service coordination relationships. ARCA states that providing an eight percent down payment for immediate relief would provide needed stability for the coming year.

- Service Coordination Shortfall. ARCA requests $34.5 million General Fund to address a shortfall in RC service coordinators. Many portions of the Core Staffing Formula, which is the primary mechanism through which regional center service coordination and support services are funded, have been untouched since 1991, with the vast majority of budgeted service coordination salaries remaining stagnant in the last fifteen years. This has led to a shortage of service coordinators needed to meet statutory requirements that are tied to significant federal funding. Currently, the shortfall is 691 service coordinators statewide.

- Realigning Assumed Employment Costs. ARCA requests $117.5 million General Fund to update assumed employment costs for service coordinators. The estimated costs for each position include $55,000 annual salary, 34 percent benefit rate, and no anticipated salary savings. These costs are more representative of the true costs of employing service coordinators statewide than those in the current Core Staffing Formula. Updating costs for the 5,857 case-carrying service coordinators proposed in the 2019-20 Budget would allow individuals and families to access needed service coordination and enable regional centers to redirect resources to other critical functions such as resource development, quality assurance, and risk mitigation.

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 Melissa Hurtado
Senator Jeff Stone

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

PART B

Consultant: Scott Ogus

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PUBLIC COMMENT

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

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

Issue 1: CalHEERS System Integrator Contract Transition Activities

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

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

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

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

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

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

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

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

Background. DHCS serves as the single state agency responsible for the administration of Medi-Cal, California's state Medicaid program. Medi-Cal provides medical, dental, mental health, substance use disorder services, and long-term care to more than 13 million low-income Californians. Eligibility for Medi-Cal is determined by local county welfare and public health agencies. Since 1983, DHCS has used the current MEDS system for a variety of eligibility and reporting functions for the Medi-Cal program. Specifically, MEDS captures beneficiary information from the three county Statewide Automated Welfare System (SAWS) consortia (LEADER, Consortium IV and CalWORKs Information Network), state and federal partners, and Covered California.

In addition to its role maintaining eligibility information for Medi-Cal, MEDS serves as the "system of record" to determine eligibility for many of the state's health and human services programs. DHCS utilizes MEDS data for determinations regarding its Every Woman Counts, Child Health and Disability Prevention, Breast and Cervical Cancer Treatment, and Family Planning Access Care and Treatment programs. The Department of Social Services (DSS) leverages MEDS data for eligibility determinations and administration of CalWORKs, CalFresh, Cash Aid Program for Immigrants, In-Home Supportive Services, and Refugee Cash Assistance. Local governments also use MEDS data, specifically for the County Medical Services Program and the County Welfare and Tribal Temporary Assistance for Needy

Families. Access to MEDS is provided to more than 35,000 end users and DHCS must ensure that the system and its end users protect confidential beneficiary information in accordance with state and federal security and privacy requirements.

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

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

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

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

2014-15

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

2015-16

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

2016-17

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

2017-18

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

2018-19

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

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

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

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

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

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

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

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

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

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

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

Non-contract services - $5 million

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

Contract services - $12.2 million

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 3: Electronic Visit Verification Phase II Planning

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

Table 1 - BCP Resource Request

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

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

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

Table 2 - BCP Funding Request

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

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

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

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

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

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

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

Electronic Visit Verification Phase II Programs

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

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

The requested positions, by department, are described below.

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

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

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

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

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

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

Issue 4: Statewide Automated Welfare System Consolidation

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

Table 1 - BCP Resource Request

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

Table 2 - BCP Funding Request

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

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

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

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

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

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

The specific requests, by department, are outlined below

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

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

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

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

Staff Comment and Recommendation. Hold open.

Questions.

1. Please provide an overview of the proposal.

Issue 5: Healthy California For All Commission

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

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 6: Proposal for Investment – CalQualityCare.org

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

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

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

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

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

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

4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 1: Pharmacy Benefit Management (AB 315)

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

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

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

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

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

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

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

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

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

Help Center – One position

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

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

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

Office of Legal Services **–** One position

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

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

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

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

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

1. Please provide a brief overview of this proposal.

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

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

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

* Positions and resources ongoing after 2020-21.

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

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

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

Help Center – Seven positions and contract resources for IT upgrades

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

Office of Financial Review – One position

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

Office of Technology and Innovation – One position

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

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

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

1. Please provide a brief overview of this proposal.

4440 DEPARTMENT OF STATE HOSPITALS

Issue 1: Metropolitan: Consolidation of Police Operations – Reappropriation

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 2: Patton: Fire Alarm System Upgrade – Reappropriation

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of these proposals.

Issue 4: Vocational Services and Patient Minimum Wage

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

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

* Position and resources ongoing after 2020-21.

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

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

Issue 5: Workforce Development

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

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

Issue 6: Court Evaluations and Reports

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

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

Issue 7: Direct Care Nursing

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 8: Pharmacy Modernization

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 9: Technical Adjustments - Various

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Innovation Incubator Implementation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of this proposal.

Issue 2: Commission Budget Requests and Proposals for Investment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Please provide a brief overview of these proposals.

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

SUBCOMMITTEE NO. 3 Agenda

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

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

Consultants: Scott Ogus and Renita Polk

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PUBLIC COMMENT

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

ISSUES FOR VOTE ONLY

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

Issue 1: Conversion of Blanket Positions to Permanent

DOF Issue#: 4120-001-BCP-2019-GB

Budget Issue. EMSA requests establishment of four positions funded by existing appropriation authority. If approved, these positions would address ongoing Emergency Medical Services Division workload.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$-	$-
Total Funding Request:	**$-**	**$-**
Total Requested Positions:	**4.0**	**4.0**

* Positions are ongoing after 2020-21.

This issue was heard during the subcommittee's February 28th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 2: Continued Appropriation for Paramedic Discipline Case Workload

DOF Issue#: 4120-002-BCP-2019-GB

Budget Issue. EMSA requests expenditure authority from the Emergency Medical Services Personnel Fund of $309,000 annually. If approved, these resources would provide permanent funding for two positions authorized in the 2017 Budget Act to address the workload associated with prosecution of Emergency Medical Technician-Paramedic (EMT-P) license violations.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0312 – Emergency Medical Services Personnel Fund	$309,000	$309,000
Total Funding Request:	**$309,000**	**$309,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources are ongoing after 2020-21.

This issue was heard during the subcommittee's February 28th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: Increased Expenditure Authority for MH Practitioner Education Fund

DOF Issue#: 4140-001-BCP-2019-GB

Budget Issue. OSHPD requests additional expenditure authority from the Mental Health Practitioner Education Fund of $425,000. If approved, these resources would allow OSHPD to increase the grant awards provided through the Licensed Mental Health Service Provider Education Program. These resources would be funded from increased licensure fee revenue approved pursuant to AB 1188 (Nazarian), Chapter 557, Statutes of 2017.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3064 – Mental Health Practitioner Education Fund	$425,000	$425,000
Total Funding Request:	**$425,000**	**$425,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2020-21.

This issue was heard during the subcommittee's February 28th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 2: SNFs: Disclosure of Interest in Businesses Providing Services (AB 1953)

DOF Issue#: 4140-002-BCP-2019-GB

Budget Issue. OSHPD requests one position and expenditure authority from the California Health Data and Planning Fund of $369,000 in 2019-20 and $119,000 annually thereafter. If approved, these positions and resources would allow OSHPD to collect data and report on disclosures by skilled nursing facilities regarding ownership interests in related parties that provide services to the facility, pursuant to the requirements of AB 1953 (Wood), Chapter 383, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0143 – CA Health Data and Planning Fund	$369,000	$119,000
Total Funding Request:	**$369,000**	**$119,000**
Total Requested Positions:	**1.0**	**1.0**

* Positions and Resources ongoing after 2020-21.

This issue was heard during the subcommittee's February 28th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

4150 DEPARTMENT OF MANAGED HEALTH CARE

Issue 1: Division of Plan Surveys Workload

DOF Issue#: 4150-001-BCP-2019-GB

Budget Issue. DMHC requests four positions and expenditure authority from the Managed Care Fund of $2.1 million in 2019-20 and $2 million annually thereafter. If approved, these resources would allow DMHC to manage increased workload from a higher number of licensed health plans and increased expenditures from higher rates for clinical consultants.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0933 – Managed Care Fund	$2,077,000	$2,045,000
Total Funding Request:	**$2,077,000**	**$2,045,000**
Total Requested Positions:	**4.0**	**4.0**

* Positions and resources ongoing after 2020-21.

This issue was heard during the subcommittee's March 21st hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 2: Conversion of Blanket Positions to Permanent

DOF Issue#: 4150-002-BCP-2019-GB

Budget Issue. DMHC requests 16 positions funded by existing Managed Care Fund expenditure authority. If approved, these positions would allow DMHC to convert temporary help positions to permanent that more accurately reflect the department's current workload needs.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0933 – Managed Care Fund	$0	$0
Total Funding Request:	**0**	**$0**
Total Requested Positions:	**16.0**	**16.0**

* Positions ongoing after 2020-21.

This issue was heard during the subcommittee's March 21st hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 3: Health Care Service Plan Mergers and Acquisitions (AB 595)

DOF Issue#: 4150-003-BCP-2019-GB

Budget Issue. DMHC requests expenditure authority from the Managed Care Fund of $1 million annually. If approved, these positions would allow DMHC to analyze and assess the impact of mergers

and other transactions on subscribers, enrollees, provider networks, the overall stability of the health care delivery system, and anti-competitive impacts, pursuant to the requirements of AB 595 (Wood), Chapter 292, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0933 – Managed Care Fund	$1,031,000	$1,031,000
Total Funding Request:	**$1,031,000**	**$1,031,000**
Total Requested Positions:	**0.0**	**0.0**

* Resources ongoing after 2020-21.

This issue was heard during the subcommittee's March 21st hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 4: Pharmacy Benefit Management (AB 315)

DOF Issue#: 4150-300-BCP-2019-A1

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

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

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

This issue was heard during the subcommittee's May 2nd hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 5: Health Care Service Plan Disciplinary Actions (AB 2674)

DOF Issue#: 4150-301-BCP-2019-A1

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

Program Funding Request Summary

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

* Positions and resources ongoing after 2020-21.

This issue was heard during the subcommittee's May 2nd hearing.

Subcommittee Staff Comment and Recommendation—Approve.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Every Woman Counts Program Staffing

DOF Issue#: 4260-010-BCP-2019-GB

Budget Issue. DHCS requests conversion of one expiring, limited-term position to permanent and expenditure authority of $175,000 from the Breast Cancer Control Account annually. If approved, this position and resources would allow DHCS to continue ongoing data management, programming, and data analysis requirements for the Every Woman Counts program.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0009 – Breast Cancer Control Acct, Breast Cancer Fund	$175,000	$175,000
Total Funding Request:	**$175,000**	**$175,000**
Total Requested Positions:	**1.0**	**1.0**

* Position and Resources ongoing after 2020-21.

This issue was heard during the subcommittee's March 21st hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 2: Extension of Health Home Program Funding

DOF Issue#: Trailer Bill Language Proposal

Trailer Bill Language Proposal. DHCS requests the adoption of trailer bill language to extend the period of availability of funding for implementation of the Health Homes Program from June 30, 2020, to June 30, 2023. If approved, this language would allow DHCS to continue implementation and funding for the Health Homes Program, which began July 1, 2018.

This issue was heard during the subcommittee's March 21st hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 3: Medi-Cal Checkwrite Contingency Payments

DOF Issue#: Trailer Bill Language Proposal

Trailer Bill Language Proposal. DHCS requests adoption of trailer bill language to authorize contingency payments to Medi-Cal providers during periods of delay, non-functionality, or system errors in the Medi-Cal Checkwrite Schedule provider claims processing system. If approved, this statutory authority would allow DHCS to maintain continuity of access to Medi-Cal healthcare services for beneficiaries and payments to providers in the event of a disruption in the Medi-Cal Checkwrite service.

This issue was heard during the subcommittee's March 21st hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 4: Medi-Cal Drug Rebates Fund

DOF Issue#: Trailer Bill Language Proposal

Budget Issue and Trailer Bill Language Proposal. DHCS requests trailer bill language to establish the Medi-Cal Drug Rebate Fund to deposit the proceeds of rebates on prescription drugs purchased on behalf of Medi-Cal beneficiaries. If approved, DHCS estimates $1.4 billion would be deposited in the fund in 2019-20, which would offset General Fund expenditures in the Medi-Cal program.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20**
0001 – General Fund	$-	($1,440,526,000)
3331 – Medi-Cal Drug Rebate Fund*	$-	$1,440,526,000
Total Funding Request:	**$-**	**$-**

* Fund proposed to be created by trailer bill language.

This issue was heard during the subcommittee's March 21st hearing.

Subcommittee Staff Comment and Recommendation—Approve.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: Improving Vital Records Interoperability and Data Quality

DOF Issue#: 4265-003-BCP-2019-GB

Budget Issue. DPH requests three positions and expenditure authority from the Health Statistics Special Fund of $1.2 million in 2019-20 and 2020-21, $1.3 million in 2021-22 and 2022-23, $1.4 million in 2023-24, and $21,000 annually thereafter. If approved, these resources would allow DPH to renew and modify an agreement with the University of California, Davis for vital records system

enhancements and operations, and to shift activities performed by the University of California, Santa Barbara to department staff.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0099 – Health Statistics Special Fund	$1,223,000	$1,161,000
Total Funding Request:	**$1,223,000**	**$1,161,000**
Total Requested Positions:	**3.0**	**3.0**

* Additional fiscal year resources requested: 2021-22: $1,327,000; 2022-23: $1,308,000; 2023-24: $1,415,000; 2024-25 and ongoing: $21,000.

This issue was heard during the subcommittee's February 28th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 2: Gambling Disorder Training and Education Services

DOF Issue#: 4265-004-BCP-2019-GB

Budget Issue. DPH requests establishment of three positions funded by redirection of resources from the Indian Gaming Special Distribution Fund (IGSD) due to an expiring contract. If approved, these positions would allow DPH to conduct public outreach for gambling disorder prevention.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0367 – Indian Gaming Special Distribution Fund	[$451,000]	[$451,000]
Total Funding Request:	**[$451,000]**	**[$451,000]**
Total Requested Positions:	**3.0**	**3.0**

* Positions and Resources ongoing after 2020-21. (Note: funding is non-add and represents savings from expiring contract)

This issue was heard during the subcommittee's February 28th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 3: Childhood Lead Poisoning Prevention Program IT Project Implementation

DOF Issue#: 4265-005-BCP-2019-GB

Budget Issue. DPH requests eight positions and expenditure authority from the Childhood Lead Poisoning Prevention Fund of $8 million in 2019-20, $9.3 million in 2020-21, $5.9 million in 2021-22, and $3.4 million annually thereafter. If approved, these positions and resources would allow DPH to support the development and implementation of the Surveillance, Health, Intervention, and Environmental Lead Database (SHIELD) Information Technology Project.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***

0080 – Childhood Lead Poisoning Prevention Fund	$8,005,000	$9,285,000
Total Funding Request:	**$8,005,000**	**$9,285,000**
Total Requested Positions:	**8.0**	**8.0**

* Additional fiscal year resources requested: 2021-22: $5,948,000; 2022-23 and ongoing: $3,376,000.

This issue was heard during the subcommittee's February 28th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 4: Oral Health Program Additional Positions

DOF Issue#: 4265-009-BCP-2019-GB

Budget Issue. DPH requests establishment of seven positions funded by Proposition 56 tobacco tax revenue allocated to the Oral Health Program. If approve, these positions would allow DPH to continue implementation of the California Oral Health Plan.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3307 – Proposition 56 – State Dental Program Account	$-	$-
Total Funding Request:	**$-**	**$-**
Total Requested Positions:	**7.0**	**7.0**

* Positions ongoing after 2020-21.

This issue was heard during the subcommittee's February 28th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 5: Newborn Screening Program Implementation of Spinal Muscular Atrophy Screening

DOF Issue#: 4265-011-BCP-2019-GB

Budget Issue. DPH requests 5.8 positions and expenditure authority from the Genetic Disease Testing Fund (GDTF) of $4.3 million ($907,000 state operations and $3.4 million local assistance) in 2019-20, and eight positions and expenditure authority from the GDTF of $2.6 million ($1.2 million state operations and $1.4 million local assistance) annually thereafter. If approved, these resources would allow DPH to comply with expanded testing requirements for spinal muscular atrophy (SMA), pursuant to the requirements of SB 1095 (Pan), Chapter 363, Statutes of 2016.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0203 – Genetic Disease Testing Fund		
State Operations:	$907,000	$1,232,000
Local Assistance**:	[$3,400,000]	[$1,400,000]
Total Funding Request:	**$907,000**	**$1,232,000**
Total Requested Positions:	**5.8**	**8.0**

* Positions and Resources ongoing after 2020-21.
** Local Assistance expenditures are non-add and are reflected in the GDSP Local Assistance Estimate.

This issue was heard during the subcommittee's February 28th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 6: Childhood Lead Poisoning Prevention Program Reporting (SB 1097 and SB 1041)

DOF Issue#: 4265-014-BCP-2019-GB

Budget Issue. DPH requests six positions and expenditure authority from the Childhood Lead Poisoning Prevention Fund of $769,000 annually. If approved, these positions and resources would allow DPH to carry out blood lead screening data collection, analysis, and reporting pursuant to the requirements of SB 1097 (Hueso), Chapter 691, Statutes of 2018, and SB 1041 (Leyva), Chapter 690, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0080 – Childhood Lead Poisoning Prevention Fund	$769,000	$769,000
Total Funding Request:	**$769,000**	**$769,000**
Total Requested Positions:	**6.0**	**6.0**

* Positions and resources ongoing after 2020-21.

This issue was heard during the subcommittee's February 28th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 7: L&C - Creation of a Centralized Program Flex Unit

DOF Issue#: 4265-001-BCP-2019-GB

Budget Issue. DPH requests six positions and expenditure authority from the Licensing and Certification Program Fund of $973,000 annually. If approved, these positions and resources would allow DPH to shift health facility program flexibility application workload from district offices to a new centralized headquarters unit.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3098 – Licensing and Certification Program Fund	$973,000	$973,000
Total Funding Request:	**$973,000**	**$973,000**
Total Positions Requested:	**6.0**	**6.0**

* Positions and resources ongoing after 2020-21.

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 8: L&C - Increased IT Customer Support

DOF Issue#: 4265-002-BCP-2019-GB

Budget Issue. DPH requests six positions and expenditure authority from the Licensing and Certification Program Fund of $911,000 annually. If approved, these positions and resources would allow DPH to increase information technology services associated with a new federally required health facility survey automation system.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3098 – Licensing and Certification Program Fund	$911,000	$911,000
Total Funding Request:	**$911,000**	**$911,000**
Total Positions Requested:	**6.0**	**6.0**

* Positions and resources ongoing after 2020-21.

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 9: Infant Botulism Treatment and Prevention Program Compliance Costs for BabyBIG

DOF Issue#: 4265-008-BCP-2019-GB

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 10: Online and Distance-Learning Nurse Assistant Training Programs (AB 2850)

DOF Issue#: 4265-015-BCP-2019-GB

Budget Issue. DPH requests nine positions and expenditure authority from the Licensing and Certification Program Fund of $1.2 million annually. If approved, these positions and resources would allow DPH to review, approve, and monitor applications from new online and distance learning nurse assistant training programs and instructors, pursuant to the provisions of AB 2850 (Rubio), Chapter 769, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3098 – Licensing and Certification Program Fund	$1,243,000	$1,243,000
Total Funding Request:	**$1,243,000**	**$1,243,000**
Total Positions Requested:	**9.0**	**9.0**

* Positions and resources ongoing after 2020-21.

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 11: Timelines for Hospital Licensing Applications (AB 2798)

DOF Issue#: 4265-016-BCP-2019-GB

Budget Issue and Trailer Bill Language. DPH requests 21 positions and expenditure authority from the Licensing and Certification Program Fund of $3.4 million annually. If approved, these positions and resources would allow DPH to comply with new health facility licensing application processing timelines, pursuant to the requirements of AB 2798 (Maienschein), Chapter 922, Statutes of 2018. DPH also requests trailer bill language to amend a provision of AB 2798 to allow the Licensing and Certification Program Fund to support the required workload.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3098 – Licensing and Certification Program Fund	$3,386,000	$3,386,000
Total Funding Request:	**$3,386,000**	**$3,386,000**
Total Positions Requested:	**21.0**	**21.0**

* Positions and resources ongoing after 2020-21.

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 12: Increased Drinking Water Laboratory Services

DOF Issue#: 4265-006-BCP-2019-GB

Governor's Proposal. The Governor's budget proposes $837,000 in 2019-20 and $782,000 annually thereafter from the Safe Drinking Water Account to fund four positions and laboratory equipment under an interagency agreement between the State Water Resources Control Board and the California Department of Public Health to meet the primacy agreement with the United States Environmental Protection Agency and, in support of those activities, meet new laboratory standards.

This issue was heard in Budget Subcommittee #2 on March 21st and approved as budgeted.

Subcommittee Staff Comment and Recommendation—Approve (Conforming Action).

Issue 13: Soliciting and Implementation of Projects to Benefit Nursing Home Residents

DOF Issue#: 4265-302-BCP-2019-A1

Spring Finance Letter and Budget Bill Language. DPH requests one position and expenditure authority from the Federal Health Facilities Citation Penalties Account of $680,000 in 2019-20,

$431,000 in 2020-21, and $149,000 annually thereafter. If approved, this position and resources would allow DPH to implement a federally approved Nurse Leadership project and solicit future projects to benefit skilled nursing facility residents. In addition, DPH requests budget bill language to augment expenditure authority from the Federal Health Facilities Citation Penalties Account upon federal approval of project planning funded by the account and after legislative notification.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0942 – Special Deposit Fund**	$680,000	$431,000
Total Funding Request:	**$680,000**	**$431,000**
Total Positions Requested:	**1.0**	**1.0**

* Additional fiscal year resources requested: 2021-22 and ongoing: $149,000.
** Special Deposit Fund - Federal Health Facilities Citation Penalties Account

Provisional Language to Augment Expenditure Authority Upon Federal Approval. DPH also requests budget bill language to augment expenditure authority from the Federal Health Facilities Citation Penalties Account upon federal approval of project planning funded by the account and after legislative notification. According to DPH, CMS recently released guidance requesting states to obtain sufficient expenditure authority to timely and efficiently expend federal penalty funds. Without sufficient expenditure authority, projects may be delayed by up to one year and such delays may discourage entities from submitting project applications. The requested budget bill language is as follows:

Item 4265-115-0942

1. The Department of Finance may augment this item, after review of a request submitted by the State Department of Public Health reflecting federal approval to use this account. Any augmentation shall be authorized not sooner than 30 days after notification in writing to the Chairperson of the Joint Legislative Budget Committee, or not 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 25th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 14: Public Health Crisis Response Grant

DOF Issue#: Budget Bill Language Proposal

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

1. Notwithstanding any other law, the Department of Finance may augment this item in excess of the amount appropriated upon notice by the State Department of Public Health that additional funds are available funds pursuant to a United States Department of Health and Human Services, Centers for Disease Control and Prevention Cooperative Agreement for Emergency Response: Public Health Crisis Response grant. Within 10 working days of authorizing that 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 law, the Department of Finance may augment this item in excess of the amount appropriated upon notice by the State Department of Public Health that additional funds are available funds pursuant to a United States Department of Health and Human Services, Centers for Disease Control and Prevention Cooperative Agreement for Emergency Response: Public Health Crisis Response grant. Within 10 working days of authorizing that 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 25th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Transition Staff from Temporary to Permanent

DOF Issue#: 4560-002-BCP-2019-GB

Budget Issue. MHSOAC requests one position funded by existing expenditure authority from the Mental Health Services Fund. If approved, this position authority would transition a temporary help position to permanent status.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3085 – Mental Health Services Fund	$-	$-
Total Funding Request:	**$-**	**$-**
Total Requested Positions:	**1.0**	**1.0**

* Position ongoing after 2020-21.

This issue was heard during the subcommittee's April 4th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 2: Innovation Incubator Implementation

DOF Issue#: 4560-300-BCP-2019-A1

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

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

This issue was heard during the subcommittee's May 2nd hearing.

Subcommittee Staff Comment and Recommendation—Approve.

5175 DEPARTMENT OF CHILD SUPPORT SERVICES

Issue 1: TBL – Improved Performance Incentives

Governor's Proposal. The Governor's budget includes trailer bill language that would suspend Family Code Section 17706 until 2021-2022. The statute provides performance incentives to the top ten performing LCSAs. The General Fund would fund these incentives. As the top ten performing counties fluctuate from year to year, the annual General Fund impact is uncertain but could be as high as $6 million without this suspension.

This issue was heard during the subcommittee's March 28th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 2: TBL – Federal Deficit Reduction Act (FDRA) Mandatory Fee Increase

Governor's Proposal. The Governor's budget includes trailer bill language that would raise the administrative services fee on a never-assisted custodial party receiving services from the child support program for order establishment, enforcement, and collection services provided. The first automated assessment of the increased fee would be October 1, 2020, resulting in an estimated additional $1.6 million in assessed fees.

This issue was heard during the subcommittee's March 28th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: TBL – Statewide Fingerprinting Imaging System (SFIS) Technical Clean-up

Governor's Proposal. The Governor's budget includes trailer bill language (TBL) to remove obsolete references to a now defunct fingerprint imaging system, and instead reference identity verification requirements.

This issue was heard during the subcommittee's March 28th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 2: BCP – Reducing Law Enforcement Contacts in Children's Residential Facilities

Governor's Proposal. The Governor's budget includes $341,000 Technical Assistance Fund for three two-year limited-term positions to strengthen the Department's effort to curb the usage of law enforcement in the management of behaviors for youth placed in residential facilities.

This issue was heard during the subcommittee's April 4th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 3: TBL - California Newcomer Education & Well-Being Project (CalNEW)

Governor's Proposal. The Governor's budget includes trailer bill language to eliminate administrative barriers for school districts by clarifying the state's intention to provide funding for school programs for refugees and other populations currently served by the Office of Refugee Resettlement, including unaccompanied undocumented minors (UUM).

This issue was heard during the subcommittee's April 11th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 4: BCP – CalFresh Employment and Training Program

Governor's Proposal. The Governor's budget includes $928,000 federal funds in 2019-20, and $820,000 federal funds every year thereafter, to form a new Employment and Training (E&T) unit with six new permanent positions.

This issue was heard during the subcommittee's April 11th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 5: TBL – Application Fee Reimbursement for Child Care Providers in the Emergency Child Care Bridge Program

Governor's Proposal. The Governor's budget proposes language to allow for the reimbursement of the fees associated with registering as a Trustline child care provider in the Bridge Program. Currently, only license-exempt child care providers working with families in CalWORKs stages one, two, and three and Alternative Payment Programs can have their Trustline fees paid for at no cost to the provider. Total processing fees range from about $135 to $170.

This issue was heard during the subcommittee's April 11th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

Issue 6: TBL - Work Incentive Nutritional Supplement (WINS) Two-parent Population

Governor's Proposal. The Governor's budget includes trailer bill language to align state law with current practice and the budget in regards to the payment of the two-parent portion of WINS benefits.

This issue was heard during the subcommittee's April 11th hearing.

Subcommittee Staff Comment and Recommendation—Approve.

ISSUES FOR DISCUSSION

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: California Children's Services - Implementation of the Whole Child Model

Oversight Issue. The California Children's Services (CCS) program, established in 1927, is one of the oldest public health care programs in the nation. CCS is administered in partnership with county health departments and provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under 21 years of age 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. CCS-eligible children who are also eligible for Medi-Cal receive services related to the CCS-eligible condition through the CCS program and other health care services through Medi-Cal, typically through a managed care plan. The budget estimates Medi-Cal CCS caseload of 178,371 and state-only CCS caseload of 15,131 in 2019-20.

DHCS developed a multi-year framework, known as the Whole Child Model, to move incrementally toward a better integrated and coordinated system of care for CCS that builds on existing successful models and delivery systems. The approach is intended to assure maintenance of core CCS provider standards and network of pediatric specialty and subspecialty care providers by implementing a gradual change in CCS service delivery with an extended phase-in and stringent readiness and monitoring requirements that will ensure continuity of care and continued access to high-quality specialty care.

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. Services previously provided to CCS beneficiaries on a fee-for-service basis will be delivered by Medi-Cal managed care plans. DHCS will implement 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

Six COHS counties implemented the Whole Child Model on July 1, 2018. Partnership Health Plan, operating in 14 counties, implemented the Whole Child Model on January 1, 2019. CalOptima, operating in Orange County, is scheduled to implement the Whole Child Model no sooner than July 1, 2019. The budget includes $28.5 million ($12.8 million General Fund and $15.7 million federal funds) in 2018-19 and $791,000 ($365,000 General Fund and $426,000 federal funds) in 2019-20 for implementation of the Whole Child Model.

SB 586 requires DHCS to contract with an independent entity to conduct an evaluation to assess Medi-Cal managed care plan performance and the outcomes and experience of CCS-eligible children and youth participating in the Whole Child Model program. The evaluation is required to: (1) compare plan performance to performance of the CCS program prior to implementation in each county; (2) compare plan performance in participating counties to CCS program performance in non-participating counties; and (3) evaluate whether inclusion of CCS services in managed care improves access, quality, and the patient experience. The evaluation must also, when possible, disaggregate results based on the child's or youth's race, ethnicity, and primary language spoken at home. The evaluation must evaluate the following within counties compared to the CCS program prior to implementation of the Whole Child Model:

1. Access to specialty and primary care, and utilization of CCS-paneled providers.
2. Type and location of CCS services and the extent to which CCS services are provided in-network compared to out of network.
3. Utilization rates of inpatient admissions, outpatient services, durable medical equipment, behavioral health services, home health, pharmacy, and other ancillary services.
4. Patient and family satisfaction.
5. Appeals and grievances, including requests to extend continuity of care, appeals, and the results of those appeals.
6. Authorization of CCS-eligible services.
7. Network and provider participation, including participation of pediatricians, pediatric specialists, and pediatric subspecialists.
8. The ability of a child or youth who ages out of CCS and remains in the same Medi-Cal managed care plan to retain existing providers.

The evaluation must also evaluate the following compared to CCS programs in non-participating counties:

1. The rate of new CCS enrollment in each county.
2. The percentage of CCS-eligible children and youth with a diagnosis requiring a referral to a CCS special care center who have been seen by a CCS special care center.
3. The percentage of CCS children and youth discharged from a hospital who had at least one followup contact or visit within 28 days after discharge.
4. Appeals and grivevances.

The evaluation is required to be submitted to the Legislature by January 1, 2021, or three years from the date when all counties are fully operational, whichever is later. Assuming CalOptima implements the Whole Child Model as scheduled on July 1, 2019, the evaluation would be required to be provided to the Legislature by July 1, 2022.

According to DHCS, the University of California, San Francisco, has been selected to conduct the evaluation. The department plans to receive feedback and make any necessary revisions for the evaluation design and scope of work in April 2019, finalize the evaluation design and scope of work in May through June 2019, and execute the contract on July 1, 2019. DHCS expects to report on progress of the evaluation, instrument development, and data collection in December 2019; progress of evaluation, preliminary results and data collection in June 2020, preliminary results from phase 1 and phase 2 counties in January 2021; final results from all counties in June 2021. The department's

evaluation instruments include CCS authorized and non-authorized claims datasets, managed care encounters, appeals and grievances, qualitative interviews of families in the Whole Child Model, and telephone surveys of families in the Whole Child Model.

Stakeholders have raised several concerns about the department's scope of work for the evaluation. In particular, stakeholders note the scope of work lacks specificity on certain requirements included in the statutory requirements for the evaluation, particularly the utilization of durable medical equipment, pharmacy, and home health services. Stakeholders are also concerned about the reliance on surveys for data collection, particularly in instances when more reliable data could be obtained from patient records, claims and encounter data. In addition, stakeholders note the department's timeline for final evaluation results is one year prior to the required timeline outlined in statute of July 1, 2022.

In addition to concerns about the evaluation, stakeholders have raised concerns about the availability of certain services in the Whole Child Model that were received in the CCS program prior to implementation. In particular, stakeholders are concerned about some plans' willingness to provide appropriate case management services. Previously, a public health nurse would review medical reports on an ongoing basis and direct referrals when needed, while a case management team would coordinate making the appointments and arranging for the family to attend. Stakeholders report some plans have identified the child's primary care provider as the provider of case management services, and that these providers may not be qualified to provide these services at the same level as the previous CCS programs. The lack of equivalent case management services may also be responsible for an increase in lapsed Medi-Cal enrollment. Previous case management staff would help families navigate issues with lapsed Medi-Cal enrollment, particularly for paperwork related issues, to avoid loss of services. In addition, stakeholders have raised concerns about counties not receiving timely medical documentation from plans, and children not being able to access the full maintenance and transportation benefit required under CCS.

Discussion Panel. The subcommittee has requested the following panelists to discuss the implementation of the Whole Child Model:

- **Jennifer Kent,** Director, Department of Health Care Services
- **Maya Altman,** Chief Executive Officer, Health Plan of San Mateo
- **Mira Morton,** Director of Government Relations, California Children's Hospital Association
- **Ali Barclay**, Outreach Education Manager, Whole Child Model Project, Family Voices of California
- **Erin Kelly,** Executive Director, Children's Specialty Care Coalition

Subcommittee Staff Comment. This is an informational item.

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

1. DHCS: Please provide a brief update of implementation of the Whole Child Model.

2. DHCS: Please describe the current status of the evaluation design for the Whole Child Model. Why is the final timeline only two years after the planned implementation of Orange County, when the statute calls for three years?

3. DHCS/Plans: Please describe the availability of case management services in Whole Child Model counties including which providers deliver these services and how they are provided.

4. DHCS/Plans: How do Whole Child Model plans manage lapses in Medi-Cal eligibility? Is there any outreach to ensure the lapse is not due to paperwork or other non-eligibility issues and attempt to maintain continuity of enrollment and availability of services?

5. DHCS/Plans: Please describe the availability of the CCS covered maintenance and transportation benefits. What services are plans covering for Whole Child Model beneficiaries?

6. CCHA: Please describe your member hospitals' experience with implementation of the Whole Child Model and any concerns that have been raised.

7. Family Voices of CA: Please describe what your organization has heard from families participating in the Whole Child model regarding their child's experience and any concerns that have been raised.

8. CSCC: Please describe what your organization has heard from practitioners participating in the Whole Child model and any concerns that have been raised.

9. DHCS/Plans/CCHA/Family Voices/CSCC: Please describe what metrics are the most important measures of whether the Whole Child Model is ultimately successful in its goal of improving the coordinated delivery of primary and specialty care for CCS-eligible children.

4170 DEPARTMENT OF AGING

Issue 1: Spring Finance Letter (SFL) – SSI Cash-out Reversal Implementation via Area Agencies on Aging (AAA)

Budget Issue. The California Department of Aging (CDA) requests reimbursement authority of $1.7 million to implement the SSI Cash-out Reversal, or the CalFresh expansion, via the AAAs. $200,000 will fund departmental operations, and $1.5 million will be distributed to the AAAs for CalFresh application assistance and outreach.

Background. The "SSI Cash-out" is a state policy that provides Supplemental Security Income/State Supplementary Payment (SSI/SSP) recipients with an extra $10 payment in lieu of their being eligible to receive federal food benefits through the CalFresh program. AB 1811 (Committee on Budget), Chapter 35, Statutes of 2018, ended this policy. This expansion of benefits is effective beginning June 1, 2019. It is estimated that the policy change will increase the CalFresh caseload by approximately 370,000 new households, or 20 percent.

The Department of Social Services (DSS) is responsible for oversight and implementation of the CalFresh program. However, the AAAs were identified as organizations likely to reach the potential new recipients of CalFresh. CDA delivers many programs through contracts with the state's 33 local AAA. At the local level, AAA contract for and coordinate community-based services to older adults, adults with disabilities, family caregivers, and residents of long-term care facilities. Thus, CDA and the AAAs have contracted to work with DSS on outreach and application assistance for this CalFresh expansion.

The AAAs will disseminate outreach materials, designate application assisters to help with the application process, and report to CDA on application outcomes. All 33 AAAs will receive funding for outreach, however the department is still working to determine which AAAs will receive application assistance funding. CDA estimates that 221,365 of older adults will be newly eligible for CalFresh, and expects to reach close to 155,000, or 70 percent, of those adults with their outreach materials. Out of the newly eligible population, CDA expects 55,341 will receive application assistance. The department would provide oversight of the AAAs, including technical assistance and training, as well as provide outcomes reporting.

Staff Comment and Recommendation. Approve as proposed.

Questions.

1. Please provide an overview of the proposal.

Issue 2: SFL – Federal Title III Funding Augmentation

Budget Issue. CDA requests federal fund authority of $17.5 million and seven positions due to an increase in federal Title III funding. $897,000 will be used for operations, and $16.6 million will be for local assistance.

Background. Title III funding supports the department's Congregate Nutrition and Home Delivered Nutrition Programs, supportive services, disease prevention, family caregiver programs, and the state Long-Term Care Ombudsman (LTCO). Title III federal funding increased beginning in federal fiscal year (FFY) 2018 and continued in FFY 2019. The table below provides further detail on how the funding was distributed amongst the Title III programs.

Current Year 2018-19 Title III/VII/NSIP Increases by Program	
Programs	Federal Fiscal Year- Grant 18 (October 1, 2017- September 30, 2018)
Title IIIB Supportive Services	$4.6 million
Title IIIB Ombudsman	$0
Title VII Ombudsman	$115,644
Title IIIC1 Congregate Nutrition	$4.4 million
Title IIIC2 Home Delivered Nutrition	$4.7 million
Title IIID Disease Prevention	$522,707
Title IIIE Family Caregiver	$3.1 million
TOTAL, All Programs	**$17.5 million**

The seven requested positions will provide oversight and regulatory guidance, ensure AAAs receive payments on time, conduct required program audits in a timely manner, ensure compliance with federal and state laws and provide curriculum for LTCO trainings. Specifically, the requested positions are:

- **Three Aging Program Analyst II positions.** The three analyst positions would provide support for the LTCO program and the Family Caregiver Support program. One analyst would help in establishing training for certification and continuing education for Ombudsman representatives. The other two positions would ensure compliance with federal requirements and provide technical assistance and oversight within the Family Caregiver Support Program.
- **One Staff Services Manager (SSM) I position.** The SSM would be responsible for grant writing and management, as well as representing CDA on interagency workgroups.

- **One Accountant Trainee position.** The Accountant Trainee would be responsible for expenditure recording and payment processing to provide AAAs with payments within 30 days.

- **One General Auditor II position.** The addition of this position will allow CDA to increase the number of AAAs it audits per year from 11 to 16. This would ensure that each AAA is audited every two years.

- **One Information Technology (IT) Specialist I position.** The IT specialist would update critical data tracking systems and ensure effective management of data due to increased Title III funding.

Staff Comment and Recommendation. Approve as proposed.

Questions.

1. Please provide a brief overview of the proposal.

Issue 3: SFL - Medicare Improvements for Patients and Providers Act (MIPPA) Authority

Budget Issue. CDA requests to revise budget bill language in Item 4170-101-0890 to allow for augmentation of the MIPPA federal grant authority. Specific amendments are proposed in the following language:

"Notwithstanding subdivision (e) of Section 28.00, the Department of Finance, upon notification by the California Department of Aging, may authorize augmentations in this item for federal Title Ill, Title VII, HICAP, and MIPPA one-time only allocations, and for unexpended 2018-19 federal grant funds. The Department of Finance shall provide notification of the augmentation to the Joint Legislative Budget Committee within 10 working days from the date of the Department of Finance approval of the adjustment."

Background. CDA receives the MIPPA grant from the federal Administration for Community Living (ACL). This grant enhances state efforts to provide assistance to Medicare beneficiaries. MIPPA emphasizes intensified outreach activities to beneficiaries likely to be eligible for the low income subsidy or the Medicare Savings program, and assisting those beneficiaries in applying for benefits. CDA has administered this grant through local AAAs since 2008. In 2008, the grant was categorized as a demonstration award, but has since been categorized as mandatory. ACL has also indicated that the funding will be ongoing. Because of this change, CDA is requesting a revision to the budget bill language.

Staff Comment and Recommendation. Approve as proposed.

Questions.

1. Please provide an overview of the proposal.

Issue 4: Proposals for Investment

The Subcommittee has received the following proposals for investment.

1. Increased Support for the "No Wrong Door" Model

Budget Issue. The California Association of Area Agencies on Aging and the California Foundation for Independent Living Centers request $5 million ongoing funding to expand the use of the "No Wrong Door" model within the Aging and Disability Resource Centers (ADRCs) throughout the state. ADRCs help navigate the long-term services and supports system by using the "No Wrong Door" model, in which people are connected to services within their communities, regardless of income level or other program criteria. The planning process for applying for ADRC designation can take six months or longer, and it is difficult for Area Agencies on Aging (AAAs) or Independent Living Centers (ILCs) to dedicate their limited staff and resources to this task when their clientele have many unmet needs. The requested funding would provide additional resources for AAAs and ILCs seeking ADRC designation to complete the lengthy application process and provide existing ADRCs with resources to better serve their communities.

Staff Comment and Recommendation. Hold open.

2. Dignity at Home Fall Prevention Program

Budget Issue. Multiple advocacy organizations, including the California Senior Legislature and the MS Society, request $5 million for the CDA to fund a program to help older adults and others at risk of falling make home modifications and take steps to reduce the risk of falls in the home. For older adults and those with disabilities, the risk of fall is very real and can have long-lasting repercussions. For many, the difference between aging in place at home and institutionalization may be simple home modifications to prevent falls and ease access. The program would provide funding for injury prevention equipment, activities, and labor costs. Additionally, the program would encourage AAAs to partner with local public and private agencies with experience in injury prevention in the provision of these services. Services would be provided based on determination of need.

Staff Comment and Recommendation. Hold open.

3. Master Plan for Aging

Budget Issue. Multiple advocacy organizations, including the Ventura County AAA and the California Collaborative, request $1 million for the support of a Master Plan for Aging to assist the state in addressing coordination challenges around programming and services for seniors and those with disabilities. Proponents state that despite the programs and services administered by the range of state departments, families struggle to weave together services and finance care in the hopes of helping loved ones remain at home. The Master Plan would create a framework to empower all Californians to age with dignity, choice, and independence.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES (DSS)

Issue 1: SFL/BCP - Increased Inspections of Child Care Centers and Family Care Homes

Budget Issue. The department requests Item 5180-001-0001 be increased by 138 positions to increase the frequency of inspections of childcare centers and family care homes. The 2018 Budget Act included $26.4 million federal Child Care and Development Block Grant (CCDBG) funds to increase inspections of these facilities from every three years to annually. These positions will allow the Department of Social Services (DSS) to achieve annual inspections beginning in fiscal year 2020-21.

Background. The California Department of Education (CDE) is the lead agency for the CCDBG. CDE provides approximately $8 million in CCDBG funding to DSS annually to support inspections of childcare centers. The 2018 budget provided an additional $26.4 million one-time funding to increase inspection frequency and work towards achieving the CCDBG requirement of annual inspections for childcare facilities. The funding was provided through an interagency agreement between CDE and DSS, as DSS is the entity responsible for inspections and oversight of childcare facilities.

The Child Care Program within DSS has 235 licensing program analysts to support the current three-year inspection frequency. The requested positions will help the department reach the goal of annual inspections. If approved, hiring will be phased in. 128 positions will be hired in 2019-20, and the remaining 69 will be hired in 2020-21.

The table below shows the classification and number of requested positions by DSS division.

Division	Classification	Number
Community Care Licensing Division – Child Care Program Field and Office	Licensing Program Analyst (LPA)	106
	Licensing Program Manager (LPM) I	18
	LPM II	5
	LPM III	1
	Office Technician	30
	Office Assistant	2
	Office Services Supervisor II	1
	Staff Services Manager (SSM) II	1
	SSM II	1
	Associate Government Program Analyst (AGPA)/Staff Services Analyst	14
Legal Division	Attorney III	8
	Senior Legal Analyst	4
	Legal Secretary	3
	AGPA	1
Information Services Division	Informational Technology Specialist I	6
Administration Division	Personnel Specialist	3
	Accountant I	3
Total Positions		207

Staff Comment and Recommendation. Approve as proposed.

Questions.

1. Please provide an overview of the proposal.

Issue 2: SFL – Fiscal Monitoring and Oversight of County Operations

Budget Issue. The department requests $694,000 ($272,000 General Fund; $384,000 federal funds; and $38,000 reimbursements) to support five permanent positions to establish a Fiscal Monitoring Unit within the department.

Background. Previously, DSS had a dedicated field monitoring unit to perform required fiscal oversight for federal funding. The unit was responsible for monitoring county adherence to federal and state policies and supported the maximization of federal financial participation. The unit staffing was reduced due to budget reductions during the 1990s and eliminated by 1998. Since that time, CDSS has used temporary staff redirections and desk audits to provide review, but has still received multiple audit findings regarding the lack of fiscal monitoring. Multiple audits by the federal government have found the department to be out of compliance. The state's federal fiscal year 2019 budget plan was approved by the federal government contingent on the department meeting regulatory requirements for sufficient oversight and monitoring of specific programs.

The department believes the requested positions will bring its programs up to the minimum level of review acceptable by federal oversight agencies. The increased staffing will increase review capacity for all major DSS programs from four to six counties each fiscal year, and ensure all counties are reviewed every ten years. Specifically, the department requests:

- **Four Associate Governmental Program Analysts (AGPAs)/Staff Services Analysts (SSAs).**
- **One Staff Services Manager I.**

Staff Comment and Recommendation. Approve as proposed.

Questions.

1. Please provide an overview of the proposal.

Issue 3: SFL/BCP – Housing and Homelessness Programs

Budget Issue. The department requests a total of $590,000 ($297,000 General Fund and $293,000 federal funds) to support three permanent positions and one two-year limited-term positions to administer various housing support programs and analyze outcomes.

Background. The department currently administers several housing and/or homelessness programs. These programs include the Home Safe Program, the Bringing Families Home program, the CalWORKs Housing Support Program, and the Housing and Disability Advocacy (HDAP) program. The Home Safe Program provides housing supports to those experiencing homelessness or at risk of experiencing homelessness in the Adult Protective Services system. The Bringing Families Home program provides housing supports to homeless child welfare-involved families. The CalWORKs Housing Support program provides housing supports to homeless CalWORKs families using evidence based models. The HDAP assists homeless, disabled individuals apply for disability benefit programs and provides housing supports. In 2018-19, the department implemented and expanded several different housing programs with total funds equaling $202 million. Currently, the department has nine positions within the unit that administers these programs. The requested additional resources would aid the department in performing more in-depth analysis of county expenditures and ensure resources are adequately allocated.

Specifically, the department requests:

- **Two Associate Governmental Program Analysts (AGPAs).** One AGPA position would be permanent and the other would be a two-year limited-term position. The permanent position would provide support for the CalWORKs Housing Support program by interfacing with counties, reviewing and assessing proposals, and responding to client or public inquiries, among other duties. The limited-term AGPA would provide similar duties to support the temporary Home Safe program.

- **One Research Data Analyst (RDA) II.** The RDA would provide data analysis for the department's housing and homelessness programs. Duties include devising a data collection methodology, leading a workgroup to define and refine data elements, and analyzing data reports.

  One Staff Services Manager I. The department is requesting a manger position to comply with staffing ratios and supervise the additional positions.

Staff Comment and Recommendation. Approve as proposed.

Questions.

1. Please provide an overview of the proposal.

Issue 4: Proposals for Investment

The Subcommittee has received the following proposals for investment.

1. Increased Funding for Immigration Emergencies

Budget Issue. Jewish Family Service requests $5 million for immigration emergencies and humanitarian rapid response. The additional funding will supplement necessary medical services and personnel that play a critical role in providing daily medical screening for arriving migrants and asylum-seekers. The Jewish Family Service of San Diego providers shelter operations, case management, legal services, education, and outreach through a contract with the Department of Social Services.

Staff Comment and Recommendation. Hold open. Note that the Governor's budget proposes $20 million for immigration emergencies. This request would be in addition to what is proposed in the Governor's budget.

2. Foster Youth Enrichment Pilot Program

Budget Issue. Multiple advocacy organizations, including the Youth Law Center, request $12.5 million General Fund for the Foster Youth Enrichment Pilot Program. The program would provide grants of $500 or less to foster youth to participate in enrichment activities that enhance the youth's skills, abilities, self-esteem, and overall well-being. Proponents state that extracurricular and enrichment activities have been proven to have a positive impact on a young person's academic achievement, self-esteem, and behavior. Yet, many foster youth face barriers to participate in these activities.

Staff Comment and Recommendation. Hold open.

3. Transitional Housing Placement (THP)-Plus Program

Budget Issue. John Burton Advocates for Youth, along with many other organizations, request a $5 million augmentation for the THP-Plus program, as well as an expansion of eligibility for youth who were in foster care at age 16. THP-Plus is a supportive housing program that provides up to 34 months of affordable housing and support services to former foster youth between the ages of 18 and 24. In 2017-18, the program assisted 1,946 youth and 498 of their minor children. The additional requested funding would allow the program to assist an estimated additional 173 youth and an estimated 73 minor children.

Staff Comment and Recommendation. Hold open.

4. California Peer-Run Warm Line

Budget Issue. The San Francisco Peer Run Warm Line requests $3.6 million to implement a 24-hour line to serve the entire state. The Warm Line is a phone and instant messaging-based service that provides information, referrals, and emotional support to callers. Their mission is to offer accessible, relevant, non-judgmental peer support to anyone who reaches out to them. The line had

operated statewide 24 hours a day from August 2014 to June 2018, when funding was cut. Due to these funding changes, the line currently serves nine Bay Area counties on a limited basis of 36 hours per week.

Staff Comment and Recommendation. Hold open.

5. OpenHouse and Shanti Project

Budget Issue. OpenHouse and Shanti Project request $500,000 to support their work serving the expanding aging LGBTQ population. Both organizations provide specific support to LGBTQ seniors through one-on-one volunteers, peer support, and navigation of the health and social service system. The requested funding would provide an additional 300 seniors to receive these services. The funding would facilitate early interventions to LGBTQ seniors at high risk for depression, isolation, and suicidal ideation using care navigation, emotional and practical support, and support programming.

Staff Comment and Recommendation. Hold open.

6. Offices of Youth Development and Diversion

Budget Issue. A coalition of organizations, including the National Center for Youth Law and the Youth Justice Coalition, request $10 million to fund the development of a three-year pilot program for Office of Youth Development and Diversion (OYDD) in up to five counties throughout the state. In California, the law permits police officers to divert youth away from formal juvenile court processing for most crimes, but the majority of counties have no infrastructure to do so. The requested funding would finance local pilot OYDD under counties. Each grant would be no less than $2 million and each participating county would be required to provide at least a 25 percent match of funds, with an exception of at least a ten percent match for counties that have a high need and little to no local infrastructure for the program.

Staff Comment and Recommendation. Hold open.

7. Increased Funding for Non-Medical Out of Home Care (NMOHC)

Budget Issue. The Steinberg Institute requests additional funding for rates paid to providers serving low-income residents in Adult Residential Facilities (ARFs) and Residential Care Facilities for the Elderly (RCFEs). ARFs and RFCEs provide support and care services for adults of all ages suffering from severe mental illness or cognitive impairment. The state sets the rate for low-income residents living in ARFs or RCFEs at $1,058 per month. Proponents request a temporary increase in the NMOHC rate to $2,586 per month, while the Legislature determines a permanent solution. The current rate is intended to cover room and board as well as the facility's insurance, workers' comp insurance, staff wages, license fees, and other costs associated with running a safe residence. Facilities cannot charge residents anything beyond this. Consequently, many facilities refuse to accept low-income clients who could thrive in an ARF or RCFE facility because they cannot sustain themselves financially with only $1,058 a month.

Staff Comment and Recommendation. Hold open.

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES

Issue 1: Vendor Rate Study

Background. The Department of Developmental Services (DDS) provides a variety of services to more than 330,000 children and adults. Home and community-based services (HCBS) are primarily delivered through 21 nonprofit Regional Centers (RCs) that, in turn, contract with several thousand nonprofit and for-profit service providers.

The state's system for establishing payment rates for the services delivered by these providers is complex, encompassing several different methodologies depending on the service provided. Rates are often inconsistent, with providers delivering the same service in the same area being paid different rates. Further, between 2003 and 2015, these payment rates were subject to various reductions, freezes, and other constraints, particularly during economic downturns. In response to concerns raised by service providers, RCs, and consumers, the Legislature required the department to conduct a study of provider payment rates.

Pursuant to Welfare and Institutions Code (W&IC) Section 4519.8, the DDS was required to submit a rate study addressing the sustainability, quality, and transparency of community-based services for individuals with developmental disabilities to the Legislature. The Legislature approved $3 million General Fund for the study, and DDS contracted with Burns & Associates (B&A), Inc. to conduct the study. The study was submitted to the Legislature on March 15, 2019.

W&IC Section 4519.8

On or before March 1, 2019, the Department shall submit a rate study to the appropriate fiscal and policy committees of the Legislature, addressing the sustainability, quality, and transparency of community-based services for individuals with developmental disabilities. The Department shall consult with stakeholders, through the developmental services task force process, in developing the study. The study shall include, but not be limited to, all of the following:

(a) An assessment of the effectiveness of the methods used to pay each category of community service provider. This assessment shall include consideration of the following factors for each category of service provider:

(1) Whether the current method of rate-setting for a service category provides an adequate supply of providers in that category, including, but not limited to, whether there is a sufficient supply of providers to enable consumers throughout the state to have a choice of providers, depending upon the nature of the service.

(2) A comparison of the estimated fiscal effects of alternative rate methodologies for each service provider category.

(3) How different rate methodologies can incentivize outcomes for consumers.

(b) An evaluation of the number and type of service codes for regional center services, including, but not limited to, recommendations for simplifying and making service codes more reflective of the level and types of services provided.

Current Rate Structure. The methodology to establish rates for services is based on the type of service vendors have been approved to provide. Below is an explanation of the various rate setting methodologies and the applicable services for each methodology.

- DDS-set rates. Some service rates are set by DDS either through cost statements, rate schedules, by statute, or by regulation. Service rates covered by this methodology include community-based day programs, community care facilities, in-home respite, supported employment, work activity programs, and infant development programs.

- Rates established by Medi-Cal[1]. If a service is also provided under the Medi-Cal program, then the RC may pay no more than the rate established by Medi-Cal for the same service. This methodology primarily applies to medical service providers, such as nurses, home health aides, and therapists.

- Usual and customary rates. Many services funded by regional centers are from providers whose business includes serving people other than those with developmental disabilities. In instances where at least 30% of a provider's customers are not regional center consumers or their families, then the rate the regional center may pay for the service is the rate the provider regularly charges the general public. Examples of services with usual and customary rates include day care, diaper services, and public transportation providers.

- Rates established by the California Department of Social Services (DSS). This category includes out-of-home respite services that are provided in facilities with rates established by the DSS.

- Rates set by regional center mileage reimbursement. Some transportation services have rates that can be set based on what the RC reimburses its own employees for travel.

- Rates set through negotiation between the regional center and the provider. If none of the other methods for establishing a service rate apply, then the service rate is determined through negotiation between the RC and the provider. Examples of services subject to negotiated rates include supported living, specialized residential facilities, and behavior analysts.

For some services, multiple methodologies may be applicable. In these instances, the rate is based on the provider's already established rate or the rate established by DDS. Otherwise, the rate is established through negotiation between the RC and provider.

Stakeholder Engagement. The Department and B&A engaged with the department's Developmental Services task force to gather input for the study. The department also conducted stakeholder meetings throughout the state to further engage the community. Surveys for both service providers and consumers and their families were also administered to inform the study. The provider survey was distributed on May 15, 2018, and was conducted to gather data from providers regarding the manner in which they

1 Note that rates set by Medi-Cal were not included in the rate study.

deliver services and their costs. 1,100 organizations out of 4,500 vendors responded to the survey. The department distributed the consumer and family survey on October 3, 2018, and received over 1,700 responses.

Development of Rate Models. The development of the rate models began with a detailed review of service requirements. With B&A's assistance, DDS undertook a comprehensive review of service definitions. This process also included a review of California-specific laws – such as labor related requirements – that impact providers' costs. From this review, DDS is compiling a list of potential statutory and regulatory changes that would be needed should the rate models be implemented. The rate models are built on detailed assumptions regarding a number of factors, including the wages, benefits, and productivity of the direct care worker; the agency's program operation and administrative costs; staffing ratios and staffing levels, attendance/absence factors, travel-related expenses, facility costs, and program supplies. Providers' costs generally reflect current rates rather than market-based conditions. For this reason, other data sources are used. These sources include California-specific, cross-industry wage data from the U.S. Department of Labor's Bureau of Labor Statistics, several sources that provide estimates of health insurance costs, and the Internal Revenue Services' mileage rate. Further, various analyses were undertaken to understand regional variability in costs associated with wages, travel, and real estate.

Draft Rate Models. Key features of the rate models resulting from the rate study include:

- A standardized approach to rate-setting such that providers delivering the same service in the same area receive the same payment.

- Simplification of service codes by consolidating a number of existing codes based on the assumption that a support should be associated with the same service code regardless of where that support is provided.

- Further alignment of payment rates with Medi-Cal rates for certain medical and clinical practitioners.

- The use of market-based cost data to reflect providers' costs to promote a stable and high-quality supply of providers.

- A detailed and transparent accounting of these costs should changes be considered over time.

- Recognition of differences in wage, travel, and real estate costs across the state by developing separate rate models for each RC.

- Supporting high-quality services through investments in direct care workers by building into the rate models market-based wages that consider the state's increasing minimum wage, a comprehensive benefits package, enhanced training, supervision, and other program operations.

- The development of enhanced rates for services delivered to individuals who do not speak English when delivered by staff who speak their language, including American Sign Language.

The draft rate models are intended to reflect assumptions on five key cost drivers: (1) the wage for the direct care worker, (2) the benefits package for the direct care worker, (3) the 'productivity' of the direct care worker (that is, the ratio of their billable hours to their work hours), (4) program operation costs, and (5) agency administration. Other cost drivers vary by service or location and may include staffing ratios, mileage, supervision, and facility costs. Key assumptions that broadly affect the draft rate models include state minimum wage requirements, a comprehensive benefits package for direct care workers, and the rate for administrative costs.

For each service and rate variant, a 'base' rate model is established. Then, to account for differences in wage, travel, and real estate costs across California, a draft rate model is established for each RC by applying a 'multiplier' for these three cost factors, as applicable, that reflects the cost in that RC in relation to the statewide value.

Fiscal Impact. The rate study estimates the cost of fully implementing the rate models would be approximately $1.8 billion total funds on an annualized basis. An estimated 60 percent, or $1.1 billion, of these costs would be General Fund. Although rates would increase overall, the rate models for some services and for some providers are less than current rates.

Public Comment Process. DDS began briefing sessions on the release of the rate study on February 25, 2019. Comments on the rate models were accepted up to March 22, 2019. DDS will review the provided comments and make modifications to the draft rate models as appropriate. The department requested parties wishing to provide comment share comments with their rates workgroup representative. The rates workgroup members were expected to aggregate comments and submit a consolidated response.

Implementation and Administrative Considerations. Implementation of the proposed rate models will involve significant and consequential adjustment at every level of the system. Specific considerations include:

- Enacting required policy changes. Implementing the rate models will require changes to statute and/or regulations. The department and B&A are still in the process of identifying all policy changes that would be needed in order to implement the proposed rate models.

- Attaining federal approvals. DDS must seek approval of any rate changes from the federal government, in order to maximize the amount of federal Medicaid waiver funding available to the system (currently about $2.2 billion). This process can take anywhere from six months to three years, depending on the extent of public comment or the amount of clarification needed by the federal government, among other factors.

- Day-to-day operational changes. Numerous changes would be needed at the department, RC, service provider, and consumer levels to successfully implement the rate models.

Benefits of Proposed Rate Models. There are a number of benefits in the models that significantly improve upon the current complex rate-setting system. Specific benefits include:

- Logical and transparent models. Each of the proposed models is built on several factors (discussed above), based on accessible data and information. Additionally, the study applies adjustments for regional variations in costs.

- Ability to update models at regular intervals. Having data built on transparent and accessible information allows individual components of the models to be updated regularly.

Legislative Analyst's Office (LAO) Comments. The LAO has provided several options for actions that could be taken by the Legislature in the 2019-20 budget year. The LAO offers two options for beginning rate reform in 2019-20. One option focuses on implementation of the rate study, and the other focuses on status quo funding increases that will provide some relief to service providers in 2019-20, that are not dependent on the implementation of the rate models proposed in the rate study.

1. **Rate Study Implementation Options.** The LAO proposes a staged rollout of the proposed rate models in up to four targeted service categories – residential, employment, respite, and independent living services (ILS). Among all of the proposed rate models, the LAO believes the rate models for those particular service categories would be the most feasible to implement from an administrative and policy perspective. Another option is to combine the staged rollout option with pilot projects in service categories that are not included in the first round of the staged rollout. The pilot projects could be small and low-cost in scope with the goal of gaining a better understanding of the implementation challenges associated with the rate models and ways to address them. Simultaneously, to either option, DDS could develop a plan for the ultimate full implementation of rate models, which could be submitted for legislative review and approval as part of the 2020-21 budget.

2. **Status Quo Funding Increase Options.** The LAO also lists options that are not dependent on the implementation of the rate models proposed in the rate study. The cost of each status quo option would be lower in most cases to the extent it is combined with a rate study implementation option (as the status quo option would be structured to benefit only those providers not benefitting from the implementation of the rate study in 2019-20). The table below summarizes the estimated cost of the staged rollout implementation option and the status quo funding increase options.

Figure 1

Estimated Costs of Various Options, Relative to the Governor's Proposed 2019-20 Budget

2019-20 Cost (In Millions)

Rate Study Implementation Options—Staged Rollout[a]			Status Quo Funding Increase Options		
Service Category	Total Funds	General Fund	Option	Total Funds	General Fund
Residential services (not including shared supported living services)	$948	$607	Fix state minimum wage quirk	$16.1	$8.0
Supported employment (group and individual)	24	15	Cover local minimum wage	Unknown	Unknown
Respite (including agency- and participant-directed)	50	32	Repeal uniform holiday schedule	50.3	30.1
Independent living services (including specialists)	-1	-1	Repeal half-day billing policy	2.7	1.6
			Restore social recreation and camp services	23.2	14.8
			Increase rates across the board: 8%	464.0	296.5
			Increase rates across the board: 4%	232.0	148.3

[a] Options reflect implementation of rate study's proposed rate model for one to four of the listed service categories. If pilot projects in other service categories were also included, there would be an additional cost as determined by the Legislature.

The LAO notes that should the Legislature package rate study implementation options with status quo funding increase options the cost could range from less than $50 million to more than $1.4 billion ($15 million to $900 million General Fund).

Panel 1. The Subcommittee has requested the following panelists, in addition to DDS and DOF to provide comment on the importance of providing fiscal relief for service providers:

- Sandra Smith, Chair, State Council on Developmental Disabilities
- Eric Zigman, Executive Director, Golden Gate Regional Center

Panel 2. The Subcommittee has requested the following panelists to provide comment on the proposed rate models in the rate study:

- Rebecca Lienhard, Executive Director, Tierra del Sol Foundation
- Dr. Diane Cullinane, Executive Director, Professional Child Development Associates, Inc.
- Harry Bruell, President/CEO, PathPoint
- Jacquie Dillard-Foss, CEO, S.T.E.P., Inc.

Staff Comment and Recommendation. Hold open. The proposed rate models offer many benefits and would significantly improve the current system, providing a much-needed relief for service providers.

The Subcommittee may want to consider a staged rollout approach, along with some of the status quo funding options proposed by the LAO, as a first step on the road to rate reform. However, it seems that further fine-tuning is needed to better understand how models for specific service types would be implemented, and to avoid unintended consequences. The Subcommittee may want to consider requiring the department to submit a plan for what it sees as the best way forward to implement those models.

Questions.

1. When does the department and B&A expect to complete review of feedback on the draft rate models and any refinements that result?

2. Please explain how the consumer and family surveys were incorporated into the rate study. How were consumer outcomes included as part of the methodology in the study? If not, how might these factors be included into rate reforms?

Issue 2: 8 Percent Across-the-Board Increase for Service Providers (Proposal for Investment)

The Subcommittee has received the following proposal related to the DDS.

Background. Several advocates, consumers, and families are in support of a proposal calling for an eight percent increase in provider rates. Requesting organizations include the Lanterman Coalition, the ARC & United Cerebral Palsy Collaborative, and Services Employees International Union.

The proposed increase has been estimated to cost approximately $290 million General Fund, matched by nearly $200 million in federal funds. Proponents state this increase will be a "down payment" on the rate study's recommendations to address the crisis in community services, sufficiently stabilize the system, and provide a solid foundation on which to implement broader reforms. This increase would provide for an initial investment in the restoration of the system, and illustrate continued commitment that all Californians living with intellectual and developmental disabilities will receive the services and supports necessary to live full, integrated lives.

Under the current rates, service providers are unable to offer competitive wages to direct service staff, resulting in reduced hiring qualifications and risking the quality of services provided to individuals with intellectual and developmental disabilities (I/DD). Proponents state that without the requested relief, there is no doubt that we will continue to ask direct service professionals to perform complex, important work for no more than the minimum wage.

Staff Comment and Recommendation. Hold open.

0000 VARIOUS DEPARTMENTS

Issue 1: Proposals for Investment

Stakeholder Proposals. Various stakeholders have proposed the following investments:

California Health Facilities Financing Authority (CHFFA)

Community Clinic Vision Integration Project. The California Optometric Association requests one-time General Fund expenditure authority of $26 million to establish the Community Clinic Vision Integration Project, a grant program to assist in establishing optometric services at community health centers that do not now offer these services. The project would be administered by CHFFA. Grants would be awarded to community health centers based on the center's population served, completeness of plan, readiness to provide services, financial capacity, the geographic distribution of optometric services, and other criteria that the CHFFA may establish.

Office of Statewide Health Planning and Development (OSHPD)

Nonprofit Access to OSHPD Public Use File. The California State Council of the Service Employees International Union (SEIU California) requests trailer bill language to restore nonprofits' access to the hospital Public Use File (PUF) dataset housed at the Office of Statewide Health Planning and Development (OSHPD). These files were the only patient-level product non-hospital entities could receive and have been an important component of our work examining healthcare utilization, quality, and disparities. Without any new change in law, OSHPD has reinterpreted existing privacy laws as the basis for their decision to eliminate the PUF. According to OSHPD, their interpretation of existing state privacy laws changed with the conversion to ICD-10, an updated medical coding system which applies internationally, along with updated technological resources that have increased the likelihood of a breach, in OSHPD's legal opinion. Consequently, they are no longer producing the PUF. Meanwhile, SEIU researchers continue to access similar data for Medicare patients available through the Center for Medicare and Medicaid Services (CMS), including some data sets which we only access with specific training via a HIPAA-Compliant server. The requested trailer bill language would reestablish nonprofit researchers as a class of individuals who would be permitted direct access to patient-level administrative data, similar to what was contained in the PUF.

Psychiatry Fellowships. The California Psychiatric Association requests General Fund expenditure authority of $2.7 million in 2019-20 for scholarships to pay tuition in a one-year fellowship program for primary care provider training in the essentials of primary care psychiatry. Two University of California medical school Departments of Psychiatry (UC Irvine and UC Davis) jointly administer this program which has been training fellows for 4 years. It uses a "Train New Trainers" model, in which fellows are equipped by the training to return to their practice settings and in turn train colleagues and staff on these same essentials of psychiatry for primary care practice. In this respect the training program operates as a force multiplier providing psychiatric training reaching well beyond cohorts of fellows. The requested resources would continue to provide scholarships for primary care and emergency physicians from underserved areas, as well as provide funding for an additional 100 scholarships, provide targeted marketing to ensure the program reaches the communities most in need, provide tuition for the Essentials of Primary Care Psychiatry conference, and conduct evaluation of program outcomes.

Health Care Workforce in Underserved Areas. A coalition of health care organizations including the California Hospital Association, California Health+ Advocates, and the California Rural Legal Assistance Foundation requests General Fund expenditure authority of $50 million in 2019-20 for OSHPD to expand opportunities to students from underrepresented and low-income areas to enter health careers. Specifically, the funding would support programs that would: 1) expand the number of primary care physicians and psychiatry residency positions and prioritize residency programs in health professional shortage areas (HPSAs), 2) recruit and train students from areas with a large disparity in patient-to-doctor ratios to practice in health centers in the area from which each student was recruited, 3) expand and strengthen loan repayment programs for primary care physicians and clinicians that agree to serve in HPSAs, and 4) expand and strengthen programs to recruit and prepare students from underrepresented and low-income backgrounds for health careers.

Transgender, Gender Non-Conforming, and Intersex (TGI) Inclusive Healthcare Workforce Training. The TransLatin@ Coalition requests General Fund expenditure authority of $1 million for technical assistance and training for health and human services providers and all organizations or agencies with over 50 employees, including staff, healthcare workers, and administrators. These resources directly relate to the proposed budget for Mental Health Workforce Investment to increase the number of practitioners able to provide TGI-inclusive medical and mental health care.

Department of Health Care Services (DHCS)

Personal Needs Allowance Increase. The California Long-Term Care Ombudsman Association and a coalition of organizations request resources to increase the Personal Needs Allowance (PNA) from $35 to $85 for individuals in long term care. Many individuals rely on Medicaid programs to fund long-term care. In California, Medi-Cal covers the cost of care only after a resident pays their share of cost to the facility minus the 35 dollar PNA that the resident may keep for personal expenses not covered by the facility. The PNA cap was set at $35 in 1985 and, although states have authority to spend funds to increase the PNA, California has not exercised this authority and has one of the lowest PNAs in the country.

Northeast Valley Health Wellness Garden Program. The Northeast Valley Health Corporation (NEVHC) requests General Fund expenditure authority of $250,000 in 2019-20 for the expansion of NEVHC's Wellness Garden and Food Distribution Program. Support for the Wellness Garden Program is an investment in building healthier communities that will culminate with a model and toolkit for California's community health centers to guide them in addressing the social determinants of health affecting underserved populations through a comprehensive community gardens and food distribution program. The Wellness Garden and Food Distribution Program would address social, economic, and environmental factors that impact patient health and strengthen community well-being. At the end of the one-year funding period, NEVHC would produce the following deliverables:

- Construct a new Wellness Garden at the Sun Valley Health Center to provide patients with continuous access to nutritious food to mitigate food insecurity and treat or prevent chronic diseases.
- Utilize a Supplemental Nutrition Assistance Program-Education (SNAP-Ed) approved, evidence-based educational curriculum which uses hands-on strategies to teach patients about nutrition, exercise, and healthy living.

- Implement local food markets and produce swaps in locations that are considered food deserts and provide patients with the opportunity to access and exchange healthy produce.
- Increase access to green space to conduct medical visits that would support the future launch of food prescription programs in the community health center setting.
- Create a model or "toolkit" to guide California's community health centers on how to develop their own wellness garden program that can be personalized to meet the individual needs of the community served.

Rate Increase for Psychologists in Skilled Nursing Facilities. CHE Behavioral Health Services requests General Fund expenditure authority of $6 million annually to fund a Medi-Cal rate increase toward professional fees for psychologists who provide behavioral health services in nursing homes across California. According to CHE, California's Medicaid rates are among the lowest in the country, failing to adequately cover the cost of daily care for nursing home seniors. As a result, in many cases, care isn't being adequately delivered. The funding shortfall will no doubt result in fewer facilities, leaving more senior citizens homeless, and a potentially significant collapse in the health care delivery system for aging Californians. Additionally, failure to identify and treat behavioral health disorders could result in loss of federal reimbursement opportunities for California.

Positive Parenting Program at Federally Qualified Health Centers (FQHCs). Triple P America requests General Fund expenditure authority of $8 million annually for DHCS to implement online, evidence-based, positive parenting support for at-risk families with children, especially those who receive services within the network of over 1,000 community health centers (FQHCs, FQHC look-alikes, and rural health centers) across the state. In order to ensure that dollars are spent on assisting the state's most vulnerable families, Triple P America requests at least 50 percent of the funding be reserved for families receiving services at community health centers, with the remainder being available to families in the general population. According to Triple P America, primary care providers, as trusted sources of parenting information, are positioned to promote positive parenting practices and to refer families into quality online self-directed programs. Such an approach provides jurisdictions a relatively straightforward and consumer-preferred manner for scaling up positive parenting practices. Because families who receive services at community health centers represent the state's most vulnerable population, this proposal seeks to equip primary care providers with the resources to make referrals into an evidence-based online program.

Medication Assisted Treatment Reimbursement. Alkermes, Inc., requests trailer bill language to direct DHCS to undertake, and complete, setting reimbursement codes and rates for ancillary services (e.g. psychosocial support, counseling, and urinalysis) for all Food and Drug Administration (FDA) approved medications for Medication Assisted Treatment (MAT) in Narcotic Treatment Programs (NTPs). According to Alkermes, the Legislature passed AB 395 (Bocanegra), Chapter 223, Statutes of 2017, to enhance the MAT offerings within NTPs by allowing all forms of MAT to be provided for the treatment of substance use disorders. AB 395 had no new costs associated with it by the Legislature, the Department of Finance, or DHCS. However, DHCS maintains it requires specific direction to implement the necessary changes in the NTP treatment system. This trailer bill language request provides that direction.

Peg Taylor Adult Day Health Center Funding. The Peg Taylor Center requests General Fund expenditure authority of $500,000 in 2019-20 for its Peg Taylor Center for Adult Day Health Care, which has been disproportionately affected by the Camp Fire of November 2018. The Peg Taylor

Center is an adult day health care facility currently serving 54 vulnerable, at-risk adults with serious health conditions and has the capacity to further meet Butte County's crisis needs if additional funding is available. The population served is at high risk due to the Camp Fire and the impacts of the disaster will affect their health and well-being for years to come. Some of the challenges include loss of established care arrangements and increased medical issues due to poor air quality and trauma. For caregivers and families, there is a large need for respite care and direct assistance to navigate the Camp Fire recovery process.

Assisted Living Waiver Expansion. The California Long-Term Care Ombudsman Association and a coalition of organizations request General Fund expenditure authority of $36.1 million over four years to expand the Assisted Living Waiver (ALW) from 5,744 slots to 18,500 slots incrementally by March 1, 2023, The costs of this proposal would be offset by savings achieved from transitioning individuals from skilled nursing facilities into the community and would result in net General Fund savings of $44.6 million. Expanding the ALW program would create a significant cost-savings to the state because the average annual participant cost in a skilled nursing facility is assumed to be $68,046 while the average cost of providing waiver services in a community setting is $16,477. This action would be in line with the state's efforts to rebalance Medi-Cal spending by investing in consumer-preferred, lower-cost home- and community-based services.

Medical Interpreters Pilot. The American Federation of State, County, and Municipal Employees (AFSCME) requests General Fund expenditure authority of $5 million in 2019-20 to implement a pilot project for medical interpreters previously approved by the Legislature in AB 635 (Atkins), Chapter 600, Statutes of 2016. According to AFSCME, the original $3 million allocated in AB 635 was exhausted by DHCS to fund a study of medical interpretation services, although the funds were intended for both a study and a pilot project. This funding would ensure the ability to fund a legitimate pilot program capable of providing measurable outcomes that could be used to inform future public policy decisions.

Outreach and Enrollment Assistance. California Coverage and Health Initiatives (CCHI) requests General Fund expenditure authority of $15 million in 2019-20 and 2020-21 for maintaining and strengthening the enrollment process at the local community level. According to CCHI, DHCS would distribute most of the funds, net of administrative costs to a respected intermediary, a nonprofit fiscal oversight agency, an organization with which CCHI has worked in the recent past. The intermediary organization would implement its already existing transparent and fully accountable criteria for allocating the funds to the participating member community-based organizations, with an emphasis on dispatch, and urgency of need. CCHI would administer the allocation and grant process, using criteria and processes already applied to previous contract and grant programs funded by the federal government, state government, and foundations.

Santa Barbara County Mental Health and Criminal Justice Involvement Prevention. The County of Santa Barbara requests General Fund expenditure authority of $855,000 annually for diversion efforts for those with mental illness or involved in the criminal justice system. Specifically, Santa Barbara requests $500,000 to fund a mental health rehabilitation center to provide short-term inpatient mental health care for individuals as an alternative to psychiatric hospital placement, $220,000 for a Holistic Defense Partnership consisting of an interdisciplinary team to provide a continuum of care and connections for clients to existing community resources, and $135,000 for a criminal justice diversion and process mapping project to provide data and analysis on where diversion efforts could be enhanced to reduce incarceration without jeopardizing the community's safety.

Department of Public Health (DPH)

Little by Little Early Literacy Program. Heluna Health requests expenditure authority of $36.4 million to support statewide expansion of the Little by Little School Readiness Program, a Los Angeles based early literacy pilot project delivered at service sites for the Women, Infants, and Children (WIC) program. According to Heluna Health, Little by Little creates a stimulating home environment, fosters literacy, and improves school readiness for underserved and low-income children. The program begins in the third trimester of pregnancy and continues until the child's fifth birthday. Families receive information about the importance of strengthening literacy practices within the home, each child chooses a new age-appropriate book at each visit, and parents receive informational handouts which provide parental guidance tied to their children's developmental milestones.

Sugar – Awareness and Research. Public Health Advocates request General Fund expenditure authority of $10 million over three years for DPH's Division of Chronic Disease & Injury Control, Nutrition Education and Obesity Prevention Branch to issue statewide community grants to California organizations for a Sugar-Sweetened Beverage Awareness Campaign. The campaign would employ a multi-pronged approach combining social media and targeted grassroots messaging to achieve three key aims: 1) increase consumer awareness of the health implications of sugar sweetened beverages, 2) increase consumer ability to identify drinks with added sugar, and 3) inform consumers how to interpret sugar content on product labels.

Public Health Advocates also request General Fund expenditure authority of $6.9 million in 2019-20 for DPH's Division of Chronic Disease & Injury Control, Chronic Disease Control Branch to issue and administer research grants to California-based academic and research institutions. DPH would solicit proposals to conduct a randomized clinical trial to determine whether sugar in liquid form causes more detrimental health effects than sugar in solid food by examining immediate changes in established biomarkers known to increase the risk for cardiovascular disease and diabetes.

Behavioral Risk Factor Surveillance System. The Alzheimer's Association requests transfer of expenditure authority from the Alzheimer's Disease and Related Disorders Research Fund of $45,000 from local assistance to state operations to allow DPH to participate in the 2020 Behavioral Risk Factor Surveillance System (BRFSS) survey on subjective cognitive decline. According to the Alzheimer's Association, BRFSS is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. Established in 1984 with 15 states, BRFSS now collects data in all 50 states as well as the District of Columbia and three U.S. territories. BRFSS completes more than 400,000 adult interviews each year, making it the largest continuously conducted health survey system in the world.

Parkinson's Registry Funding. The Michael J. Fox Foundation for Parkinson's Research requests General Fund expenditure authority of $10 million in 2019-20, available for three years, and trailer bill language to continue legislative authority for the California Parkinson's Disease Registry. The 2017 Budget Act created and funded the registry to measure the incidence and prevalence of Parkinson's disease and ultimately improve the lives of those affected. Thousands of cases have already been reported to the registry within the last year and thousands more are arriving this month as medical groups and hospitals begin to submit their patient data. The funding included in the 2017 Budget Act

money was used in 2017, 2018 and 2019. DPH needs additional funding and legislative authority to continue the program since healthcare providers just started submitting patient data.

23rd Biennial International AIDS Conference – AIDS 2020. AIDS 2020 requests General Fund expenditure authority of $2 million to support San Francisco and Oakland, the two cities selected by the International AIDS Society to host the 23rd biennial International AIDS Conference, known as AIDS 2020. According to the LGBTQ Caucus, hosting AIDS 2020 will provide California's elected officials, community leaders, and academic researchers an opportunity to collaborate in a meaningful way that will undoubtedly create the foundation for long-term partnerships to allow California to "get to zero". In addition, San Francisco and Oakland, in partnership with cities across California, are well positioned to achieve the objectives of the International AIDS Conference to bring together the world's experts to advance scientific collaborations in HIV and help foster new relationships. The conference will provide the opportunity to highlight our research, advocacy, and promising HIV therapies.

Mental Health Services Oversight and Accountability Commission (MHSOAC)

Youth Mental Health Drop-In Centers. MHSOAC requests General Fund expenditure authority of $25 million annually to develop a series of innovative youth mental health drop-in centers across California. This investment would spur additional federal, state, local, and philanthropic support to help cover the operating costs of these centers. MHSOAC, in partnership with county behavioral health leaders, researchers, and community providers, has initiated an approach called *alcove* in Santa Clara County to improve services to youth and young adults through integrated approaches to health, mental health, substance use services, reproductive health and related needs, including education, social, employment, and housing support. This request would allow the state to extend the work underway to a statewide scale.

Innovation Project Timeline Trailer Bill Language Proposal. The California Behavioral Health Director's Association (CBHDA) requests trailer bill language to align the timeline of funding for innovation projects under the Mental Health Services Act (MHSA) with the full term of the project plan approved by the MHSOAC. According to CBHDA, when the MHSA was written an arbitrary three-year timeline was included into the act. The current law does not reflect the actual time it takes for a county program to produce a successful project or program. Often contracting, hiring staff or simply receiving approval from the MHSOAC will significantly delay any progress. Additionally, any delays related to "Not in My Backyard" (NIMBY) issues could effectively end an otherwise on-time and successful project. On many occasions counties will encumber funds with approved projects only to be delayed with issues outside their control. The proposed technical change conforming project approval would allow counties to align project timelines with the actual time it takes to onboard and implement programs and initiatives.

California Health Benefit Exchange – Covered California

Bronze High Deductible Health Plans Trailer Bill Language. Health Access California requests trailer bill language to allow Covered California to offer bronze level High Deductible Health Plans (HDHPs) at a higher actuarial value to comply with new regulations from the Internal Revenue Service. According to Health Access, there are over 235,000 Californians who have bronze HDHP products who are at risk of losing access to this type of coverage if California law is not updated. These are consumers both on and off Covered California and in both the individual and small group markets.

IRS rules for setting the maximum out-of-pocket costs for HDHPs are different than the rules for the maximum out of pocket for Covered California exchange plans. The result is that the maximum out-of-pocket costs for HDHPs are almost $1,000 lower than for other bronze products causing the actuarial value to be richer. This actuarial value exceeds the threshold set in California law of plus or minus two percent. However, to meet the IRS rules, Covered California needs to be able to sell a product that is 62.2 percent actuarial value, which is higher than the 62 percent actuarial value maximum (60 percent plus or minus two percent). The proposed trailer bill language would allow the variation in the actuarial value for bronze HDHPs to range from plus four percent to minus two percent, creating an effective range for these plans' actuarial value of 58 percent to 64 percent.

Single Invoice for All Plan Covered Services. Health Access California requests trailer bill language to make statutory clarifications to allow health plans and insurers to comply with both the California Constitution and pending federal regulations. According to Health Access, the California Constitution requires coverage of the full range of medically necessary health care services. A pending federal rule would make it difficult for health plans and insurers to comply with the constitutional requirement and the federal rule. The proposed trailer bill language would require health plans and insurers to send a single invoice and collect one payment from subscribers, while segregating the portion of the payment collected for services for which federal funding is prohibited.

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

SUBCOMMITTEE NO. 3 Agenda

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

Tuesday, May 14, 2019
10:00 a.m.
State Capitol - Room 4203

PART A

Consultant: Scott Ogus

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PUBLIC COMMENT

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

ISSUES FOR DISCUSSION

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
4260 DEPARTMENT OF HEALTH CARE SERVICES
5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: State Verification Hub Planning Activities (Issue 405-MR)

May Revision. The Administration requests that the following items be modified to begin planning activities for a State Verification Hub to enhance eligibility verifications in public assistance programs. The requested adjustments are as follows:

- Health and Human Services Agency - The Administration requests that Item 0530-001-9745 be increased by $747,000 on a two-year limited-term basis to support one position and consultant services.

- Department of Health Care Services – The Administration requests that Item 4260-001-0001 be increased by $78,000 and Item 4260-001-0890 be increased by $77,000 on a two-year limited-term basis to support one position and consultant services.

- Department of Social Services – The Administration requests that Item 5180-001-0001 be increased by $149,000 and one position and Item 5180-001-0890 be increased by $144,000 and one position on a two-year limited-term basis to support two positions.

Staff Comment and Recommendation – Hold Open.

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

1. Please provide a brief overview of this proposal.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: AIDS Drug Assistance Program (ADAP) – May Revision Estimate and Adjustments

DOF Issue#: 4265-003-ECP-2019-GB
4265-036-BBA-2019-GB
4265-401-ECP-2019-MR

ADAP Local Assistance Estimate May Revision Update. The May 2019 ADAP Local Assistance Estimate reflects revised 2018-19 expenditures of $407.5 million, which is a decrease of $362,000 or less than 0.1 percent compared to the Governor's January budget. According to DPH, this decrease is primarily due to reduced medication expenditures for medication-only clients. For 2019-20, DPH estimates ADAP expenditures of $449.5 million, a decrease of $320,000 or less than 0.1 percent, compared to the Governor's January Budget, and an increase of $42 million or 10.3 percent, compared to the revised 2018-19 estimate. DPH also reports this decrease is primarily due to reduced medication expenditures for medication-only clients.

ADAP Local Assistance Funding 2018-19 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0890 – Federal Trust Fund	$129,143,000	$129,143,000
3080 – AIDS Drug Assistance Program Rebate Fund	$278,735,000	$278,373,000
Total ADAP Local Assistance Funding – All Funds	**$407,878,000**	**$407,516,000**

ADAP Local Assistance Funding 2019-20 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0890 – Federal Trust Fund	$135,138,000	$135,138,000
3080 – AIDS Drug Assistance Program Rebate Fund	$314,650,000	$314,330,000
Total ADAP Local Assistance Funding – All Funds	**$449,789,000**	**$449,468,000**

ADAP tracks caseload and expenditures by client group. After May Revision updates, DPH estimates ADAP caseload and expenditures for 2018-19 and 2019-20 will be as follows:

Caseload by Client Group	**2018-19**	**2019-20**
Medication-Only	12,809	12,580
Medi-Cal Share of Cost	118	136
Private Insurance	9,883	10,687
Medicare Part D	7,683	7,683
Pre-Exposure Prophylaxis (PrEP) Assistance Program	1,490	3,542

Expenditures by Client Group	2018-19	2019-20
Medication-Only	$304,807,079	$315,972,368
Medi-Cal Share of Cost	$1,071,494	$1,477,505
Private Insurance	$65,031,384	$87,982,784
Medicare Part D	$23,838,377	$27,631,337
PrEP Assistance Program	$3,865,266	$7,309,358

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 includes 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 $7.1 million in 2018-19 and $7.7 million in 2019-20 under the new reimbursement methodology.

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 changes to caseload and expenditures in the ADAP May Revision Estimate.

Issue 2: HIV Care Program Financial Eligibility – Trailer Bill Language Proposal

DOF Issue#: Trailer Bill Language Proposal

Trailer Bill Language Proposal. DPH requests trailer bill language to adopt the financial eligibility requirement used by the AIDS Drug Assistance Program for the HIV Care Program. Adoption of this language would allow the HIV Care Program to address a finding from the federal Health Resources and Services Administration (HRSA) that the program does not have consistent, statewide financial eligibility standards, as required by the federal Ryan White HIV/AIDS program.

Background. DPH contracts with 43 local health departments and community-based organizations to provide services under the HIV Care Program in all 58 counties. Contractors may fund any combination of 21 allowable service categories including medical case management, outpatient or ambulatory health services, food bank or home-delivered meals, and medical transportation services. DPH receives funding for the program from the federal Ryan White HIV/AIDS Program of $33 million, consisting of $27 million in base award and $6 million in supplemental funds. According to DPH, the program served about 12,790 clients in 2018.

Individuals are eligible for programs funded through the Ryan White HIV/AIDS Program if the individual has a medical diagnosis of HIV/AIDS and is low-income as defined by the state. In March 2016, HRSA issued a finding that the HIV Care Program had no established statewide financial eligibility requirement, with eligibility requirements varying from county to county. HRSA findings stated that DPH did not "consistently define 'low-income' in Part B eligibility criteria throughout the state."

DPH requests trailer bill language to adopt the financial eligibility requirements used by the AIDS Drug Assistance Program (ADAP) for the HIV Care Program. ADAP is also funded by the Ryan White HIV/AIDS Program and shares many of the same clients as the HIV Care Program. Individuals are eligible for ADAP if the individual's modified adjusted gross income does not exceed 500 percent of the federal poverty level. According to DPH, approximately 91 existing clients, representing one percent of all clients served, would no longer be eligible for services under the proposed adoption of statewide eligibility requirements consistent with ADAP.

In addition to defining the financial eligibility for the program, the proposed trailer bill language would rename the CARE Services Program to the HIV Care Program, as it is currently known. These changes would become operative on April 1, 2020 to coincide with the start of the Ryan White HIV/AIDS Program fiscal year, coincide with the conclusion of the next open enrollment period for Covered California, and provide sufficient time for all current clients to complete their biannual recertification.

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 statutory changes.

Issue 3: Infectious Disease Prevention and Control

DOF Issue#: 4265-404-BCP-2019-MR

May Revision Issue. DPH requests four positions and General Fund expenditure authority of $40 million in 2019-20, available until June 30, 2023. If approved, these positions and resources would allow DPH to provide one-time grants to local health jurisdictions and tribal communities for infectious disease prevention, testing, and treatment. Of these resources, $32 million would be provided to local health jurisdictions and $8 million would support state administration costs.

Program Funding Request Summary		
Fund Source	**2019-20***	**2020-21**
0001 – General Fund		
State Operations	$8,000,000	**$-**
Local Assistance	$32,000,000	$-
Total Funding Request:	**$40,000,000**	**$-**
Total Positions Requested:	**4.0**	

* Resources available until June 30, 2023.

Background. DPH and 61 local health jurisdictions across the state work to monitor, prevent, and control more than 90 different infectious diseases. DPH estimates there were between 7.6 million and 10.8 million cases and between 1,760 and 7,160 deaths due to infectious disease in 2016. In recent years, DPH and local health jurisdictions have experienced significant increases in the incidence and risk of infectious diseases, including sexually transmitted diseases (STDs), foodborne diseases, vaccine-preventable diseases, and new emerging infectious diseases.

DPH requests four positions and General Fund expenditure authority of $40 million in 2019-20, available until June 30, 2023 to provide one-time grants to local health jurisdictions and tribal communities for infectious disease prevention, testing, and treatment. Of these resources, $32 million would be provided to local health jurisdictions and $8 million would support state administration costs.

The $32 million for local health jurisdictions would be allocated after engaging with stakeholders to determine metrics and appropriate weighting for each metric. According to DPH, the short-term outcomes expected from this funding would be: 1) infectious disease prevention, 2) increased partnerships between DPH and local health jurisdictions and providers and payers that serve communities at risk, 3) enhanced integration between public health and health care data systems to monitor delivery of preventive services, and 4) increased training, consultation, and quality improvement activities related to infectious disease prevention. Long term, DPH expects these resources would help reduce incidence of tuberculosis, STDs, vaccine preventable diseases and outbreaks, severe pertussis cases in infants, disparities in the burden of these diseases among disproportionately affected populations, and prevention of illness, death, disability, and further spread of infectious diseases.

The $8 million of state administration funding would support the following positions:

- **One Staff Services Manager II** position would supervise a contract monitoring unit which would oversee the grant allocations, contract execution, and monitoring and evaluation of tasks associated with the grants.
- **Two Associate Governmental Program Analysts** would provide coordination between a disease investigation team and grant recipients, and provide technical assistance to grant recipients regarding data requirements. These positions would also manage and monitor the administrative requirements of grant recipients and coordinate the collection of work plans and progress reports from grant recipients for review.
- **One Senior Accounting Officer** would support administrative functions including payment processing and accounting record oversight.

DPH would also enter into an interagency agreement to perform activities including, but not limited to, epidemiology and disease surveillance, communication, data management, and disease investigation for outbreak response. This request allocates $5.2 million of the state administration funding for this purpose.

May Revision Proposal Similar to Funding Request from Local Health Departments. The subcommittee previously heard a similar request from the County Health Executives Association of California (CHEAC) and the Health Officers Association of California (HOAC) for annual General Fund expenditure authority of $50 million to improve infrastructure to prevent and control the spread of infectious disease in California using strategies that best meet the needs of local jurisdictions. According to CHEAC and HOAC, local health departments do not have adequate funding to fulfill their unique mandate to prevent and control infectious diseases within their jurisdictions. State and federal funding for communicable disease control activities have considerably declined over time and are primarily siloed based on disease. This has led to significant challenges in addressing the rising rates of ever-present diseases such as sexually transmitted diseases and tuberculosis, and addressing outbreaks experienced in California such as Hepatitis A, influenza, Zika and measles, posing a health and safety risk to residents throughout the state.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. What entities would be part of the planned interagency agreement for surveillance, communication, data management, and outbreak response? What are each of the parties' responsibilities under the agreement?

Issue 4: Genetic Disease Screening Program – May Revision Estimate and Adjustments

DOF Issue#: 4265-002-ECP-2019-GB
4265-402-ECP-2019-MR

Genetic Disease Screening Program Estimate - May Revision Update. The May 2019 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of $133.8 million ($30.6 million state operations and $103.2 million local assistance) in 2018-19, a decrease of $273,000 or 0.3 percent compared to the January budget. According to DPH, the decreased costs are primarily attributable to reduced estimates of live births in California. The estimate also includes $143 million ($31.4 million state operations and $111.6 million local assistance) in 2019-20, an increase of $1.8 million or 1.6 percent compared to the January budget, and an increase of $9.2 million or 6.8 percent compared to the revised 2018-19 estimate. According to DPH, the increase in costs is due to increased laboratory supply and equipment costs and an increasing need for case management and coordination services for newborn screening.

Genetic Disease Screening Program 2018-19 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0203 – Genetic Disease Testing Fund		
State Operations:	$29,451,000	$30,593,000
Local Assistance:	$103,501,000	$103,228,000
Total GDSP Funding	**$132,952,000**	**$133,821,000**

Genetic Disease Screening Program 2019-20 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0203 – Genetic Disease Testing Fund		
State Operations:	$31,351,000	$31,351,000
Local Assistance:	$109,825,000	$111,624,000
Total GDSP Funding	**$141,176,000**	**$142,975,000**

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 2017, 18,920,529 babies were screened resulting in early identification of 18,015 cases for the following disorders:

Disorder	Cases
Phenylketonuria (PKU) and hyperphenylalaninemia	1,264
Primary congenital hypothyroidism	7,857
Galactosemia	1,018
Sickle cell disease and other clinically significant hemoglobinopathies[1/]	5,006
Biotinidase deficiency (BD)	209
Cystic fibrosis (CF)	636
Congenital adrenal hyperplasia (CAH)	376
Metabolic fatty acid oxidation disorders	741
Metabolic amino acid disorders other than PKU	203
Metabolic organic acid disorders	518
Other metabolic disorders	62
Severe combined immunodeficiencies	75
X-linked adrenoleukodystrophy (ALD) and other peroxisomal disorders	50
TOTAL	**18,015**

The NBS program currently screens infants in California for more than 80 separate disorders. Pursuant to SB 1095 (Pan), Chapter 363, Statutes of 2016, two additional disorders, Mucopolysaccharidosis type I (MPS-I) and Pompe disease, were added to the screening panel in 2018. In addition, as conditions are added to the federal Recommended Uniform Screening Panel (RUSP), SB 1095 requires them to be

added to the NBS program screening panel within two years. In July, 2018, the U.S. Secretary of Health and Human Services added spinal muscular atrophy (SMA) to the RUSP, which must be added to the NBS screening panel within two years. The fee for screening in the NBS program is currently $142.25.

Caseload Estimate: The budget estimates NBS program caseload of 461,083 in 2018-19, a decrease of 8,067 or 1.7 percent, compared to the January budget estimate. The budget estimates NBS program caseload of 460,153 in 2019-20, a decrease of 930 or 0.2 percent, compared to the revised 2018-19 estimate. These estimates are based on state projections of a decrease in live births. DPH assumes 100 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 329,081 in 2018-19, a decrease of 5,349 or 1.6 percent, compared to the January budget estimate. The budget estimates PNS program caseload of 326,472 in 2019-20, a decrease of 2,609 or 0.8 percent, compared to the revised 2018-19 estimate. These estimates are based on state projections of a decrease in live births.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the caseload and expenditure changes for the Newborn Screening Program.

2. Please provide a brief overview of the caseload and expenditure changes for the Prenatal Screening Program.

Issue 5: Women, Infants, and Children Program – May Revision Estimate

DOF Issue#: 4265-001-ECP-2019-GB
4265-403-ECP-2019-MR

Women, Infants, and Children Program Estimate – May Revision Update. The May 2019 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of $1.1 billion ($902.2 million federal funds and $226.2 million WIC manufacturer rebate funds) in 2018-19, an increase of $7.2 million ($10.1 million federal funds offset by a decrease of $2.9 million WIC manufacturer rebate funds) compared to the Governor's January budget. The May 2019 WIC Program Estimate includes $1.1 billion ($880.7 million federal funds and $213.7 million WIC manufacturer rebate funds) in 2019-20, an increase of $1.3 million ($2.6 million federal funds offset by a decrease of $1.3 million WIC manufacturer rebate funds) compared to the Governor's January budget, and a decrease of $34 million ($21.4 million federal funds and $12.5 million WIC manufacturer rebate funds) compared to the revised 2018-19 estimate. The federal fund amounts include state operations costs of $63.7 million in 2018-19 and $62.3 million in 2019-20.

WIC Funding Summary 2018-19 May Revision Comparison to January Budget			
	2018-19		**Jan to May**
Fund Source	***January Budget***	***May Revision***	***Change***
0890 – Federal Trust Fund			
State Operations:	$63,684,000	$63,684,000	$-
Local Assistance:	$828,388,000	$838,489,000	$10,101,000
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$229,080,000	$226,211,000	($2,869,000)
Total WIC Expenditures	**$1,121,152,000**	**$1,128,384,000**	**$7,232,000**

WIC Funding Summary 2019-20 May Revision Comparison to January Budget			
	2019-20		**Jan to May**
Fund Source	***January Budget***	***May Revision***	***Change***
0890 – Federal Trust Fund			
State Operations:	$62,270,000	$62,270,000	$-
Local Assistance:	$815,905,000	$818,462,000	$2,557,000
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$214,929,000	$213,678,000	($1,251,000)
Total WIC Expenditures	**$1,093,104,000**	**$1,094,410,000**	**$1,306,000**

The May Revision assumes a monthly average of 959,513 WIC participants in 2018-19, a decrease of 12,466 or 1.3 percent compared to the Governor's January budget. The May Revision assumes a monthly average of 905,182 WIC participants in 2019-20, a decrease of 11,875 or 1.3 percent compared to the Governor's January budget, and a decrease of 54,331 or 5.7 compared to the revised 2018-19 caseload estimate.

Food Expenditures Estimate. The May Revision includes $745.3 million ($519.1 million federal funds and $226.2 million WIC manufacturer rebate funds) in 2018-19 for WIC program food expenditures, a decrease of $11.3 million ($8.4 million federal funds and $2.9 million WIC manufacturer rebate funds) or 1.5 percent, compared to the January budget. The May Revision includes $717.3 million ($503.6 million federal funds and $213.7 million WIC manufacturer rebate funds) in 2019-20 for WIC program food expenditures, a decrease of $12.7 million ($11.4 million federal funds and $1.2 million WIC manufacturer rebate funds) or 1.7 percent compared to the January budget, and a decrease of $28 million ($15.5 million federal funds and $12.5 million WIC manufacturer rebate funds) or 3.8 percent compared to the revised 2018-19 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 $319.4 million for other local assistance expenditures for the NSA budget in 2018-19, an increase of $18.5 million or 6.1 percent compared to the January budget. The May Revision includes $314.8 million for the NSA budget in 2019-20, an increase of $13.9 million or 4.6 percent compared to the January budget, and a decrease of $4.6 million or 1.4 percent compared to the revised estimate for 2018-19. According to DPH, the increases in NSA funding are for grants provided to the Office of Systems Integration to fund the transition to the California WIC Card, an electronic benefit card system that will replace paper checks for WIC recipients.

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 6: California Home Visiting and Black Infant Health Programs – Federal Matching Funds

DOF Issue#: 4265-017-BCP-2019-GB
4265-018-BCP-2019-GB
4265-402-BCP-2019-MR
4265-403-BCP-2019-MR

May Revision Issue. DPH requests reimbursement expenditure authority of $34.8 million annually. If approved, these resources would allow DPH to draw down federal Medicaid funds for services provided by the California Home Visiting Program (CHVP) and the Black Infant Health (BIH) Program to Medi-Cal beneficiaries. For CHVP, DPH is requesting increased reimbursement expenditure authority of $2 million for state operations and $20.9 million for local assistance. For the BIH Program, DPH is requesting increased reimbursement authority of $1.3 million for state operations and $10.7 million for local assistance.

In the January budget, DPH requested 13 positions and General Fund expenditure authority of $23 million annually to expand participation in current and new sites for the California Home Visiting Program (CHVP), and to include new evidence-based home visiting models, with a focus on low-income, young mothers. DPH also requested four positions and General Fund expenditure authority of $7.5 million annually to expand the Black Infant Health Program to improve African-American infant and maternal health.

Combined Program Funding Request Summary – California Home Visiting Program		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund		
State Operations	$2,000,000	$2,000,000
Local Assistance	$21,000,000	$21,000,000
0995 – Reimbursements		
State Operations	$2,000,000	$2,000,000
Local Assistance	$20,869,000	$20,869,000
Total Combined Funding Request:	**$45,869,000**	**$45,869,000**
Total Positions Requested*:	**13.0**	

* Positions and resources ongoing after 2020-21.

Combined Program Funding Request Summary – Black Infant Health Program		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund		
State Operations	$500,000	$500,000
Local Assistance	$7,000,000	$7,000,000
0995 – Reimbursements		
State Operations	$1,300,000	$1,300,000
Local Assistance	$10,650,000	$10,650,000
Total Combined Funding Request:	**$19,450,000**	**$19,450,000**
Total Positions Requested*:	**4.0**	

* Positions and resources ongoing after 2020-21.

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, depression, 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.

The Black Infant Health Program, administered by DPH, 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.

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 changes.

Issue 7: Proposition 99 Adjustments – Health Education, Research, and Unallocated Accounts

DOF Issue#: 4265-031-BBA-2019-GB
4265-402-BBA-2019-MR

Proposition 99 Tobacco Tax Allocations. DPH requests the following technical corrections reflecting changes in Proposition 99 revenues:

Health Education Account
- Item 4265-001-0231 be increased by $950,000
- Item 4265-111-0231 be increased by $500,000

Research Account
- Item 4265-001-0234 be increased by $521,000

Unallocated Account
- Item 4265-001-0236 be increased by $29,000

According to DPH, these adjustments would support state administrative activities and competitive grants.

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 8: Adult Use of Marijuana Act: Cannabis Surveillance and Education

DOF Issue#: 4265-404-BBA-2019-MR

May Revision Issue. The May Revision includes 15 positions and reimbursement expenditure authority of $12 million in 2019-20, transferred by DHCS from the California Cannabis Tax Fund, pursuant to the Adult Use of Marijuana Act approved by voters in 2016. The expenditure authority supporting these positions and resources is continuously appropriated to DHCS from cannabis tax revenue, and will be transferred to DPH under an interagency agreement to conduct cannabis surveillance and education activities.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0995 – Reimbursements	$12,000,000	$-
Total Funding Request:	**$12,000,000**	**$-**
Total Positions Requested:	**15.0**	

Background. The Adult Use of Marijuana Act (Proposition 64) imposes a 15 percent excise tax on the sale of recreational cannabis products sold in the state of California to be deposited in the California Cannabis Tax Fund. Proposition 64 requires tax proceeds deposited in the fund to be distributed as follows:

1) Costs incurred by state agencies for requirements of Proposition 64.
2) $10 million dollars to universities annually for ten years to research the effect of Proposition 64.
3) $3 million dollars annually for five years to the California Highway Patrol to adopt protocols to determine whether a driver is operating a vehicle while impaired by the use of cannabis or cannabis products.
4) $10 million dollars annually in 2018-19, increasing to $50 million dollars in 2022-23 and annually thereafter for the Governor's Office of Business and Economic Development to administer a community reinvestments grants program.
5) $2 million dollars annually to the University of California San Diego Center for Medicinal Cannabis Research.

After disbursing funds for these purposes, 60 percent of the remaining funds are deposited into the Youth Education, Prevention, Early Intervention and Treatment Account and continuously appropriated to DHCS to enter into interagency agreements with DPH and the California Department of Education (CDE) to implement and administer programs for youth that are designed to educate about and to prevent substance use disorders and to prevent harm from substance use. Proposition 64 requires the programs to emphasize accurate education, effective prevention, early intervention, school retention, and timely treatment services for youth, their families and caregivers.

The May Revision reflects a total Proposition 64 allocation of $119.3 million to DHCS for these programs. According to the Administration, $80.5 million will be transferred to CDE to subsidize up to 9,600 child care slots for school-age children up to 13 years old from income-eligible families. $21.5 million will be retained by DHCS for stakeholder engagement, program oversight, and staffing for local programs emphasizing prevention-oriented care that promotes health and well-being for youth. $5.3

million will be transferred to the California Natural Resources Agency to support youth community access grants to support youth access to natural or cultural resources, with a focus on low-income and disadvantaged communities, for positive programming to discourage substance use.

The May Revision also reflects $12 million transferred to DPH to conduct cannabis surveillance and education activities. According to DPH, these resources would be allocated as follows:

1) Data Analysis ($3 million) – DPH staff will gather, analyze, and interpret data from multiple sources to produce surveillance reports, develop targeted educational materials informed by surveillance data, and help provide relevant, actionable information to state and local regulators and stakeholders.

2) Survey Data Purchase and Development ($1 million) – DPH will determine the data questions among multiple survey tools, including the Behavioral Risk Factor Surveillance System, the California Health Interview Survey, and development of a DPH-specific survey tool.

3) Data Interface Development ($6 million) – DPH will integrate various data systems interfaces to create an interoperable system and identify gaps in data. The data systems may include emergency department data, poison control, and emergency medical services data. DPH proposes to integrate four data sets in the first year. Larger investments may be needed at the outset and reduced amounts may be sufficient for ongoing maintenance and operation.

4) Educational Activities ($2 million) – DPH staff will update and enhance its Let's Talk Cannabis website. The updates include development of targeted materials such as fact sheets, frequently asked questions, social media, user friendly data report, references to new research. The enhancements include development of a data dashboard.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposed allocation of cannabis tax revenue.

4440 DEPARTMENT OF STATE HOSPITALS

Issue 1: 2019-20 Program Updates – May Revision Adjustments

DOF Issue#: 4440-043-ECP-2019-GB
4440-044-ECP-2019-GB
4440-045-ECP-2019-GB
4440-047-ECP-2019-GB
4440-049-ECP-2019-GB
4440-050-ECP-2019-GB
4440-051-ECP-2019-GB
4440-053-ECP-2019-GB
4440-058-ECP-2019-GB
4440-089-ECP-2019-MR
4440-090-ECP-2019-MR
4440-091-ECP-2019-MR
4440-092-ECP-2019-MR
4440-093-ECP-2019-MR
4440-094-ECP-2019-MR
4440-095-ECP-2019-MR
4440-096-ECP-2019-MR
4440-097-ECP-2019-MR
4440-100-ECP-2019-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 an operational bed capacity of 1,184.

- **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 an operational bed capacity of 1,286.

- **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 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 an operational bed capacity of 1,255.

- **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 and has 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.

	2018-19	2019-20
Population by Hospital		
Atascadero	1,143	1,106
Coalinga	1,403	1,403
Metropolitan	858	1,046
Napa	1,278	1,278
Patton	1,509	1,484
Population Total	**6,191**	**6,317**
Population by Commitment Type		
Incomptent to Stand Trial (IST)	1,491	1,617
Not Guilty by Reason of Insanity (NGI)	1,396	1,396
Mentally Disordered Offender (MDO)	1,425	1,416
Sexually Violent Predator (SVP)	953	953
Lanterman-Petris-Short Civil Commitments (LPS)	694	703
Coleman Referrals	230	230
Dept. of Juvenile Justice (DJJ)	2	2
Jail-Based Competency Treatment (JBCT) and Contracted Programs		
Kern Admission, Evaluation, and Stabilization (AES) Center	60	60
Riverside JBCT	25	25
Sacramento JBCT (Male and Female)	44	44
San Bernardino JBCT	126	146
San Diego JBCT	30	30
Sonoma JBCT	10	10
Stansislaus JBCT	12	18
Monterey JBCT	10	10
San Joaquin JBCT	--	10
Solano JBCT	12	12
Mendocino JBCT	TBD	TBD
Mariposa JBCT	TBD	TBD
Butte JBCT	5	5
Proposed New JBCT (Northern, Central, and Southern CA)	5	74
Total JBCT Programs	**339**	**444**

Figure 1: State Hospital Population by Hospital, Commitment Type and JBCT Programs
Source: *2019-20 May Revision Estimates, Department of State Hospitals,May 2019*

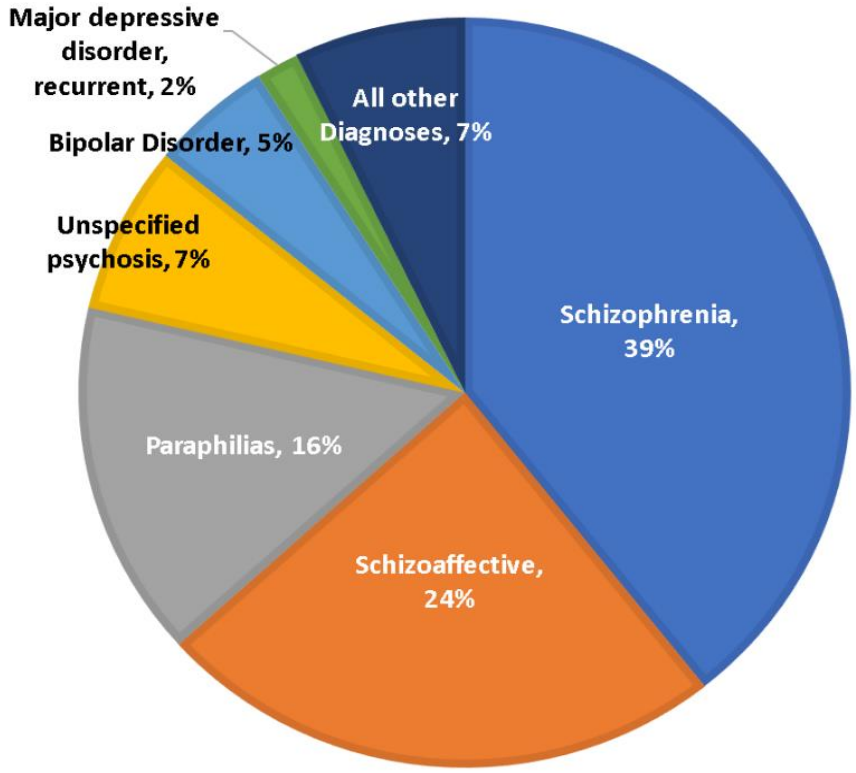

Figure 2: State Hospital Population By Major Diagnosis
Source: *2019-20 Governor's Budget Proposals and Estimates, Department of State Hospitals, January 2019*

Program Update: Patient Driven Operating Expenses and Equipment. In a 2015 report, the Legislative Analyst's Office made recommendations for improvement in the DSH budgeting methodology, including the establishment of a standardized per patient operating expenses and equipment cost estimate and an annual budget adjustment based on patient census. According to DSH, the average operating cost per patient is $19,534 across all five state hospitals, which represents an increase of 18 percent over the last six years. This increase is primarily driven by the costs of pharmaceuticals and outside hospitalization.

Over the past five years, DSH reports its patient population has increased by 547 beds, including expansions of 236 secured beds at Metropolitan State Hospital. However, DSH did not budget for operating expenses and equipment for much of these new beds. The 2018 Budget Act included $3.7 million for the operating expenses and equipment for the 236 secured beds at Metropolitan. Due to delays in unit activations, DSH reports 140 of those beds will not be activated as expected, resulting in $2.2 million General Fund savings in 2018-19.

In the January budget, DSH requested General Fund expenditure authority of $10.5 million annually to support the full cost of operating expenses and equipment for the 547 beds activated since 2012-13 in the five state hospitals.

In the May Revision, DSH requests additional General Fund expenditure authority of $547,000, for a total of $11 million annually, based on updated projected census figures.

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. In 2017-18, DSH had a budgeted LPS capacity of 628. As of July 2018, DSH reported a total LPS census of 690. The 2018 Budget Act included a $20.1 million adjustment in reimbursement authority to account for actual expenditures for LPS patients.

In the January budget, DSH requested additional reimbursement expenditure authority of $606,000 in 2019-20 and annually thereafter. This additional authority would allow DSH to have sufficient authority to accept the expected LPS caseload from county commitments. The amount of this additional authority was calculated based on 2018-19 projected expenditures of $157.4 million, which is $606,000 less than its 2018-19 authority of $156.7 million.

In the May Revision, DSH requests additional reimbursement expenditure authority of $2.7 million in 2019-20 and annually thereafter, for a total increase in reimbursement expenditure authority of $3.3 million. According to DSH, these adjustments are due to updated collection figures.

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. DSH received expenditure authority in previous budgets to make repairs associated with the South Napa Earthquake. As of the 2018 Budget Act, 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	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**

In the May Revision, DSH requests reduction of General Fund expenditure authority of $1.1 million in 2018-19 and $608,479 in 2019-20 as the department will not be proceeding with the completion of the remaining Project 3 repairs, which are comprised of minor cosmetic repairs. DSH reports ongoing challenges and delays in the availability and hiring of labor for this project, leading to no significant efforts towards completing the repairs. In addition, DSH reports these repairs are within patient-occupied areas and would require swing space to complete the project that is currently unavailable.

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 an independent patients' 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 began in September 2018 and was completed February 2019, while construction for the second unit was expected to begin February 2019 and be completed June 2019.

The 2018 Budget Act included reversion of General Fund savings of $4.9 million General Fund in 2017-18 and $4.6 million in 2018-19 related to construction delays of the ETP units. For 2019-20, the 2018 Budget Act included 60.3 positions and General Fund expenditure authority of $8.3 million annually thereafter to fund an additional ETP unit at Atascadero, as well as one unit at Patton. According to DSH, construction for the third unit at Atascadero is expected to begin June 2019 and be completed in September 2019, while construction for the unit at Patton is expected to begin September 2019 and be completed in January 2020.

In the January budget, DSH estimated General Fund savings in 2019-20 of $1.8 million due to a five-month delay for the ETP unit at Patton.

In the May Revision, DSH estimates additional General Fund savings of $2.6 million and a reduction of 7.1 positions in 2018-19 and $716,000 and 2.3 positions in 2019-20, for a total reduction in 2019-20 of $2.5 million. These savings are the result of implementation delays due to unforeseen electrical and ducting work. DSH also proposes to redirect $139,000 of savings in 2019-20 to critical needs identified by the Patton ETP unit.

Program Update: Metropolitan State Hospital Bed Expansion. The 2016 Budget Act included capital outlay construction funding to securely enclose existing patient buildings at Metropolitan State Hospital that housed civilly committed patients under the Lanterman-Petris-Short (LPS) Act. Once secured, the LPS patients 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. The 2017 Budget Act included 22.2 positions in 2017-18, and 38.5 positions and $12.4 million in 2018-19 to prepare for the expansion by relocating LPS patients and hiring hospital police officers. The 2018 Budget Act included a reduction of 10.1 positions and savings of $1.1 million in 2017-18 due to delays in activations. The 2018 Budget Act also included 162.8 positions and $24.8 million in 2018-19 and 342.2 positions and $50.6 million in 2019-20 for patient movement and activation of four new forensic units. The current budget request activates and provides staff for approximately 236 forensic beds between March and November 2019 to treat IST patients.

In the January budget, DSH requested 119.3 positions and General Fund expenditure authority of $18.6 million in 2019-20 and 130 positions and General Fund expenditure authority of $20.1 million in 2020-21 and annually thereafter to activate the newly secured units at Metropolitan to provide increased capacity for the treatment of IST patients.

In the May Revision, DSH requests reduction of 22.5 positions and General Fund expenditure authority of $3.4 million in 2018-19 and reduction of 20.1 positions and General Fund expenditure authority of $3.1 million in 2019-20. These reductions result in a net request of 96.8 positions and General Fund expenditure authority of $15.2 million in 2018-19 and 109.9 positions and General Fund expenditure authority of $17 million in 2019-20. According to DSH, the reduction in requested expenditure authority is due to minor delays in the award of the contract, and a new State Fire Marshall requirement for fire sprinkler pipe fitter companies to have certified workers.

Program Update: Telepsychiatry Resources. In the May Revision, DSH requests 11 positions and General Fund expenditure authority of $2.2 million in 2019-20 and 21 positions and General Fund expenditure authority of $3.7 million annually thereafter. If approved, these resources would allow DSH to expand its use of telepsychiatry as an alternative to providing in-person psychiatric treatment to patients and ensure appropriate delivery of care. Specifically, these resources would add clinical oversight and supervision, telepsychiatry coordinators, as well as information technology equipment and resources.

Program Update: Forensic Conditional Release Program (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 there are currently 14 patients residing in a house and two in a motel throughout California within the county of commitment. DSH has established two rate structures for CONREP-SVPs: 1) $310,000 per SVP where a permanent residence has been established, and 2) $653,000 per CONREP-SVP when ordered as a transient release.

In the January budget, DSH requested General Fund expenditure authority of $768,000 in 2018-19 and $2.1 million annually thereafter. If approved, these resources would support an expected caseload increase of four SVPs in 2018-19, including two transient releases, for a total of 21 SVPs conditionally released to the community by June 2019, and an additional two SVPs released by June 2020 for a total caseload of 23.

In the May Revision, DSH requests a decrease in General Fund expenditure authority of $1 million in 2018-19 and $994,000 in 2019-20, for a net decrease in expenditure authority of $245,000 in 2018-19 and a net increase in expenditure authority of $1.1 million. DSH indicates these downward adjustments are based on a net decrease of two SVP commitments compared to the January budget.

Program Update: Forensic Conditional Release Program (CONREP) – Step-Down Transition Program. In the May Revision, DSH requests General Fund expenditure authority of $5.7 million in 2019-20 and $11.6 million annually thereafter. If approved, these resources would allow DSH to expand its continuum of care for CONREP patients by establishing a step-down program. DSH would contract for a 78-bed vendor operated community step-down program for MDO and NGI patients preparing for conditional release from state hospitals within 18 and 24 months. The requested resources would also allow DSH to expand its existing contract with Sylmar Health and Rehabilitation Center by four beds for a total of 24 beds.

Program Update: Jail-Based Competency Treatment Program Expansions. In the January budget, DSH reported net General Fund savings of $253,000 in 2018-19 composed of one-time cost savings of $1.9 million at San Bernardino and San Joaquin JBCT programs, offset by $1.6 million in increased costs at Sacramento, Sonoma, Mariposa, Solano, Mendocino, and Butte JBCT programs. In the January budget, DSH also requested General Fund expenditure authority of $1.1 million in 2019-20, and $1.7 million in 2020-21 and annually thereafter to activate jail-based competency treatment 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. DSH expects these programs to increase bed capacity by 254 in 2018-19 and 274 in 2019-20.

In the May Revision, DSH requests a reduction in General Fund expenditure authority of $725,000 in 2018-19 and $5.9 million annually thereafter for existing JBCT programs due to activation delays and changes to program capacity.

In the January budget, DSH requested General Fund expenditure authority of $191,000 in 2018-19, $11 million in 2019-20, and $11.4 million in 2020-21 and annually thereafter for the proposed activation of new JBCT programs. DSH proposed: 1) an April 2019 activation of a five-bed JBCT program in a

Southern California county; 2) a July 2019 activation of a five-bed JBCT program in a Central California county, a six-bed JBCT program in a Northern California county, and a 48-bed JBCT program in a Northern California county; and 3) an October 2019 activation of a 10-bed JBCT program in a Southern California County. According to DSH, the cost estimate is based on an expected per diem rate of $420 per patient.

In the May Revision, DSH requests additional General Fund expenditure authority of $2,000 in 2018-19, $5.7 million in 2019-20, and $9,000 annually thereafter. According to DSH, the increase in requested resources are due to updated assumptions regarding the timing of contract execution and program activation for new programs identified in the January budget.

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: Technical Adjustment – Interagency Agreement with Health and Human Services Agency

DOF Issue#: 4440-103-BCP-2019-MR

May Revision Issue. DSH requests reduction of General Fund expenditure authority of $222,000 annually to reflect an adjustment to the interagency agreement between DSH and the California Health and Human Services Agency. This adjustment is related to a commensurate increase in positions and General Fund expenditure authority requested by CHHSA to replace the historical funding for one position provided by DSH.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	($220,000)	($220,000)
Total Funding Request:	**($220,000)**	**($220,000)**

* Resource reduction ongoing after 2020-21.

Background. According to DSH, the department has historically funded one Assistant Secretary position at the Health and Human Services Agency (CHHSA). CHHSA has a companion request that establishes the position authority and funding for the Assistant Secretary position within the CHHSA budget. As a result, this request for a reduction of General Fund expenditure authority of $222,000 annually is consistent with the proposed transfer of funding for the Assistant Secretary position from DSH to CHHSA.

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: Technical Adjustment – California State Lottery Fund

DOF Issue#: 4440-098-BBA-2019-MR

May Revision Issue. DSH requests expenditure authority from the California State Lottery Education Fund of $6,000 annually. These resources reflect updated funding derived from the sale of lottery tickets to fund DSH programs.

Background. The California State Lottery was established in 1985 after approval of a voter initiative. In general, the state distributes approximately 50 percent of lottery sales revenue back to the public in the form of prizes. The state distributes the remaining revenues to public schools, the California State University, the University of California, and various other state entities including DSH. The allocation to DSH is designated for clients with developmental or mental disabilities who are enrolled in state hospital education programs.

According to DSH, the California State Lottery has updated the funding allocations from the California State Lottery Education Fund. DSH requests expenditure authority from the California State Lottery Education Fund of $6,000 annually to reflect this updated funding allocation for DSH education programs for state hospital patients.

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 4: Enhanced Treatment Units - Statewide

DOF Issue#: 4440-304-COBCP-2019-MR

May Revision Capital Outlay Issue. DSH requests General Fund expenditure authority of $2.4 million in 2019-20. If approved, these resources would allow DSH to complete construction of Enhanced Treatment Units at Atascadero and Patton State Hospitals.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$2,387,000	$-
Total Funding Request:	**$2,387,000**	**$-**

Background. AB 1340, Chapter 718, Statutes of 2014, authorized the construction of Enhanced Treatment Units at Atascadero and Patton State Hospitals that will provide a more secure environment for patients that become psychiatrically unstable, resulting in highly aggressive and dangerous behaviors. According to DSH, patients in this state of psychiatric crisis require individualized and intensive treatment of their underlying mental illness, while reducing highly volatile and violent behavior. The proposed units will create secure locations within the existing hospitals to provide a safe treatment environment for both staff and patients. Patients will be housed individually and provided with the heightened level of structure necessary to allow progress in their respective treatment.

Once completed, the Enhanced Treatment Program will provide 39 secured beds at Atascadero State Hospital and 10 beds (female only) at Patton State Hospital. The Atascadero project is currently under construction, and is approximately 25 percent complete. However, DSH reports bids recently received for construction of the Patton project were significantly higher than the state's estimate due to an underestimation of the cost of installing fire sprinklers in an existing facility and for procurement of detention doors, coordination of construction activities of a phased project within a secured environment, and current conditions in the construction services market in San Bernardino. According to DSH, these issues have resulted in the need to provide additional funding to complete construction of the project at Patton.

DSH requests General Fund expenditure authority of $2.4 million in 2019-20 to allow DSH to complete construction of the Enhanced Treatment Units at Atascadero and Patton State Hospitals. DSH expects the total project will cost $16 million, including $1.2 million for preliminary plans, $869,000 for working drawings, and $13.9 million for construction. The preliminary plans and working drawings components of the project have been completed. If approved, this request would only support completion of construction for the Enhanced Treatment Units.

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.

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES
4440 DEPARTMENT OF STATE HOSPITALS

Issue 1: Relocation to the Clifford L. Allenby Building

DOF Issue#: 4300-410-BCP-2019-MR
4440-077-BCP-2019-MR

May Revision Finance Letter. The California Health and Human Services Agency (CHHSA), in collaboration with the Department of Developmental Services (DDS) and DSH request positions and resources to support the services and equipment necessary to relocate these entities to the new Clifford L. Allenby Building in January 2021. The components of this request are as follows:

DSH requests two limited-term positions and General Fund expenditure authority of $4.9 million in 2019-20, $1.8 million in 2020-21, and $2.8 million annually thereafter.

DDS requests one position and General Fund expenditure authority of $3.4 million in 2019-20, $1.8 million in 2020-21, $1.2 million in 2021-22 and 2022-23, and $1.4 million annually thereafter. The subcommittee will hear the DDS portion of this request during consideration of the DDS May Revision adjustments.

Program Funding Request Summary - DDS		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$3,401,000	$1,814,000
Total Funding Request:	**$3,401,000**	**$1,814,000**
Total Positions Requested:**	**1.0**	

* Additional fiscal year resources requested: 2021-22 to 2022-23: $1,185,000; 2023-24 and ongoing: $1,429,000
** Positions are ongoing.

Program Funding Request Summary - DSH		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$4,891,000	$1,760,000
Total Funding Request:	**$4,891,000**	**$1,760,000**
Total Positions Requested:**	**2.0**	

* Additional fiscal year resources requested: 2021-22 and ongoing: $2,760,000;
** Positions are limited-term and expire at the end of 2020-21.

Background. A 2015 study of Sacramento state office infrastructure identified serious deficiencies with existing state building including the Bateson Building, occupied by CHHSA, DDS, and DSH. The 2016 Budget Act included a $1.3 billion transfer over two years from the General Fund to a new State Project Infrastructure Fund to be used specifically for the renovation or replacement of state office buildings in the Sacramento area. One of the initial projects that received funding was the construction of a new building at 1215 O Street in Sacramento to replace the vacant Department of Food and Agriculture Annex. Since that time, CHHSA, DDS and DSH were chosen as the new building's future tenants and the building has been named the "Clifford L. Allenby Building (Allenby Building)." Construction of the

Allenby Building is currently underway, and all three departments expect to occupy the building beginning in January of 2021.

According to the DDS and DSH, to physically move to, occupy and conduct business in the new Allenby Building, the departments must move some of the current office contents to the Allenby Building and decommission the Bateson Building, outfit the new building with necessary items and equipment not included in the project's scope of work, and reduce the current Bateson Building document storage footprint to fit into the new storage space. The three departments are currently pursuing a shared contract for moving services to relocate each department's office contents and equipment from the Bateson Building to the Allenby Building. This contract would also include the disposal of surplus assets and equipment. The Bateson Building decommission would include the removal of the data cables from all workstations and the disconnection of all hard-wired connections to existing furniture.

DDS and DSH report that if the three departments are to physically fit their documents into the new building, the current document storage footprint will have to be reduced significantly. Part of the expectation of tenancy in the Allenby Building is a 50 to 70 percent reduction in storage needs. Each department is currently reviewing their respective document retention schedules and plan to update them before the end of 2018-19. This will be followed by the destruction of documents as permitted by the retention schedule and organization of the remaining documents into a system conducive for digitalization. Despite this effort, the departments anticipate a need to further reduce storage needs by January of 2021 to meet the Allenby Building's requirements.

According to DDS and DSH, the requested resources would fund the following activities:

Move to the New Allenby Building – Moving to the new building includes physical relocation of the contents of the Bateson building and required removal of surplus items and certain electronic and telecommunication connections. The Department of General Services (DGS) will be contracting with a professional moving consultant to conduct a comprehensive review of the established acquisition and relocation strategies developed by the tenant agencies.

New Equipment Required for the Allenby Building – The DGS capital outlay project does not include all the equipment that will be necessary for the three departments to function in the new building. Certain items must be purchased by the individual departments and installed in the Allenby Building prior to occupancy. The operation and management of an energy efficient and robust shared enterprise IT environment in the new building entails the following composite hardware, software, network resources and services:

- Migration of on premise business applications and server infrastructure to the cloud
- Cloud performance monitoring tools
- Network infrastructure which includes the Local Area Network, Wide Area Network, Wireless LAN
- Personal computer deployments
- Print and Fax management
- Telecommunications
- Project management

Short and Long-Term Document Solution – The three departments must reduce the current document storage space to physically fit into the Allenby Building. To do this, the departments propose to contract with an outside vendor which would scan and store the existing 38 million documents housed in the Bateson Building. The three departments report that, due to need to scan all these documents by January 2021, an outside contract would contract with the departments to scan, electronically store, and then destroy all the existing documents by the proposed move date. The cost for this service would be approximately $4 million and would require about a $1,000 per month in user fees for as long as the departments use the system.

Positions and Funding Requested – DDS requests one position and General Fund expenditure authority of $3.4 million in 2019-20, $1.8 million in 2020-21, $1.2 million in 2021-22 and 2022-23, and $1.4 million annually thereafter. DSH requests two limited-term positions and General Fund expenditure authority of $4.9 million in 2019-20, $1.8 million in 2020-21, and $2.8 million annually thereafter. According to the departments, the DDS funding would support **one Staff Services Manager I** position that would provide IT support.

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.

4120 EMERGENCY MEDICAL SERVICES AUTHORITY
4265 DEPARTMENT OF PUBLIC HEALTH
4440 DEPARTMENT OF STATE HOSPITALS
5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: Disaster Preparedness, Response, and Recovery

DOF Issue#: 4120-401-BCP-2019-MR
4265-401-BCP-2019-MR
4440-087-BCP-2019-MR
5180-407-BCP-2019-MR

May Revision Issue. The Administration proposes new positions and additional General Fund and special fund expenditure authority for various departments, including EMSA, DPH, DSH, and DSS, to enhance the state's disaster preparedness, response, and recovery capabilities.

Program Funding Request Summary - EMSA		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$979,000	$303,000
Total Funding Request:	**$979,000**	**$303,000**
Total Positions Requested*:	**2.0**	

* Positions and resources ongoing after 2020-21.

Program Funding Request Summary - DPH		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$569,000	$569,000
3098 – Licensing and Certification Program Fund	$390,000	$390,000
Total Funding Request:	**$959,000**	**$959,000**
Total Positions Requested*:	**6.0**	

* Positions and resources ongoing after 2020-21.

Program Funding Request Summary - DSH		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$996,000	$826,000
Total Funding Request:	**$996,000**	**$826,000**
Total Positions Requested*:	**6..0**	

* Positions and resources ongoing after 2020-21.

Program Funding Request Summary - DSS		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$2,943,000	$2,739,000
Total Funding Request:	**$2,943,000**	**$2,739,000**
Total Positions Requested*:	**20.0**	

* Positions and resources ongoing after 2020-21.

Statewide Disaster Preparedness, Response, Recovery. According to the Administration, California is experiencing unprecedented wildfire activity with increases in the number and severity of wildfires. 15 of the 20 most destructive wildfires in the state's history have occurred since 2000 and ten of the most destructive fires have occurred since 2015. The fire season is getting longer each year with many parts of the state experiencing nearly year-round fire danger. Climate change has led to historic periods of drought, which has created critically dangerous fuel conditions and resulted in over 147 million dead or dying trees. Additionally, growth in the wildland urban interface has put more Californians at risk than ever before. More than 25 million acres of the state's wildlands are classified as under very high or extreme fire threat. The catastrophic wildfire activity in 2018, including the Camp, Woolsey, and Hill fires, underscores the serious dangers that current conditions pose to individuals and communities in high-risk areas of the state.

Based on lessons learned and because of the increased magnitude, frequency, and complexity of recent disasters, the Administration proposes $39.9 million ($38.6 million General Fund) and 159.5 positions for various departments to enhance the state's disaster preparedness, response, and recovery capabilities; support the continuity of state government during disasters, and increase technical proficiency to best position the state to maximize appropriate federal reimbursements of billions of dollars. This includes resources to enhance disaster contingency planning and preparedness for the following departments:

- Office of Emergency Services (Cal OES)—$5.9 million in ongoing funds ($5.1 million General Fund) and 76 positions to enhance Cal OES disaster preparedness and response capacity for future state disasters. Without the appropriate tracking and coordination of disaster costs, California would be at risk of losing federal funding.

- Department of Housing and Community Development—$2 million General Fund (with $740,000 in ongoing resources) and four positions to create a permanent Disaster Response and Recovery Unit that will provide housing expertise in coordination with statewide disaster recovery efforts and to hire a consultant that will conduct local needs assessments related to the 2018 Camp and Woolsey fires as well as create local long-term recovery plan frameworks.

- State Water Resources Control Board—$1 million ongoing General Fund and six positions to improve emergency response capabilities between the State Water Board, regional boards, and other state entities during emergencies. These resources will enable the Water Board to lessen the impacts of disasters on vulnerable populations by addressing a wide range of issues in the periods following and between emergencies, including addressing engineering and operation issues facing drinking water systems and waste water utilities, and preventing or minimizing impacts to water quality, water supply security, and safety.

- Department of Resources Recycling and Recovery—$2.8 million ongoing General Fund and 21.5 positions for the Department to continue its significant role in emergency response mission tasking responsibilities. These resources will establish a dedicated team to help facilitate timely, safe, and effective debris removal operations as well as to assist local governments in the preparation of debris removal plans for future incidents.

- Emergency Medical Services Authority—$979,000 ongoing General Fund and two positions to increase disaster medical services capacity, including coordination of medical assets during

emergency response efforts and one-time purchases of medical treatment and communications equipment.

- Department of Public Health—$959,000 in ongoing funds ($569,000 General Fund) and six positions to support health care facilities and mass care shelters during emergencies as well as disaster preparedness, response, and recovery efforts. Activities will include deployment of infection control teams and continuous updates to an existing health facility mapping application used during disasters.

- Department of State Hospitals—$996,000 ongoing General Fund and six positions to improve emergency coordination and preparedness, and business continuity planning at five state hospitals and the Department of State Hospitals headquarters. The additional resources will enhance the Department's ability and capacity to more effectively care for patients and coordinate staff in the event of a disaster.

- Department of Social Services—$2.9 million ongoing General Fund and 20 positions to support the Department of Social Services' mandated disaster planning, coordination, and training activities. The Department is responsible for statewide mass care and shelter responsibilities, as designated by Cal OES.

Emergency Medical Services Authority. According to EMSA, the rapidity of its ability to provide emergency medical care to disaster victims is critical in any disaster or major event. While EMSA plans and stands ready for California's threat of a major earthquake, tsunami, flooding or volcano; recent wildfire response activities have identified gaps in response capabilities. EMSA is requesting General Fund expenditure authority of $979,000 to support the following:

Medical Treatment Site Deployment – $256,000 and 2 positions
These resources would support **two Emergency Medical Services Coordinators** to support preparedness, response, and recovery medical services operations.

Bio-Medical/ Medical Supply – $169,000
According to EMSA, some of its bio-medical equipment, such as portable ventilators, AEDs, intravenous fluid pumps, is beyond the average lifespan. The requested bio-medical/medical supply items are generally more compact, durable and efficient, providing increased field reliability and capability.

Medical Treatment Site Deployment Equipment – $103,000
This funding would supply lighting for safety and security at the EMSA base of operations, to allow 24 hour operation, rather than having to wait for rented light towers to arrive. This funding would also be used to purchase basic fire safety equipment for deploying personnel into active fire areas, such as fire shelter packs and helmets.

Fleet/ Station – $189,000
This funding would allow EMSA to purchase a stake bed truck with a four-wheel drive rough terrain forklift attachment, and three UTV-style vehicles that allow for movement of supplies, equipment and personnel, due to the size of base of operations or shelters\close quarters of other structures in which regular vehicles would not be allowed and rough roadway conditions. This funding would also support

the replacement of the generator on EMSA's command and control vehicle due to poor performance operating communications equipment.

Communications/Information Technology – $262,000
This funding would replace the rack radios, communications rack, upgrade telex radio dispatch panel and update the V-Sat system on the command and control vehicle. The radio stacks in the three Mission Support Team vehicles would also be replaced. According to EMSA, these dated systems and legacy devices are slow, unreliable and often incompatible with the EMSA's response partner's communication infrastructure.

Department of Public Health. Public Health requests six positions and annual expenditure authority of $959,000 ($569,000 General Fund and $390,000 Licensing and Certification Program Fund), to address California's continuing efforts to better prepare for public health emergencies, response, and recovery efforts. Of the six positions, 2.5 positions would directly serve health facilities and may be funded through licensing fees. These resources would support **three Staff Services Manager I Specialists, two Nurse Consultants,** and **one Information Technology Specialist I** position, based out of the department's Emergency Preparedness and Disaster Response Unit, which would support the recovery of the health care delivery system by collectively exploring and pursuing opportunities for rebuilding after an emergency event and options that allow health care facilities to return to operations quickly. These opportunities and options may include submitting waiver requests, reviewing and approving regulatory flex requests, and applying for various reimbursement mechanisms.

Department of State Hospitals. According to DSH, during a disaster, state hospitals are responsible for the lives, safety, care, and treatment of medically fragile, severely mentally ill, and forensic patients. Each of the five state hospitals have over 1,000 patients and employ thousands of staff who are responsible for the patients' care. Hospital emergency preparedness, staff training, plan exercises, and mitigation to protect this fragile and high-risk population is critical to ensure healthcare personnel are ready to respond effectively to a crisis and keep patients safe from harm. While DSH has demonstrated the ability to care for the patient population and communicate with staff and emergency management partners during a disaster, the October 2017 Atlas/Tubbs fire experiences have identified gaps in response capabilities. DSH request six positions and annual General Fund expenditure authority of $996,000 to support the following:

Expanded Emergency Notification System – $50,000
DSH seeks to utilize the current partnership with DDS to expand the existing emergency notification system used for Sacramento employees into a statewide network. This system expansion would increase the number of employees who are able to receive emergency notifications from 515 in Sacramento to over 11,000 statewide. This system could also be used to notify and communicate critical information during an emergency event with the families and guardians of nearly 7,000 patients.

Emergency Satellite Phone Network Expansion for Hospitals – $30,000 annually, $20,000 in 2019-20.
According to DSH, each state hospital sits upon a large parcel of land, includes dozens of buildings, uses secure treatment areas with significant security and access restrictions, and services a variety of critical safety, treatment and infrastructure operations. Each hospital has four satellite phones currently, and this proposal would raise that number to nine satellite phones per site. The Sacramento headquarters has four satellite phones.

Emergency Intermediate Operations Facility for Business Continuity – $30,000
During the October 2017 Atlas-Tubbs fires impacting Napa State Hospital, the facility's power, cellular communications, access to the internet, DSH email, and patient data systems were disabled. Napa staff convened in the executive director's conference room and communicated with emergency responders and DSH headquarters via a land-line "red phone" emergency communications system. DSH proposes to contract services for mobile emergency operations facilities that would be delivered to a designated site and activated with office space, satellite links for technology and communications, power generators and experienced personnel to support activation and decommissioning of the facility. These facilities would service 20 Emergency Operations Center management and staff to administer life and safety decisions and business continuity administration.

Business Continuity Plan Statewide Consolidation Consultant – $150,000 in 2019-20
DSH currently conducts the emergency preparedness, response, and recovery activities with a 2016-2021 Business Continuity Plan and five hospital Emergency Operational Plans (EOP). This proposal would use expert consultant guidance to create, consolidate and coordinate existing plans into one statewide "Business Continuity, Response and Recovery Plan" for all six sites. The consultant would evaluate current plan connectivity, propose consolidation designs, draft the approved consolidation plan for review, and upon approvals would conduct training and hospital exercises at each site. Following the plan approval, training, and exercises, the consultant would provide an evaluation for future improvements to be addressed by DSH.

Emergency Management Coordinators – $716,000
DSH proposes to recruit an Emergency Management Services Coordinator for each hospital, and one Senior Emergency Management Coordinator in Sacramento to organize and coordinate efforts statewide. These coordinators would be responsible for emergency preparedness coordination at each hospital and would work with headquarters to establish a standardized, consistent, and coordinated statewide emergency preparedness program. The coordinators would be responsible for integrating the needs and program deliverables of Fire/Police, Medical/Clinical, Administration/Health and Safety, Infrastructure/Plant Operations into the "Emergency Operation/Business Continuity Plan," and conduct training, exercises, and performance evaluations. The coordinators would work with subject matter experts to ensure compliance with regulatory/oversight agency requirements, including The Joint Commission. The coordinators would work with the senior management coordinator to improve existing systems, test those systems, and develop recommendations for improvements to meet DSH emergency response and management needs.

Department of Social Services. The Administration requests that Item 5180-001-0001 be increased by $2.9 million and 20 positions to support mandated disaster preparedness, response, and recovery operations related to the Department of Social Services' mass care and shelter responsibilities. This proposal is part of the Administration's larger Disaster Preparedness, Response, and Recovery May Revision package. Based on lessons learned and due to the increased magnitude, frequency, and complexity of recent disasters and those likely to come, the May Revision includes resources for various departments to enhance the state's disaster response preparedness and support the continuity of state government during disasters.

DSS is 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, and in the California Disaster Recovery Framework as the lead for Social Services Recovery for the state. Prior to 2015, incidents requiring state

Mass Care & Shelter leadership and support were infrequent, but disasters, specifically fires, in California are increasing in frequency and destructiveness. The October 2017 Wildfires forced tens of thousands to evacuate and destroyed over 5,000 homes. Mass Care and Shelter operations included over 50 shelters being supported and incurred an estimated 15,000 hours of staff time for response and recovery. This figure does not capture additional workload associated with training, demobilization, and administrative work associated with a disaster response.

Even with staff members working long hours (nearly 300 hours of overtime a month in some cases). Disaster Services Bureau programs are experiencing delays in service delivery during fire response. Inadequate bandwidth to mobilize and deploy mass care and shelter support workforce has resulted in a lack of adequate staffing at shelters in every major fire over the past two years. Grant processing can be delayed, causing citizens to wait for critical financial assistance.

According to the department, approval of the requested staff resources will allow DSS to increase mass care capabilities and strengthen relationships with community non-profit, tribal, local, state, and federal partners. Additionally, these staff will allow the department to build critical capacity necessary to carry out its disaster-related responsibilities. Utilizing the requested resources, the department intends to complete the following annual tasks:

- Develop and/or revise 24 local, state, and federal mass care and social services recovery plans.
- Conduct 48 training courses and exercises to internal and external stakeholders.
- Deploy 25 additional specialized staff to local, state, and federal emergency operations centers to coordinate mass care response and social services recovery operations.
- Complete 120 critical shelter facility assessments.
- Coordinate and facilitate 12 Regional Mass Care and Shelter Workshops.
- Develop and/or revise 12 departmental disaster program response/recovery plans.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions. The subcommittee has requested EMSA, DPH, DSH, and DSS to respond to the following:

1. Please provide a brief overview of these proposals.

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

SUBCOMMITTEE NO. 3 Agenda

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

Tuesday, May 14, 2019
10:00 a.m.
State Capitol - Room 4203

PART B

Consultant: Renita Polk

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ISSUES FOR VOTE ONLY

4170 DEPARTMENT OF AGING (CDA)

Issue 1: Community Based Adult Services Additional Staffing for Mandate Compliance (Governor's Budget)

Governor's Proposal. CDA requests $751,000 ($427,000 federal funds and $324,000 General Fund) and four positions to ensure that Community Based Adult Services (CBAS) provider recertification is occurring within the statutorily required timeframe and those providers are complying with new federal rules.

This issue was heard during the subcommittee's March 14th hearing.

Staff Comment and Recommendation. Approve as budgeted.

Issue 2: Spring Finance Letter (SFL) – SSI Cash-out Reversal Implementation via Area Agencies on Aging (AAA)

Budget Issue. CDA requests reimbursement authority of $1.7 million to implement the SSI Cash-out Reversal, or the CalFresh expansion, via the AAAs. $200,000 will fund departmental operations, and $1.5 million will be distributed to the AAAs for CalFresh application assistance and outreach.

This issue was heard during the subcommittee's May 9th hearing.

Staff Comment and Recommendation. Approve as requested.

Issue 3: SFL – Federal Title III Funding Augmentation

Budget Issue. CDA requests federal fund authority of $17.5 million and seven positions due to an increase in federal Title III funding. $897,000 will be used for operations, and $16.6 million will be for local assistance.

This issue was heard during the subcommittee's May 9th hearing.

Staff Comment and Recommendation. Approve as requested.

Issue 4: SFL - Medicare Improvements for Patients and Providers Act (MIPPA) Authority

Budget Issue. CDA requests a revision of budget bill language in Item 4170-101-0890 to allow for augmentation of the MIPPA federal grant authority.

This issue was heard during the subcommittee's May 9th hearing.

Staff Comment and Recommendation. Approve as requested.

5160 DEPARTMENT OF REHABILITATION (DOR)

Issue 1: Mission-Based Review (Governor's Budget)

Governor's Proposal. The Governor's budget includes additional resources for the department's VR and TBI programs, separated into the following three components:

- $3.4 million General Fund annually for a ten percent increase to Community Rehabilitation Program provider rates.
- $1.6 million General Fund for improvements to the department's information technology (IT) infrastructure.
- $1.2 million General Fund annually until 2023-24 to fund the department's TBI program.

This issue was heard during the Subcommittee's May 2nd hearing.

Staff Comment and Recommendation. Approve as budgeted.

Issue 2: CalFresh Outreach via ILCs (SFL)

Governor's Proposal. CDA requests an increase of $2.5 million in reimbursement authority for 2019-20 to assist with implementation and oversight of the state's CalFresh program outreach plan. The Department of Social Services (DSS) will reimburse DOR for costs in communicating new eligibility requirements for the Supplemental Nutrition Assistance Program (SNAP).

This issue was heard during the Subcommittee's May 2nd hearing.

Staff Comment and Recommendation. Approve as requested.

5175 DEPARTMENT OF CHILD SUPPORT SERVICES

Issue 1: Human Services Technical BCP - Voluntary Parentage Establishment Program (Governor's Budget)

Governor's Proposal. The Governor's budget includes three-year limited-term funding in the amount of $596,000 ($199,000 General Fund) for the implementation of AB 2684 (Bloom), Chapter 876, Statutes of 2018.

This issue was heard during the Subcommittee's March 28th hearing.

Staff Comment and Recommendation. Approve as budgeted.

5180 DEPARTMENT OF SOCIAL SERVICES – STATE HEARINGS DIVISION

Issue 1: Appeals Case Management System (ACMS) Permanent Maintenance & Operations Support (Governor's Budget)

Governor's Proposal. The Administration requests $395,000 ($151,000 General Fund) and three positions to be a part of the state's maintenance and operations and project management support team for the Appeals Case Management System (ACMS).

This issue was heard during the Subcommittee's March 28th hearing.

Staff Comment and Recommendation. Approve as budgeted.

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

Issue 1: Human Services Technical BCPs – AB 605 and AB 2370 (Governor's Budget)

Governor's Proposal. The Governor's budget includes the following CCL-related technical proposals.

1. AB 605 Implementation. The Governor's budget includes $394,000 General Fund in 2019-20; $253,000 General Fund in 2020-21; and $127,000 General Fund in 2021-22 in order to implement AB 605 (Mullin), Chapter 574, Statutes of 2018. AB 605 requires the Community Care Licensing Division (CCLD) to adopt regulations by January 1, 2021 that would create a childcare center license with individual program components that service infant, toddler, preschool, and school age children.

2. AB 2370 Implementation. The Governor's budget includes $142,000 General Fund in 2019-20 and $127,000 General Fund ongoing to implement AB 2370 (Holden), Chapter 676, Statutes 2018. AB 2370 requires the CCLD, in consultation with the State Water Resources Control Board, to adopt regulations to test a licensed child day care facility's drinking water for lead contamination levels beginning January 1, 2020, but no later than January 1, 2023 and every five years thereafter.

3. Strengthening Program Infrastructure. The Governor's budget includes $2.5 million in 2019-20; $2.5 million in 2020-21; and $375,000 General Fund every year thereafter for three permanent positions and the extension of $1.92 million temporary Technical Assistance Fund (TAF) through 2020-21. The requested resources will address workload associated with Adult and Senior Care Residential Facility license application processing and a backlog of complaint investigations in the Children's Residential Program.

These issues were heard during the Subcommittee's April 4th hearing.

Staff Comment and Recommendation. Approve as budgeted.

Issue 2: Human Services Technical BCPs – AB 2455 (Governor's Budget)

Governor's Proposal. The Governor's budget includes a one-time augmentation of $300,000 to implement AB 2455 (Kalra), Chapter 917, Statutes of 2018. AB 2455 requires the CCLD, after July 1, 2019, to share, upon a labor organization's request, the name, phone number, and cell phone number, if available, of each newly registered or renewed Home Care Aide, who has not opted-out of sharing this information. It also requires Department of Social Services (DSS) to develop a simple opt-out procedure for aides and applicants to request that their contact information not be disclosed.

These issues were heard during the Subcommittee's April 4th hearing.

Staff Comment and Recommendation. Approve as budgeted.

5180 DEPARTMENT OF SOCIAL SERVICES – CHILD WELFARE SERVICES (CWS)

Issue 1: The Office of Foster Care Ombudsperson Foster Child Complaint Investigation (Governor's Budget)

Governor's Proposal. The Governor's budget proposes an increase of $894,000 ($407,000 General Fund) in 2019-20 and $779,000 ($354,000 General Fund) in 2020-21 for limited-term two-year resources to address an increased caseload backlog associated with the investigation of complaints about child welfare and foster care.

This issue was heard during the Subcommittee's April 4th hearing.

Staff Comment and Recommendation. Approve as budgeted.

Issue 2: State-Tribal-County Engagement and Indian Child Welfare Act Compliance (Governor's Budget)

Governor's Proposal. The Governor's budget proposes an increase of $797,000 ($392,000 General Fund) in 2019-20 and 2020-21 for limited-term two-year resources to address workload associated with new state and federal regulations and to support counties with technical assistance and specialized training.

This issue was heard during the Subcommittee's April 4th hearing.

Staff Comment and Recommendation. Approve as budgeted.

Issue 3: CWS-related Human Services Technical BCPs (Governor's Budget)

Governor's Proposal. The Governor's budget includes the following CWS-related technical proposals.

1. Child Wellbeing Waiver Project. The Governor's budget includes $1.6 million ($454,000 General Fund) in 2019-20 and $909,000 ($454,000 General Fund) in 2020-21 to extend limited-term resources for the phase-down of the Child Well-being Waiver Project. Additionally, funding would be used for the project evaluation contract that was funded, but not executed in 2014-15.

2. AB 2967 – Ensuring Foster Youth Have Access to Vital Documents. The Governor's budget includes $122,000 ($56,000 General Fund) in 2019-20 and $114,000 ($52,000 General Fund) in 2020-21 in order to implement AB 2967 (Quirk-Silva), Chapter 551, Statues of 2018. AB 2967 requires a county welfare agency to verify the eligibility of an applicant requesting a free copy of their birth certificate, based on the qualification of being a current or former foster youth.

These issues were heard during the Subcommittee's April 4th hearing.

Staff Comment and Recommendation. Approve as budgeted.

Issue 4: CCR-related Human Services Technical BCPs (Governor's Budget)

Governor's Proposal. The Governor's budget includes the following CCR-related technical BCPs.

1. AB 2083 Implementation. The Governor's budget includes $413,000 in 2019-20 and $292,000 ongoing to implement AB 2083 (Cooley), Chapter 815, Statutes of 2018. AB 2083 requires both the state and local governments to create integrated programs serving children under both the Short-Term Residential Therapeutic Program (STRTP) and Therapeutic Foster Care models of care, as well as through integrated implementation of Child and Family Teams and the CANS tool.

2. CCR Increased Workload. The Governor's budget includes $4.4 million ($3.1 million General Fund) in 2019-20 and 2020-21 for 34 limited-term positions to address additional workload and compliance requirements associated with CCR.

These issues were heard during the Subcommittee's April 4th hearing.

Staff Comment and Recommendation. Approve as budgeted.

5180 DEPARTMENT OF SOCIAL SERVICES (DSS) – IMMIGRATION SERVICES BRANCH

Issue 1: Human Services Technical BCP – Immigration Initiatives and Legal Services State Support (Governor's Budget)

Governor's Proposal. The Governor's budget includes $885,000 for six positions to support the increase in capacity to provide immigration services and support interdepartmental immigrant integration efforts.

This issue was heard during the Subcommittee's April 11th hearing.

Staff Comment and Recommendation. Approve as budgeted.

5180 DEPARTMENT OF SOCIAL SERVICES – SSI/SSP AND CALFRESH

Issue 1: SSI/SSP and CalFresh Expansion (Governor's Budget)

Governor's Proposal. The Governor's budget includes $1.4 million ($711,000 General Fund and $710,000 federal funds) to expand CalFresh to SSI/SSP recipients (also known as reversal of the SSI Cash-out policy), along with the Supplemental and Transitional Nutrition Benefit programs. The request includes two-year limited-term funding for eleven positions.

This issue was heard during the Subcommittee's March 14th hearing.

Staff Comment and Recommendation. Approve as budgeted.

5180 DEPARTMENT OF SOCIAL SERVICES – CALFRESH

Issue 1: Human Services Technical BCP – California Fruit and Vegetable EBT Pilot (Governor's Budget)

Governor's Proposal. The Governor's budget includes $311,000 in 2019-20 and 2020-21 for the implementation of the California Fruit and Vegetable EBT pilot. The 2018 Budget Act included $9 million to cover all costs of this pilot, of which $311,000 is being requested in both 2019-20 and 2020-21 to carry out state operations activities.

This issue was heard during the Subcommittee's April 11th hearing.

Staff Comment and Recommendation. Approve as budgeted.

ISSUES FOR DISCUSSION

4170 DEPARTMENT OF AGING

Issue 1: Long-Term Care Ombudsman Augmentation (May Revision)

May Revision. The Administration requests that Item 4170-102-0942 be increased by $1 million to provide additional one-time funding to local Long-Term Care Ombudsman programs. The 2018 Budget Act includes provisional language that allows the Department of Finance to augment Item 4170-102-0942 by up to $1 million if the 2018-19 ending fund balance of the State Health Facilities Citation Penalties Account is projected to exceed $6 million. The Department of Finance currently projects the 2018-19 ending fund balance to be approximately $9.9 million.

Staff Comment and Recommendation. Hold open.

5160 DEPARTMENT OF REHABILITATION (DOR)

Issue 1: Supported Employment – Provider Rate Adjustment (May Revision)

May Revision. The Administration requests Item 5160-001-0001 be increased by $1.3 million to reflect a two-year limited-term provider rate increase for supported employment services, effective January 1, 2020. This adjustment aligns Vocational Rehabilitation program provider rates with those of the Department of Developmental Services for this service category.

Legislative Analyst's Office (LAO) Comment. In general, the LAO has expressed concerns with many proposals within the May Revision where the Governor chooses to treat policies that are fundamentally ongoing in nature as temporary, which creates programmatic challenges and increases cost pressures. According to the LAO, this approach implicitly prioritizes new ongoing spending proposals largely at the expense of existing programmatic commitments.

Staff Comment and Recommendation. Hold open.

5175 DEPARTMENT OF CHILD SUPPORT SERVICES

Issue 1: May Revision Estimate

May Revision. The Administration requests that Item 5175-101-0890 be increased by $2.6 million and Item 5175-101-8004 be decreased by $2.6 million to reflect revised forecasts of child support collections. Total costs for local assistance are estimated to be $912.8 million ($283.3 million General Fund) in 2019-20. Total child support collections and revenues are projected to be $2.59 billion ($174.5 million General Fund) for 2019-20.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – AUTOMATION PROJECTS

Issue 1: CWS-CARES (Issue 406-MR)

May Revision. The Administration requests that Items 5180-001-0001 and 5180-001-0890 both be increased by $539,000 to provide two-year limited-term resources through fiscal year 2020-21 to support continuing development and implementation of the CWS-CARES project.

Staff Comment and Recommendation. Hold open.

Issue 2: BBL - California Statewide Automated Welfare System (CalSAWS) Augmentation

May Revision. The Administration requests that Provision 8 be added to Item 5180-141-0001 and Provision 1 of Item 5180-141-0890 be amended to authorize an increase in expenditures related to mid-year changes in CalSAWS project schedule and costs.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – VARIOUS PROGRAMS

Issue 1: May Revision Caseload Adjustments (Issues 401-MR, 402-MR, 403-MR, 404-MR, and 405-MR)

May Revision. The May Revision proposes a net increase of $266.4 million (increases of $71.6 million General Fund, $354.6 million reimbursements, $189,000 Emergency Food Assistance Program Fund, and $146,000 School Supplies for Homeless Children Fund, partially offset by decreases of $160.2 million Federal Trust Fund, and $2,000 Child Health and Safety Fund) primarily resulting from updated caseload estimates since the Governor's budget. Caseload and workload changes since the Governor's budget are displayed in the following table:

Program	Item	Change from Governor's Budget
CalWORKs	5180-101-0001	($34,503,000)
	5180-101-0890	($15,783,000)
	Reimbursements	$11,000
Kinship Guardianship Assistance Payment	5180-101-0001	$1,145,000
SSI/SSP	5180-111-0001	($18,015,000)
IHSS	5180-111-0001	$136,279,000
	Reimbursements	$344,990,000
Other Assistance Payments	5180-101-0001	($17,899,000)
	5180-101-0122	$189,000
	5180-101-0890	($19,252,000)
	5180-101-8075	$146,000
County Administration and Automation Projects	5180-141-0001	($2,421,000)
	5180-141-0890	($19,784,000)
	Reimbursements	($6,935,000)
Community Care Licensing	5180-151-0890	$214,000
Special Programs	5180-151-0001	$7,723,000
Realigned Programs		
Adoption	5180-101-0890	$1,777,000
Foster Care	5180-101-0890	($283,000)
	5180-141-0890	($366,000)
Child Welfare Services (CWS)	5180-151-0001	$8,061,000
	5180-151-0279	($2,000)
	5180-151-0890	($61,907,000)
	Reimbursements	$449,000
Title IV-E Waiver	5180-153-0001	($8,759,000)
	5180-153-0890	($44,913,000)
Adult Protective Services	5180-151-0890	$81,000
	Reimbursements	$16,114,000

Staff Comment and Recommendation. Hold open.

Questions.

1. DSS: Please provide an overview of the May Revision estimates for major programs.

2. LAO: Are the estimates reasonable?

Issue 2: Special Olympics (Issue 423-MR)

May Revision. The Administration requests that Item 5180-101-0001 be increased by $2 million to provide one-time funding for the Special Olympics. It is also requested that provisional language be added to Item 5180-101-0001 to allow the DSS to provide the funding to the Special Olympics.

Staff Comment and Recommendation. Hold open.

Issue 3: BBL – Cash Disbursement Authority

May Revision. The Administration requests that Provision 2 of Item 5180-101-0001 be amended to allow DSS to ensure county cash disbursements are met when federal funds and the Local Revenue Fund are insufficient to cover county expenditures.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – IMMIGRATION SERVICES BRANCH

Issue 1: Rapid Response Funding (Issue 414-MR)

May Revision. The Administration requests that Item 5180-151-0001 be increased by $7.3 million to provide funding for nonprofits who operate emergency shelters for migrants in San Diego and Riverside counties. A corresponding decrease will be made to the Rapid Response Reserve.

Staff Comment and Recommendation. Hold open.

Issue 2: TBL – Rapid Response Reserve Fund

May Revision. The Administration proposes language that would transfer $12.7 million General Fund to the Rapid Response Reserve Fund. These funds will be available over three years to assist qualified community-based organizations and nonprofit entities in providing services during immigration emergent situations when federal funding is not available.

The total amount proposed in 2019-20 for Rapid Response is $20 million General Fund, of which $7.3 million has been shifted to the Department of Social Services (see previous issue).

Staff Comment and Recommendation. Hold open.

Issue 3: BBL - Expansion of Immigration-Related Services

May Revision. The Administration requests that Provision 15 of Item 5180-151-0001 be amended and Provision 19 be added to Item 5180-151-0001 to authorize $5 million of the $10 million General Fund budgeted in 2019-20 for the provision of legal services to unaccompanied undocumented minors and Temporary Protected Status beneficiaries to: (1) provide mental health screenings and evaluations related to legal defense, and (2) develop a family reunification navigator pilot to link undocumented minors with services in the community.

Staff Comment and Recommendation. Hold open.

Issue 4: TBL – Administration of Refugee Services (Wilson-Fish Program)

May Revision. The Administration proposes language to update the existing statute governing the administration of refugee social services and Refugee Cash Assistance to provide the state with the authority to contract directly with a qualified nonprofit organization for services when necessary to ensure effective program delivery.

Background. Currently, California provides refugee services through a state-supervised, county-administered model. However, certain refugee services are also provided by a nonprofit organization, which contracts directly with the federal Office of Refugee Resettlement (ORR) under the Wilson-Fish Program. ORR recently notified DSS that it intends to end the Wilson-Fish Program in federal fiscal year 2019 and requested that the state explore establishing a public-private partnership directly. The federal regulations allow for a public-private partnership model, whereby the state contracts with a private organization to deliver refugee services.

Existing law does not currently authorize the state to contract directly with private partners. The proposed language would provide the state with flexibility in contracting for the administration of refugee social services and Refugee Cash Assistance. In addition, the federal government over time has made changes to its refugee resettlement programs and funding structure, and these changes are not currently reflected in the current statute governing the administration of refugee services.

Staff Comment and Recommendation. Hold open.

5180 – DEPARTMENT OF SOCIAL SERVICES – CHILD WELFARE SERVICES

Issue 1: Resource Family Approval Administration and Backlog (Issue 406-MR)

May Revision. The Administration requests that Item 5180-151-0001 be increased by $14.4 million and Item 5180-151-0890 be increased by $6.2 million to provide one-time funding to support Resource Family Approval administration workload, including application backlogs.

Staff Comment and Recommendation. Hold open.

Issue 2: Placement Prior to Approval (Issue 407-MR) and Emergency Caregiver Payments (TBL)

May Revision. The Administration requests that Item 5180-101-0001 be increased by $15.1 million and Item 5180-101-0890 be increased by $6.6 million for counties to support up to four months of emergency assistance payments prior to resource family approval in 2019-20.

The Administration also proposes language that would allow, through June 30, 2020, emergency assistance payments prior to resource family approval for up to 120 days, or up to 180 days if the county provides "good cause."

Current law provides that emergency assistance payments to relative caregivers prior to resource family approval shall not exceed 90 days, effective July 1, 2019.

Staff Comment and Recommendation. Hold open. At the time of writing this agenda, trailer bill language was not available.

Issue 3: Foster Parent Recruitment, Retention, and Support (Issue 408-MR)

May Revision. The Administration requests that Item 5180-151-0001 be increased by $10.8 million, Item 5180-151-0890 be increased by $5.1 million, and Item 5180-153-0001 be increased by $10.9 million to provide one-time funding to counties for recruitment, retention, and support of foster parents.

Staff Comment and Recommendation. Hold open.

Issue 4: Dependency Counsel Title IV-E Funding (Issue 409-MR)

May Revision. The Administration requests that Item 5180-151-0890 be increased by $34 million to provide the Judicial Branch with federal Title IV-E reimbursements for legal support provided to certain children and parents who are involved with the child welfare system.

Staff Comment and Recommendation. Hold open.

Issue 5: TBL – Continuum of Care Reform Contracts

May Revision. The Administration proposes language that would exempt DSS from specified contract laws, rules, and review processes until July 1, 2021 for training or technical assistance grants and contracts related to the implementation or evaluation of the Continuum of Care Reform (CCR) initiative.

Background. Any contract funded over the delegated authority of $150,000 requires the Department of General Services (DGS) approval, conducted in accordance with the Public Contract Code and the State Contracting Manual. This process takes a minimum of 12-18 months per contract, and longer if additional processes and review are needed due to the nature of the contract. Any contracts over $10,000 require the competitive bidding process, unless some other exemption applies.

The formal competitive bidding process involves numerous factors and decisions. For example, the contractor selection method depends on the services involved and/or the circumstances. The contract must be processed for signature, approval, and distribution. Management of the contract must be built

into the contract to facilitate measurement of achievement and measurement of contractor performance. However, given the highly technical nature of specific components of CCR, DSS has frequently identified a single private entity that is capable of providing the level of expertise and engages the non-competitive bid (NCB) process. This process can take up to a year internally and DGS has no timeline limits reviewing the contract-or for approving it. If it is not approved, CDSS must either keep trying through the NCB process or start from scratch through the competitive bid process, which delays service delivery.

Contracting delays can significantly impede DSS' ability to fully and timely implement critical components of CCR. This proposal would provide the ability to, for a limited time, self-execute necessary contracts related to the implementation or evaluation of the CCR initiative.

Staff Comment and Recommendation. Hold open.

Issue 6: BBL – Bringing Families Home Re-appropriation

May Revision. The Administration requests that Item 5180-492 be amended to allow the re-appropriation of unexpended funds appropriated in the 2017 Budget Act for the Bringing Families Home Program.

Staff Comment and Recommendation. Hold open.

Issue 7: TBL – Kin-GAP Beginning Date of Aid

May Revision. The Administration proposes language that would change the beginning date of aid for Kin-GAP payments. The language clarifies that foster care payments cease immediately upon discontinuance of dependency and that Kin-GAP assistance payments may begin the following day.

Background. Current state law provides that if dependency from the state is dismissed and guardianship of the youth is established mid-month, a foster care payment to the guardian can continue until the end of the month (when the youth is no longer in foster care and is not considered a dependent of the state); this allows the actual Kin-GAP payments to then begin the first of the following month. In July and August of 2018, the federal Department of Health and Human Services (DHHS) audited the State's Title IV-E Foster Care program, which is the primary funding source for foster care and guardianship programs. As part of that review process, DHHS informed DSS that statute, regulation, and All County Letters related to the beginning date of aid for Kin-GAP was inconsistent with federal law and policy.

DHHS instructed DSS to change its foster care and Kin-GAP payment policies to comport with federal law. To avoid noncompliance with federal law, and to avoid future disallowances, state statute must be changed so that foster care payments cease immediately upon discontinuance of the dependency.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – SSI/SSP

Issue 1: TBL – Housing and Disability Advocacy Program (HDAP)

May Revision. The Administration proposes language that would include recognized tribes to the list of eligible recipients, clarify that funding for the HDAP can be used for either SSI advocacy or housing supports for potentially SSI-eligible individuals, and adds flexibility to the requirement that HDAP clients must be housed in units sustainable upon approval of disability benefits.

Background. HDAP assists homeless, disabled individuals apply for disability benefit programs, while also providing housing supports. HDAP requires that participating counties offer outreach, case management, benefits advocacy, and housing support to all program participants. The 2017 Budget Act appropriated $45 million for the program over a three-year period, and requires a dollar for dollar county match. The 2019-20 State Budget proposes an additional $25 million for the program on an ongoing annual basis.

DSS proposes adding tribes due to the unmet need in tribal communities. Additionally, the proposed language provides greater flexibility for counties to administer the program in a way that supports county needs. Due to the cost of housing, counties are often not able to house HDAP clients in a unit sustainable on Supplemental Security Income (SSI) or other disability benefit program. Often the only sustainable option is a housing voucher or other ongoing housing resource, which may not be available until after disability benefits are approved. In such cases, it may be necessary to house HDAP clients in units not sustainable on SSI but which may be sustainable once a voucher becomes available.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – CALFRESH

Issue 1: TBL - Expanding CalFresh to Recipients of SSI Clean-up

May Revision. The Administration proposes "clean-up" language to ensure the following:

- The reversal of the "SSI Cash-Out" policy is not subject to appropriation. The language clarifies that only the SNB and TNB are subject to appropriation, not the reversal of the "SSI Cash-out" policy.

- The Supplemental Nutrition Benefit (SNB) and Transitional Nutrition Benefit (TNB) Programs may be implemented by All County Letter (ACL) or similar instructions. DSS issued initial implementation guidance for both the SNB and TNB Programs via ACL. The proposed language allows DSS to provide additional guidance through the same method.

- The Cash Assistance Program for Immigrants (CAPI) monthly benefit amount is no longer different from SSI and/or California State Supplementary Payment (SSI/SSP) monthly benefit amount. Because of the reversal of the "SSI Cash-out" policy, AB 1811 also increased the individual monthly CAPI grant for parity with the individual monthly SSI/SSP grant. The

proposed language removes language that previously reduced the individual monthly CAPI grant by $10.

Background. The "SSI Cash-out" is a state policy that provides SSI/SSP recipients with an extra $10 payment in lieu of their being eligible to receive federal food benefits through the CalFresh program. AB 1811 (Committee on Budget), Chapter 35, Statutes of 2018, ended this policy. This expansion of benefits is effective beginning June 1, 2019. AB 1811 also created two state-funded nutrition benefit programs intended to "hold harmless" existing CalFresh households negatively affected by the policy change. The two state-funded programs, known as the SNB Program and the TNB Program, will provide CalFresh households with nutrition benefits to mitigate the reduction of CalFresh benefits or CalFresh ineligibility, respectively.

Staff Comment and Recommendation. Hold open.

Issue 2: One-Time County Administration Funding for the Expanded CalFresh Population (Issue 420-MR)

May Revision. The Administration requests that Item 5180-141-0001 be increased by $15 million and Item 5180-141-0890 be increased by $21,428,000 to support county administrative efforts to process new CalFresh applicants as a result of eliminating the SSI Cash-Out policy. It is also requested that Provision 9 be added to Item 5180-141-0001 to allow the Department of Social Services to provide the additional General Fund to counties upon approval by the Department of Finance.

Staff Comment and Recommendation. Hold open.

Issue 3: County Work Number Contract (Issue 417-MR)

May Revision. The Administration requests that Item 5180-101-0890 be increased by $1,916,000, Item 5180-141-0001 be increased by $2,235,000, and Item 5180-141-0890 be increased by $2,235,000 to reflect counties' increased usage of the Work Number Express Service for income and employment verification in the CalWORKs and CalFresh programs.

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 Melissa Hurtado
Senator Jeff Stone

Tuesday, May 14, 2019
10:00 a.m.
State Capitol - Room 4203

PART A

Consultant: Scott Ogus

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PUBLIC COMMENT

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

ISSUES FOR DISCUSSION

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
4260 DEPARTMENT OF HEALTH CARE SERVICES
5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: State Verification Hub Planning Activities (Issue 405-MR)

May Revision. The Administration requests that the following items be modified to begin planning activities for a State Verification Hub to enhance eligibility verifications in public assistance programs. The requested adjustments are as follows:

- Health and Human Services Agency - The Administration requests that Item 0530-001-9745 be increased by $747,000 on a two-year limited-term basis to support one position and consultant services.

- Department of Health Care Services – The Administration requests that Item 4260-001-0001 be increased by $78,000 and Item 4260-001-0890 be increased by $77,000 on a two-year limited-term basis to support one position and consultant services.

- Department of Social Services – The Administration requests that Item 5180-001-0001 be increased by $149,000 and one position and Item 5180-001-0890 be increased by $144,000 and one position on a two-year limited-term basis to support two positions.

Staff Comment and Recommendation – Hold Open.

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

1. Please provide a brief overview of this proposal.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: AIDS Drug Assistance Program (ADAP) – May Revision Estimate and Adjustments

DOF Issue#: 4265-003-ECP-2019-GB
4265-036-BBA-2019-GB
4265-401-ECP-2019-MR

ADAP Local Assistance Estimate May Revision Update. The May 2019 ADAP Local Assistance Estimate reflects revised 2018-19 expenditures of $407.5 million, which is a decrease of $362,000 or less than 0.1 percent compared to the Governor's January budget. According to DPH, this decrease is primarily due to reduced medication expenditures for medication-only clients. For 2019-20, DPH estimates ADAP expenditures of $449.5 million, a decrease of $320,000 or less than 0.1 percent, compared to the Governor's January Budget, and an increase of $42 million or 10.3 percent, compared to the revised 2018-19 estimate. DPH also reports this decrease is primarily due to reduced medication expenditures for medication-only clients.

ADAP Local Assistance Funding 2018-19 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0890 – Federal Trust Fund	$129,143,000	$129,143,000
3080 – AIDS Drug Assistance Program Rebate Fund	$278,735,000	$278,373,000
Total ADAP Local Assistance Funding – All Funds	**$407,878,000**	**$407,516,000**

ADAP Local Assistance Funding 2019-20 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0890 – Federal Trust Fund	$135,138,000	$135,138,000
3080 – AIDS Drug Assistance Program Rebate Fund	$314,650,000	$314,330,000
Total ADAP Local Assistance Funding – All Funds	**$449,789,000**	**$449,468,000**

ADAP tracks caseload and expenditures by client group. After May Revision updates, DPH estimates ADAP caseload and expenditures for 2018-19 and 2019-20 will be as follows:

Caseload by Client Group	**2018-19**	**2019-20**
Medication-Only	12,809	12,580
Medi-Cal Share of Cost	118	136
Private Insurance	9,883	10,687
Medicare Part D	7,683	7,683
Pre-Exposure Prophylaxis (PrEP) Assistance Program	1,490	3,542

Expenditures by Client Group	2018-19	2019-20
Medication-Only	$304,807,079	$315,972,368
Medi-Cal Share of Cost	$1,071,494	$1,477,505
Private Insurance	$65,031,384	$87,982,784
Medicare Part D	$23,838,377	$27,631,337
PrEP Assistance Program	$3,865,266	$7,309,358

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 includes 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 $7.1 million in 2018-19 and $7.7 million in 2019-20 under the new reimbursement methodology.

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 changes to caseload and expenditures in the ADAP May Revision Estimate.

Issue 2: HIV Care Program Financial Eligibility – Trailer Bill Language Proposal

DOF Issue#: Trailer Bill Language Proposal

Trailer Bill Language Proposal. DPH requests trailer bill language to adopt the financial eligibility requirement used by the AIDS Drug Assistance Program for the HIV Care Program. Adoption of this language would allow the HIV Care Program to address a finding from the federal Health Resources and Services Administration (HRSA) that the program does not have consistent, statewide financial eligibility standards, as required by the federal Ryan White HIV/AIDS program.

Background. DPH contracts with 43 local health departments and community-based organizations to provide services under the HIV Care Program in all 58 counties. Contractors may fund any combination of 21 allowable service categories including medical case management, outpatient or ambulatory health services, food bank or home-delivered meals, and medical transportation services. DPH receives funding for the program from the federal Ryan White HIV/AIDS Program of $33 million, consisting of $27 million in base award and $6 million in supplemental funds. According to DPH, the program served about 12,790 clients in 2018.

Individuals are eligible for programs funded through the Ryan White HIV/AIDS Program if the individual has a medical diagnosis of HIV/AIDS and is low-income as defined by the state. In March 2016, HRSA issued a finding that the HIV Care Program had no established statewide financial eligibility requirement, with eligibility requirements varying from county to county. HRSA findings stated that DPH did not "consistently define 'low-income' in Part B eligibility criteria throughout the state."

DPH requests trailer bill language to adopt the financial eligibility requirements used by the AIDS Drug Assistance Program (ADAP) for the HIV Care Program. ADAP is also funded by the Ryan White HIV/AIDS Program and shares many of the same clients as the HIV Care Program. Individuals are eligible for ADAP if the individual's modified adjusted gross income does not exceed 500 percent of the federal poverty level. According to DPH, approximately 91 existing clients, representing one percent of all clients served, would no longer be eligible for services under the proposed adoption of statewide eligibility requirements consistent with ADAP.

In addition to defining the financial eligibility for the program, the proposed trailer bill language would rename the CARE Services Program to the HIV Care Program, as it is currently known. These changes would become operative on April 1, 2020 to coincide with the start of the Ryan White HIV/AIDS Program fiscal year, coincide with the conclusion of the next open enrollment period for Covered California, and provide sufficient time for all current clients to complete their biannual recertification.

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 statutory changes.

Issue 3: Infectious Disease Prevention and Control

DOF Issue#: 4265-404-BCP-2019-MR

May Revision Issue. DPH requests four positions and General Fund expenditure authority of $40 million in 2019-20, available until June 30, 2023. If approved, these positions and resources would allow DPH to provide one-time grants to local health jurisdictions and tribal communities for infectious disease prevention, testing, and treatment. Of these resources, $32 million would be provided to local health jurisdictions and $8 million would support state administration costs.

Program Funding Request Summary		
Fund Source	**2019-20***	**2020-21**
0001 – General Fund		
State Operations	$8,000,000	**$-**
Local Assistance	$32,000,000	$-
Total Funding Request:	**$40,000,000**	**$-**
Total Positions Requested:	**4.0**	

* Resources available until June 30, 2023.

Background. DPH and 61 local health jurisdictions across the state work to monitor, prevent, and control more than 90 different infectious diseases. DPH estimates there were between 7.6 million and 10.8 million cases and between 1,760 and 7,160 deaths due to infectious disease in 2016. In recent years, DPH and local health jurisdictions have experienced significant increases in the incidence and risk of infectious diseases, including sexually transmitted diseases (STDs), foodborne diseases, vaccine-preventable diseases, and new emerging infectious diseases.

DPH requests four positions and General Fund expenditure authority of $40 million in 2019-20, available until June 30, 2023 to provide one-time grants to local health jurisdictions and tribal communities for infectious disease prevention, testing, and treatment. Of these resources, $32 million would be provided to local health jurisdictions and $8 million would support state administration costs.

The $32 million for local health jurisdictions would be allocated after engaging with stakeholders to determine metrics and appropriate weighting for each metric. According to DPH, the short-term outcomes expected from this funding would be: 1) infectious disease prevention, 2) increased partnerships between DPH and local health jurisdictions and providers and payers that serve communities at risk, 3) enhanced integration between public health and health care data systems to monitor delivery of preventive services, and 4) increased training, consultation, and quality improvement activities related to infectious disease prevention. Long term, DPH expects these resources would help reduce incidence of tuberculosis, STDs, vaccine preventable diseases and outbreaks, severe pertussis cases in infants, disparities in the burden of these diseases among disproportionately affected populations, and prevention of illness, death, disability, and further spread of infectious diseases.

The $8 million of state administration funding would support the following positions:

- **One Staff Services Manager II** position would supervise a contract monitoring unit which would oversee the grant allocations, contract execution, and monitoring and evaluation of tasks associated with the grants.
- **Two Associate Governmental Program Analysts** would provide coordination between a disease investigation team and grant recipients, and provide technical assistance to grant recipients regarding data requirements. These positions would also manage and monitor the administrative requirements of grant recipients and coordinate the collection of work plans and progress reports from grant recipients for review.
- **One Senior Accounting Officer** would support administrative functions including payment processing and accounting record oversight.

DPH would also enter into an interagency agreement to perform activities including, but not limited to, epidemiology and disease surveillance, communication, data management, and disease investigation for outbreak response. This request allocates $5.2 million of the state administration funding for this purpose.

May Revision Proposal Similar to Funding Request from Local Health Departments. The subcommittee previously heard a similar request from the County Health Executives Association of California (CHEAC) and the Health Officers Association of California (HOAC) for annual General Fund expenditure authority of $50 million to improve infrastructure to prevent and control the spread of infectious disease in California using strategies that best meet the needs of local jurisdictions. According to CHEAC and HOAC, local health departments do not have adequate funding to fulfill their unique mandate to prevent and control infectious diseases within their jurisdictions. State and federal funding for communicable disease control activities have considerably declined over time and are primarily siloed based on disease. This has led to significant challenges in addressing the rising rates of ever-present diseases such as sexually transmitted diseases and tuberculosis, and addressing outbreaks experienced in California such as Hepatitis A, influenza, Zika and measles, posing a health and safety risk to residents throughout the state.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. What entities would be part of the planned interagency agreement for surveillance, communication, data management, and outbreak response? What are each of the parties' responsibilities under the agreement?

Issue 4: Genetic Disease Screening Program – May Revision Estimate and Adjustments

DOF Issue#: 4265-002-ECP-2019-GB
4265-402-ECP-2019-MR

Genetic Disease Screening Program Estimate - May Revision Update. The May 2019 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of $133.8 million ($30.6 million state operations and $103.2 million local assistance) in 2018-19, a decrease of $273,000 or 0.3 percent compared to the January budget. According to DPH, the decreased costs are primarily attributable to reduced estimates of live births in California. The estimate also includes $143 million ($31.4 million state operations and $111.6 million local assistance) in 2019-20, an increase of $1.8 million or 1.6 percent compared to the January budget, and an increase of $9.2 million or 6.8 percent compared to the revised 2018-19 estimate. According to DPH, the increase in costs is due to increased laboratory supply and equipment costs and an increasing need for case management and coordination services for newborn screening.

Genetic Disease Screening Program 2018-19 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0203 – Genetic Disease Testing Fund		
State Operations:	$29,451,000	$30,593,000
Local Assistance:	$103,501,000	$103,228,000
Total GDSP Funding	**$132,952,000**	**$133,821,000**

Genetic Disease Screening Program 2019-20 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0203 – Genetic Disease Testing Fund		
State Operations:	$31,351,000	$31,351,000
Local Assistance:	$109,825,000	$111,624,000
Total GDSP Funding	**$141,176,000**	**$142,975,000**

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 2017, 18,920,529 babies were screened resulting in early identification of 18,015 cases for the following disorders:

Disorder	Cases
Phenylketonuria (PKU) and hyperphenylalaninemia	1,264
Primary congenital hypothyroidism	7,857
Galactosemia	1,018
Sickle cell disease and other clinically significant hemoglobinopathies[1/]	5,006
Biotinidase deficiency (BD)	209
Cystic fibrosis (CF)	636
Congenital adrenal hyperplasia (CAH)	376
Metabolic fatty acid oxidation disorders	741
Metabolic amino acid disorders other than PKU	203
Metabolic organic acid disorders	518
Other metabolic disorders	62
Severe combined immunodeficiencies	75
X-linked adrenoleukodystrophy (ALD) and other peroxisomal disorders	50
TOTAL	**18,015**

The NBS program currently screens infants in California for more than 80 separate disorders. Pursuant to SB 1095 (Pan), Chapter 363, Statutes of 2016, two additional disorders, Mucopolysaccharidosis type I (MPS-I) and Pompe disease, were added to the screening panel in 2018. In addition, as conditions are added to the federal Recommended Uniform Screening Panel (RUSP), SB 1095 requires them to be

added to the NBS program screening panel within two years. In July, 2018, the U.S. Secretary of Health and Human Services added spinal muscular atrophy (SMA) to the RUSP, which must be added to the NBS screening panel within two years. The fee for screening in the NBS program is currently $142.25.

Caseload Estimate: The budget estimates NBS program caseload of 461,083 in 2018-19, a decrease of 8,067 or 1.7 percent, compared to the January budget estimate. The budget estimates NBS program caseload of 460,153 in 2019-20, a decrease of 930 or 0.2 percent, compared to the revised 2018-19 estimate. These estimates are based on state projections of a decrease in live births. DPH assumes 100 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 329,081 in 2018-19, a decrease of 5,349 or 1.6 percent, compared to the January budget estimate. The budget estimates PNS program caseload of 326,472 in 2019-20, a decrease of 2,609 or 0.8 percent, compared to the revised 2018-19 estimate. These estimates are based on state projections of a decrease in live births.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of the caseload and expenditure changes for the Newborn Screening Program.

2. Please provide a brief overview of the caseload and expenditure changes for the Prenatal Screening Program.

Issue 5: Women, Infants, and Children Program – May Revision Estimate

DOF Issue#: 4265-001-ECP-2019-GB
4265-403-ECP-2019-MR

Women, Infants, and Children Program Estimate – May Revision Update. The May 2019 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of $1.1 billion ($902.2 million federal funds and $226.2 million WIC manufacturer rebate funds) in 2018-19, an increase of $7.2 million ($10.1 million federal funds offset by a decrease of $2.9 million WIC manufacturer rebate funds) compared to the Governor's January budget. The May 2019 WIC Program Estimate includes $1.1 billion ($880.7 million federal funds and $213.7 million WIC manufacturer rebate funds) in 2019-20, an increase of $1.3 million ($2.6 million federal funds offset by a decrease of $1.3 million WIC manufacturer rebate funds) compared to the Governor's January budget, and a decrease of $34 million ($21.4 million federal funds and $12.5 million WIC manufacturer rebate funds) compared to the revised 2018-19 estimate. The federal fund amounts include state operations costs of $63.7 million in 2018-19 and $62.3 million in 2019-20.

WIC Funding Summary 2018-19 May Revision Comparison to January Budget			
	2018-19		**Jan to May**
Fund Source	***January Budget***	***May Revision***	***Change***
0890 – Federal Trust Fund			
State Operations:	$63,684,000	$63,684,000	$-
Local Assistance:	$828,388,000	$838,489,000	$10,101,000
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$229,080,000	$226,211,000	($2,869,000)
Total WIC Expenditures	**$1,121,152,000**	**$1,128,384,000**	**$7,232,000**

WIC Funding Summary 2019-20 May Revision Comparison to January Budget			
	2019-20		**Jan to May**
Fund Source	***January Budget***	***May Revision***	***Change***
0890 – Federal Trust Fund			
State Operations:	$62,270,000	$62,270,000	$-
Local Assistance:	$815,905,000	$818,462,000	$2,557,000
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$214,929,000	$213,678,000	($1,251,000)
Total WIC Expenditures	**$1,093,104,000**	**$1,094,410,000**	**$1,306,000**

The May Revision assumes a monthly average of 959,513 WIC participants in 2018-19, a decrease of 12,466 or 1.3 percent compared to the Governor's January budget. The May Revision assumes a monthly average of 905,182 WIC participants in 2019-20, a decrease of 11,875 or 1.3 percent compared to the Governor's January budget, and a decrease of 54,331 or 5.7 compared to the revised 2018-19 caseload estimate.

Food Expenditures Estimate. The May Revision includes $745.3 million ($519.1 million federal funds and $226.2 million WIC manufacturer rebate funds) in 2018-19 for WIC program food expenditures, a decrease of $11.3 million ($8.4 million federal funds and $2.9 million WIC manufacturer rebate funds) or 1.5 percent, compared to the January budget. The May Revision includes $717.3 million ($503.6 million federal funds and $213.7 million WIC manufacturer rebate funds) in 2019-20 for WIC program food expenditures, a decrease of $12.7 million ($11.4 million federal funds and $1.2 million WIC manufacturer rebate funds) or 1.7 percent compared to the January budget, and a decrease of $28 million ($15.5 million federal funds and $12.5 million WIC manufacturer rebate funds) or 3.8 percent compared to the revised 2018-19 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 $319.4 million for other local assistance expenditures for the NSA budget in 2018-19, an increase of $18.5 million or 6.1 percent compared to the January budget. The May Revision includes $314.8 million for the NSA budget in 2019-20, an increase of $13.9 million or 4.6 percent compared to the January budget, and a decrease of $4.6 million or 1.4 percent compared to the revised estimate for 2018-19. According to DPH, the increases in NSA funding are for grants provided to the Office of Systems Integration to fund the transition to the California WIC Card, an electronic benefit card system that will replace paper checks for WIC recipients.

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 6: California Home Visiting and Black Infant Health Programs – Federal Matching Funds

DOF Issue#: 4265-017-BCP-2019-GB
4265-018-BCP-2019-GB
4265-402-BCP-2019-MR
4265-403-BCP-2019-MR

May Revision Issue. DPH requests reimbursement expenditure authority of $34.8 million annually. If approved, these resources would allow DPH to draw down federal Medicaid funds for services provided by the California Home Visiting Program (CHVP) and the Black Infant Health (BIH) Program to Medi-Cal beneficiaries. For CHVP, DPH is requesting increased reimbursement expenditure authority of $2 million for state operations and $20.9 million for local assistance. For the BIH Program, DPH is requesting increased reimbursement authority of $1.3 million for state operations and $10.7 million for local assistance.

In the January budget, DPH requested 13 positions and General Fund expenditure authority of $23 million annually to expand participation in current and new sites for the California Home Visiting Program (CHVP), and to include new evidence-based home visiting models, with a focus on low-income, young mothers. DPH also requested four positions and General Fund expenditure authority of $7.5 million annually to expand the Black Infant Health Program to improve African-American infant and maternal health.

Combined Program Funding Request Summary – California Home Visiting Program		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund		
State Operations	$2,000,000	$2,000,000
Local Assistance	$21,000,000	$21,000,000
0995 – Reimbursements		
State Operations	$2,000,000	$2,000,000
Local Assistance	$20,869,000	$20,869,000
Total Combined Funding Request:	**$45,869,000**	**$45,869,000**
Total Positions Requested*:	**13.0**	

* Positions and resources ongoing after 2020-21.

Combined Program Funding Request Summary – Black Infant Health Program		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund		
State Operations	$500,000	$500,000
Local Assistance	$7,000,000	$7,000,000
0995 – Reimbursements		
State Operations	$1,300,000	$1,300,000
Local Assistance	$10,650,000	$10,650,000
Total Combined Funding Request:	**$19,450,000**	**$19,450,000**
Total Positions Requested*:	**4.0**	

* Positions and resources ongoing after 2020-21.

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, depression, 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.

The Black Infant Health Program, administered by DPH, 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.

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 changes.

Issue 7: Proposition 99 Adjustments – Health Education, Research, and Unallocated Accounts

DOF Issue#: 4265-031-BBA-2019-GB
4265-402-BBA-2019-MR

Proposition 99 Tobacco Tax Allocations. DPH requests the following technical corrections reflecting changes in Proposition 99 revenues:

Health Education Account
- Item 4265-001-0231 be increased by $950,000
- Item 4265-111-0231 be increased by $500,000

Research Account
- Item 4265-001-0234 be increased by $521,000

Unallocated Account
- Item 4265-001-0236 be increased by $29,000

According to DPH, these adjustments would support state administrative activities and competitive grants.

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 8: Adult Use of Marijuana Act: Cannabis Surveillance and Education

DOF Issue#: 4265-404-BBA-2019-MR

May Revision Issue. The May Revision includes 15 positions and reimbursement expenditure authority of $12 million in 2019-20, transferred by DHCS from the California Cannabis Tax Fund, pursuant to the Adult Use of Marijuana Act approved by voters in 2016. The expenditure authority supporting these positions and resources is continuously appropriated to DHCS from cannabis tax revenue, and will be transferred to DPH under an interagency agreement to conduct cannabis surveillance and education activities.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0995 – Reimbursements	$12,000,000	$-
Total Funding Request:	**$12,000,000**	**$-**
Total Positions Requested:	**15.0**	

Background. The Adult Use of Marijuana Act (Proposition 64) imposes a 15 percent excise tax on the sale of recreational cannabis products sold in the state of California to be deposited in the California Cannabis Tax Fund. Proposition 64 requires tax proceeds deposited in the fund to be distributed as follows:

1) Costs incurred by state agencies for requirements of Proposition 64.
2) $10 million dollars to universities annually for ten years to research the effect of Proposition 64.
3) $3 million dollars annually for five years to the California Highway Patrol to adopt protocols to determine whether a driver is operating a vehicle while impaired by the use of cannabis or cannabis products.
4) $10 million dollars annually in 2018-19, increasing to $50 million dollars in 2022-23 and annually thereafter for the Governor's Office of Business and Economic Development to administer a community reinvestments grants program.
5) $2 million dollars annually to the University of California San Diego Center for Medicinal Cannabis Research.

After disbursing funds for these purposes, 60 percent of the remaining funds are deposited into the Youth Education, Prevention, Early Intervention and Treatment Account and continuously appropriated to DHCS to enter into interagency agreements with DPH and the California Department of Education (CDE) to implement and administer programs for youth that are designed to educate about and to prevent substance use disorders and to prevent harm from substance use. Proposition 64 requires the programs to emphasize accurate education, effective prevention, early intervention, school retention, and timely treatment services for youth, their families and caregivers.

The May Revision reflects a total Proposition 64 allocation of $119.3 million to DHCS for these programs. According to the Administration, $80.5 million will be transferred to CDE to subsidize up to 9,600 child care slots for school-age children up to 13 years old from income-eligible families. $21.5 million will be retained by DHCS for stakeholder engagement, program oversight, and staffing for local programs emphasizing prevention-oriented care that promotes health and well-being for youth. $5.3

million will be transferred to the California Natural Resources Agency to support youth community access grants to support youth access to natural or cultural resources, with a focus on low-income and disadvantaged communities, for positive programming to discourage substance use.

The May Revision also reflects $12 million transferred to DPH to conduct cannabis surveillance and education activities. According to DPH, these resources would be allocated as follows:

1) Data Analysis ($3 million) – DPH staff will gather, analyze, and interpret data from multiple sources to produce surveillance reports, develop targeted educational materials informed by surveillance data, and help provide relevant, actionable information to state and local regulators and stakeholders.

2) Survey Data Purchase and Development ($1 million) – DPH will determine the data questions among multiple survey tools, including the Behavioral Risk Factor Surveillance System, the California Health Interview Survey, and development of a DPH-specific survey tool.

3) Data Interface Development ($6 million) – DPH will integrate various data systems interfaces to create an interoperable system and identify gaps in data. The data systems may include emergency department data, poison control, and emergency medical services data. DPH proposes to integrate four data sets in the first year. Larger investments may be needed at the outset and reduced amounts may be sufficient for ongoing maintenance and operation.

4) Educational Activities ($2 million) – DPH staff will update and enhance its Let's Talk Cannabis website. The updates include development of targeted materials such as fact sheets, frequently asked questions, social media, user friendly data report, references to new research. The enhancements include development of a data dashboard.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposed allocation of cannabis tax revenue.

4440 DEPARTMENT OF STATE HOSPITALS

Issue 1: 2019-20 Program Updates – May Revision Adjustments

DOF Issue#: 4440-043-ECP-2019-GB
4440-044-ECP-2019-GB
4440-045-ECP-2019-GB
4440-047-ECP-2019-GB
4440-049-ECP-2019-GB
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4440-058-ECP-2019-GB
4440-089-ECP-2019-MR
4440-090-ECP-2019-MR
4440-091-ECP-2019-MR
4440-092-ECP-2019-MR
4440-093-ECP-2019-MR
4440-094-ECP-2019-MR
4440-095-ECP-2019-MR
4440-096-ECP-2019-MR
4440-097-ECP-2019-MR
4440-100-ECP-2019-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 an operational bed capacity of 1,184.

- **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 an operational bed capacity of 1,286.

- **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 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 an operational bed capacity of 1,255.

- **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 and has 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.

	2018-19	2019-20
Population by Hospital		
Atascadero	1,143	1,106
Coalinga	1,403	1,403
Metropolitan	858	1,046
Napa	1,278	1,278
Patton	1,509	1,484
Population Total	**6,191**	**6,317**
Population by Commitment Type		
Incomptent to Stand Trial (IST)	1,491	1,617
Not Guilty by Reason of Insanity (NGI)	1,396	1,396
Mentally Disordered Offender (MDO)	1,425	1,416
Sexually Violent Predator (SVP)	953	953
Lanterman-Petris-Short Civil Commitments (LPS)	694	703
Coleman Referrals	230	230
Dept. of Juvenile Justice (DJJ)	2	2
Jail-Based Competency Treatment (JBCT) and Contracted Programs		
Kern Admission, Evaluation, and Stabilization (AES) Center	60	60
Riverside JBCT	25	25
Sacramento JBCT (Male and Female)	44	44
San Bernardino JBCT	126	146
San Diego JBCT	30	30
Sonoma JBCT	10	10
Stansislaus JBCT	12	18
Monterey JBCT	10	10
San Joaquin JBCT	--	10
Solano JBCT	12	12
Mendocino JBCT	TBD	TBD
Mariposa JBCT	TBD	TBD
Butte JBCT	5	5
Proposed New JBCT (Northern, Central, and Southern CA)	5	74
Total JBCT Programs	**339**	**444**

Figure 1: State Hospital Population by Hospital, Commitment Type and JBCT Programs
Source: *2019-20 May Revision Estimates, Department of State Hospitals,May 2019*

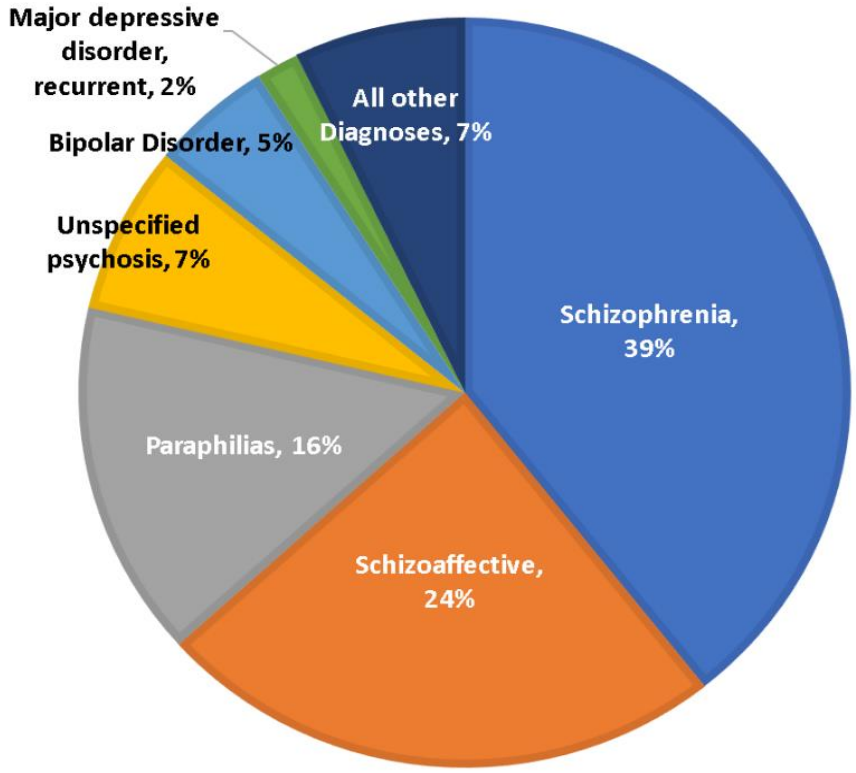

Figure 2: State Hospital Population By Major Diagnosis
Source: *2019-20 Governor's Budget Proposals and Estimates, Department of State Hospitals, January 2019*

Program Update: Patient Driven Operating Expenses and Equipment. In a 2015 report, the Legislative Analyst's Office made recommendations for improvement in the DSH budgeting methodology, including the establishment of a standardized per patient operating expenses and equipment cost estimate and an annual budget adjustment based on patient census. According to DSH, the average operating cost per patient is $19,534 across all five state hospitals, which represents an increase of 18 percent over the last six years. This increase is primarily driven by the costs of pharmaceuticals and outside hospitalization.

Over the past five years, DSH reports its patient population has increased by 547 beds, including expansions of 236 secured beds at Metropolitan State Hospital. However, DSH did not budget for operating expenses and equipment for much of these new beds. The 2018 Budget Act included $3.7 million for the operating expenses and equipment for the 236 secured beds at Metropolitan. Due to delays in unit activations, DSH reports 140 of those beds will not be activated as expected, resulting in $2.2 million General Fund savings in 2018-19.

In the January budget, DSH requested General Fund expenditure authority of $10.5 million annually to support the full cost of operating expenses and equipment for the 547 beds activated since 2012-13 in the five state hospitals.

In the May Revision, DSH requests additional General Fund expenditure authority of $547,000, for a total of $11 million annually, based on updated projected census figures.

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. In 2017-18, DSH had a budgeted LPS capacity of 628. As of July 2018, DSH reported a total LPS census of 690. The 2018 Budget Act included a $20.1 million adjustment in reimbursement authority to account for actual expenditures for LPS patients.

In the January budget, DSH requested additional reimbursement expenditure authority of $606,000 in 2019-20 and annually thereafter. This additional authority would allow DSH to have sufficient authority to accept the expected LPS caseload from county commitments. The amount of this additional authority was calculated based on 2018-19 projected expenditures of $157.4 million, which is $606,000 less than its 2018-19 authority of $156.7 million.

In the May Revision, DSH requests additional reimbursement expenditure authority of $2.7 million in 2019-20 and annually thereafter, for a total increase in reimbursement expenditure authority of $3.3 million. According to DSH, these adjustments are due to updated collection figures.

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. DSH received expenditure authority in previous budgets to make repairs associated with the South Napa Earthquake. As of the 2018 Budget Act, 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	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**

In the May Revision, DSH requests reduction of General Fund expenditure authority of $1.1 million in 2018-19 and $608,479 in 2019-20 as the department will not be proceeding with the completion of the remaining Project 3 repairs, which are comprised of minor cosmetic repairs. DSH reports ongoing challenges and delays in the availability and hiring of labor for this project, leading to no significant efforts towards completing the repairs. In addition, DSH reports these repairs are within patient-occupied areas and would require swing space to complete the project that is currently unavailable.

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 an independent patients' 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 began in September 2018 and was completed February 2019, while construction for the second unit was expected to begin February 2019 and be completed June 2019.

The 2018 Budget Act included reversion of General Fund savings of $4.9 million General Fund in 2017-18 and $4.6 million in 2018-19 related to construction delays of the ETP units. For 2019-20, the 2018 Budget Act included 60.3 positions and General Fund expenditure authority of $8.3 million annually thereafter to fund an additional ETP unit at Atascadero, as well as one unit at Patton. According to DSH, construction for the third unit at Atascadero is expected to begin June 2019 and be completed in September 2019, while construction for the unit at Patton is expected to begin September 2019 and be completed in January 2020.

In the January budget, DSH estimated General Fund savings in 2019-20 of $1.8 million due to a five-month delay for the ETP unit at Patton.

In the May Revision, DSH estimates additional General Fund savings of $2.6 million and a reduction of 7.1 positions in 2018-19 and $716,000 and 2.3 positions in 2019-20, for a total reduction in 2019-20 of $2.5 million. These savings are the result of implementation delays due to unforeseen electrical and ducting work. DSH also proposes to redirect $139,000 of savings in 2019-20 to critical needs identified by the Patton ETP unit.

Program Update: Metropolitan State Hospital Bed Expansion. The 2016 Budget Act included capital outlay construction funding to securely enclose existing patient buildings at Metropolitan State Hospital that housed civilly committed patients under the Lanterman-Petris-Short (LPS) Act. Once secured, the LPS patients 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. The 2017 Budget Act included 22.2 positions in 2017-18, and 38.5 positions and $12.4 million in 2018-19 to prepare for the expansion by relocating LPS patients and hiring hospital police officers. The 2018 Budget Act included a reduction of 10.1 positions and savings of $1.1 million in 2017-18 due to delays in activations. The 2018 Budget Act also included 162.8 positions and $24.8 million in 2018-19 and 342.2 positions and $50.6 million in 2019-20 for patient movement and activation of four new forensic units. The current budget request activates and provides staff for approximately 236 forensic beds between March and November 2019 to treat IST patients.

In the January budget, DSH requested 119.3 positions and General Fund expenditure authority of $18.6 million in 2019-20 and 130 positions and General Fund expenditure authority of $20.1 million in 2020-21 and annually thereafter to activate the newly secured units at Metropolitan to provide increased capacity for the treatment of IST patients.

In the May Revision, DSH requests reduction of 22.5 positions and General Fund expenditure authority of $3.4 million in 2018-19 and reduction of 20.1 positions and General Fund expenditure authority of $3.1 million in 2019-20. These reductions result in a net request of 96.8 positions and General Fund expenditure authority of $15.2 million in 2018-19 and 109.9 positions and General Fund expenditure authority of $17 million in 2019-20. According to DSH, the reduction in requested expenditure authority is due to minor delays in the award of the contract, and a new State Fire Marshall requirement for fire sprinkler pipe fitter companies to have certified workers.

Program Update: Telepsychiatry Resources. In the May Revision, DSH requests 11 positions and General Fund expenditure authority of $2.2 million in 2019-20 and 21 positions and General Fund expenditure authority of $3.7 million annually thereafter. If approved, these resources would allow DSH to expand its use of telepsychiatry as an alternative to providing in-person psychiatric treatment to patients and ensure appropriate delivery of care. Specifically, these resources would add clinical oversight and supervision, telepsychiatry coordinators, as well as information technology equipment and resources.

Program Update: Forensic Conditional Release Program (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 there are currently 14 patients residing in a house and two in a motel throughout California within the county of commitment. DSH has established two rate structures for CONREP-SVPs: 1) $310,000 per SVP where a permanent residence has been established, and 2) $653,000 per CONREP-SVP when ordered as a transient release.

In the January budget, DSH requested General Fund expenditure authority of $768,000 in 2018-19 and $2.1 million annually thereafter. If approved, these resources would support an expected caseload increase of four SVPs in 2018-19, including two transient releases, for a total of 21 SVPs conditionally released to the community by June 2019, and an additional two SVPs released by June 2020 for a total caseload of 23.

In the May Revision, DSH requests a decrease in General Fund expenditure authority of $1 million in 2018-19 and $994,000 in 2019-20, for a net decrease in expenditure authority of $245,000 in 2018-19 and a net increase in expenditure authority of $1.1 million. DSH indicates these downward adjustments are based on a net decrease of two SVP commitments compared to the January budget.

Program Update: Forensic Conditional Release Program (CONREP) – Step-Down Transition Program. In the May Revision, DSH requests General Fund expenditure authority of $5.7 million in 2019-20 and $11.6 million annually thereafter. If approved, these resources would allow DSH to expand its continuum of care for CONREP patients by establishing a step-down program. DSH would contract for a 78-bed vendor operated community step-down program for MDO and NGI patients preparing for conditional release from state hospitals within 18 and 24 months. The requested resources would also allow DSH to expand its existing contract with Sylmar Health and Rehabilitation Center by four beds for a total of 24 beds.

Program Update: Jail-Based Competency Treatment Program Expansions. In the January budget, DSH reported net General Fund savings of $253,000 in 2018-19 composed of one-time cost savings of $1.9 million at San Bernardino and San Joaquin JBCT programs, offset by $1.6 million in increased costs at Sacramento, Sonoma, Mariposa, Solano, Mendocino, and Butte JBCT programs. In the January budget, DSH also requested General Fund expenditure authority of $1.1 million in 2019-20, and $1.7 million in 2020-21 and annually thereafter to activate jail-based competency treatment 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. DSH expects these programs to increase bed capacity by 254 in 2018-19 and 274 in 2019-20.

In the May Revision, DSH requests a reduction in General Fund expenditure authority of $725,000 in 2018-19 and $5.9 million annually thereafter for existing JBCT programs due to activation delays and changes to program capacity.

In the January budget, DSH requested General Fund expenditure authority of $191,000 in 2018-19, $11 million in 2019-20, and $11.4 million in 2020-21 and annually thereafter for the proposed activation of new JBCT programs. DSH proposed: 1) an April 2019 activation of a five-bed JBCT program in a

Southern California county; 2) a July 2019 activation of a five-bed JBCT program in a Central California county, a six-bed JBCT program in a Northern California county, and a 48-bed JBCT program in a Northern California county; and 3) an October 2019 activation of a 10-bed JBCT program in a Southern California County. According to DSH, the cost estimate is based on an expected per diem rate of $420 per patient.

In the May Revision, DSH requests additional General Fund expenditure authority of $2,000 in 2018-19, $5.7 million in 2019-20, and $9,000 annually thereafter. According to DSH, the increase in requested resources are due to updated assumptions regarding the timing of contract execution and program activation for new programs identified in the January budget.

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: Technical Adjustment – Interagency Agreement with Health and Human Services Agency

DOF Issue#: 4440-103-BCP-2019-MR

May Revision Issue. DSH requests reduction of General Fund expenditure authority of $222,000 annually to reflect an adjustment to the interagency agreement between DSH and the California Health and Human Services Agency. This adjustment is related to a commensurate increase in positions and General Fund expenditure authority requested by CHHSA to replace the historical funding for one position provided by DSH.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	($220,000)	($220,000)
Total Funding Request:	**($220,000)**	**($220,000)**

* Resource reduction ongoing after 2020-21.

Background. According to DSH, the department has historically funded one Assistant Secretary position at the Health and Human Services Agency (CHHSA). CHHSA has a companion request that establishes the position authority and funding for the Assistant Secretary position within the CHHSA budget. As a result, this request for a reduction of General Fund expenditure authority of $222,000 annually is consistent with the proposed transfer of funding for the Assistant Secretary position from DSH to CHHSA.

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: Technical Adjustment – California State Lottery Fund

DOF Issue#: 4440-098-BBA-2019-MR

May Revision Issue. DSH requests expenditure authority from the California State Lottery Education Fund of $6,000 annually. These resources reflect updated funding derived from the sale of lottery tickets to fund DSH programs.

Background. The California State Lottery was established in 1985 after approval of a voter initiative. In general, the state distributes approximately 50 percent of lottery sales revenue back to the public in the form of prizes. The state distributes the remaining revenues to public schools, the California State University, the University of California, and various other state entities including DSH. The allocation to DSH is designated for clients with developmental or mental disabilities who are enrolled in state hospital education programs.

According to DSH, the California State Lottery has updated the funding allocations from the California State Lottery Education Fund. DSH requests expenditure authority from the California State Lottery Education Fund of $6,000 annually to reflect this updated funding allocation for DSH education programs for state hospital patients.

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 4: Enhanced Treatment Units - Statewide

DOF Issue#: 4440-304-COBCP-2019-MR

May Revision Capital Outlay Issue. DSH requests General Fund expenditure authority of $2.4 million in 2019-20. If approved, these resources would allow DSH to complete construction of Enhanced Treatment Units at Atascadero and Patton State Hospitals.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$2,387,000	$-
Total Funding Request:	**$2,387,000**	**$-**

Background. AB 1340, Chapter 718, Statutes of 2014, authorized the construction of Enhanced Treatment Units at Atascadero and Patton State Hospitals that will provide a more secure environment for patients that become psychiatrically unstable, resulting in highly aggressive and dangerous behaviors. According to DSH, patients in this state of psychiatric crisis require individualized and intensive treatment of their underlying mental illness, while reducing highly volatile and violent behavior. The proposed units will create secure locations within the existing hospitals to provide a safe treatment environment for both staff and patients. Patients will be housed individually and provided with the heightened level of structure necessary to allow progress in their respective treatment.

Once completed, the Enhanced Treatment Program will provide 39 secured beds at Atascadero State Hospital and 10 beds (female only) at Patton State Hospital. The Atascadero project is currently under construction, and is approximately 25 percent complete. However, DSH reports bids recently received for construction of the Patton project were significantly higher than the state's estimate due to an underestimation of the cost of installing fire sprinklers in an existing facility and for procurement of detention doors, coordination of construction activities of a phased project within a secured environment, and current conditions in the construction services market in San Bernardino. According to DSH, these issues have resulted in the need to provide additional funding to complete construction of the project at Patton.

DSH requests General Fund expenditure authority of $2.4 million in 2019-20 to allow DSH to complete construction of the Enhanced Treatment Units at Atascadero and Patton State Hospitals. DSH expects the total project will cost $16 million, including $1.2 million for preliminary plans, $869,000 for working drawings, and $13.9 million for construction. The preliminary plans and working drawings components of the project have been completed. If approved, this request would only support completion of construction for the Enhanced Treatment Units.

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.

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES
4440 DEPARTMENT OF STATE HOSPITALS

Issue 1: Relocation to the Clifford L. Allenby Building

DOF Issue#: 4300-410-BCP-2019-MR
4440-077-BCP-2019-MR

May Revision Finance Letter. The California Health and Human Services Agency (CHHSA), in collaboration with the Department of Developmental Services (DDS) and DSH request positions and resources to support the services and equipment necessary to relocate these entities to the new Clifford L. Allenby Building in January 2021. The components of this request are as follows:

DSH requests two limited-term positions and General Fund expenditure authority of $4.9 million in 2019-20, $1.8 million in 2020-21, and $2.8 million annually thereafter.

DDS requests one position and General Fund expenditure authority of $3.4 million in 2019-20, $1.8 million in 2020-21, $1.2 million in 2021-22 and 2022-23, and $1.4 million annually thereafter. The subcommittee will hear the DDS portion of this request during consideration of the DDS May Revision adjustments.

Program Funding Request Summary - DDS		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$3,401,000	$1,814,000
Total Funding Request:	**$3,401,000**	**$1,814,000**
Total Positions Requested:**	**1.0**	

* Additional fiscal year resources requested: 2021-22 to 2022-23: $1,185,000; 2023-24 and ongoing: $1,429,000
** Positions are ongoing.

Program Funding Request Summary - DSH		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$4,891,000	$1,760,000
Total Funding Request:	**$4,891,000**	**$1,760,000**
Total Positions Requested:**	**2.0**	

* Additional fiscal year resources requested: 2021-22 and ongoing: $2,760,000;
** Positions are limited-term and expire at the end of 2020-21.

Background. A 2015 study of Sacramento state office infrastructure identified serious deficiencies with existing state building including the Bateson Building, occupied by CHHSA, DDS, and DSH. The 2016 Budget Act included a $1.3 billion transfer over two years from the General Fund to a new State Project Infrastructure Fund to be used specifically for the renovation or replacement of state office buildings in the Sacramento area. One of the initial projects that received funding was the construction of a new building at 1215 O Street in Sacramento to replace the vacant Department of Food and Agriculture Annex. Since that time, CHHSA, DDS and DSH were chosen as the new building's future tenants and the building has been named the "Clifford L. Allenby Building (Allenby Building)." Construction of the

Allenby Building is currently underway, and all three departments expect to occupy the building beginning in January of 2021.

According to the DDS and DSH, to physically move to, occupy and conduct business in the new Allenby Building, the departments must move some of the current office contents to the Allenby Building and decommission the Bateson Building, outfit the new building with necessary items and equipment not included in the project's scope of work, and reduce the current Bateson Building document storage footprint to fit into the new storage space. The three departments are currently pursuing a shared contract for moving services to relocate each department's office contents and equipment from the Bateson Building to the Allenby Building. This contract would also include the disposal of surplus assets and equipment. The Bateson Building decommission would include the removal of the data cables from all workstations and the disconnection of all hard-wired connections to existing furniture.

DDS and DSH report that if the three departments are to physically fit their documents into the new building, the current document storage footprint will have to be reduced significantly. Part of the expectation of tenancy in the Allenby Building is a 50 to 70 percent reduction in storage needs. Each department is currently reviewing their respective document retention schedules and plan to update them before the end of 2018-19. This will be followed by the destruction of documents as permitted by the retention schedule and organization of the remaining documents into a system conducive for digitalization. Despite this effort, the departments anticipate a need to further reduce storage needs by January of 2021 to meet the Allenby Building's requirements.

According to DDS and DSH, the requested resources would fund the following activities:

Move to the New Allenby Building – Moving to the new building includes physical relocation of the contents of the Bateson building and required removal of surplus items and certain electronic and telecommunication connections. The Department of General Services (DGS) will be contracting with a professional moving consultant to conduct a comprehensive review of the established acquisition and relocation strategies developed by the tenant agencies.

New Equipment Required for the Allenby Building – The DGS capital outlay project does not include all the equipment that will be necessary for the three departments to function in the new building. Certain items must be purchased by the individual departments and installed in the Allenby Building prior to occupancy. The operation and management of an energy efficient and robust shared enterprise IT environment in the new building entails the following composite hardware, software, network resources and services:

- Migration of on premise business applications and server infrastructure to the cloud
- Cloud performance monitoring tools
- Network infrastructure which includes the Local Area Network, Wide Area Network, Wireless LAN
- Personal computer deployments
- Print and Fax management
- Telecommunications
- Project management

Short and Long-Term Document Solution – The three departments must reduce the current document storage space to physically fit into the Allenby Building. To do this, the departments propose to contract with an outside vendor which would scan and store the existing 38 million documents housed in the Bateson Building. The three departments report that, due to need to scan all these documents by January 2021, an outside contract would contract with the departments to scan, electronically store, and then destroy all the existing documents by the proposed move date. The cost for this service would be approximately $4 million and would require about a $1,000 per month in user fees for as long as the departments use the system.

Positions and Funding Requested – DDS requests one position and General Fund expenditure authority of $3.4 million in 2019-20, $1.8 million in 2020-21, $1.2 million in 2021-22 and 2022-23, and $1.4 million annually thereafter. DSH requests two limited-term positions and General Fund expenditure authority of $4.9 million in 2019-20, $1.8 million in 2020-21, and $2.8 million annually thereafter. According to the departments, the DDS funding would support **one Staff Services Manager I** position that would provide IT support.

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.

4120 EMERGENCY MEDICAL SERVICES AUTHORITY
4265 DEPARTMENT OF PUBLIC HEALTH
4440 DEPARTMENT OF STATE HOSPITALS
5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: Disaster Preparedness, Response, and Recovery

DOF Issue#: 4120-401-BCP-2019-MR
4265-401-BCP-2019-MR
4440-087-BCP-2019-MR
5180-407-BCP-2019-MR

May Revision Issue. The Administration proposes new positions and additional General Fund and special fund expenditure authority for various departments, including EMSA, DPH, DSH, and DSS, to enhance the state's disaster preparedness, response, and recovery capabilities.

Program Funding Request Summary - EMSA		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$979,000	$303,000
Total Funding Request:	**$979,000**	**$303,000**
Total Positions Requested*:	**2.0**	

* Positions and resources ongoing after 2020-21.

Program Funding Request Summary - DPH		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$569,000	$569,000
3098 – Licensing and Certification Program Fund	$390,000	$390,000
Total Funding Request:	**$959,000**	**$959,000**
Total Positions Requested*:	**6.0**	

* Positions and resources ongoing after 2020-21.

Program Funding Request Summary - DSH		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$996,000	$826,000
Total Funding Request:	**$996,000**	**$826,000**
Total Positions Requested*:	**6..0**	

* Positions and resources ongoing after 2020-21.

Program Funding Request Summary - DSS		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$2,943,000	$2,739,000
Total Funding Request:	**$2,943,000**	**$2,739,000**
Total Positions Requested*:	**20.0**	

* Positions and resources ongoing after 2020-21.

Statewide Disaster Preparedness, Response, Recovery. According to the Administration, California is experiencing unprecedented wildfire activity with increases in the number and severity of wildfires. 15 of the 20 most destructive wildfires in the state's history have occurred since 2000 and ten of the most destructive fires have occurred since 2015. The fire season is getting longer each year with many parts of the state experiencing nearly year-round fire danger. Climate change has led to historic periods of drought, which has created critically dangerous fuel conditions and resulted in over 147 million dead or dying trees. Additionally, growth in the wildland urban interface has put more Californians at risk than ever before. More than 25 million acres of the state's wildlands are classified as under very high or extreme fire threat. The catastrophic wildfire activity in 2018, including the Camp, Woolsey, and Hill fires, underscores the serious dangers that current conditions pose to individuals and communities in high-risk areas of the state.

Based on lessons learned and because of the increased magnitude, frequency, and complexity of recent disasters, the Administration proposes $39.9 million ($38.6 million General Fund) and 159.5 positions for various departments to enhance the state's disaster preparedness, response, and recovery capabilities; support the continuity of state government during disasters, and increase technical proficiency to best position the state to maximize appropriate federal reimbursements of billions of dollars. This includes resources to enhance disaster contingency planning and preparedness for the following departments:

- Office of Emergency Services (Cal OES)—$5.9 million in ongoing funds ($5.1 million General Fund) and 76 positions to enhance Cal OES disaster preparedness and response capacity for future state disasters. Without the appropriate tracking and coordination of disaster costs, California would be at risk of losing federal funding.

- Department of Housing and Community Development—$2 million General Fund (with $740,000 in ongoing resources) and four positions to create a permanent Disaster Response and Recovery Unit that will provide housing expertise in coordination with statewide disaster recovery efforts and to hire a consultant that will conduct local needs assessments related to the 2018 Camp and Woolsey fires as well as create local long-term recovery plan frameworks.

- State Water Resources Control Board—$1 million ongoing General Fund and six positions to improve emergency response capabilities between the State Water Board, regional boards, and other state entities during emergencies. These resources will enable the Water Board to lessen the impacts of disasters on vulnerable populations by addressing a wide range of issues in the periods following and between emergencies, including addressing engineering and operation issues facing drinking water systems and waste water utilities, and preventing or minimizing impacts to water quality, water supply security, and safety.

- Department of Resources Recycling and Recovery—$2.8 million ongoing General Fund and 21.5 positions for the Department to continue its significant role in emergency response mission tasking responsibilities. These resources will establish a dedicated team to help facilitate timely, safe, and effective debris removal operations as well as to assist local governments in the preparation of debris removal plans for future incidents.

- Emergency Medical Services Authority—$979,000 ongoing General Fund and two positions to increase disaster medical services capacity, including coordination of medical assets during

emergency response efforts and one-time purchases of medical treatment and communications equipment.

- Department of Public Health—$959,000 in ongoing funds ($569,000 General Fund) and six positions to support health care facilities and mass care shelters during emergencies as well as disaster preparedness, response, and recovery efforts. Activities will include deployment of infection control teams and continuous updates to an existing health facility mapping application used during disasters.

- Department of State Hospitals—$996,000 ongoing General Fund and six positions to improve emergency coordination and preparedness, and business continuity planning at five state hospitals and the Department of State Hospitals headquarters. The additional resources will enhance the Department's ability and capacity to more effectively care for patients and coordinate staff in the event of a disaster.

- Department of Social Services—$2.9 million ongoing General Fund and 20 positions to support the Department of Social Services' mandated disaster planning, coordination, and training activities. The Department is responsible for statewide mass care and shelter responsibilities, as designated by Cal OES.

Emergency Medical Services Authority. According to EMSA, the rapidity of its ability to provide emergency medical care to disaster victims is critical in any disaster or major event. While EMSA plans and stands ready for California's threat of a major earthquake, tsunami, flooding or volcano; recent wildfire response activities have identified gaps in response capabilities. EMSA is requesting General Fund expenditure authority of $979,000 to support the following:

Medical Treatment Site Deployment – $256,000 and 2 positions
These resources would support **two Emergency Medical Services Coordinators** to support preparedness, response, and recovery medical services operations.

Bio-Medical/ Medical Supply – $169,000
According to EMSA, some of its bio-medical equipment, such as portable ventilators, AEDs, intravenous fluid pumps, is beyond the average lifespan. The requested bio-medical/medical supply items are generally more compact, durable and efficient, providing increased field reliability and capability.

Medical Treatment Site Deployment Equipment – $103,000
This funding would supply lighting for safety and security at the EMSA base of operations, to allow 24 hour operation, rather than having to wait for rented light towers to arrive. This funding would also be used to purchase basic fire safety equipment for deploying personnel into active fire areas, such as fire shelter packs and helmets.

Fleet/ Station – $189,000
This funding would allow EMSA to purchase a stake bed truck with a four-wheel drive rough terrain forklift attachment, and three UTV-style vehicles that allow for movement of supplies, equipment and personnel, due to the size of base of operations or shelters\close quarters of other structures in which regular vehicles would not be allowed and rough roadway conditions. This funding would also support

the replacement of the generator on EMSA's command and control vehicle due to poor performance operating communications equipment.

Communications/Information Technology – $262,000
This funding would replace the rack radios, communications rack, upgrade telex radio dispatch panel and update the V-Sat system on the command and control vehicle. The radio stacks in the three Mission Support Team vehicles would also be replaced. According to EMSA, these dated systems and legacy devices are slow, unreliable and often incompatible with the EMSA's response partner's communication infrastructure.

Department of Public Health. Public Health requests six positions and annual expenditure authority of $959,000 ($569,000 General Fund and $390,000 Licensing and Certification Program Fund), to address California's continuing efforts to better prepare for public health emergencies, response, and recovery efforts. Of the six positions, 2.5 positions would directly serve health facilities and may be funded through licensing fees. These resources would support **three Staff Services Manager I Specialists, two Nurse Consultants,** and **one Information Technology Specialist I** position, based out of the department's Emergency Preparedness and Disaster Response Unit, which would support the recovery of the health care delivery system by collectively exploring and pursuing opportunities for rebuilding after an emergency event and options that allow health care facilities to return to operations quickly. These opportunities and options may include submitting waiver requests, reviewing and approving regulatory flex requests, and applying for various reimbursement mechanisms.

Department of State Hospitals. According to DSH, during a disaster, state hospitals are responsible for the lives, safety, care, and treatment of medically fragile, severely mentally ill, and forensic patients. Each of the five state hospitals have over 1,000 patients and employ thousands of staff who are responsible for the patients' care. Hospital emergency preparedness, staff training, plan exercises, and mitigation to protect this fragile and high-risk population is critical to ensure healthcare personnel are ready to respond effectively to a crisis and keep patients safe from harm. While DSH has demonstrated the ability to care for the patient population and communicate with staff and emergency management partners during a disaster, the October 2017 Atlas/Tubbs fire experiences have identified gaps in response capabilities. DSH request six positions and annual General Fund expenditure authority of $996,000 to support the following:

Expanded Emergency Notification System – $50,000
DSH seeks to utilize the current partnership with DDS to expand the existing emergency notification system used for Sacramento employees into a statewide network. This system expansion would increase the number of employees who are able to receive emergency notifications from 515 in Sacramento to over 11,000 statewide. This system could also be used to notify and communicate critical information during an emergency event with the families and guardians of nearly 7,000 patients.

Emergency Satellite Phone Network Expansion for Hospitals – $30,000 annually, $20,000 in 2019-20.
According to DSH, each state hospital sits upon a large parcel of land, includes dozens of buildings, uses secure treatment areas with significant security and access restrictions, and services a variety of critical safety, treatment and infrastructure operations. Each hospital has four satellite phones currently, and this proposal would raise that number to nine satellite phones per site. The Sacramento headquarters has four satellite phones.

Emergency Intermediate Operations Facility for Business Continuity – $30,000
During the October 2017 Atlas-Tubbs fires impacting Napa State Hospital, the facility's power, cellular communications, access to the internet, DSH email, and patient data systems were disabled. Napa staff convened in the executive director's conference room and communicated with emergency responders and DSH headquarters via a land-line "red phone" emergency communications system. DSH proposes to contract services for mobile emergency operations facilities that would be delivered to a designated site and activated with office space, satellite links for technology and communications, power generators and experienced personnel to support activation and decommissioning of the facility. These facilities would service 20 Emergency Operations Center management and staff to administer life and safety decisions and business continuity administration.

Business Continuity Plan Statewide Consolidation Consultant – $150,000 in 2019-20
DSH currently conducts the emergency preparedness, response, and recovery activities with a 2016-2021 Business Continuity Plan and five hospital Emergency Operational Plans (EOP). This proposal would use expert consultant guidance to create, consolidate and coordinate existing plans into one statewide "Business Continuity, Response and Recovery Plan" for all six sites. The consultant would evaluate current plan connectivity, propose consolidation designs, draft the approved consolidation plan for review, and upon approvals would conduct training and hospital exercises at each site. Following the plan approval, training, and exercises, the consultant would provide an evaluation for future improvements to be addressed by DSH.

Emergency Management Coordinators – $716,000
DSH proposes to recruit an Emergency Management Services Coordinator for each hospital, and one Senior Emergency Management Coordinator in Sacramento to organize and coordinate efforts statewide. These coordinators would be responsible for emergency preparedness coordination at each hospital and would work with headquarters to establish a standardized, consistent, and coordinated statewide emergency preparedness program. The coordinators would be responsible for integrating the needs and program deliverables of Fire/Police, Medical/Clinical, Administration/Health and Safety, Infrastructure/Plant Operations into the "Emergency Operation/Business Continuity Plan," and conduct training, exercises, and performance evaluations. The coordinators would work with subject matter experts to ensure compliance with regulatory/oversight agency requirements, including The Joint Commission. The coordinators would work with the senior management coordinator to improve existing systems, test those systems, and develop recommendations for improvements to meet DSH emergency response and management needs.

Department of Social Services. The Administration requests that Item 5180-001-0001 be increased by $2.9 million and 20 positions to support mandated disaster preparedness, response, and recovery operations related to the Department of Social Services' mass care and shelter responsibilities. This proposal is part of the Administration's larger Disaster Preparedness, Response, and Recovery May Revision package. Based on lessons learned and due to the increased magnitude, frequency, and complexity of recent disasters and those likely to come, the May Revision includes resources for various departments to enhance the state's disaster response preparedness and support the continuity of state government during disasters.

DSS is 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, and in the California Disaster Recovery Framework as the lead for Social Services Recovery for the state. Prior to 2015, incidents requiring state

Mass Care & Shelter leadership and support were infrequent, but disasters, specifically fires, in California are increasing in frequency and destructiveness. The October 2017 Wildfires forced tens of thousands to evacuate and destroyed over 5,000 homes. Mass Care and Shelter operations included over 50 shelters being supported and incurred an estimated 15,000 hours of staff time for response and recovery. This figure does not capture additional workload associated with training, demobilization, and administrative work associated with a disaster response.

Even with staff members working long hours (nearly 300 hours of overtime a month in some cases). Disaster Services Bureau programs are experiencing delays in service delivery during fire response. Inadequate bandwidth to mobilize and deploy mass care and shelter support workforce has resulted in a lack of adequate staffing at shelters in every major fire over the past two years. Grant processing can be delayed, causing citizens to wait for critical financial assistance.

According to the department, approval of the requested staff resources will allow DSS to increase mass care capabilities and strengthen relationships with community non-profit, tribal, local, state, and federal partners. Additionally, these staff will allow the department to build critical capacity necessary to carry out its disaster-related responsibilities. Utilizing the requested resources, the department intends to complete the following annual tasks:

- Develop and/or revise 24 local, state, and federal mass care and social services recovery plans.
- Conduct 48 training courses and exercises to internal and external stakeholders.
- Deploy 25 additional specialized staff to local, state, and federal emergency operations centers to coordinate mass care response and social services recovery operations.
- Complete 120 critical shelter facility assessments.
- Coordinate and facilitate 12 Regional Mass Care and Shelter Workshops.
- Develop and/or revise 12 departmental disaster program response/recovery plans.

Subcommittee Staff Comment and Recommendation—Hold Open.

Questions. The subcommittee has requested EMSA, DPH, DSH, and DSS to respond to the following:

1. Please provide a brief overview of these proposals.

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

SUBCOMMITTEE NO. 3 Agenda

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

Tuesday, May 14, 2019
10:00 a.m.
State Capitol - Room 4203

PART B

Consultant: Renita Polk

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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 VOTE ONLY

4170 DEPARTMENT OF AGING (CDA)

Issue 1: Community Based Adult Services Additional Staffing for Mandate Compliance (Governor's Budget)

Governor's Proposal. CDA requests $751,000 ($427,000 federal funds and $324,000 General Fund) and four positions to ensure that Community Based Adult Services (CBAS) provider recertification is occurring within the statutorily required timeframe and those providers are complying with new federal rules.

This issue was heard during the subcommittee's March 14th hearing.

Staff Comment and Recommendation. Approve as budgeted.

Issue 2: Spring Finance Letter (SFL) – SSI Cash-out Reversal Implementation via Area Agencies on Aging (AAA)

Budget Issue. CDA requests reimbursement authority of $1.7 million to implement the SSI Cash-out Reversal, or the CalFresh expansion, via the AAAs. $200,000 will fund departmental operations, and $1.5 million will be distributed to the AAAs for CalFresh application assistance and outreach.

This issue was heard during the subcommittee's May 9th hearing.

Staff Comment and Recommendation. Approve as requested.

Issue 3: SFL – Federal Title III Funding Augmentation

Budget Issue. CDA requests federal fund authority of $17.5 million and seven positions due to an increase in federal Title III funding. $897,000 will be used for operations, and $16.6 million will be for local assistance.

This issue was heard during the subcommittee's May 9th hearing.

Staff Comment and Recommendation. Approve as requested.

Issue 4: SFL - Medicare Improvements for Patients and Providers Act (MIPPA) Authority

Budget Issue. CDA requests a revision of budget bill language in Item 4170-101-0890 to allow for augmentation of the MIPPA federal grant authority.

This issue was heard during the subcommittee's May 9th hearing.

Staff Comment and Recommendation. Approve as requested.

5160 DEPARTMENT OF REHABILITATION (DOR)

Issue 1: Mission-Based Review (Governor's Budget)

Governor's Proposal. The Governor's budget includes additional resources for the department's VR and TBI programs, separated into the following three components:

- $3.4 million General Fund annually for a ten percent increase to Community Rehabilitation Program provider rates.
- $1.6 million General Fund for improvements to the department's information technology (IT) infrastructure.
- $1.2 million General Fund annually until 2023-24 to fund the department's TBI program.

This issue was heard during the Subcommittee's May 2nd hearing.

Staff Comment and Recommendation. Approve as budgeted.

Issue 2: CalFresh Outreach via ILCs (SFL)

Governor's Proposal. CDA requests an increase of $2.5 million in reimbursement authority for 2019-20 to assist with implementation and oversight of the state's CalFresh program outreach plan. The Department of Social Services (DSS) will reimburse DOR for costs in communicating new eligibility requirements for the Supplemental Nutrition Assistance Program (SNAP).

This issue was heard during the Subcommittee's May 2nd hearing.

Staff Comment and Recommendation. Approve as requested.

5175 DEPARTMENT OF CHILD SUPPORT SERVICES

Issue 1: Human Services Technical BCP - Voluntary Parentage Establishment Program (Governor's Budget)

Governor's Proposal. The Governor's budget includes three-year limited-term funding in the amount of $596,000 ($199,000 General Fund) for the implementation of AB 2684 (Bloom), Chapter 876, Statutes of 2018.

This issue was heard during the Subcommittee's March 28th hearing.

Staff Comment and Recommendation. Approve as budgeted.

5180 DEPARTMENT OF SOCIAL SERVICES – STATE HEARINGS DIVISION

Issue 1: Appeals Case Management System (ACMS) Permanent Maintenance & Operations Support (Governor's Budget)

Governor's Proposal. The Administration requests $395,000 ($151,000 General Fund) and three positions to be a part of the state's maintenance and operations and project management support team for the Appeals Case Management System (ACMS).

This issue was heard during the Subcommittee's March 28th hearing.

Staff Comment and Recommendation. Approve as budgeted.

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

Issue 1: Human Services Technical BCPs – AB 605 and AB 2370 (Governor's Budget)

Governor's Proposal. The Governor's budget includes the following CCL-related technical proposals.

1. AB 605 Implementation. The Governor's budget includes $394,000 General Fund in 2019-20; $253,000 General Fund in 2020-21; and $127,000 General Fund in 2021-22 in order to implement AB 605 (Mullin), Chapter 574, Statutes of 2018. AB 605 requires the Community Care Licensing Division (CCLD) to adopt regulations by January 1, 2021 that would create a childcare center license with individual program components that service infant, toddler, preschool, and school age children.

2. AB 2370 Implementation. The Governor's budget includes $142,000 General Fund in 2019-20 and $127,000 General Fund ongoing to implement AB 2370 (Holden), Chapter 676, Statutes 2018. AB 2370 requires the CCLD, in consultation with the State Water Resources Control Board, to adopt regulations to test a licensed child day care facility's drinking water for lead contamination levels beginning January 1, 2020, but no later than January 1, 2023 and every five years thereafter.

3. Strengthening Program Infrastructure. The Governor's budget includes $2.5 million in 2019-20; $2.5 million in 2020-21; and $375,000 General Fund every year thereafter for three permanent positions and the extension of $1.92 million temporary Technical Assistance Fund (TAF) through 2020-21. The requested resources will address workload associated with Adult and Senior Care Residential Facility license application processing and a backlog of complaint investigations in the Children's Residential Program.

These issues were heard during the Subcommittee's April 4th hearing.

Staff Comment and Recommendation. Approve as budgeted.

Issue 2: Human Services Technical BCPs – AB 2455 (Governor's Budget)

Governor's Proposal. The Governor's budget includes a one-time augmentation of $300,000 to implement AB 2455 (Kalra), Chapter 917, Statutes of 2018. AB 2455 requires the CCLD, after July 1, 2019, to share, upon a labor organization's request, the name, phone number, and cell phone number, if available, of each newly registered or renewed Home Care Aide, who has not opted-out of sharing this information. It also requires Department of Social Services (DSS) to develop a simple opt-out procedure for aides and applicants to request that their contact information not be disclosed.

These issues were heard during the Subcommittee's April 4th hearing.

Staff Comment and Recommendation. Approve as budgeted.

5180 DEPARTMENT OF SOCIAL SERVICES – CHILD WELFARE SERVICES (CWS)

Issue 1: The Office of Foster Care Ombudsperson Foster Child Complaint Investigation (Governor's Budget)

Governor's Proposal. The Governor's budget proposes an increase of $894,000 ($407,000 General Fund) in 2019-20 and $779,000 ($354,000 General Fund) in 2020-21 for limited-term two-year resources to address an increased caseload backlog associated with the investigation of complaints about child welfare and foster care.

This issue was heard during the Subcommittee's April 4th hearing.

Staff Comment and Recommendation. Approve as budgeted.

Issue 2: State-Tribal-County Engagement and Indian Child Welfare Act Compliance (Governor's Budget)

Governor's Proposal. The Governor's budget proposes an increase of $797,000 ($392,000 General Fund) in 2019-20 and 2020-21 for limited-term two-year resources to address workload associated with new state and federal regulations and to support counties with technical assistance and specialized training.

This issue was heard during the Subcommittee's April 4th hearing.

Staff Comment and Recommendation. Approve as budgeted.

Issue 3: CWS-related Human Services Technical BCPs (Governor's Budget)

Governor's Proposal. The Governor's budget includes the following CWS-related technical proposals.

1. Child Wellbeing Waiver Project. The Governor's budget includes $1.6 million ($454,000 General Fund) in 2019-20 and $909,000 ($454,000 General Fund) in 2020-21 to extend limited-term resources for the phase-down of the Child Well-being Waiver Project. Additionally, funding would be used for the project evaluation contract that was funded, but not executed in 2014-15.

2. AB 2967 – Ensuring Foster Youth Have Access to Vital Documents. The Governor's budget includes $122,000 ($56,000 General Fund) in 2019-20 and $114,000 ($52,000 General Fund) in 2020-21 in order to implement AB 2967 (Quirk-Silva), Chapter 551, Statues of 2018. AB 2967 requires a county welfare agency to verify the eligibility of an applicant requesting a free copy of their birth certificate, based on the qualification of being a current or former foster youth.

These issues were heard during the Subcommittee's April 4th hearing.

Staff Comment and Recommendation. Approve as budgeted.

Issue 4: CCR-related Human Services Technical BCPs (Governor's Budget)

Governor's Proposal. The Governor's budget includes the following CCR-related technical BCPs.

1. AB 2083 Implementation. The Governor's budget includes $413,000 in 2019-20 and $292,000 ongoing to implement AB 2083 (Cooley), Chapter 815, Statutes of 2018. AB 2083 requires both the state and local governments to create integrated programs serving children under both the Short-Term Residential Therapeutic Program (STRTP) and Therapeutic Foster Care models of care, as well as through integrated implementation of Child and Family Teams and the CANS tool.

2. CCR Increased Workload. The Governor's budget includes $4.4 million ($3.1 million General Fund) in 2019-20 and 2020-21 for 34 limited-term positions to address additional workload and compliance requirements associated with CCR.

These issues were heard during the Subcommittee's April 4th hearing.

Staff Comment and Recommendation. Approve as budgeted.

5180 DEPARTMENT OF SOCIAL SERVICES (DSS) – IMMIGRATION SERVICES BRANCH

Issue 1: Human Services Technical BCP – Immigration Initiatives and Legal Services State Support (Governor's Budget)

Governor's Proposal. The Governor's budget includes $885,000 for six positions to support the increase in capacity to provide immigration services and support interdepartmental immigrant integration efforts.

This issue was heard during the Subcommittee's April 11th hearing.

Staff Comment and Recommendation. Approve as budgeted.

5180 DEPARTMENT OF SOCIAL SERVICES – SSI/SSP AND CALFRESH

Issue 1: SSI/SSP and CalFresh Expansion (Governor's Budget)

Governor's Proposal. The Governor's budget includes $1.4 million ($711,000 General Fund and $710,000 federal funds) to expand CalFresh to SSI/SSP recipients (also known as reversal of the SSI Cash-out policy), along with the Supplemental and Transitional Nutrition Benefit programs. The request includes two-year limited-term funding for eleven positions.

This issue was heard during the Subcommittee's March 14th hearing.

Staff Comment and Recommendation. Approve as budgeted.

5180 DEPARTMENT OF SOCIAL SERVICES – CALFRESH

Issue 1: Human Services Technical BCP – California Fruit and Vegetable EBT Pilot (Governor's Budget)

Governor's Proposal. The Governor's budget includes $311,000 in 2019-20 and 2020-21 for the implementation of the California Fruit and Vegetable EBT pilot. The 2018 Budget Act included $9 million to cover all costs of this pilot, of which $311,000 is being requested in both 2019-20 and 2020-21 to carry out state operations activities.

This issue was heard during the Subcommittee's April 11th hearing.

Staff Comment and Recommendation. Approve as budgeted.

ISSUES FOR DISCUSSION

4170 DEPARTMENT OF AGING

Issue 1: Long-Term Care Ombudsman Augmentation (May Revision)

May Revision. The Administration requests that Item 4170-102-0942 be increased by $1 million to provide additional one-time funding to local Long-Term Care Ombudsman programs. The 2018 Budget Act includes provisional language that allows the Department of Finance to augment Item 4170-102-0942 by up to $1 million if the 2018-19 ending fund balance of the State Health Facilities Citation Penalties Account is projected to exceed $6 million. The Department of Finance currently projects the 2018-19 ending fund balance to be approximately $9.9 million.

Staff Comment and Recommendation. Hold open.

5160 DEPARTMENT OF REHABILITATION (DOR)

Issue 1: Supported Employment – Provider Rate Adjustment (May Revision)

May Revision. The Administration requests Item 5160-001-0001 be increased by $1.3 million to reflect a two-year limited-term provider rate increase for supported employment services, effective January 1, 2020. This adjustment aligns Vocational Rehabilitation program provider rates with those of the Department of Developmental Services for this service category.

Legislative Analyst's Office (LAO) Comment. In general, the LAO has expressed concerns with many proposals within the May Revision where the Governor chooses to treat policies that are fundamentally ongoing in nature as temporary, which creates programmatic challenges and increases cost pressures. According to the LAO, this approach implicitly prioritizes new ongoing spending proposals largely at the expense of existing programmatic commitments.

Staff Comment and Recommendation. Hold open.

5175 DEPARTMENT OF CHILD SUPPORT SERVICES

Issue 1: May Revision Estimate

May Revision. The Administration requests that Item 5175-101-0890 be increased by $2.6 million and Item 5175-101-8004 be decreased by $2.6 million to reflect revised forecasts of child support collections. Total costs for local assistance are estimated to be $912.8 million ($283.3 million General Fund) in 2019-20. Total child support collections and revenues are projected to be $2.59 billion ($174.5 million General Fund) for 2019-20.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – AUTOMATION PROJECTS

Issue 1: CWS-CARES (Issue 406-MR)

May Revision. The Administration requests that Items 5180-001-0001 and 5180-001-0890 both be increased by $539,000 to provide two-year limited-term resources through fiscal year 2020-21 to support continuing development and implementation of the CWS-CARES project.

Staff Comment and Recommendation. Hold open.

Issue 2: BBL - California Statewide Automated Welfare System (CalSAWS) Augmentation

May Revision. The Administration requests that Provision 8 be added to Item 5180-141-0001 and Provision 1 of Item 5180-141-0890 be amended to authorize an increase in expenditures related to mid-year changes in CalSAWS project schedule and costs.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – VARIOUS PROGRAMS

Issue 1: May Revision Caseload Adjustments (Issues 401-MR, 402-MR, 403-MR, 404-MR, and 405-MR)

May Revision. The May Revision proposes a net increase of $266.4 million (increases of $71.6 million General Fund, $354.6 million reimbursements, $189,000 Emergency Food Assistance Program Fund, and $146,000 School Supplies for Homeless Children Fund, partially offset by decreases of $160.2 million Federal Trust Fund, and $2,000 Child Health and Safety Fund) primarily resulting from updated caseload estimates since the Governor's budget. Caseload and workload changes since the Governor's budget are displayed in the following table:

Program	Item	Change from Governor's Budget
CalWORKs	5180-101-0001	($34,503,000)
	5180-101-0890	($15,783,000)
	Reimbursements	$11,000
Kinship Guardianship Assistance Payment	5180-101-0001	$1,145,000
SSI/SSP	5180-111-0001	($18,015,000)
IHSS	5180-111-0001	$136,279,000
	Reimbursements	$344,990,000
Other Assistance Payments	5180-101-0001	($17,899,000)
	5180-101-0122	$189,000
	5180-101-0890	($19,252,000)
	5180-101-8075	$146,000
County Administration and Automation Projects	5180-141-0001	($2,421,000)
	5180-141-0890	($19,784,000)
	Reimbursements	($6,935,000)
Community Care Licensing	5180-151-0890	$214,000
Special Programs	5180-151-0001	$7,723,000
Realigned Programs		
Adoption	5180-101-0890	$1,777,000
Foster Care	5180-101-0890	($283,000)
	5180-141-0890	($366,000)
Child Welfare Services (CWS)	5180-151-0001	$8,061,000
	5180-151-0279	($2,000)
	5180-151-0890	($61,907,000)
	Reimbursements	$449,000
Title IV-E Waiver	5180-153-0001	($8,759,000)
	5180-153-0890	($44,913,000)
Adult Protective Services	5180-151-0890	$81,000
	Reimbursements	$16,114,000

Staff Comment and Recommendation. Hold open.

Questions.

1. DSS: Please provide an overview of the May Revision estimates for major programs.

2. LAO: Are the estimates reasonable?

Issue 2: Special Olympics (Issue 423-MR)

May Revision. The Administration requests that Item 5180-101-0001 be increased by $2 million to provide one-time funding for the Special Olympics. It is also requested that provisional language be added to Item 5180-101-0001 to allow the DSS to provide the funding to the Special Olympics.

Staff Comment and Recommendation. Hold open.

Issue 3: BBL – Cash Disbursement Authority

May Revision. The Administration requests that Provision 2 of Item 5180-101-0001 be amended to allow DSS to ensure county cash disbursements are met when federal funds and the Local Revenue Fund are insufficient to cover county expenditures.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – IMMIGRATION SERVICES BRANCH

Issue 1: Rapid Response Funding (Issue 414-MR)

May Revision. The Administration requests that Item 5180-151-0001 be increased by $7.3 million to provide funding for nonprofits who operate emergency shelters for migrants in San Diego and Riverside counties. A corresponding decrease will be made to the Rapid Response Reserve.

Staff Comment and Recommendation. Hold open.

Issue 2: TBL – Rapid Response Reserve Fund

May Revision. The Administration proposes language that would transfer $12.7 million General Fund to the Rapid Response Reserve Fund. These funds will be available over three years to assist qualified community-based organizations and nonprofit entities in providing services during immigration emergent situations when federal funding is not available.

The total amount proposed in 2019-20 for Rapid Response is $20 million General Fund, of which $7.3 million has been shifted to the Department of Social Services (see previous issue).

Staff Comment and Recommendation. Hold open.

Issue 3: BBL - Expansion of Immigration-Related Services

May Revision. The Administration requests that Provision 15 of Item 5180-151-0001 be amended and Provision 19 be added to Item 5180-151-0001 to authorize $5 million of the $10 million General Fund budgeted in 2019-20 for the provision of legal services to unaccompanied undocumented minors and Temporary Protected Status beneficiaries to: (1) provide mental health screenings and evaluations related to legal defense, and (2) develop a family reunification navigator pilot to link undocumented minors with services in the community.

Staff Comment and Recommendation. Hold open.

Issue 4: TBL – Administration of Refugee Services (Wilson-Fish Program)

May Revision. The Administration proposes language to update the existing statute governing the administration of refugee social services and Refugee Cash Assistance to provide the state with the authority to contract directly with a qualified nonprofit organization for services when necessary to ensure effective program delivery.

Background. Currently, California provides refugee services through a state-supervised, county-administered model. However, certain refugee services are also provided by a nonprofit organization, which contracts directly with the federal Office of Refugee Resettlement (ORR) under the Wilson-Fish Program. ORR recently notified DSS that it intends to end the Wilson-Fish Program in federal fiscal year 2019 and requested that the state explore establishing a public-private partnership directly. The federal regulations allow for a public-private partnership model, whereby the state contracts with a private organization to deliver refugee services.

Existing law does not currently authorize the state to contract directly with private partners. The proposed language would provide the state with flexibility in contracting for the administration of refugee social services and Refugee Cash Assistance. In addition, the federal government over time has made changes to its refugee resettlement programs and funding structure, and these changes are not currently reflected in the current statute governing the administration of refugee services.

Staff Comment and Recommendation. Hold open.

5180 – DEPARTMENT OF SOCIAL SERVICES – CHILD WELFARE SERVICES

Issue 1: Resource Family Approval Administration and Backlog (Issue 406-MR)

May Revision. The Administration requests that Item 5180-151-0001 be increased by $14.4 million and Item 5180-151-0890 be increased by $6.2 million to provide one-time funding to support Resource Family Approval administration workload, including application backlogs.

Staff Comment and Recommendation. Hold open.

Issue 2: Placement Prior to Approval (Issue 407-MR) and Emergency Caregiver Payments (TBL)

May Revision. The Administration requests that Item 5180-101-0001 be increased by $15.1 million and Item 5180-101-0890 be increased by $6.6 million for counties to support up to four months of emergency assistance payments prior to resource family approval in 2019-20.

The Administration also proposes language that would allow, through June 30, 2020, emergency assistance payments prior to resource family approval for up to 120 days, or up to 180 days if the county provides "good cause."

Current law provides that emergency assistance payments to relative caregivers prior to resource family approval shall not exceed 90 days, effective July 1, 2019.

Staff Comment and Recommendation. Hold open. At the time of writing this agenda, trailer bill language was not available.

Issue 3: Foster Parent Recruitment, Retention, and Support (Issue 408-MR)

May Revision. The Administration requests that Item 5180-151-0001 be increased by $10.8 million, Item 5180-151-0890 be increased by $5.1 million, and Item 5180-153-0001 be increased by $10.9 million to provide one-time funding to counties for recruitment, retention, and support of foster parents.

Staff Comment and Recommendation. Hold open.

Issue 4: Dependency Counsel Title IV-E Funding (Issue 409-MR)

May Revision. The Administration requests that Item 5180-151-0890 be increased by $34 million to provide the Judicial Branch with federal Title IV-E reimbursements for legal support provided to certain children and parents who are involved with the child welfare system.

Staff Comment and Recommendation. Hold open.

Issue 5: TBL – Continuum of Care Reform Contracts

May Revision. The Administration proposes language that would exempt DSS from specified contract laws, rules, and review processes until July 1, 2021 for training or technical assistance grants and contracts related to the implementation or evaluation of the Continuum of Care Reform (CCR) initiative.

Background. Any contract funded over the delegated authority of $150,000 requires the Department of General Services (DGS) approval, conducted in accordance with the Public Contract Code and the State Contracting Manual. This process takes a minimum of 12-18 months per contract, and longer if additional processes and review are needed due to the nature of the contract. Any contracts over $10,000 require the competitive bidding process, unless some other exemption applies.

The formal competitive bidding process involves numerous factors and decisions. For example, the contractor selection method depends on the services involved and/or the circumstances. The contract must be processed for signature, approval, and distribution. Management of the contract must be built

into the contract to facilitate measurement of achievement and measurement of contractor performance. However, given the highly technical nature of specific components of CCR, DSS has frequently identified a single private entity that is capable of providing the level of expertise and engages the non-competitive bid (NCB) process. This process can take up to a year internally and DGS has no timeline limits reviewing the contract-or for approving it. If it is not approved, CDSS must either keep trying through the NCB process or start from scratch through the competitive bid process, which delays service delivery.

Contracting delays can significantly impede DSS' ability to fully and timely implement critical components of CCR. This proposal would provide the ability to, for a limited time, self-execute necessary contracts related to the implementation or evaluation of the CCR initiative.

Staff Comment and Recommendation. Hold open.

Issue 6: BBL – Bringing Families Home Re-appropriation

May Revision. The Administration requests that Item 5180-492 be amended to allow the re-appropriation of unexpended funds appropriated in the 2017 Budget Act for the Bringing Families Home Program.

Staff Comment and Recommendation. Hold open.

Issue 7: TBL – Kin-GAP Beginning Date of Aid

May Revision. The Administration proposes language that would change the beginning date of aid for Kin-GAP payments. The language clarifies that foster care payments cease immediately upon discontinuance of dependency and that Kin-GAP assistance payments may begin the following day.

Background. Current state law provides that if dependency from the state is dismissed and guardianship of the youth is established mid-month, a foster care payment to the guardian can continue until the end of the month (when the youth is no longer in foster care and is not considered a dependent of the state); this allows the actual Kin-GAP payments to then begin the first of the following month. In July and August of 2018, the federal Department of Health and Human Services (DHHS) audited the State's Title IV-E Foster Care program, which is the primary funding source for foster care and guardianship programs. As part of that review process, DHHS informed DSS that statute, regulation, and All County Letters related to the beginning date of aid for Kin-GAP was inconsistent with federal law and policy.

DHHS instructed DSS to change its foster care and Kin-GAP payment policies to comport with federal law. To avoid noncompliance with federal law, and to avoid future disallowances, state statute must be changed so that foster care payments cease immediately upon discontinuance of the dependency.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – SSI/SSP

Issue 1: TBL – Housing and Disability Advocacy Program (HDAP)

May Revision. The Administration proposes language that would include recognized tribes to the list of eligible recipients, clarify that funding for the HDAP can be used for either SSI advocacy or housing supports for potentially SSI-eligible individuals, and adds flexibility to the requirement that HDAP clients must be housed in units sustainable upon approval of disability benefits.

Background. HDAP assists homeless, disabled individuals apply for disability benefit programs, while also providing housing supports. HDAP requires that participating counties offer outreach, case management, benefits advocacy, and housing support to all program participants. The 2017 Budget Act appropriated $45 million for the program over a three-year period, and requires a dollar for dollar county match. The 2019-20 State Budget proposes an additional $25 million for the program on an ongoing annual basis.

DSS proposes adding tribes due to the unmet need in tribal communities. Additionally, the proposed language provides greater flexibility for counties to administer the program in a way that supports county needs. Due to the cost of housing, counties are often not able to house HDAP clients in a unit sustainable on Supplemental Security Income (SSI) or other disability benefit program. Often the only sustainable option is a housing voucher or other ongoing housing resource, which may not be available until after disability benefits are approved. In such cases, it may be necessary to house HDAP clients in units not sustainable on SSI but which may be sustainable once a voucher becomes available.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – CALFRESH

Issue 1: TBL - Expanding CalFresh to Recipients of SSI Clean-up

May Revision. The Administration proposes "clean-up" language to ensure the following:

- The reversal of the "SSI Cash-Out" policy is not subject to appropriation. The language clarifies that only the SNB and TNB are subject to appropriation, not the reversal of the "SSI Cash-out" policy.

- The Supplemental Nutrition Benefit (SNB) and Transitional Nutrition Benefit (TNB) Programs may be implemented by All County Letter (ACL) or similar instructions. DSS issued initial implementation guidance for both the SNB and TNB Programs via ACL. The proposed language allows DSS to provide additional guidance through the same method.

- The Cash Assistance Program for Immigrants (CAPI) monthly benefit amount is no longer different from SSI and/or California State Supplementary Payment (SSI/SSP) monthly benefit amount. Because of the reversal of the "SSI Cash-out" policy, AB 1811 also increased the individual monthly CAPI grant for parity with the individual monthly SSI/SSP grant. The

proposed language removes language that previously reduced the individual monthly CAPI grant by $10.

Background. The "SSI Cash-out" is a state policy that provides SSI/SSP recipients with an extra $10 payment in lieu of their being eligible to receive federal food benefits through the CalFresh program. AB 1811 (Committee on Budget), Chapter 35, Statutes of 2018, ended this policy. This expansion of benefits is effective beginning June 1, 2019. AB 1811 also created two state-funded nutrition benefit programs intended to "hold harmless" existing CalFresh households negatively affected by the policy change. The two state-funded programs, known as the SNB Program and the TNB Program, will provide CalFresh households with nutrition benefits to mitigate the reduction of CalFresh benefits or CalFresh ineligibility, respectively.

Staff Comment and Recommendation. Hold open.

Issue 2: One-Time County Administration Funding for the Expanded CalFresh Population (Issue 420-MR)

May Revision. The Administration requests that Item 5180-141-0001 be increased by $15 million and Item 5180-141-0890 be increased by $21,428,000 to support county administrative efforts to process new CalFresh applicants as a result of eliminating the SSI Cash-Out policy. It is also requested that Provision 9 be added to Item 5180-141-0001 to allow the Department of Social Services to provide the additional General Fund to counties upon approval by the Department of Finance.

Staff Comment and Recommendation. Hold open.

Issue 3: County Work Number Contract (Issue 417-MR)

May Revision. The Administration requests that Item 5180-101-0890 be increased by $1,916,000, Item 5180-141-0001 be increased by $2,235,000, and Item 5180-141-0890 be increased by $2,235,000 to reflect counties' increased usage of the Work Number Express Service for income and employment verification in the CalWORKs and CalFresh programs.

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 Melissa Hurtado
Senator Jeff Stone

Wednesday, May 15, 2019
10:00 a.m.
State Capitol - Room 4203

PART A

Consultant: Renita Polk

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ISSUES FOR VOTE ONLY

5180 DEPARTMENT OF SOCIAL SERVICES – IN-HOME SUPPORTIVE SERVICES (IHSS)

Issue 1: IHSS State Administrative Review and Data Analysis (Governor's Budget)

Governor's Proposal. The Administration requests $235,000 for the permanent extension of two three-year limited term positions to support ongoing workload for the State Administrative Review (SAR) process and data analysis.

This issue was heard during the Subcommittee's March 14th hearing.

Staff Comment and Recommendation. Approve as budgeted.

ISSUES FOR DISCUSSION

5180 DEPARTMENT OF SOCIAL SERVICES - IHSS

The Governor's May Revision includes about $3.8 billion from the General Fund for IHSS in 2018-19. For 2019-20, the May Revision proposes $4.5 billion in General Fund for IHSS. Relative to the Governor's January budget, the May Revision estimates that IHSS General Fund costs will be, on net, about $60 million higher in 2018-19 and, on net, about $210 million higher in 2019-20. The increase in General Fund IHSS costs in the current year and budget year relative to the Governor's January proposal is primarily driven by two factors: (1) higher estimated hours per case, and (2) higher estimated provider costs per hour.

Issue 1: Public Authority Administration Funding (Issue 411-MR)

May Revision. The Administration requests that Item 5180-111-0001 be increased by $1,838,000 and reimbursements be increased by $1,899,000 for public authority administration based on updated workload assumptions.

Staff Comment and Recommendation. Hold open.

Issue 2: Restoration of the 7-Percent Across-the-Board Reduction (Issue 413-MR)

May Revision. The Administration requests that Item 5180-111-0001 be increased by $15,250,000 and reimbursements be increased by $22,151,000 to reflect the updated costs to restore the 7-percent across-the-board reduction to IHSS hours. The May Revision proposes to temporarily restore the 7-percent reduction through December 31, 2021, due to lower than expected revenues over the forecast period and ongoing efforts to contain costs.

LAO Comment. In general, the LAO has expressed concerns with many proposals within the May Revision where the Governor chooses to treat policies that are fundamentally ongoing in nature as temporary, which creates programmatic challenges and increases cost pressures. According to the LAO, this approach implicitly prioritizes new ongoing spending proposals largely at the expense of existing programmatic commitments.

Staff Comment and Recommendation. Hold open. Note that in January the Administration proposed to continue the restoration on an ongoing basis, but the Administration now proposes to continue the restoration only through December 21, 2021 due to lower than expected revenues over the forecast period and ongoing efforts to contain costs.

Issue 3: Electronic Visit Verification County Administration Funding (Issue 412-MR)

May Revision. The Administration requests that Item 5180-111-0001 be increased by $1,503,000 and reimbursements be increased by $4,507,000 to reflect adjustments in county administrative workload associated with the final implementation plan for electronic visit verification.

Staff Comment and Recommendation. Hold open.

Issue 4: Maintenance-of-Effort Increased Costs (Issue 424-MR)

May Revision. The Administration requests that Item 5180-111-0001 be increased by $55,098,000 related to the re-benching of the County IHSS maintenance-of-effort to reflect revised 1991 Realignment revenue projections and revised IHSS caseload and cost estimates.

Background. In January, the Governor estimated that the base County IHSS MOE would have increased to $2 billion in 2019-20. Absent any changes, DOF found that 1991 realignment revenues were not enough to cover these increasing MOE costs. In January, the Governor proposed to reduce the base County IHSS MOE itself to an amount that could be covered by 1991 realignment revenues. Specifically, the Governor proposed to reduce the base County IHSS MOE from $2 billion to $1.56 billion in 2019-20. As a result of these changes, it was estimated that, on net, about $240 million of county costs would be shifted to the state in 2019-20.

In May, the Governor estimates that, on net, an additional $55 million in General Fund is required to lower the base County IHSS MOE to an amount that can be covered by 1991 realignment. This is because, based on higher IHSS cost projections, the Governor's May Revision estimates that base County IHSS MOE costs would have been $2.06 billion in 2019-20 under current law—about $60 million higher than January estimates. Additionally, the Governor's May Revision estimates that 1991 realignment revenues can cover about $4 million in additional base county IHSS costs relative to January estimates (still about $1.56 billion in total). Based on these updated estimates, reducing the County IHSS MOE to $1.56 billion would, on net, shift about $300 million of county costs to the state in 2019-20—about $55 million more than initial January estimates.

Staff Comment and Recommendation. Hold open.

5180 DEPARTMENT OF SOCIAL SERVICES – CALWORKS

The Governor's May Revision assumes total CalWORKs costs in 2018-19 will be $4.8 billion—$47 million (1 percent) lower than the amount proposed in January. This slight decrease is due to a lower-then-anticipated estimated caseload. The Governor's May Revision assumes total CalWORKs costs in 2019-20 will be about $5.3 billion—$43 million (1 percent) higher than the January proposal. This increase reflects the effect of (1) new costs related to 12-month eligibility within Stage 1 child care, (2) slightly higher spending for the CalWORKs Home Visiting Initiative, and (3) a larger allocation to counties to provide case management for employment services. These additional costs are offset somewhat by lower costs as a result of a larger-than-expected caseload decline.

Issue 1: Single Allocation Employment Services Budget Methodology Changes (Issue 415-MR)

May Revision. The Administration requests that Item 5180-101-0001 be increased by $128,000 and Item 5180-101-0890 be increased by $41,296,000 to reflect a revised budgeting methodology for the employment services component of the CalWORKs Single Allocation to counties. It is also requested that Provision 11 be added to Item 5180-101-0001, and Provision 1 of Item 5180-101-0890 be amended to clarify that funding allocated for the purposes of CalWORKs Stage One Child Care services is independent of the CalWORKs Single Allocation.

Background. The May Revision proposes to use a new budgeting methodology to determine county funding for CalWORKs employment services. Historically, counties have received a funding for these purposes based on a flat per-client rate that was to be used for case management and direct employment services, such as vocation training, coursework, and job skills workshops. In the May Revision, the Administration proposes to set different budgeted funding amounts for case management depending on the amount of time county staff dedicate to working with different types of clients. (The Administration has indicated that funding for direct services, such as those discussed above, will continue to be provided based under the historical methodology until this portion can be updated as well.) The groupings of the case types are as follows:

- Intensive Cases. The highest funding level, corresponding to employment services case management for individuals who have significant barriers to employment.

- Basic Cases. Employment services case management for individuals who have some barriers to employment.

- Work-ready Cases. Employment services case management for individuals who have job skills and work experience and are prepared to re-enter the labor force.

- Re-engagement. Employment services case management for individuals who have not been participating in the CalWORKs program—for example, individuals who have been under sanction status for more than 12 months—or individuals who are exempt from the work participation requirement because they are caring for young children.

The new funding methodology for employment services results in a year-over-year increase of about $110 million (16 percent) from 2018-19 to 2019-20 for this component of the single allocation. Relative to the Governor's January proposal, the May Revision estimate for employment services is $140 million higher than the previous estimate for 2019-20 due to the new methodology, which on average provides higher funding-per-case than the previous method.

Legislative Analyst's Office (LAO) Comments. The LAO states that the new methodology represent a promising step, as it takes into account the level of services and case management each requires, but also raises key questions. First, the new funding methodology, which accounts for different case types, is based on an assessment of statewide need and not county need. In other words, the Administration has estimated the number of individuals statewide in each grouping (as listed above) and provided statewide funding based on that assessment. It is the LAO's understanding that funding will continue to be allocated to each county based on the size of their total caseload rather than the size of the newly defined caseload groupings. Secondly, the Administration's new methodology estimates the number of individuals in each grouping based on a set of proxies—for example, the number of intensive cases is based on the number of cases that receive specialized services under the existing Family Stabilization program. The use of these proxies nevertheless raises the question: how accurately does the new budgeting methodology identify participants who need more or less intensive services, and how will this assessment be refined in future years based on feedback from counties and state officials?

Staff Comment and Recommendation. Hold open.

Issue 2: CalWORKs Outcomes and Accountability Review County Administration (Issue 416-MR)

May Revision. The Administration requests that Item 5180-101-0001 be increased by $887,000 and Item 5180-101-0890 be increased by $12,293,000 to support county administrative activities related to the CalWORKs Outcomes and Accountability Review Continuous Quality Improvement process.

Staff Comment and Recommendation. Hold open.

Issue 3: Revised CalWORKs Home Visiting Assumptions (Issue 418-MR)

May Revision. The Administration requests that Item 5180-101-0001 be decreased by $3,289,000 and Item 5180-101-0890 be increased by $13,969,000 to reflect revised projections of CalWORKs cases eligible for Home Visiting Services.

Staff Comment and Recommendation. Hold open.

Issue 4: CalWORKs Stage One 12-month Eligibility (Issue 421-MR)

May Revision. The Administration requests that Item 5180-101-0001 be increased by $40,663,000 to establish a 12-month eligibility period for CalWORKs Stage One Child Care services, effective October 1, 2019. This proposal requires trailer bill language.

LAO Comments. The May Revision includes $41 million in 2019-20 (increasing to $54 million in 2020-21) to implement certain changes to CalWORKs Stage 1 child care. Specifically, the May Revision proposes to lengthen the amount of time a family stays in Stage 1 child care. Under current law, families in Stage 1 child care transfer to Stage 2 when the county deems them stable. (Every county has its own definition of stability.) The May Revision proposes that a family receive Stage 1 child care for at least twelve months before being transferred to Stage 2 child care. The proposal also reduces the frequency with which Stage 1 families must be recertified for child care. These proposals would become effective beginning October 1, 2019. Trailer bill was just released by the Administration on May 14th and the LAO is still reviewing.

Staff Comment and Recommendation. Hold open.

Issue 5: Cal-Learn Case Management Standards Change (Issue 422-MR)

May Revision. The Administration requests that Item 5180-101-0001 be increased by $230,000 and Item 5180-101-0890 be increased by $5,777,000 to reflect adherence to new case management standards in the CalWORKs Cal-Learn program.

Staff Comment and Recommendation. Hold open.

Issue 6: Decreased TANF Funding for Cal Grants (Issue 419-MR)

May Revision. The Administration requests that Item 5180-101-0890 be decreased by $5.9 million to reflect a decrease in the amount of federal TANF block grant funds available to offset General Fund costs in the Cal Grant program.

Staff Comment and Recommendation. Hold open.

Issue 7: BBL - CalWORKs Housing Support Program Re-appropriation

May Revision. The Administration requests that Item 5180-493 be amended for the purpose of re-appropriating the unexpended balances from funds appropriated in the 2018 Budget Act for the CalWORKs Housing Support Program.

Staff Comment and Recommendation. Hold open.

Issue 8: TBL – SB 726 Terminology Change and Delayed Implementation

May Revision. The Administration proposes trailer bill language to make a terminology change to the EBT expungement process changes as a result of Senate Bill 726 (Wiener), Chapter 930, Statutes of 2018.

Background. SB 726 requires an expungement process for non-fraudulent cash assistance overpayments to former CalWORKs recipients who have not received cash aid for 36 consecutive months. SB 726 also allowed for mass overpayment expungement in the event overpayments were a result of negligence or major systemic error. The county welfare departments and Statewide Automated Welfare System (SAWS) consortia use the term "expunge" for a different process. This language changes the SB 726 terminology from "expunge" to "discharge." Additionally, the total automation changes necessary to implement this bill cannot be made in SAWS until 2023 when the single CalSAWS is completed. As such, this language delays implementation date from July 1, 2019 to July 1, 2020, at which point a phased implementation would be carried out through 2023 when all necessary functionality is built into SAWS.

Staff Comment and Recommendation. Hold open.

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS)

Issue 1: May Revision Adjustments

May Revision. The May Revision includes $8.2 billion total funds ($5.0 billion General Fund) for the Department in 2019-20; a net increase of $736.5 million ($534.3 million General Fund) over the updated 2018-19 budget.

Community Services Program/Regional Centers

The updated 2018-19 projected community population is 333,094, a net increase of 356 consumers, compared to the 2018 Enacted Budget. 333,010, a net decrease of 84 consumers compared to the 2019-20 Governor's Budget. The net decrease reflects an increase of 377 consumers in the Active caseload, and a decrease of 461 in the Early Start caseload. The 2019 May Revision updates the 2019-20 Governor's Budget to $7.0 billion ($4.1 billion General Fund); an increase of $67.6 million ($35.8 million General Fund). This includes a $66.6 million increase ($37.2 million General Fund) in Purchase of Service (POS). The updated budget overall includes an increase of $1.0 million ($1.4 million General Fund decrease) in Operations costs.

The budget year projection for the community population is 350,161, a net increase of 555 consumers as compared to the 2019-20 Governor's Budget. The May Revision proposes $7.8 billion ($4.7 billion General Fund) for the Regional Center system, an increase of $356.9 million ($225.2 million General Fund) as compared to the proposed 2019-20 Governor's Budget.

State Operated Residential and Community Facilities

The population on July 1, 2018, was 514 residents. The Department projects an ending population of 326 residents on July 1, 2019. The 2019 May Revision updates the budget to $404.4 million ($316.7 million General Fund), which is a net increase of $10.0 million General Fund as compared to the 2019-20 Governor's Budget.

The 2019 May Revision proposes a total of $323.8 million ($282.2 million General Fund) for the State Operated Residential and Community Facilities Program; a net increase of $14.4 million ($16.4 million General Fund) from the 2019-20 Governor's Budget.

Headquarters

The 2019 May Revision proposes no changes to the 2018-19 Headquarters' budget of $70.9 million ($42.3 million General Fund).

The May Revision proposes $92.5 million ($59.4 million General Fund) for Headquarters which is a net increase of $7.7 million ($6.2 million General Fund) compared to the 2019-20 Governor's Budget.

Staff Comment and Recommendation. Hold open. Note that additional resources for the department's relocation to the Clifford Allenby Building are included in the May Revision, but were discussed as part of a cross-departmental proposal on May 14th.

Issue 2: Provider Rate Adjustment (Issue 410-MR)

May Revision. The Administration requests that Item 4300-001-0001 be increased by $2.5 million and four positions, Item 4300-101-0001 be increased by $101,183,000, and reimbursements be increased by $66,950,000. These adjustments reflect a two-year limited-term provider rate increase, effective January 1, 2020, and resources necessary for the implementation of regional center accountability and oversight reform measures. The rate increases would begin in January 2020 to give the department time to obtain federal approval from the Centers for Medicare and Medicaid Services (to ensure continued receipt of federal matching funds).

Background. The proposed rate increases would be for service providers in the following categories:

- Residential services (in homes with 6 beds or fewer): $82.6 million total funds
- Support services (including supported living services): $67.6 million total funds
- Supported employment (group and individual): $12 million total funds
- Transportation assistance: $1.6 million total funds

DDS designed the temporary rate increases based on information obtained from the rate study submitted to the Legislature on March 15, 2019 in two ways. Specifically, DDS used information

from the rate study to decide which services to target and how to better achieve rate parity across providers. DDS indicates that it is targeting service categories based on which services had the largest gap between current rates and what the rate would be under the rate models presented in the rate study. However, the proposed rate increase does not implement the rate study's proposed models. As with the rate study, the Governor's May Revision proposes to capture regional variations in cost by applying regional adjustment factors. Additionally, the Governor's proposal attempts to narrow the arbitrary differences in rates among similar providers that are located in the same area. While no provider would receive a rate reduction, some providers would receive a larger rate increase than others.

DDS also states it designed the proposed rate increases to stabilize residential capacity and options; to stabilize the workforce; and to set the stage for "systems reform and innovative redesign." DDS estimates that the targeted service providers would receive, on average, a temporary 18 percent rate increase.

LAO Comments. In general, the LAO has expressed concerns with many proposals within the May Revision where the Governor chooses to treat policies that are fundamentally ongoing in nature as temporary, which creates programmatic challenges and increases cost pressures. According to the LAO, this approach implicitly prioritizes new ongoing spending proposals largely at the expense of existing programmatic commitments.

Questions.

1. The department has indicated that it has targeted rate increases for specific service categories based on which services had the largest gap between current rates and the rates under the proposed rate models. What is the impact of this proposal on those gaps? How do the adjusted gaps as a result of this proposal compare to the gaps of service providers not included in the proposal?

2. The department has indicated it designed the proposed rate increases to stabilize residential capacity and options. Please talk to the stability of other service providers not included in this proposal.

3. Several stakeholders have advocated for an eight percent across-the-board increase for service providers. Please explain why the department chose not to implement that proposal.

Staff Comment and Recommendation. Hold open.

Issue 3: TBL – Regional Center Transparency and Accountability

May Revision. The Administration proposes language that would provide additional measures to enhance regional center and provider oversight.

To increase transparency, accountability, and oversight, DDS proposes the following statutory changes aimed at providing the community more information on the service quality, outcomes, and regional center performance.

- Performance contract reporting: Require regional center governing boards to annually report on performance contract outcomes and receive community input in a public meeting, and to report to DDS on the outcomes of the meeting and the regional center's plan to address areas where improvement is needed. This information will allow DDS and stakeholders to actively oversee and monitor regional center performance and compliance, as well as identify best practices and disseminate those broadly.

- Regional Center process standardization: Provide DDS the authority to standardize regional center processes where appropriate to provide greater consistency and predictability for consumers and their families. DDS will begin this effort by creating, with stakeholder input, a consumer and family-friendly information packet that must be provided to anyone seeking regional center services.
- Performance dashboard requirements: Require DDS to provide the dashboard in a machine readable format, and require regional centers to post their data on their websites consistent with DDS' dashboard outcomes and to link to DDS' data dashboard. This could include an expansion of outcomes data to be reported to DDS.

To improve regional center Board Governance, DDS is also proposing the following:

- Governing board meetings with DDS: Require regional center governing boards to meet with DDS representatives upon a request by the department's director. The board will exclude regional center employees from the meeting if so requested by the director.

- Governing boards expertise: Require regional center governing boards to include a member with financial expertise, as well as adding an option for board governance to the current management experience requirement. Governing boards will no longer be required to have a member with public relations skills.

- Legal counsel conflicts-of-interest: Require regional center governing boards to ensure that any attorney retained by the board to provide legal services is not an employee of the regional center or a consultant who acts as a member of the regional center's management team.

To improve consumer safety and transparency, DDS also proposes the following:

- Consumer safety: Require fingerprinting/background clearance for all direct service professionals in service areas that are targeted for rate adjustments. These services

include, personal assistance, supported living services, supplemental program support services, transportation assistants, supported employment and Independent Living Skills. Require regional centers to monitor compliance.

- Health and safety: Provide the director of DDS the authority to issue a directive to regional centers and require the regional centers to comply with the directive. A directive may be issued by the director of DDS to protect consumer health and safety.

- Service provider quality: Require regional centers to send to DDS reports regarding service provider corrective action plans, including but not limited to, information on service provider names, types of actions taken and dates of actions.

- National Core Indicators (NCI) survey results: Require regional centers to post on their websites NCI survey results specific to their regional center, to hold an annual public board meeting to discuss the data, and to report to DDS on the outcomes of those meetings and the regional center's plan to address areas where improvement is needed.

Staff Comment and Recommendation. Hold open. At the time of writing this agenda, language was not available.

Issue 4: Porterville Stabilization Training Assistance and Reintegration Facilities (Issue 404-MR)

May Revision. The Administration requests that Item 4300-001-0001 be increased by $4,710,000 and reimbursements be increased by $1,177,000 to operate two Stabilization, Training, Assistance, and Reintegration (STAR) homes at the Porterville Developmental Center General Treatment Area. This one-time augmentation provides interim acute crisis stabilization services pending the completion of the Central Valley STAR homes in fiscal year 2020-21.

Staff Comment and Recommendation. Hold open.

Issue 5: Population and Staffing Adjustment (Issue 405-MR)

May Revision. The Administration requests that Item 4300-001-0001 be increased by $11,654,000 and 20.2 positions and reimbursements be decreased by $9,287,000 for the operation of one additional intermediate care facility at the Fairview Developmental Center and continued operation of all intermediate care facilities until December 31, 2019. This is due to scheduled placements occurring later than estimated in the 2019-20 Governor's Budget.

Staff Comment and Recommendation. Hold open.

Issue 6: Early Start Co-Payments (Issue 406-MR) and TBL

May Revision. The Administration requests that Item 4300-101-0001 be increased by $1 million. Trailer bill language is necessary to implement this request.

Background. As a condition of federal Early Start grant funding, DDS must ensure that insured families are not disproportionately charged more than uninsured families for early intervention services. Currently, some privately insured families pay out-of-pocket co-payments while regional centers cover all early intervention service costs for uninsured families. These changes enable regional centers to make co-payments on behalf of privately insured families in order to comply with federal requirements.

Staff Comment and Recommendation. Hold open.

Issue 7: Family Home Agency Oversight (Issue 407-MR)

May Revision. The Administration requests that Item 4300-101-0001 be increased by $1.1 million and reimbursements be increased by $519,000. These funds will enable regional centers to expand Family Home Agency monitoring of individuals who transition out of high-cost models of care into more cost-effective, less restrictive settings.

Staff Comment and Recommendation. Hold open.

Issue 8: Specialized Home Monitors (Issue 408-MR)

May Revision. The Administration requests that Item 4300-101-0001 be increased by $207,000 and reimbursements be increased by $99,000. This is a technical salary adjustment for regional center Board Certified Behavioral Analyst positions proposed in the Governor's Budget.

Staff Comment and Recommendation. Hold open.

Issue 9: Caseload and Utilization Adjustment (Issue 409-MR)

May Revision. The Administration requests that Item 4300-101-0001 be increased by $90,038,000, reimbursements be increased by $44,054,000, and Item 4300-101-0890 be decreased by $696,000. These changes reflect updated expenditures in caseload-driven operations and purchase of service costs.

Staff Comment and Recommendation. Hold open.

Issue 10: Uniform Holiday Schedule Suspension (Issue 411-MR)

May Revision. The Administration requests that Item 4300-101-0001 be increased by $30.1 million and reimbursements be increased by $20.2 million to suspend the implementation of the Uniform Holiday Schedule. Provisional language is necessary to implement this request. The May Revision proposes to continue the suspension through December 31, 2021.

Staff Comment and Recommendation. Hold open.

Issue 11: Best Buddies (Issue 412-MR)

May Revision. The Administration requests that Item 4300-101-0001 be increased by $500,000. This adjustment supports Best Buddies' delivery of peer-to-peer mentoring and supported employment services.

Staff Comment and Recommendation. Hold open.

Issue 12: TBL – Enhanced Behavioral Supports Homes Sunset Extension

May Revision. The Administration proposes language that would extend the Enhanced Behavioral Support Home program sunset from Jan. 1, 2020 – to Jan 1. 2021. This will allow for continued development of homes that serve individuals who have challenging behavioral needs.

Staff Comment and Recommendation. Hold open.

Issue 13: TBL – Canyon Springs Admissions Expansion

May Revision. The Administration proposes language that would expand admissions into Canyon Springs for individuals currently admitted to acute psychiatric facilities, Institution for Mental Disease, or state operated Stabilization, Training, Assistance, and Reintegration homes and have no community placement options to meet high intensity need.

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 Melissa Hurtado
Senator Jeff Stone

Wednesday, May 15, 2019
10:00 a.m.
State Capitol - Room 4203

PART B

Consultant: Scott Ogus

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PUBLIC COMMENT

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

ISSUES FOR DISCUSSION

4800 CALIFORNIA HEALTH BENEFIT EXCHANGE – COVERED CALIFORNIA

Issue 1: Expanding Affordability in the Individual Health Insurance Market – Update

DOF Issue#: 4800-401-BCP-2019-MR

May Revision Issue and Trailer Bill Language Proposal. The Administration requests General Fund expenditure authority of $295.3 million in 2019-20, $330.4 million in 2020-21, and $379.9 million in 2021-22. If approved, these resources would allow Covered California to provide premium subsidies to individuals between 200 and 600 percent of the federal poverty level (FPL) purchasing coverage in the state's health benefit exchange. This request is an adjustment to the Administration's January budget proposal. The Administration also proposes adjustments to the trailer bill language included in the January budget to implement the premium subsidy program and impose a state-based individual mandate penalty. According to the Administration, revenue from the mandate penalty would offset the requested General Fund expenditures by $317.2 million in 2020-21, $335.9 million in 2021-22, and $352.8 million in 2022-23.

Background. In the January budget, the Administration proposed to increase premium subsidies to individuals with incomes between 250 and 400 percent of the federal poverty level (FPL) who are purchasing coverage on the Covered California health benefit exchange. All of these individuals currently receive premium subsidies from the federal advance premium tax credit (APTC). The January budget also proposed to expand premium subsidies to individuals with incomes between 400 and 600 percent of the FPL, all of whom are currently ineligible for premium subsidies from the federal APTC. The Administration proposes to fund the increased and expanded subsidies by implementing a state-based individual mandate penalty. Similar to the recently reduced federal mandate penalty, under the state-based mandate penalty, individuals would be required to purchase minimum essential coverage or face a penalty modeled on the federal requirement prior to its reduction under the federal tax bill.

Updated May Revision Proposal. According to the Administration, the May Revision changes to the January budget proposal would make health insurance more accessible and affordable for low- and middle-income families who purchase coverage through Covered California and would stabilize the insurance market by encouraging younger, healthier consumers to enroll in coverage. Specifically, the updated May Revision proposal would:

- For the coverage year beginning January 1, 2020, create an individual mandate penalty that would require California residents to obtain minimum essential coverage or pay a penalty similar to the penalty imposed under the federal Affordable Care Act.

- Exempt from the penalty individuals with hardships, such as short coverage gaps, low incomes, and unaffordable coverage, consistent with federal law and guidance. Additionally, the proposal would exempt individuals not required to file a California income tax return. According to the Administration, because California's income tax filing threshold is higher than that of the federal government, about 115,000 fewer low-income filers would be subject to California's mandate than if the federal mandate had remained in place.

- Offer advanced premium assistance subsidies to families earning between 200 and 600 percent of the federal poverty level (between $50,000 and $150,000 for a family of four) through Covered California, beginning January 1, 2020. California would be the first state in the nation to offer financial assistance to qualified individuals with incomes between 400 percent and 600 percent of the federal poverty level (FPL).

- Allocate about 75 percent of subsidies to about 190,000 individuals with incomes between 400 percent and 600 percent of the FPL. Subsidies for these individuals would average around $100 per month and around $150 per household. About 660,000 individuals with incomes between 200 percent and 400 percent of the FPL would receive average state subsidies of around $10 per month in addition to substantial federal subsidies. Similar to the federal subsidies, individual subsidy amounts would vary significantly depending upon an individual's income, family size, age, region, and health care premium costs.

- Require consumers to reconcile subsidies on their income tax return. Given some consumers above 400 percent of FPL—generally older individuals living in high cost markets—would be eligible for large state subsidies, in some cases exceeding $1,000 per month per individual, the Administration believes reconciliation is necessary to ensure individuals receive correct subsidy amounts.

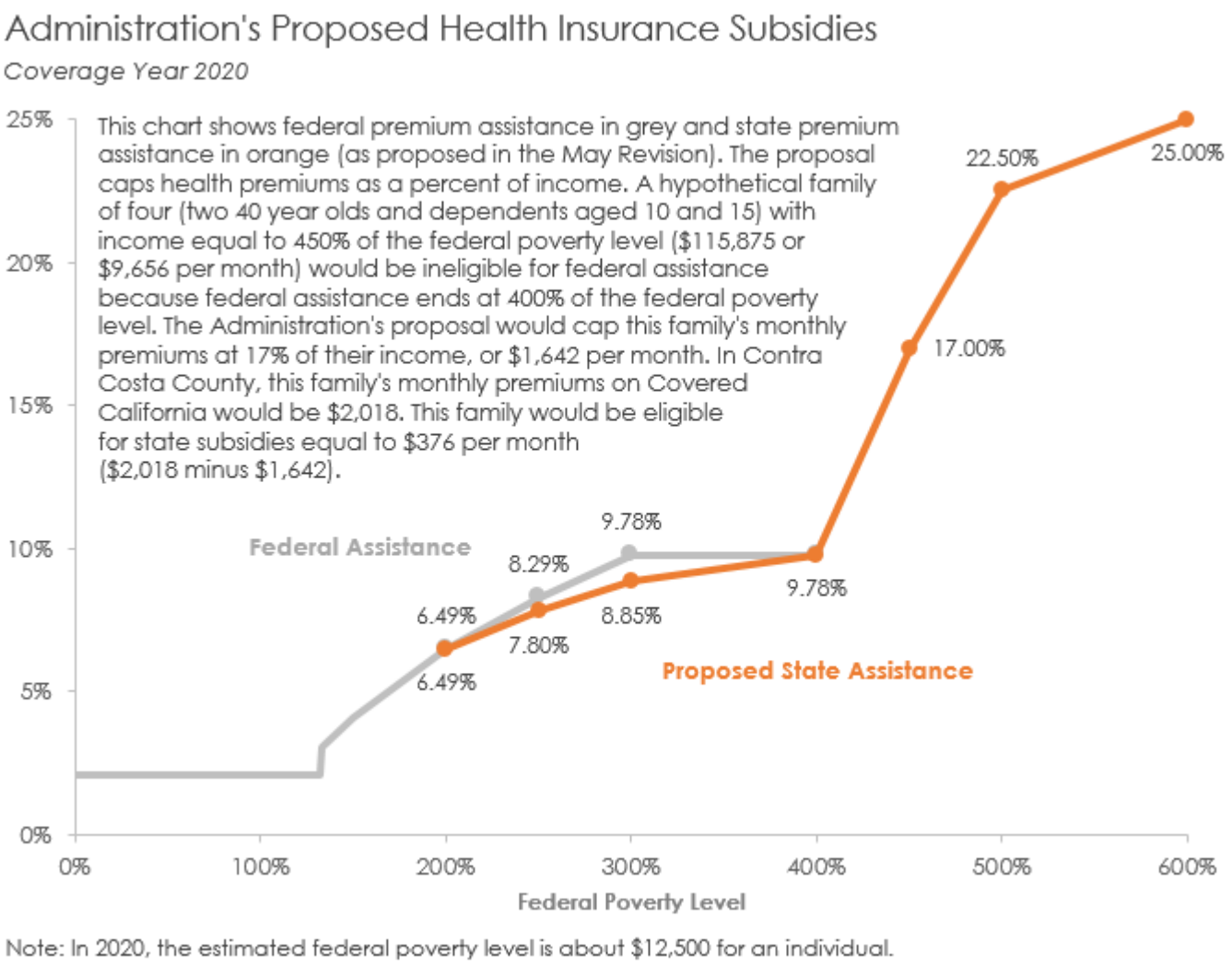
- Slow premium growth on the individual market by enrolling more healthy individuals in coverage. Specifically, the proposal is estimated to result in about 180,000 additional enrollees in 2020, lowering premiums between 4 and 8 percent relative to what they would have been without the Administration's proposals.

- Adjust subsidy levels in coverage years 2021 and 2022 to maintain a budget-neutral program. The subsidy program would sunset on December 31, 2022.

According to the Administration, the multi-year balance of premium subsidies and penalty revenue over the program periods would be as follows:

(dollars in millions)	**2019-20**	**2020-21**	**2021-22**	**2022-23**	**TOTAL**
Penalty Revenue	$ -	$ 317.2	$ 335.9	$ 352.8	$ 1,005.8
Expenditures	$ 295.3	$ 330.4	$ 379.9	$ -	$ 1,005.6
TOTAL	**$ (295.3)**	**$ (13.2)**	**$ (44.0)**	**$ 352.8**	**$ 0.2**

The Administration has also provided the following chart to demonstrate the levels of its proposed premium subsidies at various income levels:



Note: In 2020, the estimated federal poverty level is about $12,500 for an individual.

Subcommittee Comment and Recommendation – Hold Open.

Questions. The subcommittee has requested the Administration and Covered California to respond to the following:

1. Please provide a brief overview of the May Revision changes to the Administration's health insurance affordability proposal.

2. Why has the Administration chosen to direct 75 percent of the premium subsidy assistance to individuals between 400 and 600 percent of the FPL?

3. How many individuals that are not receiving premium subsidy assistance would also be subject to the individual mandate penalty?

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: Investment in Workforce Education and Training Five-Year Plan

DOF Issue#: 4140-401-BCP-2019-MR

May Revision Issue and Budget Bill Language. OSHPD requests expenditure authority from the Mental Health Services Fund of $100 million in 2019-20, available for encumbrance and expenditure until June 30, 2026. If approved, these resources would allow OSHPD to support the 2020-2025 Workforce Education and Training (WET) Program Five Year Plan, a framework of strategies to remedy the shortage of qualified individuals who provide services in the public mental health system.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
3085 – Mental Health Services Fund	$100,000,000	$-
Total Funding Request:	**$100,000,000**	**$-**

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 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
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 public mental health systems

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.

According to OSHPD, the WET program reported the following participants in its various programs between 2014-15 and 2016-17:

Program Type	WET Program	Participants by Fiscal Year		
		2014-15	2015-16	2016-17
Individuals	Mental Health Loan Assumption Program	1,085	1,528	1,514
	Stipends	293	325	339
	Peer Personnel	522	933	1,207
	CalSEARCH	66	30	-
Groups	Consumer and Family Member Employment	600	4,736	4,510
	Education Capacity	63	106	111
	Mini Grants	-	10,858	7,416
	Retention	-	5,293	7,616
	All Programs	**2,629**	**23,809**	**22,713**

Expenditures between 2014-15 and 2017-18 were as follows:

State Administered WET Program	State WET Funding (2014-15 through 2017-18)
Stipends	$31,426,699
Loan Assumption	$41,500,000
Education Capacity	$16,634,556
Consumer and Family Member	$12,368,924
Regional Partnership	$9,000,000
Recruitment and Retention	$4,344,090
Evaluation	$900,000
TOTAL	**$116,174,269**

According to OSHPD, the stipend and loan repayment programs were most effective in retaining individuals within the PMHS. Of those who graduated and completed their service commitments, 91 percent continued working in the PMHS. Counties and community-based organizations also reported that the WET program was effective in increasing the PMHS workforce and increasing PMHS workforce diversity and cultural and linguistic competency.

Although the second five-year plan is scheduled to expire in 2019, the funding for the plan was previously only approved until July 1, 2018. The 2018 Budget Act included expenditure authority from the Mental Health Services Fund State Administration Account of $10 million in 2018-19 to allow existing WET programs to continue to allow time for OSHPD and stakeholders to work together on options for funding and implementing a new five-year plan for the WET program.

WET Program Five-Year Plan 2020-2025. In February 2019, OSHPD released the third five year WET plan covering the period from 2020-2025. After engaging with stakeholders, the report is meant to guide efforts to improve and expand the public mental health system (PMHS) workforce throughout

California. Unlike the previous two plans, there was no funding associated with this plan, which OSHPD designed to be programmatically flexible based on the level of funding provided. The plan sets out the following goals and objectives:

Goals

1. Increase the number of diverse, competent licensed and non-licensed professionals in the PMHS to address the needs of persons with serious mental illness.
2. Expand the capacity of California's current public mental health workforce to meet California's diverse and dynamic needs.
3. Facilitate a robust statewide, regional, and local infrastructure to develop the public mental health workforce.
4. Offer greater access to care at a lower level of intensity that enables consumers to maintain and maximize their overall well-being.
5. Support delivery of PMHS services for consumers within an integrated health system that encompasses physical health and substance use services.

Objectives

1. Expand awareness and outreach efforts to effectively recruit racially, ethnically, and culturally diverse individuals into the PMHS workforce.
2. Identify and enhance curricula to train students at all levels in competencies that align with the full spectrum of California's diverse and dynamic PMHS needs.
3. Develop career pathways for individuals entering and advancing across new and existing PMHS professions.
4. Expand the capacity of postsecondary education to meet the identified PMHS workforce needs.
5. Expand financial incentive programs for the PMHS workforce to equitably meet identified PMHS needs in underrepresented, underserved, unserved, and inappropriately served communities.
6. Expand education and training programs for the current PMHS workforce in competencies that align with the full spectrum of PMHS needs.
7. Increase the retention of PMHS workforce identified as high priority.
8. Evaluate methods to expand and enhance the quality of existing PMHS delivery systems to meet California's PMHS needs.
9. Develop and sustain new and existing collaborations and partnerships to strengthen recruitment, training, education, and retention of the PMHS workforce.
10. Explore stakeholder-identified policies that aim to further California's efforts to meet its PMHS needs.
11. Provide flexibility to allow local jurisdictions to meet their unique needs.
12. Standardize PMHS workforce education and training programs across the state.
13. Promote care that reduces demand for high-intensity PMHS services and workforce.

OSHPD requests expenditure authority from the Mental Health Services Fund of $100 million in 2019-20, available for encumbrance and expenditure until June 30, 2026, to support the 2020-2025 Workforce Education and Training (WET) Program Five Year Plan. OSHPD would directly administer programs that support systems including efforts to increase the psychiatry training of practitioners working outside

the PMHS, expand residency programs, support peer personnel within the PMHS, and conduct research and evaluation of the WET programs. The funding requested in this proposal would increase the PMHS workforce in areas with a shortage of qualified mental health personnel to meet the needs of California's diverse population. OSHPD indicates it will continue engaging with Regional Partnerships and other key stakeholders in 2019-20 and will phase implementation of new WET programs between 2020-21 and 2024-25. OSHPD intends to develop and use a county-level needs assessment to determine local behavioral health workforce needs and funding allocations.

OSHPD also requests the following budget bill language to support this request:

4140-101-3085—For local assistance, Office of Statewide Health Planning and Development, payable from the Mental Health Services Fund……..100,000,000

Schedule:
(1) 3835-Health Care Workforce ……100,000,000

Provisions:
1. Of the funds appropriated in Schedule (1), $100,000,000 is available to implement the 2020-2025 Workforce Education and Training (WET) Five-Year Plan to address workforce shortages in the state's public mental health system. This amount is available for encumbrance or expenditure until June 30, 2026.
2. The Department of Finance may authorize the transfer of expenditure authority specified in Provision 1 of Item 4140-001-3085 to administer the Workforce Education and Training (WET) Program. Any amounts transferred shall be available for encumbrance or expenditure until June 30, 2026.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

2. Specifically, please describe the types of mental health providers that would receive support under the new five-year WET plan, and what types of support these providers would receive.

3. How does this proposal interact with the Administration's $50 million augmentation for Mental Health workforce development proposed in the January budget? Are there programs or activities that would benefit from both proposals?

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Medi-Cal Local Assistance Estimate – May Revision Update

DOF Issue#: 4260-001-ECP-2019-GB (November 2018 Medi-Cal Estimate)
4260-401-ECP-2019-MR (May 2019 Medi-Cal Estimate)
4260-017-ECP-2019-GB (Medi-Cal Drug Rebate Fund)
4260-409-ECP-2019-GB (Medi-Cal Drug Rebate Fund Reserve)

Medi-Cal Local Assistance Estimate - May Revision Update. The May 2019 Medi-Cal Local Assistance Estimate includes $93.5 billion ($19.7 billion General Fund, $59.8 billion federal funds, and $13.9 billion special funds and reimbursements) for expenditures in 2018-19, and $102.2 billion ($23 billion General Fund, $66 billion federal funds, and $13.1 billion special funds and reimbursements) for expenditures in 2019-20. These figures represent a decrease in estimated General Fund expenditures in the Medi-Cal program of $999.2 million in 2018-19 and an increase of $141.4 million in 2019-20 compared to the Governor's January budget.

Caseload. In 2018-19, the May Revision assumes annual Medi-Cal caseload of 13 million, a decrease of 1.2 percent compared to assumptions in the Governor's January budget. In 2019-20, the May Revision assumes annual Medi-Cal caseload of 13 million, a decrease of 1.6 percent compared to assumptions in the Governor's January budget and an increase of 0.02 percent compared to the revised caseload estimate for 2018-19. 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. According to DHCS, these caseload reductions are attributable to the growing economy.

May Revision Local Assistance Adjustments. The Administration requests the following adjustments to reflect caseload and miscellaneous adjustments:

- Item 4260-101-0001 be increased by $147,985,000 and reimbursements be increased by $30,571,000
- Item 4260-101-0232 be increased by $4,678,000
- Item 4260-101-0233 be increased by $1,336,000
- Item 4260-101-0236 be increased by $769,000
- Item 4260-101-0890 be increased by $666,098,000
- Item 4260-101-3168 be increased by $378,000
- Item 4260-102-0001 be increased by $1,614,000
- Item 4260-102-0890 be decreased by $722,000
- Item 4260-106-0890 be increased by $4,480,000
- Item 4260-113-0001 be decreased by $58,307,000
- Item 4260-113-0890 be increased by $353,036,000
- Item 4260-117-0001 be increased by $171,000
- Item 4260-117-0890 be increased by $592,000

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	$19,695,653,000	$18,769,164,000	($926,489,000)
Federal Funds	$58,756,149,000	$55,893,565,000	($2,862,584,000)
Special Funds/Reimbursements	$15,079,839,000	$ 13,922,060,000	($1,157,779,000)
Total Expenditures	**$93,531,641,000**	**$88,584,789,000**	**($4,946,852,000)**
County Administration			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$808,388,000	$745,050,000	($63,338,000)
Federal Funds	$3,793,253,000	$3,778,741,000	($14,512,000)
Special Funds and Reimbursements	$4,997,000	$5,730,000	$733,000
Total Expenditures	**$4,606,638,000**	**$4,529,521,000**	**($77,117,000)**
Fiscal Intermediary			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$175,298,000	$165,950,000	($9,348,000)
Federal Funds	$192,408,000	$176,531,000	($15,877,000)
Special Funds and Reimbursements	$-	$-	$-
Total Expenditures	**$367,706,000**	**$342,481,000**	**($25,225,000)**
TOTAL MEDI-CAL EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$20,679,339,000	$19,680,164,000	($999,175,000)
Federal Funds	$62,741,810,000	$59,848,837,000	($2,892,973,000)
Special Funds and Reimbursements	$15,084,836,000	$13,927,790,000	($1,157,046,000)
Total Expenditures	**$98,505,985,000**	**$93,456,791,000**	**($5,049,194,000)**

Medi-Cal Local Assistance Funding Summary 2019-20 Comparison to January Budget			
Fiscal Year:	**2019-20**	**2019-20**	**Jan-May**
Benefits			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$21,851,207,000	$21,999,336,000	$148,129,000
Federal Funds	$61,717,409,000	$62,075,956,000	$358,547,000
Special Funds/Reimbursements	$12,458,842,000	$13,143,233,000	$684,391,000
Total Expenditures	**$96,027,458,000**	**$97,218,525,000**	**$1,191,067,000**
County Administration			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$906,788,000	$898,502,000	($8,286,000)
Federal Funds	$3,410,136,000	$3,708,866,000	$298,730,000
Special Funds and Reimbursements	$4,589,000	$5,961,000	$1,372,000
Total Expenditures	**$4,321,513,000**	**$4,613,329,000**	**$291,816,000**
Fiscal Intermediary			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$119,024,000	$120,568,000	$1,544,000
Federal Funds	$231,883,000	$236,453,000	$4,570,000
Special Funds and Reimbursements	$-	$-	$-
Total Expenditures	**$350,907,000**	**$357,021,000**	**$6,114,000**
TOTAL MEDI-CAL EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$22,877,019,000	$23,018,406,000	$141,387,000
Federal Funds	$65,359,428,000	$66,021,275,000	$661,847,000
Special Funds and Reimbursements	$12,463,431,000	$13,149,194,000	$685,763,000
Total Expenditures	**$100,699,878,000**	**$102,188,875,000**	**$1,488,997,000**

Significant General Fund Changes. The May 2019 Medi-Cal Local Assistance Estimate includes the following significant General Fund changes:

Medi-Cal Unanticipated 2018-19 Savings — The May Revision estimates Medi‑Cal 2018-19 General Fund savings has increased by $999.2 million compared to the Governor's January budget, from $2.3 billion to $3.3 billion. According to the Administration, this significant net increase is primarily attributable to the following factors:

- Timing of Federal Repayments ($650.2 million additional) – Changes in the timing of federal repayments resulted in net General Fund savings in 2018-19. In particular, $479.6 million had

previously been scheduled to be repaid for federal repayment of Title XXI funds in 2018-19, but due to ongoing negotiations with the federal government, this repayment is being moved to a new stand-alone budget item with provisional language allowing augmentation by the Department of Finance if federal funds must be repaid. $170.6 million additional savings is related to adjustments in deferred claims.

- Prescription Drug Rebates ($118.2 million additional savings) – Savings from federal and state supplemental drug rebates, as well as for drugs purchased in Medi-Cal managed care were revised higher based on updated utilization.

Proposition 56 Investments — The May Revision includes approximately $263 million in additional Proposition 56 revenues due to a one-time fund reconciliation. These one-time funds are allocated as follows:

- $120 million additional one-time funding for the physician and dentist loan repayment program.
- $70 million additional one-time funding for the Value-Based Payments program, specifically focused on behavioral health integration.
- $25 million in 2019-20 ($60 million over three years) to train providers to conduct trauma screenings for children and adults in Medi-Cal.
- $11.3 million to restore optician and optical lab services for adult beneficiaries of the Medi-Cal program, effective no sooner than January 1, 2020.

Due to lower projections of General Fund revenue in later years, the Administration is proposing to sunset all Proposition 56 investments on December 31, 2021. These investments include the existing supplemental payment programs for physicians, dentists, women's health, intermediate care facilities for individuals with developmental disabilities, HIV/AIDS Waiver providers, home health, pediatric day health centers, free-standing subacute pediatric facilities, and community based adult services providers.

Full-Scope Medi-Cal Expansion for Undocumented Young Adults – The May Revision includes reduced costs to expand full-scope Medi-Cal for undocumented young adults of $161.6 million ($121.9 million General Fund and $39.7 million federal funds) due to changing the implementation date from July 1, 2019, to January 1, 2020.

Medi-Cal Drug Rebate Fund Reserve –The May Revision includes a $172 million reserve in the Medi-Cal Drug Rebate Fund. DHCS intends to increase the reserve in this fund when savings exceed initial drug rebate estimates. When savings fall short of initial estimates, the reserve will be accessed to reduce the impact on the General Fund.

Medi-Cal County Administration—The May Revision includes $2.1 billion ($729 million General Fund) in 2019-20 for county eligibility determination activities, an increase of $15.3 million total funds compared with the January budget, based on higher projected growth in the California Consumer Price Index (3.39 percent compared with 2.63 percent in the January budget), which results in a higher cost-of-doing business adjustment.

Non-Whole Person Care Counties – The May Revision includes expenditure authority from the Mental Health Services Fund of $20 million in 2019-20, available for five years, for counties not currently operating Whole Person Care pilots. According to DHCS, additional counties would be able to utilize

this funding to develop and implement essential programs focused on coordinating health, behavioral health, and critical social services, such as housing.

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 2019 Medi-Cal Estimate.

2. Please provide a brief overview of the factors leading to the significant increase in 2018-19 savings.

Issue 2: Family Health Estimate – May Revision Update

DOF Issue#: 4260-002-ECP-2019-GB (November 2018 Family Health Estimate)
4260-402-ECP-2019-MR (May 2019 Family Health Estimate)

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	$78,356,000	$80,928,000	$2,572,000
Special Funds/Reimbursements	$5,453,000	$5,453,000	$-
County Funds [non-add]	[$84,124,000]	[$86,494,000]	[$2,370,000]
Total CCS Expenditures	**$83,809,000**	**$86,381,000**	**$2,572,000**
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	$112,315,000	$112,319,000	$4,000
Special Funds and Reimbursements	$11,462,000	$11,463,000	$1,000
Total GHPP Expenditures	**$123,777,000**	**$123,782,000**	**$5,000**
Every Woman Counts Program (EWC)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$16,105,000	$12,276,000	($3,829,000)
Federal Funds	$5,128,000	$5,128,000	$-
Special Funds and Reimbursements	$22,504,000	$22,504,000	$-
Total EWC Expenditures	**$43,737,000**	**$39,908,000**	**($3,829,000)**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$206,779,000	$205,526,000	($1,253,000)
Federal Funds	$5,128,000	$5,128,000	$-
Special Funds and Reimbursements	$39,419,000	$39,420,000	$1,000
County Funds [non-add]	[$84,124,000]	[$86,494,000]	[$2,370,000]
Total Family Health Expenditures	**$251,326,000**	**$250,074,000**	**($1,252,000)**

Family Health Local Assistance Funding Summary 2019-20 Comparison to January Budget			
Fiscal Year:	**2019-20**	**2019-20**	**Jan-May**
California Children's Services (CCS)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$80,318,000	$81,148,000	$830,000
Special Funds/Reimbursements	$5,453,000	$5,453,000	$-
County Funds [non-add]	[$86,088,000]	[$86,761,000]	[$673,000]
Total CCS Expenditures	**$85,771,000**	**$86,601,000**	**$830,000**
Child Health and Disability Prevention (CHDP)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$-	$-	$-
Total CHDP Expenditures	**$-**	**$-**	**$-**
Genetically Handicapped Persons Program (GHPP)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$118,146,000	$114,323,000	($3,823,000)
Special Funds and Reimbursements	$8,762,000	$11,211,000	$2,449,000
Total GHPP Expenditures	**$126,908,000**	**$125,534,000**	**($1,374,0000**
Every Woman Counts Program (EWC)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$16,737,000	$12,913,000	($3,824,000)
Federal Funds	$5,128,000	$5,128,000	$-
Special Funds and Reimbursements	$22,504,000	$22,504,000	$-
Total EWC Expenditures	**$44,369,000**	**$40,545,000**	**($3,824,000)**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$215,201,000	$208,834,000	($6,817,000)
Federal Funds	$5,128,000	$5,128,000	$-
Special Funds and Reimbursements	$36,719,000	$38,718,000	$1,999,000
County Funds [non-add]	[$86,088,000]	[$86,761,000]	[$673,000]
Total Family Health Expenditures	**$257,048,000**	**$252,680,000**	**($4,368,000)**

Family Health Estimate – May Revision Update. The May 2019 Family Health Local Assistance Estimate includes $250 million ($205.5 million General Fund, $5.1 million federal funds, and $39.4 million special funds and reimbursements) for expenditures in 2018-19, and $252.7 million ($208.8 million General Fund, $5.1 million federal funds, and $38.7 million special funds and reimbursements) for expenditures in 2019-20. These figures represent a decrease in estimated General Fund expenditures in Family Health programs of $1.3 million in 2018-19 and $6.8 million in 2019-20 compared to the

January budget. These changes are primarily attributed to changes in caseload and other miscellaneous adjustments.

The May Revision caseload estimates for Family Health programs are as follows:

- **California Children's Services (CCS) Caseload Estimate**
  Medi-Cal: The May Revision estimates Medi-Cal CCS caseload of 172,690 in 2018-19, a decrease of 3,901 or 2.2 percent, compared to the January budget. The May Revision estimates Medi-Cal CCS caseload of 173,716 in 2019-20, a decrease of 4,655 or 2.6 percent, compared to the Governor's January budget, and an increase of 1,026 or 0.6 percent, compared to the revised 2018-19 estimate.
  State-Only: The May Revision estimates state-only CCS caseload of 14,631 in 2018-19, a decrease of 500 or 3.3 percent, compared to the January budget. The May Revision estimates state-only CCS caseload of 14,639 in 2019-20, a decrease of 492 or 3.3 percent, compared to the January budget, and an increase of 8 or 0.05 percent, compared to the revised 2018-19 estimate.
- **Child Health and Disability Prevention (CHDP) Caseload Estimate**
  The May Revision estimates state-only CHDP caseload of 22 in 2018-19, unchanged compared to the January budget. The May Revision estimates state-only CHDP caseload of zero in 2019-20, a decrease of 22 or 100 percent compared to the January budget, and a decrease of 22 or 100 percent, compared to the revised 2018-19 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 783 in 2018-19, an increase of 62 or 8.6 percent, compared to the January budget. The May Revision estimates state-only GHPP caseload of 785 in 2019-20, an increase of 2 or 0.3 percent, compared to the January budget, and an increase of 2 or 0.3 percent, compared to the revised 2018-19 estimate.
- **Every Woman Counts (EWC) Program Caseload Estimate**
  The May Revision estimates EWC caseload of 26,963 in 2018-19, a decrease of 543 or 2.1 percent compared to the January budget. The May Revision estimates EWC caseload of 26,963 in 2019-20, unchanged compared to the January budget, and unchanged compared to the revised 2018-19 estimate.

May Revision Local Assistance Adjustments. The Administration requests the following adjustments to reflect caseload and miscellaneous adjustments:

- Item 4260-111-0001 be decreased by $2,993,000 and reimbursements be increased by $1,000
- Item 4260-114-0001 be decreased by $3,824,000

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 caseload and expenditure changes in the May 2019 Family Health Estimate.

Issue 3: Proposition 56 Investments

DOF Issue#: 4260-403-ECP-2019-MR

May Revision Issue. DHCS requests additional Proposition 56 expenditure authority of $261.3 million in 2019-20, derived from a one-time fund reconciliation. If approved, these resources would allow DHCS to make additional investments in the Physicians and Dentists Loan Repayment Program, the Value-Based Payments Program, training providers to conduct trauma screenings, and restoration of optician and optical lab services in Medi-Cal.

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. 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".

The May Revision includes $2.1 billion ($712.5 million Proposition 56 and $1.4 billion federal funds) in 2018-19 and $2.2 billion ($769.5 million Proposition 56 and $1.4 billion federal funds) in 2019-20 for supplemental provider payments in Medi-Cal. The supplemental payments by category are as follows:

Category	2018-19	2019-20	Category	2018-19	2019-20
Physician Services			***PDHCs***		
Total Fund	$1,311,240	$1,399,061	Total Fund	$14,246	$14,246
Proposition 56	$411,555	$458,077	Proposition 56	$6,812	$6,880
Federal Funds	$899,685	$940,984	Federal Funds	$7,434	$7,366
Dental Services			***Ped Subacute***		
Total Fund	$490,117	$518,325	Total Fund	$7,333	$1,811
Proposition 56	$177,597	$195,710	Proposition 56	$3,521	$883
Federal Funds	$312,520	$322,615	Federal Funds	$3,812	$927
Women's Health			***CBAS***		
Total Fund	$188,282	$143,325	Total Fund	$2,000	$-
Proposition 56	$48,372	$43,534	Proposition 56	$3,000	$-
Federal Funds	$139,910	$99,791	Federal Funds	$-	$-
ICF-DDs			***Home Health***		
Total Fund	$29,421	$27,819	Total Fund	$64,834	$64,834
Proposition 56	$13,785	$13,048	Proposition 56	$30,975	$31,211
Federal Funds	$15,636	$14,771	Federal Funds	$33,859	$33,623
AIDS Waiver			***TOTAL***		
Total Fund	$6,800	$6,800	Total Fund	$2,112,273	$2,176,221
Proposition 56	$3,400	$3,400	Proposition 56	$696,017	$752,743
Federal Funds	$3,400	$3,400	Federal Funds	$1,416,256	$1,423,478

Physician and Loan Repayment Program. The 2018 Budget Act included a one-time allocation of $220 million of Proposition 56 tobacco tax revenue for a loan repayment program to increase access to care for Medi-Cal beneficiaries. $190 million was allocated for recent graduate physicians and $30 million was allocated to recent graduate dentists. The funding was made available until June 30, 2025.

DHCS contracted with Physicians for a Healthy California (PHC) to administer the loan repayment program, known as CalHealthCares. Eligible physicians may apply for a loan repayment up to $300,000 in exchange for a five-year service obligation. Eligible dentists may apply for either a loan repayment up to $300,000 in exchange for a five-year services obligation or a practice support grant up to $300,000 in exchange for a ten-year service obligation. All medical and dental specialties are eligible. In this cycle, CalHealthCares expects to award approximately 125 physicians and 20 dentists. All awardees are required to maintain a patient caseload of 30 percent or more Medi-Cal beneficiaries.

Additional Augmentations Funded by Proposition 56. The January budget includes $965 million ($282.5 million Proposition 56 funds and $682.5 million federal funds) in 2019-20 for three augmentations:

- Value-Based Payments Program – The budget includes $360 million ($180 million Proposition 56 funds and $180 million federal funds) to fund a value-based payments program to encourage Medi-Cal managed care providers to meet goals in critical areas such as chronic disease management and behavioral health integration.
- Developmental and Trauma Screening – The budget includes $105 million ($52.5 million Proposition 56 funds and $52.5 million federal funds) to provide early developmental screenings for children and adverse childhood experiences (ACEs) screenings for children and adults in Medi-Cal.
- Family Planning Services – The budget includes $500 million ($50 million Proposition 56 funds and $450 million federal funds) for family planning services in the Medi-Cal program.

May Revision Includes Additional One-Time Augmentations Funded by Proposition 56. According to DHCS, prior year reconciliation of revenues and expenditures derived from Proposition 56 resulted in availability of an additional $261.3 million one-time. DHCS requests additional Proposition 56 expenditure authority of $261.3 million in 2019-20 to support the following one-time investments:

- Physician and Dentists Loan Repayment Program – The May Revision includes $240 million ($120 million Proposition 56 funds and $120 million federal funds) to provide additional awards in the Physicians and Dentists Loan Repayment Program through CalHealthCares.
- Value-Based Payments Program – The May Revision includes an additional $184.2 million ($70 million Proposition 56 funds and $114.2 million federal funds) for the Value-Based Payments Program, specifically focused on behavioral health integration. With this augmentation, the total funding for the program would be $544.2 million ($250 million Proposition 56 funds and $294.2 million federal funds)
- Provider Trauma Screening Training – The May Revision includes $50 million ($25 million Proposition 56 funds and $25 million federal funds) to train providers on delivering trauma screenings in a sensitive and appropriate manner. The January budget proposed funding for trauma screenings for children and adults in Medi-Cal.

- Restoration of Optical Benefit – The budget includes $33.4 million ($11.3 million Proposition 56 funds and $22.1 million federal funds) for restoration of optician and optical lab services authorized in the 2017 Budget Act.

In addition, DHCS indicates that, due to lower General Fund revenues in future years estimated by the Administration, the Proposition 56 investments sunsets on December 31, 2021. According to the Administration, these investments would provide a bridge to the work of the Administration's proposed Healthy California for All Commission, tasked with evaluating options for a single payer health care financing system.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of these proposals.

2. Please describe the rationale for the sunset of Proposition 56 investments in 2021.

3. Given the planned sunset of Proposition 56 investments at the end of 2021, for how long does DHCS intend to seek approval for the next round of supplemental provider payments?

4. Would the additional funding for Value-Based Payments for behavioral health integration include supplemental payments for meeting additional metrics in this area, or would the existing supplemental payments be larger?

Issue 4: Full-Scope Medi-Cal Coverage for Undocumented Young Adults – May Revision Update

DOF Issue#: 4260-015-BCP-2019-GB
4260-407-BCP-2019-MR

May Revision Issue and Trailer Bill Language Proposal. DHCS requests a reduction in expenditure authority of $161.6 million ($121.9 million General Fund and $39.8 million federal funds) in 2019-20 to account for a revision to the implementation date for expansion of full-scope Medi-Cal coverage to undocumented young adults. DHCS also proposes amendments to its January budget trailer bill on redirection of county realignment funding to reflect Yolo County as a County Medical Services Program (CMSP) county, withhold 100 percent of CMSP realignment until its reserves reach a reasonable level, and exempt Sacramento, Placer, Stanislaus, and Santa Barbara Counties from additional redirections.

Background. The January budget proposed to expand full-scope Medi-Cal coverage to approximately 138,000 income-eligible young adults up to age 26, regardless of immigration status, beginning July 1, 2019. DHCS requested expenditure authority of $257.1 million ($194 million General Fund and $63.1 million federal funds) for the expansion of coverage. In addition, DHCS requests two positions and expenditure authority of $624,000 ($237,000 General Fund and $387,000 federal funds) in 2019-20 and $306,000 ($153,000 General Fund and $153,000 federal funds) annually thereafter to allow implementation and make necessary system changes for the expansion of coverage.

AB 85 Redirection of County Realignment. As a result of the expansion of coverage to previously uninsured individuals through the state's Medi-Cal program, county indigent health programs were no longer responsible for providing care for this population. AB 85 (Committee on Budget), Chapter 24, Statutes of 2013, provides for the redirection of health-related 1991 Realignment revenues from counties to offset state General Fund costs to account for this shift in responsibility and health care expenditures for the Medi-Cal expansion population. The redirection of 1991 Realignment funds offsets expenditures in the California Work Opportunity and Responsibility to Kids (CalWORKs) program that were previously funded through the state's General Fund.

AB 85 requires CMSP counties to redirect 60 percent of the realignment funds they would have previously received. That legislation also gave another group of counties the option to redirect 60 percent of realignment funds or base the redirection amount on a formula that takes into account a county's cost and revenue experience. Five counties chose the 60 percent redirection: Yolo, Placer, Sacramento, Stanislaus, and Santa Barbara. Counties with public hospitals, except Los Angeles, base redirection amounts on the cost and revenue formula. Los Angeles County adheres to a county-specific formula.

January Budget Included Additional Redirection of County Realignment Funding. The cost of the Governor's proposal to expand full-scope Medi-Cal to undocumented young adults would be partially offset by redirecting additional county realignment funding for indigent health care to the state. In the January budget, DHCS proposed increasing the percent of realignment funds redirected from CMSP counties and Yolo, Sacramento, Placer, Stanislaus, and Santa Barbara Counties from 60 percent to 75 percent.

May Revision Adjusts Implementation Date and AB 85 Redirection Amounts. DHCS requests a reduction in expenditure authority of $161.6 million ($121.9 million General Fund and $39.8 million federal funds) in 2019-20 to account for a revision to the implementation date for expansion of full-scope Medi-Cal coverage to undocumented young adults. The January budget proposed implementation on July 1, 2019. The May Revision updates implementation to January 1, 2020.

DHCS also proposes amendments to its January budget trailer bill on redirection of county realignment funding, as follows:

1) Reflect Yolo County as a CMSP county – Since implementation of AB 85, Yolo County has become a CMSP county. DHCS proposes to treat them as a CMSP county in statute to reflect the change.
2) Temporarily Withhold 100 percent of CMSP Realignment – According to DHCS, CMSP currently has significant reserves that could support multiple years of its current expenditures. DHCS proposes to withhold 100 percent of CMSP Realignment funding until its reserves reach two years of total annual expenditures.
3) Sacramento, Placer, Stanislaus, and Santa Barbara Counties – Sacramento, Placer, Stanislaus, and Santa Barbara Counties expressed concerns about the additional redirections, indicating they exceeded the amounts that would be saved on indigent care for the Medi-Cal expansion for undocumented young adults. DHCS proposes to exempt these counties from additional redirection.

According to the Administration, these changes would result in increased General Fund costs of $5.1 million, which would be reflected in the Department of Social Services budget for CalWORKs.

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 May Revision changes to the proposed Medi-Cal expansion for undocumented young adults.

2. Please provide a brief overview of the May Revision changes to the AB 85 realignment

Issue 5: Peer-Run Mental Health Crisis Lines

DOF Issue#: 4260-407-BCP-2019-MR

May Revision Issue. DHCS requests expenditure authority from the Mental Health Services Fund of $3.6 million for three years to create a statewide peer-run mental health crisis line offering information, referrals, emotional support, and non-judgmental peer support to those living with mental illness.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3085 – Mental Health Services Fund	$3,600,000	$3,600,000
Total Funding Request:	**$3,600,000**	**$3,600,000**

* Additional fiscal year resources requested: 2021-22: $3,600,000

Background. The subcommittee previously heard a proposal from the Mental Health Association of San Francisco (MHASF) to establish a peer-run warm line for those experiencing a mental health crisis. This proposal was based on a similar warm line operated in San Francisco since 2014. The San Francisco Peer-Run Warm Line is a phone and instant-messaging based service that provides information, referrals, and emotional support to callers. Their mission is to offer accessible, relevant, non-judgmental peers support to anyone who reaches out to them. The line has taken nearly 100,000 calls from California residents seeking a wide variety of care and services.

DHCS requests expenditure authority from the Mental Health Services Fund of $3.6 million for three years to create a statewide peer-run mental health crisis line, based on the line established in San Francisco, to support those living with mental illness. This funding would support phone and instant messaging to callers across California using peer counselors with lived experience of mental health challenges. According to DHCS, the California Peer-Run Warm Line would offer accessible peer support to Californians on a 24 hour basis. These services are expected to decrease unnecessary emergency room visits, avoid public safety involvement and other types of crisis services. DHCS intends to effectuate a contract with the Mental Health Association of San Francisco to implement the California Peer-Run Warm Line.

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: Non-Whole Person Care Counties

DOF Issue#: 4260-450-ECP-2019-MR

May Revision Issue and Budget Bill Language. DHCS requests expenditure authority from the Mental Health Services Fund of $20 million in 2019-20. If approved, these resources would allow DHCS to provide funding to counties for their development and implementation of programs to focus on coordinating health, behavioral health, and social services such as housing with priority to individuals with mental illness who are also homeless or at risk of becoming homeless. DHCS proposes budget bill language to allow these funds to be available for encumbrance and expenditure until June 30, 2025.

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

* Resources available until June 30, 2025.

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	15,600	$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	625	$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	600	$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	287	$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

The May Revision includes $515.5 million ($257.7 million intergovernmental transfers and $257.7 million federal funds) in 2018-19 and $970.6 million ($485.3 million intergovernmental transfers and $485.3 million federal funds) in 2019-20 for funding WPC Pilots. The May Revision also continues the one-time General Fund augmentation of $100 million in the January budget to provide funding for supportive housing services for individuals who are homeless or are at risk of becoming homeless, with a focus on individuals with mental illness.

DHCS requests expenditure authority from the Mental Health Services Fund of $20 million in 2019-20. If approved, these resources would allow DHCS to provide funding to counties for their development and implementation of programs to focus on coordinating health, behavioral health, and social services such as housing with priority to individuals with mental illness who are also homeless or at risk of becoming homeless. DHCS proposes budget bill language to allow these funds to be available for encumbrance and expenditure until June 30, 2025. These funds would be available for counties that did not implement a WPC pilot, which requires expenditures of county funds. It is unclear whether this proposal would require any contribution from counties for implementation of these programs.

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 7: Various Reappropriations

DOF Issue#: 4260-313-BBA-2019-MR

May Revision Issue. DHCS requests various changes to reappropriation language for the following purposes:

1) $7.4 million from Item 4260-001-0001, 2018 Budget Act, for turnover and takeover of the Medi-Cal fiscal intermediary legacy contract. (This reappropriation is related *to Issue 9: CA-MMIS Oversight to Ownership and Modernization Projects*)
2) $808,000 from Item 4260-001-0001, 2018 Budget Act, for continued planning costs for the Comprehensive Behavioral Health Data Systems. (This reappropriation was heard as an April Finance Letter, "*Reappropriation: Behavioral Health Modernization Resources*" during the subcommittee's April 25th hearing).
3) Remaining expenditure authority from the initial allocation of $220 million Proposition 56 funds in the 2018 Budget Act for the Medi-Cal Physician and Loan Repayment Program. These funds would be available for encumbrance or expenditure until June 30, 2029.

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: Medi-Cal Eligibility Systems Staffing

DOF Issue#: 4260-400-BCP-2019-MR

May Revision Issue. DHCS requests conversion of 13 limited-term resources to permanent, a two-year extension of resources equivalent to seven positions, and expenditure authority of $3 million ($910,000 General Fund and $2.1 million federal funds) in 2019-20 and 2020-21, and $1.8 million ($626,000 General Fund and $1.2 million federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to oversee, govern, support, and implement the new and continuing policy-driven and infrastructure stabilization initiatives of the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS).

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$910,000	$910,000
0890 – Federal Trust Fund	$2,058,000	$2,058,000
Total Funding Request:	**$2,968,000**	**$2,968,000**
Total Positions Requested:**	**13.0**	**13.0**

***** Additional fiscal year resources requested – 2021-22 and ongoing: $1,838,000.
** Positions ongoing.

Background. Under the federal Affordable Care Act, states were required to either create a state-based insurance exchange or use the federal exchange and for such exchanges to be operational by January 1, 2014. Additionally, expansions of Medicaid to childless adults up to 138 percent of the federal poverty level were required to be implemented by January 1, 2014. Covered California, California's health benefits exchange, went live on October 1, 2013.

The 2012 Budget Act included 12 two-year limited-term positions to support the planning, design, development, implementation, and ongoing maintenance of the Medi-Cal eligibility and enrollment system changes and integration with CalHEERS and county eligibility consortia systems. The 2014 Budget Act extended these positions for another two years due to delays in federal regulations, policy guidance and state policy decisions, which caused significant scope and functionality delays in system delivery timelines. The ongoing workload included continued system integration by the Enterprise Innovation and Technology Services (EITS) division and continued development on legislation. State Plan Amendments (SPAs), policy guidance for counties, incorporation of the Modified Adjusted Gross Income (MAGI) Medicaid and Children's Health Insurance Program (CHIP) eligibility rules into CalHEERS, and coordination of insurance affordability program transitions with Covered California.

AB1 X1 (Perez), Chapter 3, Statutes of 2013, First Extraordinary Session, authorized DHCS to implement Medicaid provisions of the ACA, including: 1) implementation of the new "adult group" in California, 2) transition of the Low Income Health Program (LIHP) beneficiaries to Medi-Cal, 3) use of the MAGI methodology, 4) simplifications to the annual renewal and change in circumstances processes for Medi-Cal beneficiaries, 5) use of electronic verifications of eligibility criteria at initial application, and 6) redeterminations of eligibility and performance standards for DHCS, Covered CA, and the Statewide Automated Welfare Systems (SAWS). DHCS received an additional eight two-year limited-

term positions to handle this additional workload. The 2016 Budget Act extended all 20 positions for three years.

DHCS requests conversion of 13 limited-term resources to permanent, a two-year extension of resources equivalent to seven positions, and expenditure authority of $3 million ($910,000 General Fund and $2.1 million federal funds) in 2019-20 and 2020-21, and $1.8 million ($626,000 General Fund and $1.2 million federal funds) annually thereafter to allow DHCS to oversee, govern, support, and implement the new and continuing policy-driven and infrastructure stabilization initiatives of the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). DHCS reports the 20 limited-term positions previously approved by the Legislature are set to expire on June 30, 2019. According to DHCS, the requested positions and resources would support the following staff:

Managed Care Eligibility Division – Seven positions

- **One Staff Services Manager I, two Health Program Specialist II** positions, and **four Associate Governmental Program Analysts** would continue responsibilities directing CalHEERS related changes in eligibility and enrollment, providing oversight and governance of system gaps in CalHEERS, providing timely policy guidance to lessen administrative burdens on counties and consumers, and participate as policy subject matter experts and program decision makers of system components and strategies.

Enterprise Innovation and Technology Services Division – 13 positions (seven limited-term)

- **One Information Technology Manager I** and **one Information Technology Supervisor II** position would continue managing contracted vendor relationships and serve as the DHCS project management and oversight liaison with the various internal and external stakeholders participating in the modifications to MEDS related to the expanded business rules for eligibility, enrollment, and integration with CalHEERS and SAWS.
- **Seven Information Technology Specialist I** positions would continue to adopt the iterative Agile methodology to implement MEDS and CalHEERS changes by working closely with program staff, developing user stories, and test scripts to satisfy validating requirements are traceable between user stories and test results. These positions would also serve in lead capacity as a technical resource to analyze issues from a business perspective with technology in mind.
- **One Information Technology Specialist I** position would coordinate with DHCS and CalHEERS teams by preparing test cases, reviewing test scenarios, and executing test scripts aligned to functional and non-functional requirements.
- **One Information Technology Specialist II** position would perform ongoing architectural oversight, assessment, and guidance associated with the development and maintenance of new and existing services, system infrastructure, and interfaces between DHCS Medi-Cal eligibility and enrollment systems, SAWS, and CalHEERS. In addition, this position would lead architecture assurance to maintain compliance and alignment to Agency, state, and federal policies and initiatives, such as the CHHS Information Strategic Plan, California Enterprise Architecture Framework - Version 2.0, and the MITA 3.0 framework.
- **One Information Technology Specialist II** position would serve as the DHCS security subject matter expert for CalHEERS in performing risk analysis and consultation during changes to business process flow, software, services, usage of personal information, information technology

infrastructure, hosting location, security monitoring, and interfaces to systems such as the federal data services hub, MEDS, and SAWS systems.

- **One Information Technology Specialist II** position would provide database services including maintenance and support of existing and future database solutions and configurations essential to MEDS and production and ongoing enhancement of Database 2 Database Management Systems and other MEDS related subsystems such as Children's Medical System and Hospital Presumptive Eligibility.

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 9: CA-MMIS Oversight to Ownership and Modernization Projects

DOF Issue#: 4260-400-BCP-2019-MR

May Revision Issue. DHCS requests 11 positions and expenditure authority of $49.7 million ($15.3 million General Fund and $34.4 million federal funds) in 2019-20 and $1.7 million ($614,000 General Fund and $1.1 million federal funds) annually thereafter. If approved, these resources would allow DHCS to fund transitional efforts for turnover and takeover of the fiscal intermediary, continuation of the oversight to ownership strategy, and 3) continuation of procurements for design, development, and implementation of systems modules. Included in the request for 2019-20 is a reappropriation of $22.9 million ($7.4 million General Fund and $15.5 million federal funds) for this purpose (see *Issue 7: Various Reappropriations*)

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$15,270,000	$614,000
0890 – Federal Trust Fund	$34,401,000	$1,058,000
Total Funding Request:	**$49,671,000**	**$1,672,000**
Total Positions Requested:**	**11.0**	**11.0**

***** Positions and resources ongoing after 2020-21.

Background. DHCS currently contracts with a fiscal intermediary (FI) to operate the California Medicaid Management Information System (CA-MMIS) and is solely charged with the oversight, management, monitoring, and administration of the contract and the services provided by the FI. The services include adjudicating both Medi-Cal and non-Medi-Cal claims, as well as other services to program providers, beneficiaries, and federal and state users of the system. In 2010, DHCS contracted with a vendor to provide Information Technology Maintenance and Operations (IT M&O), Business Operations as well as the design, development and implementation (DDI) of a new replacement system. As a result of various challenges experienced by the vendor, a settlement agreement was approved in 2015 by DHCS and the vendor which included, but was not limited to, the FI transferring the DDI requirements of the contract to DHCS while maintaining the IT M&O and Business Operations activities through the end of operations for the current vendor in September 2019, and through the run out of the contract and associated stabilization period through March 31, 2020. DHCS began a procurement process to establish new contracts for: 1) IT M&O; and 2) Business Operations, prior to the September 2019 end date.

The 2017 Budget Act included seven positions for DHCS to begin modernization efforts and adopt a user-centered, iterative, modular approach to the DDI of systems modules, as well as the conversion of 21 limited-term positions to permanent positions and funding for personal services to support and oversee the ongoing maintenance and operation of the legacy system. CA-MMIS completed a statement of work, received federal approval for a Federal Draw and Reporting (FDR) Digital Services developer team, and completed the MedCompass Project.

The 2018 Budget Act included 17 additional positions in 2018-19, eight additional positions in 2019-20, and two limited-term positions for the Enterprise Innovation and Technology Services (EITS) Division, corresponding expenditure authority, and $14.7 million in Modernization contract authority.

DHCS requests 11 positions and expenditure authority of $49.7 million ($15.3 million General Fund and $34.4 million federal funds) in 2019-20 and $1.7 million ($614,000 General Fund and $1.1 million federal funds) annually thereafter to allow DHCS to fund transitional efforts for turnover and takeover of the fiscal intermediary, continuation of the oversight to ownership strategy, and 3) continuation of procurements for design, development, and implementation of systems modules.

Specifically, these resources would support the following positions and contract vendors:

Turnover and Takeover Strategy - $25 million contract

- Upon final approval of the terms of the new FI contract, DHCS is obligated to request authority to cover the remaining Turnover and Takeover costs. These costs include payments to both the current FI and the two new FIs. With the approval of the FI Business Operations contract in February 2019, DHCS indicates costs for the Turnover and Takeover contract are $25 million. This amount represents the anticipated need for the new FI who will be taking over the Business Operations responsibilities.

Oversight to Ownership Strategy – Nine positions

- **One Information Technology Associate** would support new Ownership responsibilities associated with aid code creation and updates for the federally mandated eligibility subsystem, including presumptive eligibility and all associated funding reports, resolution of system updates and issues, and invoices within the eligibility unit.
- **One Information Technology Associate** would support new Ownership responsibilities associated with updates and enhancements to the federally mandated Medi-Cal Pharmacy and Rebate Systems, resolution of system updates and issues, and invoices within the Pharmacy/Medical Supply Unit.
- **One Information Technology Associate** would support new Ownership responsibilities associated with updates and enhancements to eligibility and recipient subsystems including other intermediaries, CALPOS (PCS), Medi-Cal website, Automated Eligibility Verification System (AEVS), which manages telephone and internet eligibility transactions and responses, resolution of system updates and issues, and invoices.
- **One Associate Governmental Program Analyst** would research, analyze and evaluate program data, current procedures and processes; generate data-based reports and basic Operating Instruction Letters (OILs); review claims detail reports, error codes and edits criteria to resolve claims adjudication issues; research and generate statistical reports providing oversight of FI vendor performance, research policy development, and identify probable sources of, and solutions to, provider billing issues.
- **One Associate Governmental Program Analyst** would monitor contractor management of, and activities in, the area of provider representative trainings and onsite visits to ensure the contractor meets and maintains contractual requirements, direct, coordinate, review, and monitor FI contractor management of, and activities in, the area of claims billing and systems training development, delivery and training coordination for state employees, programs and stakeholder entities. Evaluate contractor performance and recommend corrective action plans when necessary; follow up and monitors to ensure compliance.

- **One Associate Governmental Program Analyst** would perform research, analysis and other support functions related to the contracts, inter-agency agreements, and acquisition and bid documents.
- **One Medical Consultant II** position would provide technical oversight and act as professional staff lead on large and high profile policy updates and multi-disciplinary projects; review state and vendor professional staff competency and performance. Division liaison to program medical professionals and policy owners. Provide direction, oversight and review of multi-vendor collaboration of policy research, development, review, and updates including accurate claims adjudication, system integrity and quality management. Direct CA-MMIS and FI staff in the analysis and identification of data implementation anomalies and errors that affect the integrity and efficiency of CA-MMIS to accurately interpret and implement medical policy in claims adjudication.
- **One Nurse Consultant III** position would serve as a key branch liaison between DHCS' Benefits Division, program partners, FI Business Operations, and FI Maintenance and Operations Systems Group to develop, communicate and clarify new and updated medical policy changes and system implementation in pre-defined areas of medical specialty. Analyze and identify data and implementation anomalies and errors that affect the integrity and efficiency of CA-MMIS to accurately apply medical policy in claims adjudication.
- **One Staff Services Manager II** position would direct the establishment and management of the Financial Analysis, Integrity, and Reporting (FAIR) Section, plan, organize and direct the activities of the Financial Integrity and Compliance Unit, all divisional financial reporting, and enhanced, automated fiscal systems and controls for tracking the increased level of contract expenses.

Modernization Approach – Two positions

- **Two Information Technology Specialist II** positions would develop and operate cloud-based environments, platforms, and developer tools in support of division-wide modernization development and operations 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 10: Substance Use Disorder Emerging Epidemics, Disaster Response, & Licensing Workload

DOF Issue#: 4260-402-BCP-2019-MR

May Revision Issue. DHCS requests seven positions and expenditure authority of $1.2 million ($100,000 General Fund and $1.1 million Residential and Outpatient Program Licensing Fund) in 2019-20 and $1 million Residential and Outpatient Program Licensing Fund annually thereafter. If approved, these resources would allow DHCS to address the increased workload of responding to natural disasters and other emergencies, the opioid epidemic, the resurgence of methamphetamine abuse, and the rise in the number of substance use disorder treatment facilities. Included in this request is a one-time expense of $100,000 General Fund to migrate the DHCS disaster collection and reporting process into the web-based reporting platform, NC4, through an interagency agreement with DPH.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$100,000	$-
3113 – Residential and Outpatient Program Licensing Fund	$1,060,000	$997,000
Total Funding Request:	**$1,160,000**	**$997,000**
Total Positions Requested:	**7.0**	**7.0**

***** Positions and resources ongoing after 2020-21.

Background. DHCS, Licensing and Certification Section (LCS) licenses and certifies all facilities, regardless of their funding source, that provide residential and outpatient alcohol and other drug (AOD) treatment, detoxification, or recovery services to adults. LCS is responsible for processing initial and renewal applications for residential, outpatient, detoxification, adolescent waivers, incidental medical services, and for conducting site visits for each initial and renewal. LCS is also responsible for monitoring compliance with state, federal and local laws, statutes, and regulations by conducting on-site reviews every two years. Lastly, LCS collects fees and fines, and provides technical assistance to facilities. DHCS currently has a total of 1,895 residential and outpatient facilities. This includes 394 residential licensed, 618 residential licensed and AOD certified, and 883 AOD outpatient.

SB 84 (Committee on Budget and Fiscal Review), Chapter 177, Statutes of 2007, requires DHCS to charge fees for licensure and certification of all residential AOD recovery or treatment facilities and for certification of outpatient AOD programs. The Residential and Outpatient Program Licensing Fund collects all fines, fees, and penalties assessed to licensed and certified AOD providers.

DHCS reports it cannot sustain the substantial increase in licensing workload, and other byproducts of health care reform, due to natural disasters, the opioid epidemic, the resurgence of methamphetamine use, and the rise in the number of facilities. Currently, there are backlogs of new applications, applications for the expansion of current facilities, and license and certification renewals. These backlogs delay the expansion of treatment services for new clients and create wait lists at the local level. Inadequate staffing at DHCS also delays the implementation of new government funding and creates risks without proper monitoring at the state level.

DHCS requests seven positions and expenditure authority of $1.2 million ($100,000 General Fund and $1.1 million Residential and Outpatient Program Licensing Fund) in 2019-20 and $1 million Residential

and Outpatient Program Licensing Fund annually thereafter to address the increased licensing workload. Specifically, these resources would support the following positions:

- **One Staff Services Manager II, one Health Program Specialist II,** and **two Associate Governmental Program Analysts** would address the increased workload as a result of the rise in natural disasters, which includes emergency preparedness, disaster response and reporting. With the additional resources, the Counselor and Medication Assisted Treatment Section, which is responsible for compliance activities related to narcotic treatment programs, would form an Emergency Plan Team, which would work with the other sections in developing an extensive emergency response plan for all residential and outpatient programs licensed or certified with DHCS.
- **One Staff Services Manager I** and **two Associate Governmental Program Analysts** would allow LCS to review all licensing and certification components in a timely manner, permit LCS to conduct any follow-up compliance visits for deficiencies of concern, and help reduce the average number of programs in each LCS analysts' caseload, allowing LCS staff to meet mandated requirements and critical deadlines.

Included in this request is a one-time expense of $100,000 General Fund to migrate the DHCS disaster collection and reporting process into the web-based reporting platform, NC4, through an interagency agreement with DPH.

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: Extension of Health Home Program Funding – May Revision Update

DOF Issue#: Trailer Bill Language Proposal

Trailer Bill Language Proposal. DHCS requests amendments to trailer bill language proposed in the January budget to extend the sunset date for the Health Homes Program to June 30, 2024. According to DHCS, this extension would align with the revised program implementation timeline.

Background. In the January budget, DHCS requested the adoption of trailer bill language to extend the period of availability of funding for implementation of the Health Homes Program from June 30, 2020, to June 30, 2023 to allow DHCS to continue implementation and funding for the Health Homes Program, which began July 1, 2018.

According to DHCS, in an effort to successfully implement the Health Homes Program, DHCS delayed program implementation from 2016 to 2018. The program is currently in the process of being implemented in four waves over six-month intervals. The first phase of implementation began on July 1, 2018 and the last implementation phase is set to begin January 1, 2020. Given the delay in implementation, DHCS proposes to extend the sunset date that governs the program's ability to utilize funds from June 30, 2020 to June 30, 2024. This extension would allow the funds to be available for the duration of the program, in accordance with updated implementation timelines, as well as to facilitate the completion of the evaluation required pursuant to state law.

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 12: Managed Care Sanctions

DOF Issue#: Trailer Bill Language Proposal

Trailer Bill Language Proposal. DHCS requests trailer bill language to clarify existing language authorizing the department to impose sanctions on managed care plans, mental health plans, and substance use disorder plans. According to DHCS, these changes would broaden its authority to sanction any entity that contracts with DHCS to deliver health care services, allow DHCS to enter into contracts, and be exempted from the Department of General Services' (DGS) contract approval process, for the purpose of strengthening oversight and the quality of preventive services for children in Medi-Cal.

Background. Existing law authorizes DHCS to impose sanctions, up to and including contract termination, for managed care plans that fail to comply with legal or contractual requirements. However, DHCS indicates it needs authority to hold contractors accountable in a consistent manner across multiple delivery systems for the quality of the health care services that they deliver. This proposed language would increase and standardize amounts of monetary penalties, codify specific violations previously included in state regulations, and apply the sanction authority to any contractor providing health care services. Most of the moneys collected as a result of these statutory changes would be deposited into the General Fund. Additionally, this proposed language would allow DHCS to enter into exclusive or non-exclusive contracts, and be exempt from DGS' contract review or approval process, in order to strengthen oversight and the quality of preventive services for children enrolled in health care programs administered by 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 13: Adult Use of Marijuana Act: Youth Education, Prevention and Treatment Workload

DOF Issue#: 4260-312-BBA-2019-MR

Background. The Adult Use of Marijuana Act (Proposition 64) imposes a 15 percent excise tax on the sale of recreational cannabis products sold in the state of California to be deposited in the California Cannabis Tax Fund. Proposition 64 requires tax proceeds deposited in the fund to be distributed as follows:

1) Costs incurred by state agencies for requirements of Proposition 64.
2) $10 million dollars to universities annually for ten years to research the effect of Proposition 64.
3) $3 million dollars annually for five years to the California Highway Patrol to adopt protocols to determine whether a driver is operating a vehicle while impaired by the use of cannabis or cannabis products.
4) $10 million dollars annually in 2018-19, increasing to $50 million dollars in 2022-23 and annually thereafter for the Governor's Office of Business and Economic Development to administer a community reinvestments grants program.
5) $2 million dollars annually to the University of California San Diego Center for Medicinal Cannabis Research.

After disbursing funds for these purposes, 60 percent of the remaining funds are deposited into the Youth Education, Prevention, Early Intervention and Treatment Account and continuously appropriated to DHCS to enter into interagency agreements with DPH and the California Department of Education (CDE) to implement and administer programs for youth that are designed to educate about and to prevent substance use disorders and to prevent harm from substance use. Proposition 64 requires the programs to emphasize accurate education, effective prevention, early intervention, school retention, and timely treatment services for youth, their families and caregivers.

The May Revision reflects a total Proposition 64 allocation of $119.3 million to DHCS for these programs. According to the Administration, $80.5 million will be transferred to CDE to subsidize up to 9,600 child care slots for school-age children up to 13 years old from income-eligible families. $5.3 million will be transferred to the California Natural Resources Agency to support youth community access grants to support youth access to natural or cultural resources, with a focus on low-income and disadvantaged communities, for positive programming to discourage substance use. $12 million will transferred to DPH to conduct cannabis surveillance and education activities.

The May Revision also includes Proposition 64 funding of $21.5 million for DHCS to support local programs that emphasize prevention, education and early intervention for youth through a competitive grant program and informed through a stakeholder process.

Subcommittee Staff Comment and Recommendation—Hold Open.

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

1. Please provide a brief overview of this proposal.

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

SUBCOMMITTEE NO. 3 Agenda

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

Thursday, May 16, 2019
Upon Adjournment of Appropriations Committee
State Capitol - Room 4203

PART A

Consultant: Scott Ogus

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PUBLIC COMMENT

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

VOTE ONLY

0530 CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY

Issue 1: CalHEERS System Integrator Contract Transition Activities

DOF Issue#: 0530-301-BCP-2019-A1
4260-317-BCP-2019-A1

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

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

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

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

This issue was heard during the subcommittee's May 2nd hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

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

DOF Issue#: 0530-302-BCP-2019-A1
4260-315-BCP-2019-A1

5180-302-BCP-2019-A1

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

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

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

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

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

This issue was heard during the subcommittee's May 2nd hearing.

Subcommittee Staff Comment and Recommendation – Modify. It is recommended the subcommittee take the following actions:

1. **Approve and Adopt Placeholder Budget Bill Language** to require the following prior to expenditure of funding on Phase II development and implementation activities for the Statewide Client Index component of the project:

    a. Approval of Stage 3 and Stage 4 documents by the California Department of Technology (CDT) through the Project Approval Lifecycle.
    b. Upon approval of the Stage 3 and Stage 4 documents, notification to the Joint Legislative Budget Committee 30 days prior to expenditure with information regarding costs, schedule and scope of the project.

Issue 3: Electronic Visit Verification Phase II Planning

DOF Issue#: 0530-304-BCP-2019-A1

4260-313-BCP-2019-A1
4265-303-BCP-2019-A1

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

Table 1 - BCP Resource Request

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

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

Table 2 - BCP Funding Request

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

[3] Funding requested is for CDPH, DHCS and DDS. The OSI request is Expenditure Authority Only.
[4] Funding allocation for OSI costs has been assumed to be 50/50 between DDS and DHCS, pending a determination of the cost allocation methodology.

This issue was heard during the subcommittee's May 2nd hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 4: Statewide Automated Welfare System Consolidation

DOF Issue#: 0530-305-BCP-2019-A1
4260-314-BCP-2019-A1
5180-314-BCP-2019-A1

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

Table 1 - BCP Resource Request

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

Table 2 - BCP Funding Request

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

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

This issue was heard during the subcommittee's May 2nd hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 5: Healthy California For All Commission

DOF Issue#: 0530-308-BCP-2019-A1
0530-309-BCP-2019-A1

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

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

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

This issue was heard during the subcommittee's May 2nd hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted and **adopt placeholder trailer bill language** to amend the title and responsibilities for the Council to align with the new title and single-payer-oriented responsibilities of the Healthy California for All Commission**.**

Issue 6: State Verification Hub Planning Activities (Issue 405-MR)

DOF Issue#: 0530-405-BCP-2019-MR
4260-405-BCP-2019-MR
5180-405-BCP-2019-MR

May Revision. The Administration requests that the following items be modified to begin planning activities for a State Verification Hub to enhance eligibility verifications in public assistance programs. The requested adjustments are as follows:

- Health and Human Services Agency - The Administration requests that Item 0530-001-9745 be increased by $747,000 on a two-year limited-term basis to support one position and consultant services.

- Department of Health Care Services – The Administration requests that Item 4260-001-0001 be increased by $78,000 and Item 4260-001-0890 be increased by $77,000 on a two-year limited-term basis to support one position and consultant services.

- Department of Social Services – The Administration requests that Item 5180-001-0001 be increased by $149,000 and one position and Item 5180-001-0890 be increased by $144,000 and one position on a two-year limited-term basis to support two positions.

This issue was heard during the subcommittee's May 14th hearing.

Staff Comment and Recommendation – Modify. It is recommended the subcommittee take the following actions:

1. **Approve as budgeted and adopt placeholder supplemental reporting language** to request that major automation projects summarize and communicate, beginning with the 2020 Governor's budget and at least annually thereafter, how current project developments are meeting the technical and non-technical recommendations of the State Hub roadmap.

Issue 7: CalQualityCare.org

DOF Issue#: None – Legislative Proposal

Legislative Proposal. A coalition of 17 advocacy organizations including California AARP, California Advocates for Nursing Home Reform, Disability Rights California, and Health Plan of San Mateo request expenditure authority from the Office of Patient Advocate Trust Fund of $500,000 annually. If approved, these resources would fund maintenance and operation of CalQualityCare.org, which provides a single portal for long-term services and supports (LTSS) information that displays free unbiased

information on access, quality, and costs, along with quality ratings for 20,000 licensed California LTSS providers. The website would be hosted as a joint project with the Office of Patient Advocate and the University of California, San Francisco (UCSF).

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

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

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

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3209 – Office of the Patient Advocate Trust Fund	$500,000	$500,000
Total Funding Request:	**$500,000**	**$500,000**

***** Resources ongoing after 2020-21.

This issue was heard during the subcommittee's May 2nd hearing.

Subcommittee Staff Comment and Recommendation – Approve annual expenditure authority from the Office of the Patient Advocate Trust Fund of $500,000 annually to operate the CalQualityCare.org website through the Office of Patient Advocate, in conjunction with UCSF.

0977 CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY

Issue 1: Alignment of Expenditure Authority for Children's Mental Health Crisis Services

DOF Issue#: None – Legislative Proposal

Legislative Proposal. The 2016 Budget Act authorized $30 million for children's mental health crisis services, which included $16 million General Fund and $14 million Mental Health Service Fund. The 2017 Budget Act reverted the $16 million General Fund authority and replaced it with $16.4 million from the Mental Health Services Fund. However, the first allocation of $14 million Mental Health Service Fund was made available for encumbrance or expenditure until June 30, 2019, the second allocation of $16.4 million Mental Health Service Fund was made available until June 30, 2020, and the remaining General Fund resources from previous allocations were made available for liquidation of encumbrances until December 31, 2021. CHFFA proposes reappropriation budget bill language to align the encumbrance and expenditure periods for these funds until June 30, 2024, to improve operation of the children's crisis funding under the Investment in Mental Health Wellness program.

This issue was heard during the subcommittee's April 4th hearing.

Subcommittee Staff Comment and Recommendation – Adopt Placeholder Budget Bill Language to reappropriate funding to align the encumbrance and expenditure periods for children's mental health crisis services.

4120 EMERGENCY MEDICAL SERVICES AUTHORITY

Issue 1: EMT Certification Denial Reporting (AB 2293)

DOF Issue#: 4120-004-BCP-2019-GB

Budget Issue. EMSA requests one position and General Fund expenditure authority of $159,000 in 2019-20 and $152,000 annually thereafter. If approved, these resources would allow EMSA to receive and compile data from local EMS agencies regarding approval or denial of EMT applicants and report on the extent to which prior criminal history may be an obstacle to EMT certification, pursuant to the requirements of AB 2293 (Reyes), Chapter 342, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$159,000	$152,000
Total Funding Request:	**$159,000**	**$152,000**
Total Requested Positions:	**1.0**	**1.0**

* Positions and Resources are ongoing after 2020-21.

This issue was heard during the subcommittee's February 28th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 2: Ambulance Patient Offload Time Reporting (AB 2961)

DOF Issue#: 4120-005-BCP-2019-GB

Budget Issue. EMSA requests one position and General Fund expenditure authority of $189,000 in 2019-20 and $141,000 annually thereafter. If approved, these resources would allow EMSA to analyze ambulance patient offload time data reported by local EMS agencies and report to the Legislature and the EMS Commission, pursuant to the requirements of AB 2961 (O'Donnell), Chapter 656, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$189,000	$141,000
Total Funding Request:	**$189,000**	**$141,000**
Total Requested Positions:	**1.0**	**1.0**

* Positions and Resources are ongoing after 2020-21.

This issue was heard during the subcommittee's February 28th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 3: Child Care Provider Lead Poisoning Training (AB 2370)

DOF Issue#: 4120-006-BCP-2019-GB

Budget Issue. EMSA requests General Fund expenditure authority of $177,000 in 2019-20. If approved, these resources would allow EMSA to add the topic of lead poisoning prevention to the preventive health practices course for child care providers, pursuant to AB 2370 (Holden), Chapter 676, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$177,000	$-
Total Funding Request:	**$177,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

This issue was heard during the subcommittee's February 28th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 4: Individual Tax ID Number for EMT Certification (SB 695)

DOF Issue#: 4120-007-BCP-2019-GB

Budget Issue. EMSA requests General Fund expenditure authority of $100,000 in 2019-20. If approved, these resources would allow EMSA to conduct outreach and assistance to local EMS agencies to implement acceptance of Individual Taxpayer Identification Numbers and prohibit requiring disclosure of citizenship or immigration status for the purpose of EMT certification, pursuant to the requirements of SB 695 (Lara), Chapter 838, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$100,000	$-
Total Funding Request:	**$100,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

This issue was heard during the subcommittee's February 28th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 5: Administrative Support Costs

DOF Issue#: 4120-008-BCP-2019-GB

Budget Issue. EMSA requests expenditure authority of $186,000 ($98,000 General Fund and $88,000 special funds) in 2019-20 and 2020-21, and $190,000 ($98,000 General Fund and $92,000 special funds)

annually thereafter. If approved, these resources would allow EMSA to support increased costs associated with contracted fiscal and personnel services, facilities, and utilities.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$98,000	$98,000
0194 – EMS Training Program Approval Fund	$-	$-
0312 – EMS Personnel Fund	$57,000	$57,000
3137 – EMT Certification Fund	$31,000	$31,000
Total Funding Request:	**$186,000**	**$186,000**
Total Requested Positions:	**0.0**	**0.0**

* Additional Resources in 2021-22: $4,000 EMS Training Program Approval Fund. Resources are ongoing after 2021-22.

This issue was heard during the subcommittee's February 28th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

4120 EMERGENCY MEDICAL SERVICES AUTHORITY
4265 DEPARTMENT OF PUBLIC HEALTH
4440 DEPARTMENT OF STATE HOSPITALS
5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: Disaster Preparedness, Response, and Recovery

DOF Issue#: 4120-401-BCP-2019-MR
4265-401-BCP-2019-MR
4440-087-BCP-2019-MR
5180-407-BCP-2019-MR

May Revision Issue. The Administration proposes new positions and additional General Fund and special fund expenditure authority for various departments, including EMSA, DPH, DSH, and DSS, to enhance the state's disaster preparedness, response, and recovery capabilities.

Program Funding Request Summary - EMSA		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$979,000	$303,000
Total Funding Request:	**$979,000**	**$303,000**
Total Positions Requested*:	**2.0**	

* Positions and resources ongoing after 2020-21.

Program Funding Request Summary - DPH		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$569,000	$569,000
3098 – Licensing and Certification Program Fund	$390,000	$390,000
Total Funding Request:	**$959,000**	**$959,000**
Total Positions Requested*:	**6.0**	

* Positions and resources ongoing after 2020-21.

Program Funding Request Summary - DSH		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$996,000	$826,000
Total Funding Request:	**$996,000**	**$826,000**
Total Positions Requested*:	**6..0**	

* Positions and resources ongoing after 2020-21.

Program Funding Request Summary - DSS		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$2,943,000	$2,739,000
Total Funding Request:	**$2,943,000**	**$2,739,000**
Total Positions Requested*:	**20.0**	

* Positions and resources ongoing after 2020-21.

These issues were heard during the subcommittee's May 14th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

4140 OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT

Issue 1: Mental Health Workforce Development

DOF Issue#: 4140-003-BCP-2019-GB

Budget Issue. OSHPD requests General Fund expenditure authority of $50 million, available for expenditure until June 30, 2025. If approved, these resources would allow OSHPD to support mental health workforce development through existing loan repayment and scholarship programs that support mental health professions.

Program Funding Request Summary		
Fund Source	**2019-20***	**2020-21**
0001 – General Fund	$50,000,000	$-
Total Funding Request:	**$50,000,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

* One-time funding available for expenditure until June 30, 2025.

This issue was heard during the subcommittee's February 28th hearing.

Subcommittee Staff Comment and Recommendation – Modify. It is recommended the subcommittee take the following actions:

1. **Approve as budgeted and adopt placeholder budget bill language** to set aside up to $1 million of funding to target loan repayments for former foster youth serving as mental health providers in public facilities or provider shortage areas.

Issue 2: Investment in Workforce Education and Training Five-Year Plan

DOF Issue#: 4140-401-BCP-2019-MR

May Revision Issue and Budget Bill Language. OSHPD requests expenditure authority from the Mental Health Services Fund of $100 million in 2019-20, available for encumbrance and expenditure until June 30, 2026. If approved, these resources would allow OSHPD to support the 2020-2025 Workforce Education and Training (WET) Program Five Year Plan, a framework of strategies to remedy the shortage of qualified individuals who provide services in the public mental health system.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
3085 – Mental Health Services Fund	$100,000,000	$-
Total Funding Request:	**$100,000,000**	**$-**

This issue was heard during the subcommittee's May 15th hearing.

Subcommittee Staff Comment and Recommendation – Modify. It is recommended the subcommittee take the following actions:

1. **Approve** expenditure authority from the Mental Health Services Fund of $35 million to fund WET programs.

2. **Adopt Placeholder Budget Bill Language** requiring an equivalent contribution of county matching funds from counties in which WET programs would be funded by this augmentation.

Issue 3: Reversion of Excess Funding for All Payer Claims Database

DOF Issue#: None – Legislative Proposal

Legislative Proposal. The 2018 Budget Act included General Fund expenditure authority of General Fund expenditure authority of $60 million for OSHPD to establish and administer the Health Care Cost Transparency Database. The database will collect data from health care service plans, health insurers and other payers regarding payments and pricing for health care services. In the first phase of implementation, OSHPD will convene a review committee of health care stakeholders and experts to provide guidance for developing the database.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	($50,000,000)	$-
Total Funding Request:	**($50,000,000)**	**$-**

This issue was heard during the subcommittee's February 28th hearing.

Subcommittee Staff Comment and Recommendation – Approve reversion of $50 million of General Fund expenditure authority approved in the 2018 Budget Act for the Health Care Cost Transparency Database. OSHPD will retain $10 million of General Fund expenditure authority to continue work developing the database with stakeholders and the review committee. The subcommittee encourages OSHPD to make a subsequent budget request when it is ready to begin implementation of the system after approval of the relevant CDT documentation.

Issue 4: Psychiatry Fellowships

DOF Issue#: None – Legislative Proposal

Legislative Proposal. The California Psychiatric Association requests General Fund expenditure authority of $2.7 million in 2019-20 for scholarships to pay tuition in a one-year fellowship program for primary care provider training in the essentials of primary care psychiatry. Two University of California medical school Departments of Psychiatry (UC Irvine and UC Davis) jointly administer this program which has been training fellows for 4 years. It uses a "Train New Trainers" model, in which fellows are equipped by the training to return to their practice settings and in turn train colleagues and staff on these same essentials of psychiatry for primary care practice. In this respect the training program operates as a force multiplier providing psychiatric training reaching well beyond cohorts of fellows. The requested

resources would continue to provide scholarships for primary care and emergency physicians from underserved areas, as well as provide funding for an additional 100 scholarships, provide targeted marketing to ensure the program reaches the communities most in need, provide tuition for the Essentials of Primary Care Psychiatry conference, and conduct evaluation of program outcomes.

This issue was heard during the subcommittee's May 9th hearing.

Subcommittee Staff Comment and Recommendation – Approve expenditure authority from the Mental Health Services Fund of $2.7 million in 2019-20 for scholarships to pay tuition in a one-year fellowship program for primary care provider training in the essentials of primary care psychiatry, consistent with the proposal.

4260 DEPARTMENT OF HEALTH CARE SERVICES

Issue 1: Medi-Cal Local Assistance Estimate – May Revision Update

DOF Issue#: 4260-001-ECP-2019-GB (November 2018 Medi-Cal Estimate)
4260-401-ECP-2019-MR (May 2019 Medi-Cal Estimate)
4260-017-ECP-2019-GB (Medi-Cal Drug Rebate Fund)
4260-409-ECP-2019-GB (Medi-Cal Drug Rebate Fund Reserve)

Medi-Cal Local Assistance Estimate - May Revision Update. The May 2019 Medi-Cal Local Assistance Estimate includes $93.5 billion ($19.7 billion General Fund, $59.8 billion federal funds, and $13.9 billion special funds and reimbursements) for expenditures in 2018-19, and $102.2 billion ($23 billion General Fund, $66 billion federal funds, and $13.1 billion special funds and reimbursements) for expenditures in 2019-20. These figures represent a decrease in estimated General Fund expenditures in the Medi-Cal program of $999.2 million in 2018-19 and an increase of $141.4 million in 2019-20 compared to the Governor's January budget.

Caseload. In 2018-19, the May Revision assumes annual Medi-Cal caseload of 13 million, a decrease of 1.2 percent compared to assumptions in the Governor's January budget. In 2019-20, the May Revision assumes annual Medi-Cal caseload of 13 million, a decrease of 1.6 percent compared to assumptions in the Governor's January budget and an increase of 0.02 percent compared to the revised caseload estimate for 2018-19. 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. According to DHCS, these caseload reductions are attributable to the growing economy.

May Revision Local Assistance Adjustments. The Administration requests the following adjustments to reflect caseload and miscellaneous adjustments:

- Item 4260-101-0001 be increased by $147,985,000 and reimbursements be increased by $30,571,000
- Item 4260-101-0232 be increased by $4,678,000
- Item 4260-101-0233 be increased by $1,336,000
- Item 4260-101-0236 be increased by $769,000
- Item 4260-101-0890 be increased by $666,098,000
- Item 4260-101-3168 be increased by $378,000
- Item 4260-102-0001 be increased by $1,614,000
- Item 4260-102-0890 be decreased by $722,000
- Item 4260-106-0890 be increased by $4,480,000
- Item 4260-113-0001 be decreased by $58,307,000
- Item 4260-113-0890 be increased by $353,036,000
- Item 4260-117-0001 be increased by $171,000
- Item 4260-117-0890 be increased by $592,000

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	$19,695,653,000	$18,769,164,000	($926,489,000)
Federal Funds	$58,756,149,000	$55,893,565,000	($2,862,584,000)
Special Funds/Reimbursements	$15,079,839,000	$ 13,922,060,000	($1,157,779,000)
Total Expenditures	**$93,531,641,000**	**$88,584,789,000**	**($4,946,852,000)**
County Administration			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$808,388,000	$745,050,000	($63,338,000)
Federal Funds	$3,793,253,000	$3,778,741,000	($14,512,000)
Special Funds and Reimbursements	$4,997,000	$5,730,000	$733,000
Total Expenditures	**$4,606,638,000**	**$4,529,521,000**	**($77,117,000)**
Fiscal Intermediary			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$175,298,000	$165,950,000	($9,348,000)
Federal Funds	$192,408,000	$176,531,000	($15,877,000)
Special Funds and Reimbursements	$-	$-	$-
Total Expenditures	**$367,706,000**	**$342,481,000**	**($25,225,000)**
TOTAL MEDI-CAL EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$20,679,339,000	$19,680,164,000	($999,175,000)
Federal Funds	$62,741,810,000	$59,848,837,000	($2,892,973,000)
Special Funds and Reimbursements	$15,084,836,000	$13,927,790,000	($1,157,046,000)
Total Expenditures	**$98,505,985,000**	**$93,456,791,000**	**($5,049,194,000)**

Medi-Cal Local Assistance Funding Summary 2019-20 Comparison to January Budget			
Fiscal Year:	**2019-20**	**2019-20**	**Jan-May**
Benefits			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$21,851,207,000	$21,999,336,000	$148,129,000
Federal Funds	$61,717,409,000	$62,075,956,000	$358,547,000
Special Funds/Reimbursements	$12,458,842,000	$13,143,233,000	$684,391,000
Total Expenditures	**$96,027,458,000**	**$97,218,525,000**	**$1,191,067,000**
County Administration			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$906,788,000	$898,502,000	($8,286,000)
Federal Funds	$3,410,136,000	$3,708,866,000	$298,730,000
Special Funds and Reimbursements	$4,589,000	$5,961,000	$1,372,000
Total Expenditures	**$4,321,513,000**	**$4,613,329,000**	**$291,816,000**
Fiscal Intermediary			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$119,024,000	$120,568,000	$1,544,000
Federal Funds	$231,883,000	$236,453,000	$4,570,000
Special Funds and Reimbursements	$-	$-	$-
Total Expenditures	**$350,907,000**	**$357,021,000**	**$6,114,000**
TOTAL MEDI-CAL EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$22,877,019,000	$23,018,406,000	$141,387,000
Federal Funds	$65,359,428,000	$66,021,275,000	$661,847,000
Special Funds and Reimbursements	$12,463,431,000	$13,149,194,000	$685,763,000
Total Expenditures	**$100,699,878,000**	**$102,188,875,000**	**$1,488,997,000**

This issue was heard during the subcommittee's March 21st and May 15th hearings.

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-2019-GB (November 2018 Family Health Estimate)
4260-402-ECP-2019-MR (May 2019 Family Health Estimate)

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	$78,356,000	$80,928,000	$2,572,000
Special Funds/Reimbursements	$5,453,000	$5,453,000	$-
County Funds [non-add]	[$84,124,000]	[$86,494,000]	[$2,370,000]
Total CCS Expenditures	**$83,809,000**	**$86,381,000**	**$2,572,000**
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	$112,315,000	$112,319,000	$4,000
Special Funds and Reimbursements	$11,462,000	$11,463,000	$1,000
Total GHPP Expenditures	**$123,777,000**	**$123,782,000**	**$5,000**
Every Woman Counts Program (EWC)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$16,105,000	$12,276,000	($3,829,000)
Federal Funds	$5,128,000	$5,128,000	$-
Special Funds and Reimbursements	$22,504,000	$22,504,000	$-
Total EWC Expenditures	**$43,737,000**	**$39,908,000**	**($3,829,000)**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$206,779,000	$205,526,000	($1,253,000)
Federal Funds	$5,128,000	$5,128,000	$-
Special Funds and Reimbursements	$39,419,000	$39,420,000	$1,000
County Funds [non-add]	[$84,124,000]	[$86,494,000]	[$2,370,000]
Total Family Health Expenditures	**$251,326,000**	**$250,074,000**	**($1,252,000)**

Family Health Local Assistance Funding Summary 2019-20 Comparison to January Budget			
Fiscal Year:	**2019-20**	**2019-20**	**Jan-May**
California Children's Services (CCS)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$80,318,000	$81,148,000	$830,000
Special Funds/Reimbursements	$5,453,000	$5,453,000	$-
County Funds [non-add]	[$86,088,000]	[$86,761,000]	[$673,000]
Total CCS Expenditures	**$85,771,000**	**$86,601,000**	**$830,000**
Child Health and Disability Prevention (CHDP)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$-	$-	$-
Total CHDP Expenditures	**$-**	**$-**	**$-**
Genetically Handicapped Persons Program (GHPP)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$118,146,000	$114,323,000	($3,823,000)
Special Funds and Reimbursements	$8,762,000	$11,211,000	$2,449,000
Total GHPP Expenditures	**$126,908,000**	**$125,534,000**	**($1,374,0000**
Every Woman Counts Program (EWC)			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$16,737,000	$12,913,000	($3,824,000)
Federal Funds	$5,128,000	$5,128,000	$-
Special Funds and Reimbursements	$22,504,000	$22,504,000	$-
Total EWC Expenditures	**$44,369,000**	**$40,545,000**	**($3,824,000)**
TOTAL FAMILY HEALTH EXPENDITURES			
Fund Source	***January Budget***	***May Revision***	***Change***
General Fund	$215,201,000	$208,834,000	($6,817,000)
Federal Funds	$5,128,000	$5,128,000	$-
Special Funds and Reimbursements	$36,719,000	$38,718,000	$1,999,000
County Funds [non-add]	[$86,088,000]	[$86,761,000]	[$673,000]
Total Family Health Expenditures	**$257,048,000**	**$252,680,000**	**($4,368,000)**

This issue was heard during the subcommittee's March 21st and May 15th hearings.

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: Full-Scope Medi-Cal Expansion to Undocumented Young Adults

DOF Issue#: 4260-015-ECP-2019-GB
4260-407-ECP-2019-MR
4260-027-BCP-2019-GB
Trailer Bill Language Proposals

May Revision Issue and Trailer Bill Language Proposal. DHCS requests revised expenditure authority of $98 million ($74.3 million General Fund and $23.3 million federal funds for expansion of full-scope Medi-Cal coverage to undocumented young adults age 19 to 25. DHCS proposes trailer bill language to implement the eligibility expansion effective January 1, 2020. DHCS also proposes amendments to its January budget trailer bill on redirection of county realignment funding to reflect Yolo County as a County Medical Services Program (CMSP) county, withhold 100 percent of CMSP realignment until its reserves reach a reasonable level, and exempt Sacramento, Placer, Stanislaus, and Santa Barbara Counties from additional redirections. After CMSP reserves reach a reasonable level, the state would redirect 75 percent of realignment funds.

State Operations Budget Change Proposal for Implementation of Coverage Expansion. DHCS requests two positions and expenditure authority of $624,000 ($237,000 General Fund and $387,000 federal funds) in 2019-20 and $306,000 ($153,000 General Fund and $153,000 federal funds) annually thereafter. If approved, the requested resources would support key planning activities for the implementation of the full scope Medi-Cal coverage expansion for all income-eligible immigrants from 19 through 25 years of age, regardless of immigration status.

Program Funding Request Summary – State Operations		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$237,000	$153,000
0890 – Federal Trust Fund	$387,000	$153,000
Total Funding Request:	**$624,000**	**$306,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and Resources ongoing after 2020-21.

This issue was heard during the subcommittee's March 21st and May 15th hearings.

Subcommittee Staff Comment and Recommendation – Modify. It is recommended the subcommittee take the following actions:

1. **Approve** expenditure authority of $98 million ($74.3 million General Fund and $23.3 million federal funds) for the expansion of full-scope Medi-Cal coverage to undocumented young adults age 19 to 25, effective January 1, 2020.
2. **Approve** additional expenditure authority of $62.5 million ($49.6 million General Fund and $12.8 million federal funds) to expand full-scope Medi-Cal coverage to undocumented seniors age 65 and over, effective January 1, 2020.
3. **Adopt placeholder trailer bill language** to implement the expansion of full-scope Medi-Cal coverage to undocumented young adults and seniors, effective January 1, 2020.

4. **Adopt placeholder trailer bill language** to increase eligibility for full-scope Medi-Cal for undocumented individuals one year every fiscal year, beginning with expansion to individuals age 26 in 2020-21.
5. **Adopt placeholder trailer bill language** to approve the Administration's updated May Revision trailer bill proposal for redirection of county realignment funding.
6. **Approve as budgeted** two positions and expenditure authority of $624,000 ($237,000 General Fund and $387,000 federal funds) for the budget change proposal to support implementation of the expansion of full-scope Medi-Cal coverage to undocumented young adults.

Issue 4: Managed Care Enrollment Tax

DOF Issue#: None – Legislative Proposal

Legislative Proposal. SB 2 X2 (Hernandez), Chapter 2, Statutes of 2016, Second Extraordinary Session, authorized a three-year tax on enrollment of health care service plans operating in California. The revenue from this tax serves as the non-federal share of increased capitation payments to managed care organizations providing services to Medi-Cal beneficiaries, as well as other expenditures in the Medi-Cal program. Because the revenue provides the non-federal share for these expenditures, overall General Fund spending in the program is reduced. The May Revision includes a total General Fund offset related to the managed care organization (MCO) enrollment tax of $1.8 billion in 2018-19 and $582 million in 2019-20. Although the MCO enrollment tax expires on July 1, 2019, there is a three-month lag in collections of the tax, which leads to the additional General Fund offset in 2019-20. SB 2 X2 also contained tax reform components that exempted payers of the MCO enrollment tax from liability for the state's gross premiums tax and from the business and corporations tax.

The budget does not include a proposal to reauthorize the MCO enrollment tax. As a result, expiration of the tax as scheduled on July 1, 2019, will result in a reduction in tax revenue available to offset General Fund expenditures in the Medi-Cal program of approximately $1.3 billion.

This issue was heard during the subcommittee's March 21st hearing.

Subcommittee Staff Comment and Recommendation – It is recommended the subcommittee take the following actions:

1. **Approve** additional General Fund offsets in the Medi-Cal program of $1.373 billion in 2019-20 and 1.831 billion in 2020-21 and 2021-22.
2. **Adopt placeholder trailer bill language** to extend the managed care enrollment tax, updated to reflect more current enrollment data, and adjusted accordingly to maximize funding for the Medi-Cal program and fulfill federal regulatory requirements.

Issue 5: Proposition 56 Investments

DOF Issue#: 4260-018-ECP-2019-GB
4260-403-ECP-2019-MR
Trailer Bill Language

May Revision Issue and Trailer Bill Language Proposal. The May Revision includes $2.1 billion ($712.5 million Proposition 56 and $1.4 billion federal funds) in 2018-19 and $2.2 billion ($769.5 million Proposition 56 and $1.4 billion federal funds) in 2019-20 for supplemental provider payments in Medi-Cal. The supplemental payments by category are as follows:

Category	2018-19	2019-20	Category	2018-19	2019-20
Physician Services			***PDHCs***		
Total Fund	$1,311,240	$1,399,061	Total Fund	$14,246	$14,246
Proposition 56	$411,555	$458,077	Proposition 56	$6,812	$6,880
Federal Funds	$899,685	$940,984	Federal Funds	$7,434	$7,366
Dental Services			***Ped Subacute***		
Total Fund	$490,117	$518,325	Total Fund	$7,333	$1,811
Proposition 56	$177,597	$195,710	Proposition 56	$3,521	$883
Federal Funds	$312,520	$322,615	Federal Funds	$3,812	$927
Women's Health			***CBAS***		
Total Fund	$188,282	$143,325	Total Fund	$2,000	$-
Proposition 56	$48,372	$43,534	Proposition 56	$3,000	$-
Federal Funds	$139,910	$99,791	Federal Funds	$-	$-
ICF-DDs			***Home Health***		
Total Fund	$29,421	$27,819	Total Fund	$64,834	$64,834
Proposition 56	$13,785	$13,048	Proposition 56	$30,975	$31,211
Federal Funds	$15,636	$14,771	Federal Funds	$33,859	$33,623
AIDS Waiver			***TOTAL***		
Total Fund	$6,800	$6,800	Total Fund	$2,112,273	$2,176,221
Proposition 56	$3,400	$3,400	Proposition 56	$696,017	$752,743
Federal Funds	$3,400	$3,400	Federal Funds	$1,416,256	$1,423,478

Additional Augmentations Funded by Proposition 56. The January budget includes $965 million ($282.5 million Proposition 56 funds and $682.5 million federal funds) in 2019-20 for three augmentations:

- Value-Based Payments Program – The budget includes $360 million ($180 million Proposition 56 funds and $180 million federal funds) to fund a value-based payments program to encourage Medi-Cal managed care providers to meet goals in critical areas such as chronic disease management and behavioral health integration.
- Developmental and Trauma Screening – The budget includes $105 million ($52.5 million Proposition 56 funds and $52.5 million federal funds) to provide early developmental screenings for children and adverse childhood experiences (ACEs) screenings for children and adults in Medi-Cal.
- Family Planning Services – The budget includes $500 million ($50 million Proposition 56 funds and $450 million federal funds) for family planning services in the Medi-Cal program.

May Revision Includes Additional One-Time Augmentations Funded by Proposition 56. According to DHCS, prior year reconciliation of revenues and expenditures derived from Proposition 56 resulted in availability of an additional $261.3 million one-time. DHCS requests additional Proposition 56 expenditure authority of $261.3 million in 2019-20 to support the following one-time investments:

- Physician and Dentists Loan Repayment Program – The May Revision includes $240 million ($120 million Proposition 56 funds and $120 million federal funds) to provide additional awards in the Physicians and Dentists Loan Repayment Program through CalHealthCares.
- Value-Based Payments Program – The May Revision includes an additional $184.2 million ($70 million Proposition 56 funds and $114.2 million federal funds) for the Value-Based Payments Program, specifically focused on behavioral health integration. With this augmentation, the total funding for the program would be $544.2 million ($250 million Proposition 56 funds and $294.2 million federal funds)
- Provider Trauma Screening Training – The May Revision includes $50 million ($25 million Proposition 56 funds and $25 million federal funds) to train providers on delivering trauma screenings in a sensitive and appropriate manner. The January budget proposed funding for trauma screenings for children and adults in Medi-Cal.
- Restoration of Optical Benefit – The budget includes $33.4 million ($11.3 million Proposition 56 funds and $22.1 million federal funds) for restoration of optician and optical lab services authorized in the 2017 Budget Act.

In addition, DHCS indicates that, due to lower General Fund revenues in future years estimated by the Administration, the Proposition 56 investments sunsets on December 31, 2021. According to the Administration, these investments would provide a bridge to the work of the Administration's proposed Healthy California for All Commission, tasked with evaluating options for a single payer health care financing system.

This issue was heard during the subcommittee's April 25th and May 15th hearings.

Subcommittee Staff Comment and Recommendation – Modify. It is recommended the subcommittee take the following actions:

1. **Approve** expenditure authority of $2.1 billion ($712.5 million Proposition 56 and $1.4 billion federal funds) in 2018-19 and $2.2 billion ($769.5 million Proposition 56 and $1.4 billion federal funds) in 2019-20 for supplemental provider payments in Medi-Cal.
2. **Adopt placeholder budget bill language** requiring DHCS to seek a three year state plan amendment from the federal government for all supplemental provider payments in both the fee-for-service and managed care delivery systems in Medi-Cal.
3. **Approve** total expenditure authority of $544.2 million ($250 million Proposition 56 funds and $294.2 million federal funds) for implementation of the Value-Based Payments Program.
4. **Adopt placeholder trailer bill language** implementing the Value-Based Payments Program.
5. **Approve** expenditure authority of $105 million ($52.5 million Proposition 56 funds and $52.5 million federal funds) to provide early developmental screenings for children and adverse childhood experiences (ACEs) screenings for children and adults in Medi-Cal.
6. **Approve** expenditure authority of $50 million ($25 million Proposition 56 funds and $25 million federal funds) to train providers on delivering trauma screenings in a sensitive and appropriate manner.
7. **Approve** expenditure authority of $500 million ($50 million Proposition 56 funds and $450 million federal funds) for family planning services in the Medi-Cal program.

8. **Adopt placeholder trailer bill language** to direct the family planning augmentation to evaluation and management office visits, procedures, education and counseling, and vaccinations, specific to, or related to, reproductive health and family planning.
9. **Approve** expenditure authority of $240 million ($120 million Proposition 56 funds and $120 million federal funds) to provide additional awards in the Physicians and Dentists Loan Repayment Program.
10. **Approve** expenditure authority of $33.4 million ($11.3 million Proposition 56 funds and $22.1 million federal funds) for restoration of optician and optical lab services authorized in the 2017 Budget Act.
11. **Reject** the Administration's proposed sunset of Proposition 56 investments on December 31, 2021.

Issue 6: Medi-Cal Pharmacy Services

DOF Issue#: None

Governor's Executive Order on Prescription Drug Purchasing. On January 7, 2019, the Governor issued Executive Order N-01-19, ordering state departments to implement several directives intended to reduce the cost of prescription drugs for both public and private purchasers. For the Medi-Cal program, the Executive Order directs the Department of Health Care Services (DHCS) to take all necessary steps to transition all pharmacy services currently provided by Medi-Cal managed care plans into the Medi-Cal fee-for-service delivery system. The transition, which would be completed by January 2021, is intended to create additional negotiating leverage on behalf of the state's 13.2 million Medi-Cal beneficiaries. According to the Administration, this transition would standardize the Medi-Cal drug benefit, reduce confusion among beneficiaries without sacrificing quality or outcomes, and result in hundreds of millions of dollars in additional savings beginning in the 2021-22 fiscal year. According to the Administration, while there are no costs or savings reflected in the budget for 2019-20, Medi-Cal is estimated to achieve General Fund savings of $393 million by 2022-23. This estimate does not include savings related to reduced reimbursements to 340B entities.

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation – Adopt placeholder trailer bill language to require DHCS, prior to implementation of the transition of the pharmacy benefit to fee-for-service, to engage quarterly with stakeholders during 2019-20 that may be impacted by the transition, to provide a comprehensive transition plan, and to provide a comprehensive fiscal analysis of the costs and savings to the Medi-Cal program and to impacted providers.

Issue 7: Whole Person Care Housing Services

DOF Issue#: 4260-016-ECP-2019-GB

Budget Issue. DHCS requests General Fund expenditure authority of $100 million in 2019-20 to provide funding for supportive housing services for individuals who are homeless or are at risk of

becoming homeless, with a focus on individuals with mental illness. The expenditure authority would be available until June 30, 2025.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$100,000,000	$-
Total Funding Request:	**$100,000,000**	**$-**

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 8: Non-Whole Person Care Counties

DOF Issue#: 4260-450-ECP-2019-MR

May Revision Issue and Budget Bill Language. DHCS requests expenditure authority from the Mental Health Services Fund of $20 million in 2019-20. If approved, these resources would allow DHCS to provide funding to counties for their development and implementation of programs to focus on coordinating health, behavioral health, and social services such as housing with priority to individuals with mental illness who are also homeless or at risk of becoming homeless. DHCS proposes budget bill language to allow these funds to be available for encumbrance and expenditure until June 30, 2025.

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

* Resources available until June 30, 2025.

This issue was heard during the subcommittee's May 15th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 9: Cybersecurity Program Augmentation

DOF Issue#: 4260-002-BCP-2019-GB

Budget Issue. DHCS requests three positions and expenditure authority of $1.2 million ($591,000 General Fund and $591,000 federal funds) in 2019-20 and $1.2 million ($578,000 General Fund and $577,000 federal funds) annually thereafter. If approved, these resources would allow DHCS to address cybersecurity risks identified by independent security assessments conducted by the California Military Department and the Office of Health Information Integrity. Included in the resource request is $575,000 ($288,000 General Fund and $287,000 federal funds) annually for the ongoing costs of additional enterprise security infrastructure tools.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$591,000	$578,000
0890 – Federal Trust Fund	$591,000	$577,000
Total Funding Request:	**$1,182,000**	**$1,155,000**
Total Requested Positions:	**3.0**	**3.0**

* Positions and Resources ongoing after 2020-21.

This issue was heard during the subcommittee's March 21st hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 10: Electronic Health Record Incentive Program Audits

DOF Issue#: 4260-009-BCP-2019-GB

Budget Issue. DHCS requests expenditure authority of $294,000 ($29,000 General Fund and $265,000 federal funds) in 2019-20, 2020-21, and 2021-22. If approved, these resources would allow DHCS to support program and audit close outs associated with the Medi-Cal Electronic Health record Program.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$29,000	$29,000
0890 – Federal Trust Fund	$265,000	$265,000
Total Funding Request:	**$294,000**	**$294,000**
Total Requested Positions:	**0.0**	**0.0**

* Positions and Resources requested until 2021-22.

This issue was heard during the subcommittee's March 21st hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 11: Office of Legislative and Governmental Affairs Staffing

DOF Issue#: 4260-012-BCP-2019-GB

Budget Issue. DHCS requests two positions and expenditure authority of $247,000 ($124,000 General Fund and $123,000 federal funds) annually. If approved, these resources would allow DHCS to support workload in the Office of Legislative and Governmental Affairs, which responds to external inquiries and prepares fiscal and programmatic analyses of pending legislation or budget proposals.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$124,000	$124,000
0890 – Federal Trust Fund	$123,000	$123,000
Total Funding Request:	**$247,000**	**$247,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and Resources ongoing after 2020-21.

This issue was heard during the subcommittee's March 21st hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 12: Whole Child Model Evaluation Contract Funding

DOF Issue#: 4260-015-BCP-2019-GB

Budget Issue. DHCS requests expenditure authority of $1.6 million ($800,000 General Fund and $800,000 federal funds), available for expenditure or encumbrance until June 30, 2021. If approved, these resources would allow DHCS to secure a contractor to perform an independent evaluation of the Whole Child Model implementation. An identical level of one-time resources was previously approved, but unspent, in the 2018 Budget Act.

Program Funding Request Summary		
Fund Source	**2018-19***	**2019-20**
0001 – General Fund	[($800,000)]	$800,000
0890 – Federal Trust Fund	[($800,000)]	$800,000
Total Funding Request:	**[($1,600,000)]**	**$1,600,000**
Total Requested Positions:	**0.0**	**0.0**

* Unspent expenditure authority approved in 2018-19 will revert to the General Fund and Federal Trust Fund.

This issue was heard during the subcommittee's March 21st hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 13: CA Dental Medicaid Management Information System Contract Management Staffing

DOF Issue#: 4260-016-BCP-2019-GB

Budget Issue. DHCS requests four positions and expenditure authority of $700,000 ($175,000 General Fund and $526,000 federal funds) annually. If approved, these resources would allow DHCS to support the transition to two new vendors for the California Dental Medicaid Management Information System.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$175,000	$175,000
0890 – Federal Trust Fund	$526,000	$526,000
Total Funding Request:	**$700,000**	**$700,000**
Total Requested Positions:	**4.0**	**4.0**

* Positions and Resources ongoing after 2020-21.

This issue was heard during the subcommittee's March 21st hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 14: Childhood Lead Poisoning Prevention (SB 1041)

DOF Issue#: 4260-019-BCP-2019-GB

Budget Issue. DHCS requests one position and expenditure authority of $144,000 ($72,000 General Fund and $72,000 federal funds) annually. If approved, these resources would allow DHCS to provide Medi-Cal data to the Department of Public Health for additional blood lead level reporting pursuant to SB 1041 (Leyva), Chapter 690, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$72,000	$72,000
0890 – Federal Trust Fund	$72,000	$72,000
Total Funding Request:	**$144,000**	**$144,000**
Total Requested Positions:	**1.0**	**1.0**

* Position and Resources ongoing after 2020-21.

This issue was heard during the subcommittee's March 21st hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 15: Strengthening Fiscal Estimates and Cash Flow Monitoring

DOF Issue#: 4260-023-BCP-2019-GB

Budget Issue. DHCS requests 25 positions and expenditure authority of $3.8 million ($1.8 million General Fund and $2 million federal funds) in 2019-20 and $3.6 million ($1.7 million General Fund and $1.9 million federal funds) annually thereafter. If approved, these resources would allow DHCS to improve the accuracy of the Medi-Cal and Family Health Local Assistance Estimates and provide additional oversight and monitoring of the department's cash flow.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$1,814,000	$1,706,000
0890 – Federal Trust Fund	$1,998,000	$1,881,000
Total Funding Request:	**$3,812,000**	**$3,587,000**
Total Requested Positions:	**25.0**	**25.0**

* Positions and Resources ongoing after 2020-21.

This issue was heard during the subcommittee's March 21st hearing.

Subcommittee Staff Comment and Recommendation – Modify. It is recommended the subcommittee take the following actions:

1. **Approve** requested positions and resources for strengthening fiscal estimates and cash flow monitoring.
2. **Adopt placeholder trailer bill language** requiring DHCS to: 1) provide regular updates on cash flows that would compare actual spending to estimated budget amounts; 2) develop and present to the Legislature a long-term plan with changes to budgeting, accounting, and information technology systems to promote sound estimates and budget transparency; and 3) initiate a legislative stakeholder process including legislative staff and the Legislative Analyst's Office to identify possibilities for future changes.

Issue 16: Medi-Cal Drug Rebate Fund

DOF Issue#: Trailer Bill Language

Budget Issue and Trailer Bill Language Proposal. DHCS requests trailer bill language to establish the Medi-Cal Drug Rebate Fund to deposit the proceeds of rebates on prescription drugs purchased on behalf of Medi-Cal beneficiaries. If approved, DHCS estimates $1.4 billion would be deposited in the fund in 2019-20, which would offset General Fund expenditures in the Medi-Cal program. In addition, DHCS proposes a $172 million reserve in the fund to smooth fluctuations in rebate revenue receipts.

This issue was heard during the subcommittee's March 21st hearing.

Subcommittee Staff Comment and Recommendation – Adopt placeholder trailer bill language consistent with the Administration's proposal**.**

Issue 17: Medi-Cal Checkwrite Contingency Payments

DOF Issue#: Trailer Bill Language

Trailer Bill Language Proposal. DHCS requests adoption of trailer bill language to authorize contingency payments to Medi-Cal providers during periods of delay, non-functionality, or system errors in the Medi-Cal Checkwrite Schedule provider claims processing system. If approved, this statutory authority would allow DHCS to maintain continuity of access to Medi-Cal healthcare services for beneficiaries and payments to providers in the event of a disruption in the Medi-Cal Checkwrite service.

This issue was heard during the subcommittee's March 21st hearing.

Subcommittee Staff Comment and Recommendation – Adopt placeholder trailer bill language consistent with the Administration's proposal**.**

Issue 18: Health Homes Program Funding Extension

DOF Issue#: Trailer Bill Language

Trailer Bill Language Proposal. After updates at May Revision, DHCS requests the adoption of trailer bill language to extend the period of availability of funding for implementation of the Health Homes Program from June 30, 2020, to June 30, 2024. If approved, this language would allow DHCS to continue implementation and funding for the Health Homes Program, which began July 1, 2018, and align the availability of funding with the revised program implementation timeline.

This issue was heard during the subcommittee's March 21st and May 15th hearings.

Subcommittee Staff Comment and Recommendation – Adopt placeholder trailer bill language consistent with the Administration's proposal**.**

Issue 19: Managed Care Sanctions

DOF Issue#: Trailer Bill Language Proposal

Trailer Bill Language Proposal. DHCS requests trailer bill language to clarify existing language authorizing the department to impose sanctions on managed care plans, mental health plans, and substance use disorder plans. According to DHCS, these changes would broaden its authority to sanction any entity that contracts with DHCS to deliver health care services, allow DHCS to enter into contracts, and be exempted from the Department of General Services' (DGS) contract approval process, for the purpose of strengthening oversight and the quality of preventive services for children in Medi-Cal.

This issue was heard during the subcommittee's May 15th hearing.

Subcommittee Staff Comment and Recommendation – Adopt placeholder trailer bill language consistent with the Administration's proposal**.**

Issue 20: Medi-Cal 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. AB 5 X3 (Evans), Chapter 20, Statutes of 2009, Third Extraordinary Session, 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, 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 2019-20 are as follows:

Optional Benefits	FFS	Managed Care	TF	GF
Audiology	$3,814,000	$6,126,000	$9,940,000	$3,085,000
Chiropractic	$477,000	$4,714,000	$5,191,000	$1,371,000
Incontinence Creams/Washes	$7,019,000	$8,984,000	$16,003,000	$5,105,000
Optician/Optical Lab*	$16,939,000	$58,645,000	$75,584,000	$22,024,000
Podiatry	$2,105,000	$11,721,000	$13,826,000	$3,397,000
Speech Therapy	$243,000	$2,159,000	$2,402,000	$676,000
Grand Total	**$30,597,000**	**$92,349,000**	**$122,946,000**	**$35,658,000**

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

The May Revision restores optician/optical lab benefits funded by Proposition 56 revenues.

This issue was heard during the subcommittee's March 21st hearing.

Subcommittee Staff Comment and Recommendation – It is recommended the subcommittee take the following actions:

1. **Approve** expenditure authority of $21.1 million ($6.1 million General Fund and $15 million federal funds) to restore the following optional Medi-Cal benefits: audiology, incontinence creams/washes, podiatry, and speech therapy.
2. **Adopt placeholder trailer bill language** to implement the restoration of the following optional Medi-Cal benefits: audiology, incontinence creams/washes, podiatry, and speech therapy**.**

Issue 21: Unusual Occurrences-Complaint Investigations and Disaster Response

DOF Issue#: 4260-004-BCP-2019-GB

Budget Issue. DHCS requests eight positions and expenditure authority of $1.6 million ($858,000 General Fund and $719,000 federal funds) in 2019-20, $1.5 million ($809,000 General Fund and $678,000 federal funds) in 2020-21, and $1.1 million ($595,000 General Fund and $464,000 federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to manage investigations of violations and unusual occurrences in licensed facilities, as well as supporting behavioral health resources during natural disasters or other emergencies.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$858,000	$809,000
0890 – Federal Trust Fund	$719,000	$678,000
Total Funding Request:	**$1,577,000**	**$1,487,000**
Total Requested Positions:	**8.0**	**8.0**

* Additional resources requested – 2021-22 and ongoing: $1,059,000 ($595,000 General Fund and $464,000 federal funds).

This issue was heard during the subcommittee's April 4th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 22: Drug Medi-Cal Chaptered Legislation (SB 823, SB 1228, AB 2861)

DOF Issue#: 4260-018-BCP-2019-GB

Budget Issue. DHCS requests 16 positions and expenditure authority of $1.9 million ($1.7 million General Fund and $135,000 federal funds) in 2019-20 and $2.2 million ($2 million General Fund and $135,000 federal funds) annually thereafter. If approved, these resources would allow DHCS to implement new requirements for substance use disorder treatment programs regarding clinical assessment and treatment planning, patient brokering, and telehealth. These requirements were implemented pursuant to SB 823 (Hill), Chapter 781, Statutes of 2018, SB 1228 (Lara), Chapter 792, Statutes of 2018, and AB 2861 (Salas), Chapter 500, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$1,723,000	$2,041,000
0890 – Federal Trust Fund	$135,000	$135,000
Total Funding Request:	**$1,858,000**	**$2,176,000**
Total Requested Positions:	**16.0**	**16.0**

* Positions and Resources ongoing after 2020-21.

This issue was heard during the subcommittee's April 4th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 23: SAPT Block Grant Compliance and Audit Enhancement

DOF Issue#: 4260-025-BCP-2019-GB

Budget Issue. DHCS requests 14 positions and federal fund expenditure authority of $1.9 million in 2019-20 and $2.1 million ongoing thereafter. If approved, these resources would allow DHCS to correct audit findings and comply with a corrective action plan related to deficiencies in administration of the federal Substance Abuse Prevention and Treatment Block Grant.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0890 – Federal Trust Fund	$1,9165,000	$2,078,000
Total Funding Request:	**$1,916,000**	**$2,078,000**
Total Requested Positions:	**14.0**	**14.0**

* Positions and Resources ongoing after 2020-21.

This issue was heard during the subcommittee's April 4th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 24: Mental Health Services Act Oversight and Policy Development

DOF Issue#: 4260-024-BCP-2019-GB

Budget Issue. DHCS requests 13 positions and Mental Health Services Fund expenditure authority of $1.9 million in 2019-20 and $1.8 million annually thereafter. If approved, these resources would allow DHCS to provide oversight and monitoring of the use of Mental Health Services Act funds, in response to a series of audits by the California State Auditor and hearings by the Little Hoover Commission.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3085 – Mental Health Services Fund	$1,919,000	$1,802,000
Total Funding Request:	**$1,919,000**	**$1,802,000**
Total Requested Positions:	**13.0**	**13.0**

* Positions and Resources ongoing after 2020-21.

This issue was heard during the subcommittee's April 4th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 25: Foster Youth: Trauma-Informed Systems of Care (AB 2083)

DOF Issue#: 4260-022-BCP-2019-GB

Budget Issue. DHCS requests three positions and expenditure authority of $438,000 ($219,000 General Fund and $219,000 federal funds) in 2019-20 and $411,000 ($206,000 General Fund and $205,000 federal funds) annually thereafter. If approved, these resources would allow DHCS to participate on an interagency team and provide recommendations to the Legislature for increasing capacity and delivery of trauma-informed care to foster children and youth with intensive needs, pursuant to the requirements of AB 2083 (Cooley), Chapter 815, Statutes of 2018.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$219,000	$206,000
0890 – Federal Trust Fund	$219,000	$205,000
Total Funding Request:	**$438,000**	**$411,000**
Total Requested Positions:	**3.0**	**3.0**

* Positions and Resources ongoing after 2020-21.

This issue was heard during the subcommittee's April 4th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 26: Early Psychosis Research and Treatment

DOF Issue#: 4260-019-BCP-2019-GB

Budget Issue. DHCS requests General Fund expenditure authority of $25 million in 2019-20. If approved, these resources would allow DHCS to provide grants to county mental health plans, nonprofit organizations, behavioral health providers, or academic institutions to identify and support appropriate interventions for California youth experiencing signs of early psychosis.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$25,000,000	$-
Total Funding Request:	**$25,000,000**	**$-**
Total Requested Positions:	**0.0**	**0.0**

This issue was heard during the subcommittee's April 4th hearing.

Subcommittee Staff Comment and Recommendation – Modify. It is recommended the subcommittee take the following actions:

1. **Reject** the General Fund expenditure authority of $25 million allocated to DHCS for Early Psychosis Research and Treatment.
2. **Approve** General Fund expenditure authority of $25 million for MHSOAC to fund the existing Early Psychosis Intervention Plus Program, established by AB 1315 (Mullin), Chapter 414, Statutes of 2017.
3. **Adopt placeholder trailer bill language** to allow the Early Psychosis Intervention Plus Program to be funded from the state General Fund.

Issue 27: Private Hospital Directed Payment and Quality Incentive Pool

DOF Issue#: 4260-001-BCP-2019-GB

Budget Issue. DHCS requests four positions and expenditure authority of $1.7 million ($595,000 General Fund, $864,000 federal funds, and $270,000 Hospital Quality Assurance Revenue Fund) in 2019-20 and $1.6 million ($568,000 General Fund, $819,000 federal funds, and $252,000 Hospital Quality Assurance Revenue Fund) annually thereafter. If approved, these positions and resources would allow DHCS to implement the Private Hospital Directed Payment program, and support the Quality Incentive Pool program.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$595,000	$568,000
0890 – Federal Trust Fund	$864,000	$819,000
3158 – Hospital Quality Assurance Revenue Fund	$270,000	$252,000
Total Funding Request:	**$1,729,000**	**$1,639,000**
Total Positions Requested:	**4.0**	**4.0**

***** Positions and resources ongoing after 2020-21.

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 28: Home- and Community-Based Services Waiver Programs

DOF Issue#: None – Legislative Proposal

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 received 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, the waiver 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 $16.4 million ($7.4 million General Fund and $7.4 million federal funds) in 2018-19 and $42.7 million ($21.3 million General Fund and $21.3 million federal funds) in 2019-20

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.

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation – It is recommended the subcommittee take the following actions:

1. **Approve** reduction of expenditure authority of $47.1 million ($23.6 million General Fund and $23.6 million federal funds) in 2019-20, $160.2 million ($80.1 million General Fund and $80.1 million federal funds) in 2020-21, $216.7 million ($135.5 million General Fund and $135.5 million federal funds) in 2021-22, $271 million ($135.5 million General Fund and $135.5 million federal funds) in 2022-23, and $304.1 million ($152 million General Fund and $152 million federal funds annually thereafter to account for savings achieved through a phased-in expansion of the Assisted Living Waiver to 10,756 slots by March 1, 2023.
2. **Adopt placeholder trailer bill language** expanding the Assisted Living Waiver through a phased-in expansion to 10,756 slots by March 1, 2023.

Issue 29: Statewide Transition Plan Extension

DOF Issue#: 4260-011-BCP-2019-GB

Budget Issue. DHCS requests expenditure authority of $575,000 ($288,000 General Fund and $287,000 federal funds) annually until 2021-22. If approved, these resources would support implementation, ongoing monitoring, and oversight of the Statewide Transition Plan for Home- and Community-Based Services.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$288,000	$288,000
0890 – Federal Trust Fund	$287,000	$287,000
Total Funding Request:	**$575,000**	**$575,000**

***** Additional fiscal year resources requested – 2021-22: $575,000.

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 30: Proposition 56 Staffing

DOF Issue#: 4260-028-BCP-2019-GB

Budget Issue. DHCS requests 18 positions and expenditure authority of $3 million ($1.5 million Healthcare Treatment Fund and $1.5 million federal funds) annually. If approved, these positions and resources would allow DHCS to support implementation of the new Value-Based Payments program.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0890 – Federal Trust Fund	$1,500,000	$1,500,000
3305 – Healthcare Treatment Fund	$1,500,000	$1,500,000
Total Funding Request:	**$3,000,000**	**$3,000,000**

***** Positions and resources ongoing after 2020-21.

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 31: Program for All-Inclusive Care for the Elderly Expansion

DOF Issue#: 4260-003-BCP-2019-GB

Budget Issue. DHCS requests two positions and expenditure authority of $279,000 ($140,000 General Fund and $139,000 federal funds) in 2019-20 and $261,000 ($131,000 General Fund and $131,000 federal funds) annually thereafter. If approved, these resources would allow DHCS to manage the expansion of Programs of All-Inclusive Care for the Elderly operating in California.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$140,000	$131,000
0890 – Federal Trust Fund	$139,000	$130,000
Total Funding Request:	**$279,000**	**$261,000**
Total Positions Requested:	**2.0**	**2.0**

***** Positions and resources ongoing after 2020-21.

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation – Modify. It is recommended the subcommittee take the following actions:

1. **Approve** the requested positions and resources for the expansion of PACE programs.
2. **Adopt placeholder trailer bill language** to: 1) require the PACE rate methodology to be developed in accordance with generally accepted actuarial rate development principles and to provide for all reasonable, appropriate, and attainable costs for each PACE organization within each region; 2) remove provision in existing law authorizing DHCS in the first three years after adoption of experience based rating to make adjustments to rates to avoid adverse impacts on providers; and 3) require rates, during a PACE organization's first three years, to reflect the lower enrollment and higher operating costs associated with new PACE organizations.

Issue 32: Provider Enrollment Workload Increase

DOF Issue#: 4260-305-BCP-2019-A1

Spring Finance Letter. DHCS requests expenditure authority of $3.1 million ($795,000 General Fund and $2.4 million federal funds) in 2019-20 and $3 million ($744,000 General Fund and $2.2 million federal funds) in 2020-21. If approved, these resources would allow DHCS to process an increase in provider enrollment applications from Drug Medi-Cal and Medi-Cal managed care plans resulting from new federal requirements.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$795,000	$744,000
0890 – Federal Trust Fund	$2,386,000	$2,230,000
Total Funding Request:	**$3,181,000**	**$2,974,000**

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 33: Office of Civil Rights Increased Workload

DOF Issue#: 4260-303-BCP-2019-A1

Spring Finance Letter. DHCS requests two positions and expenditure authority of $296,000 ($148,000 General Fund and $148,000 federal funds) in 2019-20 and $278,000 ($139,000 General Fund and $139,000 federal funds) annually thereafter. If approved, these resources would allow DHCS to address workload increases in its equal employment opportunity, reasonable accommodations, and civil rights compliance programs.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$148,000	$139,000
0890 – Federal Trust Fund	$148,000	$139,000
Total Funding Request:	**$296,000**	**$278,000**
Total Positions Requested:	**2.0**	**2.0**

* Positions and resources ongoing after 2020-21.

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 34: Federally Qualified Health Centers Drug Medi-Cal Providers

DOF Issue#: 4260-306-BCP-2019-A1

Spring Finance Letter. DHCS requests one position and expenditure authority of $139,000 ($70,000 General Fund and $69,000 federal funds) in 2019-20 and $130,000 ($65,000 General Fund and $65,000

federal funds) annually thereafter. If approved, this position and resources would allow DHCS to support workload to allow federally qualified health centers and rural health clinics to participate in the Drug Medi-Cal program, pursuant to the requirements of SB 323 (Mitchell), Chapter 540, Statutes of 2017.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$70,000	$65,000
0890 – Federal Trust Fund	$69,000	$65,000
Total Funding Request:	**$139,000**	**$130,000**
Total Positions Requested:	**1.0**	**1.0**

* Position and resources ongoing after 2020-21.

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 35: Reappropriation: Behavioral Health Modernization Resources

DOF Issue#: 4260-308-BCP-2019-A1

Spring Finance Letter. DHCS requests reappropriation of expenditure authority of $2.1 million ($808,000 General Fund and $1.2 million federal funds) in 2019-20. If approved, these reappropriated resources would cover planning costs of the department's Comprehensive Behavioral Health Data Systems Modernization Project.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$808,000	$-
0890 – Federal Trust Fund	$1,245,000	$-
Total Funding Request:	**$2,053,000**	**$-**

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 36: Strengthening Preventive Services for Children in Medi-Cal

DOF Issue#: 4260-312-BCP-2019-A1

Spring Finance Letter. DHCS requests 12 positions and expenditure authority of $22.7 million ($11.1 million General Fund and $11.6 million federal funds) in 2019-20, $7.5 million ($3.5 million General Fund and $4 million federal funds) in 2020-21 through 2022-23, and $6 million ($2.8 million General Fund and $3.1 million federal funds) annually thereafter. If approved, these resources would allow

DHCS to improve delivery of preventive services for children in Medi-Cal in response to findings of a state audit.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$11,079,000	$3,495,000
0890 – Federal Trust Fund	$11,603,000	$3,998,000
Total Funding Request:	**$22,682,000**	**$7,493,000**
Total Positions Requested:	**12.0**	**12.0**

* Additional fiscal year resources requested – 2021-22 through 2022-23: $7,493,000; 2023-24 and ongoing: $5,996,000.

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 37: Peer-Run Mental Health Crisis Lines

DOF Issue#: 4260-407-BCP-2019-MR

May Revision Issue. DHCS requests expenditure authority from the Mental Health Services Fund of $3.6 million for three years to create a statewide peer-run mental health crisis line offering information, referrals, emotional support, and non-judgmental peer support to those living with mental illness.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3085 – Mental Health Services Fund	$3,600,000	$3,600,000
Total Funding Request:	**$3,600,000**	**$3,600,000**

* Additional fiscal year resources requested: 2021-22: $3,600,000

This issue was heard during the subcommittee's May 15th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 38: Various Reappropriations

DOF Issue#: 4260-313-BBA-2019-MR

May Revision Issue. DHCS requests various changes to reappropriation language for the following purposes:

1) $7.4 million from Item 4260-001-0001, 2018 Budget Act, for turnover and takeover of the Medi-Cal fiscal intermediary legacy contract. (This reappropriation is related *to Issue 9: CA-MMIS Oversight to Ownership and Modernization Projects*)

2) $808,000 from Item 4260-001-0001, 2018 Budget Act, for continued planning costs for the Comprehensive Behavioral Health Data Systems. (This reappropriation was heard as an April Finance Letter, "*Reappropriation: Behavioral Health Modernization Resources*" during the subcommittee's April 25th hearing).
3) Remaining expenditure authority from the initial allocation of $220 million Proposition 56 funds in the 2018 Budget Act for the Medi-Cal Physician and Loan Repayment Program. These funds would be available for encumbrance or expenditure until June 30, 2029.

This issue was heard during the subcommittee's May 15th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 39: Medi-Cal Eligibility Systems Staffing

DOF Issue#: 4260-400-BCP-2019-MR

May Revision Issue. DHCS requests conversion of 13 limited-term resources to permanent, a two-year extension of resources equivalent to seven positions, and expenditure authority of $3 million ($910,000 General Fund and $2.1 million federal funds) in 2019-20 and 2020-21, and $1.8 million ($626,000 General Fund and $1.2 million federal funds) annually thereafter. If approved, these positions and resources would allow DHCS to oversee, govern, support, and implement the new and continuing policy-driven and infrastructure stabilization initiatives of the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS).

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$910,000	$910,000
0890 – Federal Trust Fund	$2,058,000	$2,058,000
Total Funding Request:	**$2,968,000**	**$2,968,000**
Total Positions Requested:**	**13.0**	**13.0**

***** Additional fiscal year resources requested – 2021-22 and ongoing: $1,838,000.
** Positions ongoing.

This issue was heard during the subcommittee's May 15th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 40: CA-MMIS Oversight to Ownership and Modernization Projects

DOF Issue#: 4260-400-BCP-2019-MR

May Revision Issue. DHCS requests 11 positions and expenditure authority of $49.7 million ($15.3 million General Fund and $34.4 million federal funds) in 2019-20 and $1.7 million ($614,000 General Fund and $1.1 million federal funds) annually thereafter. If approved, these resources would allow DHCS to fund transitional efforts for turnover and takeover of the fiscal intermediary, continuation of the oversight to ownership strategy, and 3) continuation of procurements for design, development, and

implementation of systems modules. Included in the request for 2019-20 is a reappropriation of $22.9 million ($7.4 million General Fund and $15.5 million federal funds) for this purpose (see *Issue 7: Various Reappropriations*)

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$15,270,000	$614,000
0890 – Federal Trust Fund	$34,401,000	$1,058,000
Total Funding Request:	**$49,671,000**	**$1,672,000**
Total Positions Requested:**	**11.0**	**11.0**

***** Positions and resources ongoing after 2020-21.

This issue was heard during the subcommittee's May 15th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 41: Substance Use Disorder Emerging Epidemics, Disaster Response, & Licensing Workload

DOF Issue#: 4260-402-BCP-2019-MR

May Revision Issue. DHCS requests seven positions and expenditure authority of $1.2 million ($100,000 General Fund and $1.1 million Residential and Outpatient Program Licensing Fund) in 2019-20 and $1 million Residential and Outpatient Program Licensing Fund annually thereafter. If approved, these resources would allow DHCS to address the increased workload of responding to natural disasters and other emergencies, the opioid epidemic, the resurgence of methamphetamine abuse, and the rise in the number of substance use disorder treatment facilities. Included in this request is a one-time expense of $100,000 General Fund to migrate the DHCS disaster collection and reporting process into the web-based reporting platform, NC4, through an interagency agreement with DPH.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$100,000	$-
3113 – Residential and Outpatient Program Licensing Fund	$1,060,000	$997,000
Total Funding Request:	**$1,160,000**	**$997,000**
Total Positions Requested:	**7.0**	**7.0**

***** Positions and resources ongoing after 2020-21.

This issue was heard during the subcommittee's May 15th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 42: Long-Term Services and Supports Actuarial Study

DOF Issue#: None – Legislative Proposal

Legislative Proposal. The California Aging and Disability Alliance, requests General Fund expenditure authority of $1 million to fund a feasibility study and actuarial analysis of long-term services and supports (LTSS) financing and benefit options to meet the growing need for these services in California. This study and analysis are an essential first step toward the ultimate goal of creating a new, independent, and sustainably funded LTSS benefit for all Californians regardless of income or zip code.

This study and analysis would provide critical guidance on the following: the scope of services for such a benefit; eligibility criteria; projected cost estimates and financing options; and projected savings to state funded programs and services associated with each option, including, but not limited to, Medi-Cal and the In-Home Supportive Services (IHSS) program.

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation – Approve General Fund expenditure authority of $1 million to fund the feasibility study and actuarial analysis of long-term services and supports financing.

Issue 43: Expand Screening, Brief Intervention, Referral to Treatment to Opioids/Other Drugs

DOF Issue#: None – Legislative Proposal

Legislative Proposal. The California Behavioral Health Directors Association requests expenditure authority of $8.4 million ($2.6 million General Fund and $5.8 million federal funds) to expand the Medi-Cal benefit for screening, brief intervention, referral and treatment (SBIRT) to include screening for overuse of opioids and other illicit drugs such as heroin and methamphetamine. The U.S. Department of Health and Human Services describes expanding SBIRT for drug use as a promising practice and the U.S. Preventive Services Task Force is re-visiting its recommendations on this topic. A comprehensive, national SBIRT grant program recently reported a 75 percent reduction in illicit drug use, consistent with other evidence linking SBIRT to reduction in the use of cocaine, amphetamine-type stimulants and opioids. Expanding screening to detect use of opioids and other drugs would be an important step in combatting the current crisis and saving lives.

This issue was heard during the subcommittee's April 4th hearing.

Subcommittee Staff Comment and Recommendation – It is recommended the subcommittee take the following actions:

1. **Approve** expenditure authority of $8.4 million ($2.6 million General Fund and $5.8 million federal funds) to expand the Medi-Cal benefit for SBIRT to include screening for overuse of opioids and other illicit drugs.
2. **Adopt placeholder trailer bill language** to implement the expansion of SBIRT to opioids and other illicit drugs.

Issue 44: Substance Use Counselors in Emergency Departments

DOF Issue#: None – Legislative Proposal

Legislative Proposal. The California Chapter of the American College of Emergency Physicians (CalACEP) requests General Fund expenditure authority of $30 million to support the hiring of trained substance use disorder peer navigators and behavioral health peer navigators in emergency departments of acute care hospitals. According to CalACEP, brief interventions are successful in a variety of settings, but there is a unique opportunity to provide this intervention in the emergency department (ED). Patients presenting to the ED are more likely to be having a mental health crisis or have a substance use disorder than those presenting to primary care. For patients coming into the ED with a substance use disorder, the visit offers the opportunity for a "teachable moment" due to the crisis that precipitated the ED visit.

This issue was heard during the subcommittee's April 4th hearing.

Subcommittee Staff Comment and Recommendation – Approve General Fund expenditure authority of $10 million to support the hiring of trained substance use disorder peer navigators and behavioral health peer navigators in emergency departments of acute care hospitals.

Issue 45: Extension of Medi-Cal for Post-Partum Mental Health

DOF Issue#: None – Legislative Proposal

Legislative Proposal. The American College of Obstetricians and Gynecologists (ACOG) requests resources to expand Medi-Cal benefits for a postpartum woman from 60 days to one year if that woman is diagnosed with a maternal mental health disorder. According to ACOG, maternal mental health is of increasing concern because of the high prevalence of depression and anxiety during the perinatal period and the resulting long-term implications of delayed, inconsistent, or absent treatment. Maternal mental health conditions influence the well-being of mothers, children, families, and communities. Low-income women and women of racial and ethnic minorities are disproportionately affected by maternal mental health disorders, as they face unique barriers to diagnosis and treatment. While many of these women may already be enrolled in Medi-Cal, others, who do not meet Medi-Cal's income eligibility, are not.

Under current law, the income eligibility requirements for pregnancy-related Medi-Cal increases from 138 percent of the federal poverty level (FPL) to 213 percent of the FPL for women who are pregnant. Pregnant women whose income is above 213 percent of the FPL up to and including 322 percent of the FPL may qualify for assistance through the Medi-Cal Access Program (MCAP). While MCAP is comprehensive coverage, it does require a small fee (1.5 percent of annual family income) to participate. These programs enable more low-income women who may not otherwise qualify for Medi-Cal to receive medically necessary treatment to ensure the health of their pregnancy and baby.

These benefits end after 60 days from the birth of the child. Unless the new mom enrolls in a Covered California program, which requires her to pay a premium, any treatment she would be receiving would no longer be covered. She would either need to obtain commercial insurance or explore community resources that offer appropriate mental health services. This disruption in coverage could break the continuity of care and potentially halt treatment altogether. This is unhealthy for the mother and the baby.

This issue was heard during the subcommittee's March 21st hearing.

Subcommittee Staff Comment and Recommendation – Approve General Fund expenditure authority of $8.6 million annually to support the extension of Medi-Cal eligibility from 60 days to one year for a post-partum woman diagnosed with a mental health disorder.

Issue 46: Medical Interpreters Pilot

DOF Issue#: None – Legislative Proposal

Legislative Proposal. The American Federation of State, County, and Municipal Employees (AFSCME) requests General Fund expenditure authority of $5 million in 2019-20 to implement a pilot project for medical interpreters previously approved by the Legislature in AB 635 (Atkins), Chapter 600, Statutes of 2016. According to AFSCME, the original $3 million allocated in AB 635 was exhausted by DHCS to fund a study of medical interpretation services, although the funds were intended for both a study and a pilot project. This funding would ensure the ability to fund a legitimate pilot program capable of providing measurable outcomes that could be used to inform future public policy decisions.

This issue was heard during the subcommittee's May 9th hearing.

Subcommittee Staff Comment and Recommendation – Approve General Fund expenditure authority of $5 million to implement a pilot project for medical interpreters, consistent with the intent of AB 635.

Issue 47: Children's Crisis Residential Programs

DOF Issue#: None – Legislative Proposal

Legislative Proposal. The California Alliance of Child and Family Services requests trailer bill language to explicitly define Children's Crisis Residential Programs (CCRPs) as Psychiatric Residential Treatment Facilities (PRTFs) and funded accordingly. According to the Alliance, AB 501 (Ridley-Thomas), Chapter 704, Statutes of 2017, created a licensing category for children's mental health crisis residential programs, which is a mental health facility designed to treat youth who are not at imminent danger to themselves or others, but are unsafe to remain in the community due to their mental health needs. The model used in the development of AB 501, as well as models throughout the country utilize the Medicaid mental health program category of Psychiatric Residential Treatment Facility (PRTF), an all-inclusive program for Medicaid beneficiaries. Since AB 501 did not explicitly identify the facility as PRTFs, DHCS refuses to recognize CCRPs as PRTFs, and has designed a funding structure that covers only specific specialty mental health services, not the entire cost of providing 24-hour care and treatment.

This issue was heard during the subcommittee's April 4th hearing.

Subcommittee Staff Comment and Recommendation – Adopt placeholder trailer bill language to explicitly define Children's Crisis Residential Programs as Psychiatric Residential Treatment Facilities.

Issue 48: Youth Mental Health First Aid

DOF Issue#: None – Legislative Proposal

Legislative Proposal. The California Council of Community Behavioral Health Agencies, the California Behavioral Health Directors Association, and the Born This Way Foundation request expenditure authority to pilot Youth Mental Health First Aid training for teachers and school personnel in districts with high rates of suicide or with high populations of at-risk youth. According to the proponents, 30 percent of high school students report experiencing depression symptoms - feeling sad or hopeless almost every day for two or more weeks in a row, so much so that they stopped doing some usual activities. 18 percent of high school students have seriously considered attempting suicide, and eight percent attempted suicide one or more times. Suicide is the second leading cause of death for youth 15 to 24 years old and the third leading cause of death among youth aged 10 to 14. In addition, marginalized populations, particularly LGBTQ youth, are at even greater risk. Youth Mental Health First Aid USA is an eight hour in-person course that teaches educators, parents, and other adults how to identify, understand, and respond to signs of mental illnesses and substance use disorders in youth. This preventative training teaches the skills needed to reach out and provide initial help and support to someone who may be experiencing a crisis or developing a mental health or substance use issue.

This issue was heard during the subcommittee's April 4th hearing.

Subcommittee Staff Comment and Recommendation – Approve expenditure authority from the Mental Health Services Fund of $1.68 million to pilot Youth Mental Health First Aid training for teachers and school personnel in districts with high rates of suicide or with high populations of at-risk youth.

Issue 49: Clinical Laboratory Reimbursement Methodology

DOF Issue#: None – Legislative Proposal

Legislative Proposal. The California Clinical Laboratory Association (CCLA) requests revision of the statutory clinical laboratory services rate methodology in Medi-Cal. According to CCLA, the historical statutory rate methodology in California has also included a provision capping Medi-Cal laboratory rates at no more than 80 percent of the Medicare rate. In 2018, the federal government implemented the Protecting Access to Medicare Act (PAMA). As a part of PAMA, Congress directed the Centers for Medicare and Medicaid Services (CMS) to establish new Medicare rates for clinical lab services based on commercial market rates calculated by CMS. This has resulted in a reduction for most Medicare clinical lab rates. As a result, now (for the first time) when DHCS applies California's existing 80 percent of Medicare cap, the resulting Medi-Cal rates are often lower than the California market-based rates that DHCS has painstakingly developed to serve the California market. This entirely undermines the purpose behind developing Medi-Cal's market-based rates, and often results in Medi-Cal rates that are well below market. This unintended and inequitable result can be remedied simply by eliminating the current statutory "80 percent of Medicare" cap for Medi-Cal clinical lab rates. CCLA requests elimination of the cap on Medi-Cal's clinical laboratory rates of 80 percent of the new Medicare rates.

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation – Adopt placeholder trailer bill language eliminating the statutory cap on 80 percent of Medicare for clinical laboratory rates.

Issue 50: Elimination of the Senior Penalty – Medi-Cal Aged and Disabled to 138 Percent FPL

DOF Issue#: None – Legislative Proposal

Legislative Proposal. The Western Center on Law and Poverty (WCLP), Disability Rights California, Justice in Aging, and a coalition of 64 organizations request resources 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.

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 21st hearing.

Subcommittee Staff Comment and Recommendation – It is recommended the subcommittee take the following actions:

1. **Approve** annual expenditure authority of $124.9 million ($62.4 million General Fund and $62.4 million federal funds) to expand Medi-Cal eligibility for aged and disabled individuals to 138 percent of the federal poverty level.
2. **Adopt placeholder trailer bill language** to implement the change in income eligibility for aged and disabled individuals to 138 percent of the federal poverty level.

4265 DEPARTMENT OF PUBLIC HEALTH

Issue 1: AIDS Drug Assistance Program (ADAP) – May Revision Estimate and Adjustments

DOF Issue#: 4265-003-ECP-2019-GB
4265-036-BBA-2019-GB
4265-401-ECP-2019-MR

ADAP Local Assistance Estimate May Revision Update. The May 2019 ADAP Local Assistance Estimate reflects revised 2018-19 expenditures of $407.5 million, which is a decrease of $362,000 or less than 0.1 percent compared to the Governor's January budget. According to DPH, this decrease is primarily due to reduced medication expenditures for medication-only clients. For 2019-20, DPH estimates ADAP expenditures of $449.5 million, a decrease of $320,000 or less than 0.1 percent, compared to the Governor's January Budget, and an increase of $42 million or 10.3 percent, compared to the revised 2018-19 estimate. DPH also reports this decrease is primarily due to reduced medication expenditures for medication-only clients.

ADAP Local Assistance Funding 2018-19 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0890 – Federal Trust Fund	$129,143,000	$129,143,000
3080 – AIDS Drug Assistance Program Rebate Fund	$278,735,000	$278,373,000
Total ADAP Local Assistance Funding – All Funds	**$407,878,000**	**$407,516,000**

ADAP Local Assistance Funding 2019-20 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0890 – Federal Trust Fund	$135,138,000	$135,138,000
3080 – AIDS Drug Assistance Program Rebate Fund	$314,650,000	$314,330,000
Total ADAP Local Assistance Funding – All Funds	**$449,789,000**	**$449,468,000**

This issue was heard during the subcommittee's February 28th and May 14th hearings.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 2: HIV Care Program Financial Eligibility – Trailer Bill Language Proposal

DOF Issue#: Trailer Bill Language Proposal

Trailer Bill Language Proposal. DPH requests trailer bill language to adopt the financial eligibility requirement used by the AIDS Drug Assistance Program for the HIV Care Program. Adoption of this language would allow the HIV Care Program to address a finding from the federal Health Resources and Services Administration (HRSA) that the program does not have consistent, statewide financial eligibility standards, as required by the federal Ryan White HIV/AIDS program.

This issue was heard during the subcommittee's May 14th hearing.

Subcommittee Staff Comment and Recommendation – Adopt placeholder trailer bill language consistent with the Administration's proposal**.**

Issue 3: Infectious Disease Prevention and Control

DOF Issue#: 4265-404-BCP-2019-MR

May Revision Issue. DPH requests four positions and General Fund expenditure authority of $40 million in 2019-20, available until June 30, 2023. If approved, these positions and resources would allow DPH to provide one-time grants to local health jurisdictions and tribal communities for infectious disease prevention, testing, and treatment. Of these resources, $32 million would be provided to local health jurisdictions and $8 million would support state administration costs.

Program Funding Request Summary		
Fund Source	**2019-20***	**2020-21**
0001 – General Fund		
State Operations	$8,000,000	**$-**
Local Assistance	$32,000,000	$-
Total Funding Request:	**$40,000,000**	**$-**
Total Positions Requested:	**4.0**	

* Resources available until June 30, 2023.

This issue was heard during the subcommittee's May 14th hearing.

Subcommittee Staff Comment and Recommendation – Modify. It is recommended the subcommittee take the following actions:

1. **Approve** General Fund expenditure authority of $4 million for state operations and $36 million for local assistance for grants to local health jurisdictions and tribal communities for infectious disease prevention and control.
2. **Adopt placeholder budget bill language** to require DPH to provide the grant funds in a lump sum available for four years, to create an allocation methodology in consultation with local health jurisdictions, and allocate $1 million of the $36 million local assistance grant funding for tribal communities.

Issue 4: Genetic Disease Screening Program – May Revision Estimate and Adjustments

DOF Issue#: 4265-002-ECP-2019-GB
4265-402-ECP-2019-MR

Genetic Disease Screening Program Estimate - May Revision Update. The May 2019 Genetic Disease Screening Program Estimate includes expenditure authority from the Genetic Disease Testing Fund of $133.8 million ($30.6 million state operations and $103.2 million local assistance) in 2018-19, a decrease of $273,000 or 0.3 percent compared to the January budget. According to DPH, the decreased costs are primarily attributable to reduced estimates of live births in California. The estimate also includes $143 million ($31.4 million state operations and $111.6 million local assistance) in 2019-20, an

increase of $1.8 million or 1.6 percent compared to the January budget, and an increase of $9.2 million or 6.8 percent compared to the revised 2018-19 estimate. According to DPH, the increase in costs is due to increased laboratory supply and equipment costs and an increasing need for case management and coordination services for newborn screening.

Genetic Disease Screening Program 2018-19 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0203 – Genetic Disease Testing Fund		
State Operations:	$29,451,000	$30,593,000
Local Assistance:	$103,501,000	$103,228,000
Total GDSP Funding	**$132,952,000**	**$133,821,000**

Genetic Disease Screening Program 2019-20 May Revision Comparison to January Budget		
Fund Source	***January Budget***	***May Revision***
0203 – Genetic Disease Testing Fund		
State Operations:	$31,351,000	$31,351,000
Local Assistance:	$109,825,000	$111,624,000
Total GDSP Funding	**$141,176,000**	**$142,975,000**

This issue was heard during the subcommittee's February 28th and May 14th hearings.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 5: Women, Infants, and Children Program – May Revision Estimate

DOF Issue#: 4265-001-ECP-2019-GB
4265-403-ECP-2019-MR

Women, Infants, and Children Program Estimate – May Revision Update. The May 2019 Women, Infants, and Children (WIC) Program Estimate includes total expenditure authority of $1.1 billion ($902.2 million federal funds and $226.2 million WIC manufacturer rebate funds) in 2018-19, an increase of $7.2 million ($10.1 million federal funds offset by a decrease of $2.9 million WIC manufacturer rebate funds) compared to the Governor's January budget. The May 2019 WIC Program Estimate includes $1.1 billion ($880.7 million federal funds and $213.7 million WIC manufacturer rebate funds) in 2019-20, an increase of $1.3 million ($2.6 million federal funds offset by a decrease of $1.3 million WIC manufacturer rebate funds) compared to the Governor's January budget, and a decrease of $34 million ($21.4 million federal funds and $12.5 million WIC manufacturer rebate funds) compared to the revised 2018-19 estimate. The federal fund amounts include state operations costs of $63.7 million in 2018-19 and $62.3 million in 2019-20.

WIC Funding Summary 2018-19 May Revision Comparison to January Budget			
	2018-19		**Jan to May**
Fund Source	***January Budget***	***May Revision***	***Change***
0890 – Federal Trust Fund			

State Operations:	$63,684,000	$63,684,000	$-
Local Assistance:	$828,388,000	$838,489,000	$10,101,000
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$229,080,000	$226,211,000	($2,869,000)
Total WIC Expenditures	**$1,121,152,000**	**$1,128,384,000**	**$7,232,000**

WIC Funding Summary 2019-20 May Revision Comparison to January Budget			
	2019-20		**Jan to May**
Fund Source	***January Budget***	***May Revision***	***Change***
0890 – Federal Trust Fund			
State Operations:	$62,270,000	$62,270,000	$-
Local Assistance:	$815,905,000	$818,462,000	$2,557,000
3023 – WIC Manufacturer Rebate Fund			
Local Assistance:	$214,929,000	$213,678,000	($1,251,000)
Total WIC Expenditures	**$1,093,104,000**	**$1,094,410,000**	**$1,306,000**

This issue was heard during the subcommittee's February 28th and May 14th hearings.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 6: California Home Visiting and Black Infant Health Programs – Federal Matching Funds

DOF Issue#: 4265-017-BCP-2019-GB
4265-018-BCP-2019-GB
4265-402-BCP-2019-MR
4265-403-BCP-2019-MR

Budget Issue. In the January budget, DPH requested 13 positions and General Fund expenditure authority of $23 million annually to expand participation in current and new sites for the California Home Visiting Program (CHVP), and to include new evidence-based home visiting models, with a focus on low-income, young mothers. DPH also requested four positions and General Fund expenditure authority of $7.5 million annually to expand the Black Infant Health Program to improve African-American infant and maternal health.

May Revision Issue. In the May Revision, DPH requests reimbursement expenditure authority of $34.8 million annually. If approved, these resources would allow DPH to draw down federal Medicaid funds for services provided by the California Home Visiting Program (CHVP) and the Black Infant Health (BIH) Program to Medi-Cal beneficiaries. For CHVP, DPH is requesting increased reimbursement expenditure authority of $2 million for state operations and $20.9 million for local assistance. For the BIH Program, DPH is requesting increased reimbursement authority of $1.3 million for state operations and $10.7 million for local assistance.

Combined Program Funding Request Summary – California Home Visiting Program		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund		
State Operations	$2,000,000	$2,000,000
Local Assistance	$21,000,000	$21,000,000
0995 – Reimbursements		
State Operations	$2,000,000	$2,000,000
Local Assistance	$20,869,000	$20,869,000
Total Combined Funding Request:	**$45,869,000**	**$45,869,000**
Total Positions Requested*:	**13.0**	

* Positions and resources ongoing after 2020-21.

Combined Program Funding Request Summary – Black Infant Health Program		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund		
State Operations	$500,000	$500,000
Local Assistance	$7,000,000	$7,000,000
0995 – Reimbursements		
State Operations	$1,300,000	$1,300,000
Local Assistance	$10,650,000	$10,650,000
Total Combined Funding Request:	**$19,450,000**	**$19,450,000**
Total Positions Requested*:	**4.0**	

* Positions and resources ongoing after 2020-21.

These issues were heard during the subcommittee's February 28th and May 14th hearings.

Subcommittee Staff Comment and Recommendation – Modify. It is recommended the subcommittee take the following actions:

1. **Approve** overall proposed General Fund expenditures for the California Home Visiting Program (CHVP) and Black Infant Health (BIH) Program.
2. **Maintain** the previous total fund allocation of state operations of $2 million for CHVP and $500,000 for BIH.
3. **Redirect** General Fund expenditures offset by federal matching funds for state operations costs to additional local assistance expenditures.
4. **Adopt placeholder budget bill language** to direct DPH to allow BIH expenditures to also be utilized by local health jurisdictions for programs implemented under the California Perinatal Equity Initiative.

Issue 7: Proposition 99 Adjustments – Health Education, Research, and Unallocated Accounts

DOF Issue#: 4265-031-BBA-2019-GB
4265-402-BBA-2019-MR

Proposition 99 Tobacco Tax Allocations. DPH requests the following technical corrections reflecting changes in Proposition 99 revenues:

Health Education Account
- Item 4265-001-0231 be increased by $950,000
- Item 4265-111-0231 be increased by $500,000

Research Account
- Item 4265-001-0234 be increased by $521,000

Unallocated Account
- Item 4265-001-0236 be increased by $29,000

According to DPH, these adjustments would support state administrative activities and competitive grants.

This issue was heard during the subcommittee's May 14th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 8: Alzheimer's Grant Awards & Governor's Task Force on Alz. Prevention & Preparedness

DOF Issue#: 4265-019-BCP-2019-GB
4265-304-BCP-2019-A1

Budget Issue. DPH requests two positions and General Fund expenditure authority of $3 million annually. If approved, these positions and resources would allow DPH to expand research grants in the Alzheimer's Disease Program focused on the prevalence of the disease among women and communities of color. These resources would also support creation and implementation of the Governor's Task Force on Alzheimer's Prevention and Preparedness.

Spring Finance Letter. DPH requests a shift of General Fund expenditure authority of $300,000 from local assistance to state operations in 2019-20. If approved, this shift of resources would support contracts needed to administer the Governor's Task Force on Alzheimer's Prevention and Preparedness and would reduce research grant funding in 2019-20 related to the incidence of Alzheimer's disease among women and communities of color.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund		
State Operations	$300,000	$-
Local Assistance	$2,700,000	$3,000,000
Total Funding Request:	**$3,000,000**	**$3,000,000**
Total Requested Positions:	**2.0**	**2.0**

* Positions and Resources ongoing after 2020-21.

This issue was heard during the subcommittee's February 28th and April 25th hearings.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 9: Maternal, Child, and Adolescent Health – Medi-Cal Oversight Activities

DOF Issue#: 4265-010-BCP-2019-GB

Budget Issue. DPH requests five positions and expenditure authority of $656,000 ($328,000 General Fund and $328,000 reimbursements) annually. If approved, these resources would allow DPH to comply with federal claiming and oversight requirements for federal Medicaid funds.

Program Funding Request Summary		
Fund Source	**2018-19**	**2019-20***
0001 – General Fund	$328,000	$328,000
0995 – Reimbursements	$328,000	$328,000
Total Funding Request:	**$656,000**	**$656,000**
Total Requested Positions:	**5.0**	**5.0**

* Positions and Resources ongoing after 2019-20.

This issue was heard during the subcommittee's February 28th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 10: Center for Healthcare Quality, Licensing and Certification Program

Budget Issue. The budget includes expenditure authority for the Center for Healthcare Quality of $291.4 million ($3.7 million General Fund, $104.5 million federal funds, and $183.1 million special funds and reimbursements) in 2018-19, an increase of $10.2 million or 3.6 percent compared to the 2018 Budget Act, and $309.6 million ($3.7 million General Fund, $99.3 million federal funds, and $206.5 million special funds and reimbursements) in 2019-20, an increase of $20.1 million or 6.9 percent compared to the revised 2018-19 budget. According to DPH, the increase in 2018-19 is attributable to adjustments for employee compensation, retirement, and federal approval of a Certified Nurse Assistant (CNA) Kickstarter program. For 2019-20, the increase in expenditures is attributed to increased costs for the department's contract with Los Angeles County, implementation of a centralized program flexibility unit, and legislatively mandated hospital licensing timelines and implementation of online and distance learning opportunities for CNA training.

CHCQ Funding Summary, November 2018 Estimate		
Fund Source	**2018-19**	**2019-20**
0001 – General Fund	$3,700,000	$3,700,000
0890 – Federal Trust Fund	$104,534,000	$99,349,000
0942 – Special Deposit Fund		
Internal Departmental Quality Improvement Account	$2,600,000	$2,600,000
State Health Facilities Citation Penalty Account	$2,144,000	$2,144,000

Federal Health Facilities Citation Penalty Account	$2,166,000	$2,201,000
0995 – Reimbursements	$12,265,000	$12,187,000
3098 – Licensing and Certification Program Fund	$163,942,000	$189,248,000
Total CHCQ Funding	**$291,351,000**	**$311,429,000**
Total CHCQ Positions	**1304.3**	**1346.3**

This issue was heard during the subcommittee's February 28th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 11: L&C – Los Angeles County Contract

Budget Issue. DPH requests expenditure authority from the Licensing and Certification Program Fund of $17.2 million in 2019-20, $38.2 million in 2020-21, and $57.3 million annually thereafter. If approved, these resources would allow DPH to implement a new three-year contract with the Los Angeles County Department of Public Health to transition workload related to federal certification, state licensing, and investigation of complaints and reported incidents in facilities located in Los Angeles County effective July 1, 2019.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
3098 – Licensing and Certification Program Fund	$17,158,000	$38,219,000
Total Funding Request:	**$17,158,000**	**$38,219,000**

* Additional fiscal year resources requested: 2021-22 and ongoing: $57,326,000

This issue was heard during the subcommittee's February 28th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 12: Sexually Transmitted Disease Prevention

Budget Issue. DPH requests General Fund expenditure authority of $2 million annually. If approved, these resources would allow DPH to provide additional funding to local health jurisdictions for the prevention of sexually transmitted diseases.

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

* Resources ongoing after 2020-21.

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation – Modify. It is recommended the subcommittee take the following actions:

1. **Approve** General Fund expenditure authority of $20 million annually to provide funding to local health jurisdictions for the prevention of sexually transmitted diseases.
2. **Adopt placeholder trailer bill language** to strengthen statutory guidance to DPH on the effective dispersal of local assistance funds.

Issue 13: Richmond Lab: Viral Rickettsial Disease Lab Enhanced Upgrade

Capital Outlay Spring Finance Letter. DPH requests additional General Fund expenditure authority of $1.1 million for its project 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	**2019-20**	**2020-21**
0001 – General Fund	$1,080,000	$-
Total Funding Request:	**$1,080,000**	**$-**

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 14: Comprehensive HIV Prevention Resources

DOF Issue#: None – Legislative Proposal

Legislative Proposal. The HIV Alliance requests General Fund expenditure authority of $20 million annually to provide grants to local health jurisdictions and community-based organizations for outreach and education, HIV testing, linkage to care, increased access to pre-exposure prophylaxis, and services for people who use drugs.

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation – Approve General Fund expenditure authority of $20 million annually for grants to local health jurisdictions and community-based organizations for comprehensive HIV prevention resources, consistent with the proposal.

Issue 15: Alzheimer's Infrastructure

DOF Issue#: None – Legislative Proposal

Legislative Proposal. The Alzheimer's Association requests one-time General Fund expenditure authority of $10 million to 1) build statewide public health infrastructure to support early detection and timely diagnosis ($3.7 million), and 2) initiate local public health efforts through community grants to eight pilot counties ($6 million – eight grants of $750,000 each). According to the Alzheimer's

Association, more individuals with Alzheimer's live in California than in any other state, and California is home to the largest number of family caregivers in the nation. California is also on track to spend over $5 billion annually on Medi-Cal expenditures for this population, an increase of 36 percent between 2018 and 2025. California has a unique opportunity to be the first in the nation to adopt the Center for Disease Control's Healthy Brain Initiative.

This issue was heard during the subcommittee's February 28th hearing.

Subcommittee Staff Comment and Recommendation – Approve General Fund expenditure authority of $10 million in 2019-20 for grants to build statewide public health infrastructure to support early detection and timely diagnosis and initiate local public health efforts through community grants to eight pilot counties, consistent with the proposal.

Issue 16: Safe Cosmetics Program Funding

DOF Issue#: None – Legislative Proposal

Legislative Proposal. 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. 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 February 28th hearing.

Subcommittee Staff Comment and Recommendation – Approve General Fund expenditure authority of $1.5 million in 2019-20 and $500,000 annually thereafter to increase staffing for enforcement and program improvement activities in the Safe Cosmetics Program, consistent with the proposal.

Issue 17: Lesbian, Bisexual, and Queer (LBQ) Women's Health

DOF Issue#: None – Legislative Proposal

Legislative Proposal. A broad coalition of LGBT organizations, health providers, governmental agencies, coalitions and advocates request General Fund expenditure authority of $17.5 million to 1)

create an LBQ Women's Health Equity Fund at DPH to support a local comprehensive grant program to address LBQ women's health disparities ($15.5 million), and 2) fund research targeting LBQ women's health needs and inventory of existing programs ($2 million).

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation – Approve General Fund expenditure authority of $17.5 million in 2019-20 to support a local comprehensive grant program to address LBQ women's health disparities and fund research targeting LBQ women's health needs and inventory of existing programs, consistent with the proposal.

Issue 18: California Immunization Registry

DOF Issue#: None – Legislative Proposal

Legislative Proposal. The California Immunization Coalition requests expenditure authority of $2.4 million annually to provide full funding for the California Immunization Registry (CAIR). According to the Coalition, state funding for CAIR was eliminated during budget reductions in 2010. Since then, the program has been primarily federally funded and subject to the uncertain availability of those funds. Full funding of the program would require approximately $7.4 million per year, $1.1 million more than its current funding level of $6 million. In addition, the program would need $1.3 million annually for system enhancements and software upgrades to modernize and integrate the registry.

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation – Approve General Fund expenditure authority of $2.4 million annually to provide full funding for the California Immunization Registry, consistent with the proposal.

Issue 19: Integrity of Facility Inspections

DOF Issue#: None – Legislative Proposal

Legislative Proposal. 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 25th hearing.

Subcommittee Staff Comment and Recommendation – Adopt placeholder 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, consistent with the proposal.

Issue 20: Syringe Access Program Amendments

DOF Issue#: None – Legislative Proposal

Legislative Proposal. The Drug Policy Alliance requests trailer bill language updating and clarifying requirements for the syringe access program.

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation – Adopt placeholder trailer bill language to update and clarify requirements for the syringe access program.

Issue 21: Behavioral Risk Factor Surveillance System

DOF Issue#: None – Legislative Proposal

Legislative Proposal. The Alzheimer's Association requests transfer of expenditure authority from the Alzheimer's Disease and Related Disorders Research Fund of $45,000 from local assistance to state operations to allow DPH to participate in the 2020 Behavioral Risk Factor Surveillance System (BRFSS) survey on subjective cognitive decline. According to the Alzheimer's Association, BRFSS is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. Established in 1984 with 15 states, BRFSS now collects data in all 50 states as well as the District of Columbia and three U.S. territories. BRFSS completes more than 400,000 adult interviews each year, making it the largest continuously conducted health survey system in the world.

This issue was heard during the subcommittee's May 9th hearing.

Subcommittee Staff Comment and Recommendation – Approve transfer of $45,000 of expenditure authority from the Alzheimer's Disease and Related Disorders Research Fund from local assistance to state operations to allow DPH to participate in the 2020 BRFSS survey on subjective cognitive decline.

4440 DEPARTMENT OF STATE HOSPITALS

Issue 1: 2019-20 Program Updates – May Revision Adjustments

DOF Issue#: 4440-043-ECP-2019-GB
4440-044-ECP-2019-GB
4440-045-ECP-2019-GB
4440-047-ECP-2019-GB
4440-049-ECP-2019-GB
4440-050-ECP-2019-GB
4440-051-ECP-2019-GB
4440-053-ECP-2019-GB
4440-058-ECP-2019-GB
4440-089-ECP-2019-MR
4440-090-ECP-2019-MR
4440-091-ECP-2019-MR
4440-092-ECP-2019-MR
4440-093-ECP-2019-MR
4440-094-ECP-2019-MR
4440-095-ECP-2019-MR
4440-096-ECP-2019-MR
4440-097-ECP-2019-MR
4440-100-ECP-2019-MR

Program Update: Patient Driven Operating Expenses and Equipment. In a 2015 report, the Legislative Analyst's Office made recommendations for improvement in the DSH budgeting methodology, including the establishment of a standardized per patient operating expenses and equipment cost estimate and an annual budget adjustment based on patient census. According to DSH, the average operating cost per patient is $19,534 across all five state hospitals, which represents an increase of 18 percent over the last six years. This increase is primarily driven by the costs of pharmaceuticals and outside hospitalization.

Over the past five years, DSH reports its patient population has increased by 547 beds, including expansions of 236 secured beds at Metropolitan State Hospital. However, DSH did not budget for operating expenses and equipment for much of these new beds. The 2018 Budget Act included $3.7 million for the operating expenses and equipment for the 236 secured beds at Metropolitan. Due to delays in unit activations, DSH reports 140 of those beds will not be activated as expected, resulting in $2.2 million General Fund savings in 2018-19.

In the January budget, DSH requested General Fund expenditure authority of $10.5 million annually to support the full cost of operating expenses and equipment for the 547 beds activated since 2012-13 in the five state hospitals.

In the May Revision, DSH requests additional General Fund expenditure authority of $547,000, for a total of $11 million annually, based on updated projected census figures.

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. In 2017-18, DSH had a budgeted LPS capacity of 628. As of July 2018, DSH reported a total LPS census of 690. The 2018 Budget Act included a $20.1 million adjustment in reimbursement authority to account for actual expenditures for LPS patients.

In the January budget, DSH requested additional reimbursement expenditure authority of $606,000 in 2019-20 and annually thereafter. This additional authority would allow DSH to have sufficient authority to accept the expected LPS caseload from county commitments. The amount of this additional authority was calculated based on 2018-19 projected expenditures of $157.4 million, which is $606,000 less than its 2018-19 authority of $156.7 million.

In the May Revision, DSH requests additional reimbursement expenditure authority of $2.7 million in 2019-20 and annually thereafter, for a total increase in reimbursement expenditure authority of $3.3 million. According to DSH, these adjustments are due to updated collection figures.

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. DSH received expenditure authority in previous budgets to make repairs associated with the South Napa Earthquake. As of the 2018 Budget Act, 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	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**

In the May Revision, DSH requests reduction of General Fund expenditure authority of $1.1 million in 2018-19 and $608,479 in 2019-20 as the department will not be proceeding with the completion of the remaining Project 3 repairs, which are comprised of minor cosmetic repairs. DSH reports ongoing challenges and delays in the availability and hiring of labor for this project, leading to no significant efforts towards completing the repairs. In addition, DSH reports these repairs are within patient-occupied areas and would require swing space to complete the project that is currently unavailable.

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 an independent patients' 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 began in September 2018 and was completed February 2019, while construction for the second unit was expected to begin February 2019 and be completed June 2019.

The 2018 Budget Act included reversion of General Fund savings of $4.9 million General Fund in 2017-18 and $4.6 million in 2018-19 related to construction delays of the ETP units. For 2019-20, the 2018 Budget Act included 60.3 positions and General Fund expenditure authority of $8.3 million annually thereafter to fund an additional ETP unit at Atascadero, as well as one unit at Patton. According to DSH, construction for the third unit at Atascadero is expected to begin June 2019 and be completed in September 2019, while construction for the unit at Patton is expected to begin September 2019 and be completed in January 2020.

In the January budget, DSH estimated General Fund savings in 2019-20 of $1.8 million due to a five month delay for the ETP unit at Patton.

In the May Revision, DSH estimates additional General Fund savings of $2.6 million and a reduction of 7.1 positions in 2018-19 and $716,000 and 2.3 positions in 2019-20, for a total reduction in 2019-20 of $2.5 million. These savings are the result of implementation delays due to unforeseen electrical and ducting work. DSH also proposes to redirect $139,000 of savings in 2019-20 to critical needs identified by the Patton ETP unit.

Program Update: Metropolitan State Hospital Bed Expansion. The 2016 Budget Act included capital outlay construction funding to securely enclose existing patient buildings at Metropolitan State Hospital that housed civilly committed patients under the Lanterman-Petris-Short (LPS) Act. Once secured, the LPS patients 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. The 2017 Budget Act included 22.2 positions in 2017-18, and 38.5 positions and $12.4 million in 2018-19 to prepare for the expansion by relocating LPS patients and hiring hospital police officers. The 2018 Budget Act included a reduction of 10.1 positions and savings of $1.1 million in 2017-18 due to delays in activations. The 2018 Budget Act also included 162.8 positions and $24.8 million in 2018-19 and 342.2 positions and $50.6 million in 2019-20 for patient movement and activation of four new forensic units. The current budget request activates and provides staff for approximately 236 forensic beds between March and November 2019 to treat IST patients.

In the January budget, DSH requested 119.3 positions and General Fund expenditure authority of $18.6 million in 2019-20 and 130 positions and General Fund expenditure authority of $20.1 million in 2020-21 and annually thereafter to activate the newly secured units at Metropolitan to provide increased capacity for the treatment of IST patients.

In the May Revision, DSH requests reduction of 22.5 positions and General Fund expenditure authority of $3.4 million in 2018-19 and reduction of 20.1 positions and General Fund expenditure authority of $3.1 million in 2019-20. These reductions result in a net request of 96.8 positions and General Fund expenditure authority of $15.2 million in 2018-19 and 109.9 positions and General Fund expenditure authority of $17 million in 2019-20. According to DSH, the reduction in requested expenditure authority is due to minor delays in the award of the contract, and a new State Fire Marshall requirement for fire sprinkler pipe fitter companies to have certified workers.

Program Update: Telepsychiatry Resources. In the May Revision, DSH requests 11 positions and General Fund expenditure authority of $2.2 million in 2019-20 and 21 positions and General Fund expenditure authority of $3.7 million annually thereafter. If approved, these resources would allow DSH to expand its use of telepsychiatry as an alternative to providing in-person psychiatric treatment to patients and ensure appropriate delivery of care. Specifically, these resources would add clinical oversight and supervision, telepsychiatry coordinators, as well as information technology equipment and resources.

Program Update: Forensic Conditional Release Program (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 there are currently 14 patients residing in a house and two in a motel throughout California within the county of commitment. DSH has established two rate structures for CONREP-SVPs: 1) $310,000 per SVP where a permanent residence has been established, and 2) $653,000 per CONREP-SVP when ordered as a transient release.

In the January budget, DSH requested General Fund expenditure authority of $768,000 in 2018-19 and $2.1 million annually thereafter. If approved, these resources would support an expected caseload increase of four SVPs in 2018-19, including two transient releases, for a total of 21 SVPs conditionally released to the community by June 2019, and an additional two SVPs released by June 2020 for a total caseload of 23.

In the May Revision, DSH requests a decrease in General Fund expenditure authority of $1 million in 2018-19 and $994,000 in 2019-20, for a net decrease in expenditure authority of $245,000 in 2018-19 and a net increase in expenditure authority of $1.1 million. DSH indicates these downward adjustments are based on a net decrease of two SVP commitments compared to the January budget.

Program Update: Forensic Conditional Release Program (CONREP) – Step-Down Transition Program. In the May Revision, DSH requests General Fund expenditure authority of $5.7 million in 2019-20 and $11.6 million annually thereafter. If approved, these resources would allow DSH to expand its continuum of care for CONREP patients by establishing a step-down program. DSH would contract for a 78-bed vendor operated community step-down program for MDO and NGI patients preparing for conditional release from state hospitals within 18 and 24 months. The requested resources would also allow DSH to expand its existing contract with Sylmar Health and Rehabilitation Center by four beds for a total of 24 beds.

Program Update: Jail-Based Competency Treatment Program Expansions. In the January budget, DSH reported net General Fund savings of $253,000 in 2018-19 composed of one-time cost savings of $1.9 million at San Bernardino and San Joaquin JBCT programs, offset by $1.6 million in increased costs at Sacramento, Sonoma, Mariposa, Solano, Mendocino, and Butte JBCT programs. In the January budget, DSH also requested General Fund expenditure authority of $1.1 million in 2019-20, and $1.7 million in 2020-21 and annually thereafter to activate jail-based competency treatment 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. DSH expects these programs to increase bed capacity by 254 in 2018-19 and 274 in 2019-20.

In the May Revision, DSH requests a reduction in General Fund expenditure authority of $725,000 in 2018-19 and $5.9 million annually thereafter for existing JBCT programs due to activation delays and changes to program capacity.

In the January budget, DSH requested General Fund expenditure authority of $191,000 in 2018-19, $11 million in 2019-20, and $11.4 million in 2020-21 and annually thereafter for the proposed activation of new JBCT programs. DSH proposed: 1) an April 2019 activation of a five-bed JBCT program in a

Southern California county; 2) a July 2019 activation of a five-bed JBCT program in a Central California county, a six-bed JBCT program in a Northern California county, and a 48-bed JBCT program in a Northern California county; and 3) an October 2019 activation of a 10-bed JBCT program in a Southern California County. According to DSH, the cost estimate is based on an expected per diem rate of $420 per patient.

In the May Revision, DSH requests additional General Fund expenditure authority of $2,000 in 2018-19, $5.7 million in 2019-20, and $9,000 annually thereafter. According to DSH, the increase in requested resources are due to updated assumptions regarding the timing of contract execution and program activation for new programs identified in the January budget.

Program Update: Hospital Police Officer Academy. The DSH Office of Protective Services (OPS) provides safety and security to patients, staff, and the community through competent, professional law enforcement services, while facilitating compassionate treatment of patients. OPS is supported by approximately 657 Hospital Police Officers (HPOs) across all five state hospitals. New HPO cadets are required to attend the DSH Police Academy, a 14 week program to ensure proper training on requirements and standards of the HPO classification.

According to DSH, the Hospital Police Academy historically ran two sessions annually of 32 cadets each. The 2017 Budget Act included $7.8 million in 2017-18 and $12.4 million and three limited-term positions in 2018-19 to expand to three academies of 50 cadets each. The academy expansion was necessary to accommodate the need for additional HPOs for the new secured bed space at Metropolitan State Hospital.

DSH requests conversion of three limited-term positions to permanent and General Fund expenditure authority of $5.8 million annually to continue the specialized expanded academy. DSH reports it has 98.7 HPO vacancies as of September 2018, primarily due to an academy failure rate of 8.2 percent, attrition, and a high proportion of law enforcement staff eligible for retirement.

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.

DSH requests General Fund expenditure authority of $1 million in 2019-20 and annually thereafter to fund its contracted CONREP caseload of 666 clients. Due to rising housing costs, DSH was required to reduce its CONREP caseload to 621 clients to remain within its budgeted authority. If approved, these additional resources will allow DSH to cover the cost increases for each of the housing types in the program.

These issues were heard during the subcommittee's April 4th and May 14th hearings.

Subcommittee Staff Comment and Recommendation—Approve the balance of the technical adjustments to the DSH 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: Technical Adjustment – Interagency Agreement with Health and Human Services Agency

DOF Issue#: 4440-103-BCP-2019-MR

May Revision Issue. DSH requests reduction of General Fund expenditure authority of $222,000 annually to reflect an adjustment to the interagency agreement between DSH and the California Health and Human Services Agency. This adjustment is related to a commensurate increase in positions and General Fund expenditure authority requested by CHHSA to replace the historical funding for one position provided by DSH.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	($220,000)	($220,000)
Total Funding Request:	**($220,000)**	**($220,000)**

* Resource reduction ongoing after 2020-21.

This issue was heard during the subcommittee's May 14th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 3: Technical Adjustment – California State Lottery Fund

DOF Issue#: 4440-098-BBA-2019-MR

May Revision Issue. DSH requests expenditure authority from the California State Lottery Education Fund of $6,000 annually. These resources reflect updated funding derived from the sale of lottery tickets to fund DSH programs.

This issue was heard during the subcommittee's May 14th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 4: Enhanced Treatment Units - Statewide

DOF Issue#: 4440-304-COBCP-2019-MR

May Revision Capital Outlay Issue. DSH requests General Fund expenditure authority of $2.4 million in 2019-20. If approved, these resources would allow DSH to complete construction of Enhanced Treatment Units at Atascadero and Patton State Hospitals.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$2,387,000	$-
Total Funding Request:	**$2,387,000**	**$-**

This issue was heard during the subcommittee's May 14th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 5: Atascadero – Potable Water Booster Pump System

DOF Issue#: 4440-001-COBCP-2019-GB

Capital Outlay Budget Issue. DSH requests General Fund expenditure authority of $113,000 in 2019-20. If approved, these resources would allow DSH to support preliminary plans for a project to install a potable water booster pump system to serve Atascadero State Hospital's main water system.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$113,000	$-
Total Funding Request:	**$113,000**	**$-**

This issue was heard during the subcommittee's April 4th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 6: Metropolitan: Consolidation of Police Operations – Reappropriation

DOF Issue#: 4440-300-COBCP-2019-A1

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

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

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

This issue was heard during the subcommittee's May 2nd hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 7: Patton: Fire Alarm System Upgrade – Reappropriation

DOF Issue#: 4440-301-COBCP-2019-A1

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

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

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

This issue was heard during the subcommittee's May 2nd hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 8: Extension of Liquidation Period – Metropolitan and Napa Kitchen Projects

DOF Issue#: 4440-302-COBCP-2019-A1
4440-303-COBCP-2019-A1

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

This issue was heard during the subcommittee's May 2nd hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 9: Relocation to the Clifford L. Allenby Building

DOF Issue#: 4300-410-BCP-2019-MR
4440-077-BCP-2019-MR

May Revision Finance Letter. The California Health and Human Services Agency (CHHSA), in collaboration with the Department of Developmental Services (DDS) and DSH request positions and resources to support the services and equipment necessary to relocate these entities to the new Clifford L. Allenby Building in January 2021. The components of this request are as follows:

DSH requests two limited-term positions and General Fund expenditure authority of $4.9 million in 2019-20, $1.8 million in 2020-21, and $2.8 million annually thereafter.

DDS requests one position and General Fund expenditure authority of $3.4 million in 2019-20, $1.8 million in 2020-21, $1.2 million in 2021-22 and 2022-23, and $1.4 million annually thereafter. The subcommittee will hear the DDS portion of this request during consideration of the DDS May Revision adjustments.

Program Funding Request Summary - DDS		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$3,401,000	$1,814,000
Total Funding Request:	**$3,401,000**	**$1,814,000**
Total Positions Requested:**	**1.0**	

* Additional fiscal year resources requested: 2021-22 to 2022-23: $1,185,000; 2023-24 and ongoing: $1,429,000
** Positions are ongoing.

Program Funding Request Summary - DSH		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$4,891,000	$1,760,000
Total Funding Request:	**$4,891,000**	**$1,760,000**
Total Positions Requested:**	**2.0**	

* Additional fiscal year resources requested: 2021-22 and ongoing: $2,760,000;
** Positions are limited-term and expire at the end of 2020-21.

This issue was heard during the subcommittee's May 14th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 10: Vocational Services and Patient Minimum Wage

DOF Issue#: 4440-040-BCP-2019-GB
4440-080-BCP-2019-GB
Trailer Bill Language

Budget Issue, Spring Finance Letter, and Trailer Bill Language Proposal. DSH requests one position and General Fund expenditure authority of $3.2 million annually. If approved, these positions

and resources would allow DSH to standardize the patient wage structure across patient-worker commitment types and across residency hospitals and continue patient vocational treatment programs. This request reflects net funding of the original January budget request and a spring finance letter request for a $151,000 reduction in General Fund expenditure authority due to a calculation error. DSH also requests trailer bill language to exempt DSH patient workers from state minimum wage requirements.

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

* Position and resources ongoing after 2020-21.

This issue was heard during the subcommittee's May 2nd hearing.

Subcommittee Staff Comment and Recommendation – Modify. It is recommended the subcommittee take the following actions:

1. **Approve** the requested positions and resources, including May Revision adjustments
2. **Adopt placeholder trailer bill language** consistent with the Administration's proposal and including additional language to prohibit DSH from sweeping patient funds to support housing and treatment costs.

Issue 11: Workforce Development

DOF Issue#: 4440-063-BCP-2019-GB
4440-081-BCP-2019-A1

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

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

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

This issue was heard during the subcommittee's May 2nd hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 12: Court Evaluations and Reports

DOF Issue#: 4440-067-BCP-2019-GB

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

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

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

This issue was heard during the subcommittee's May 2nd hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 13: Direct Care Nursing

DOF Issue#: 4440-068-BCP-2019-GB

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

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

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

This issue was heard during the subcommittee's May 2nd hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 14: Pharmacy Modernization

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

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

This issue was heard during the subcommittee's May 2nd hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 15: Technical Adjustments - Various

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

This issue was heard during the subcommittee's May 2nd hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 16: Increased Court Appearances and Public Records Act Requests

DOF Issue#: 4440-025-BCP-2019-GB

Budget Issue. DSH requests 5.5 two-year limited-term positions and General Fund expenditure authority of $767,000 in 2019-20 and 2020-21. If approved, these positions and resources would allow DSH to address increases in court hearings at which DSH attorneys are required to appear, as well as increases in requests pursuant to the Public Records Act.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21**
0001 – General Fund	$767,000	$767,000
Total Funding Request:	**$767,000**	**$767,000**
Total Requested Positions:	**5.5**	**5.5**

This issue was heard during the subcommittee's April 4th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 17: Privacy Protection Program

DOF Issue#: 4440-026-BCP-2019-GB

Budget Issue. DSH requests nine positions and General Fund expenditure authority of $1.3 million annually. If approved, these resources would allow DSH to establish a system-wide Privacy Protection Program in accordance with a recent audit by the California Office of Health Information Integrity.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$1,263,000	$1,254,000
Total Funding Request:	**$1,263,000**	**$1,254,000**
Total Requested Positions:	**9.0**	**9.0**

* Positions and resources ongoing after 2020-21.

This issue was heard during the subcommittee's April 4th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 18: Contracted Services and Patient Management Support

DOF Issue#: 4440-058-BCP-2019-GB

Budget Issue. DSH requests eight positions and General Fund expenditure authority of $1.1 million annually to manage the development and ongoing support of the expansion of competency restoration programs, an increasing caseload of patients determined incompetent to stand trial (IST), and to provide essential data and analysis for effective and efficient management of DSH patient management programs.

Program Funding Request Summary		
Fund Source	**2019-20**	**2020-21***
0001 – General Fund	$1,085,000	$1,077,000
Total Funding Request:	**$1,085,000**	**$1,077,000**
Total Requested Positions:	**8.0**	**8.0**

* Positions and resources ongoing after 2020-21.

This issue was heard during the subcommittee's April 4th hearing.

Subcommittee Staff Comment and Recommendation – Approve as budgeted.

Issue 19: Incompetent to Stand Trial – Diversion and Community-Based Treatment

DOF Issue#: None

Incompetent to Stand Trial Diversion Program. In the 2018 Budget Act, the Legislature approved trailer bill language and General Fund expenditure authority of $100 million over three years to promote community mental health treatment and diversion for individuals determined to be, or at risk of being determined to be, incompetent to stand trial. Specifically, the program included the following components:

- Diversion of Individuals with Mental Disorders – Grants pre-trial diversion to defendants, including postponement of prosecution and referral to mental health treatment, under the following conditions:

    1. The court is satisfied the defendant suffers from a qualifying mental disorder including, but not limited to, schizophrenia, schizoaffective disorder, or posttraumatic stress disorder, but excluding antisocial personality disorder, borderline personality disorder, and pedophilia.
    2. The court is satisfied the defendant's mental disorder played a significant role in the commission of the charged offense.
    3. A qualified mental health expert determines the defendant would respond to mental health treatment.
    4. The defendant consents to diversion, waives his or her right to a speedy trial, and agrees to comply with treatment as a condition of diversion.
    5. The court is satisfied the defendant will not pose an unreasonable risk of danger to public safety.
    6. The court is satisfied the recommended treatment program will meet the specialized mental health needs of the defendant.
    7. The period of diversion shall be no longer than two years.

If the court concludes a defendant has substantially complied with the requirements of diversion, has avoided significant new violations of law, and has a plan in place for long-term mental health care, the court shall dismiss the charges that prompted the initial diversion.

- Community-Based Treatment – Provides $100 million over three years to assist counties in providing diversion for individuals with serious mental illnesses who may otherwise be found incompetent to stand trial. These county programs will provide clinically appropriate or evidence-based mental health treatment and wraparound services across a continuum of care to:

    - Individuals diagnosed with schizophrenia, shizoaffective disorder, or bipolar disorder who could potentially be found incompetent to stand trial.
    - Individuals for which there is a significant relationship between the individual's mental disorder and the charged offense or between the individual's conditions of homelessness and the charged offense.
    - Individuals that do not pose an unreasonable risk of danger to public safety if treated in the community.

This issue was heard during the subcommittee's April 4th hearing.

Subcommittee Staff Comment and Recommendation – Adopt placeholder supplemental reporting language, requesting from DSH, in consultation with the Judicial Council, statistics by county on the utilization of the new pre-trial diversion authority granted to courts in the 2018 Budget Act including the number of individuals requesting pre-trial diversion, the number of requests approved, the number of

requests denied and the reasons for denial, the number of individuals successfully completing diversion, and the number of individuals not complying with the conditions of diversion.

4560 MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION

Issue 1: Triage Grant Funding

DOF Issue#: None – Legislative Proposal

Legislative Proposal. The Investment in Mental Health Wellness Act of 2013 authorized Mental Health Service Fund expenditure authority of $32 million annually to add 600 triage personnel in select rural, urban, and suburban regions. The 2016 Budget Act included an additional $3 million to provide a complete continuum of crisis intervention services and supports for children age 21 and under and their families and caregivers. Triage personnel provide intensive case management and linkage to services for individuals with mental health disorders at various points of access. Targeted case management services may be provided face to face, by telephone, or by telehealth with the individual in need of assistance or his or her significant support person, and may be provided anywhere in the community. These service activities may include, but are not limited to: 1) communication, coordination, and referral; 2) monitoring service delivery to ensure the individual accesses and receives services; 3) monitoring the individual's progress; 4) providing placement service assistance and service plan development.

Between 2013-14 and 2017-18, counties received the following grant funding for triage personnel:

County	Funding	County	Funding
Alameda	$2,666,797	Orange	$10,250,000
Butte	$1,075,070	Placer	$2,509,346
Calaveras	$262,686	Riverside	$7,441,142
Fresno	$3,073,100	Sacramento	$4,474,908
Lake	$184,794	San Bernardino	$8,113,498
Los Angeles	$31,177,000	San Francisco	$14,365,009
Madera	$1,360,596	Santa Barbara	$8,348,529
Marin	$1,099,922	Sonoma	$3,044,363
Mariposa	$699,428	Trinity	$497,713
Merced	$3,003,070	Tuolumne	$478,503
Napa	$1,323,635	Ventura	$7,573,671
Nevada	$2,477,628	Yolo	$1,728,234

The first round of grants, funded in 2014, resulted in more than 70,000 instances of individuals utilizing services provided through the grants. The program resulted in an increase in access and linkage to services and resources, utilization of peers in crisis intervention, a reduction in psychiatric hospitalizations and in stigma associated with mental illness, and improved consumer well-being and coordination of services.

The 2018 Budget Act reduced the Mental Health Service Fund expenditure authority by $12 million for an annual allocation of $20 million. In 2018, MHSOAC also requested to reappropriate unspent funding from the first round of triage grants, but the request was not included in the 2018 Budget Act.

According to MHSOAC, the combined reduction in ongoing funding has resulted in a 29 percent reduction in available funding for triage grants to counties. MHSOAC reports the reduction led counties to scale back programs that were granted under a second round of funding prior to the reduction. MHSOAC worked with grantees to ensure the programs were in alignment with the requirements of the triage program. However, the reduction in program funding ultimately led to reductions in schools served by triage personnel, reductions in personnel hours for crisis intervention and case management, and reductions in mobile treatment personnel.

This issue was heard during the subcommittee's April 4th hearing.

Subcommittee Staff Comment and Recommendation – Approve expenditure authority from the Mental Health Services Fund of $12 million annually to restore triage grant funding that was reduced in the 2018 Budget Act.

Issue 2: Commission Transparency, Technical Assistance, Staffing, and Stakeholder Proposals

DOF Issue#: None – Legislative Proposal

Legislative Proposal. MHSOAC requests the following augmentations and changes to its budget:

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

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

The third component of our transparency work is to report on outcomes. MHSA identifies a range of outcomes, including: improving educational outcomes, reducing criminal justice involvement, supporting employment, preventing child welfare involvement and homelessness, among others. We have done preliminary work to link mental health data and criminal justice data to better understand criminal justice involvement rates and to identify strategies to improve those outcomes. We also have

analyzed data on people served by Full Service Partnerships, which are typically the most expensive and highest level of care for people outside of a locked program.

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

Technical Assistance Strategy – MHSOAC requests expenditure authority from the Mental Health Services Fund of $5 million annually. If approved, these resources would fund technical assistance centers to provide support to counties in response to high-priority needs identified by the state and the counties. According to MHSOAC, as part of its discussions with county behavioral health directors over how best to support their innovation work, county leaders indicated that the most significant need they face is technical assistance. Whether focused on how to maximize draw down of federal Medi-Cal funding, or best practices in meeting the needs of young children, the counties indicate they struggle to find reliable guidance on how best to design and deliver mental health care. While many counties have developed successful strategies in response to a range of mental health needs, individual counties may not be aware of what others are doing, what approaches are in place in other states or countries, or how they might improve their local programs. California has subject matter experts working for counties, in our universities, among research partners and private providers. MHSOAC is seeking support to establish these technical assistance centers that can respond to county needs.

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

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

implementation of the objectives, metrics, data collection, and reporting strategy. To meet these requirements, the requested resources would fund the following positions:

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

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

Subcommittee Staff Comment and Recommendation – Approve four positions and expenditure authority from the Mental Health Services Fund of $8.3 million in 2019-20 and $10.8 million annually thereafter to support the MHSOAC proposals for data and outcome reporting, ongoing innovation incubator funding, technical assistance, stakeholder contracts for immigrant and refugee mental health, and SB 1004 oversight and monitoring activities.

Issue 3: Mental Health School Services Act Funding

DOF Issue#: None – Legislative Proposal

Legislative Proposal. Provide $550 million in one-time funding ($510 General Fund and $40 million Special Fund) to the Mental Health Services Oversight and Accountability Commission to create the Mental Health Student Services Act for the purpose of establishing mental health partnerships between County Mental Health or Behavioral Health Departments and K-12 school districts, charter schools, county offices of education, California Community Colleges, California State Universities, and Universities of California within a county region. The Commission shall determine funding awards based on the level of need and number of students in participating educational entities when determining one-time grant amounts. Funding shall be available to support services that at a minimum include: services provided on K-12 and (if applicable) higher education campuses, suicide prevention services, drop-out prevention services, outreach to high-risk youth, and other strategies that respond to the mental health needs of children and youth, as determined by the commission. Grants shall not supplant current services or funds provided. Adopt placeholder trailer bill language.

This issue was heard in Budget Subcommittee #1 on May 15th and approved.

Subcommittee Staff Comment and Recommendation—Approve conforming action to establish two new items, 4560–XXX-0001, 4560–XXX-3085, for the purpose of funding the Mental Health Student Services Act proposal adopted in Budget Subcommittee #1.

4800 CALIFORNIA HEALTH BENEFIT EXCHANGE – COVERED CALIFORNIA

Issue 1: Health Insurance Premium Affordability

DOF Issue#: 4800-401-BCP-2019-MR

May Revision Issue. The Administration requests General Fund expenditure authority of $295.3 million in 2019-20, $330.4 million in 2020-21, and $379.9 million in 2021-22. If approved, these resources would allow Covered California to provide premium subsidies to individuals between 200 and 600 percent of the federal poverty level (FPL) purchasing coverage in the state's health benefit exchange. This request is an adjustment to the Administration's January budget proposal. The Administration also proposes adjustments to the trailer bill language included in the January budget to implement the premium subsidy program and impose a state-based individual mandate penalty. According to the Administration, revenue from the mandate penalty would offset the requested General Fund expenditures by $317.2 million in 2020-21, $335.9 million in 2021-22, and $352.8 million in 2022-23.

This issue was heard during the subcommittee's March 21st and May 15th hearings.

Subcommittee Comment and Recommendation –Modify. It is recommended the subcommittee take the following actions:

1. **Approve** the Administration's proposed General Fund expenditure authority of $295.3 million in 2019-20, $330.4 million in 2020-21, and $379.9 million in 2021-22 to provide premium subsidies to individuals between 200 and 600 percent of the FPL purchasing coverage in the state's health benefit exchange.
2. **Augment** the General Fund expenditure authority by an additional $300 million in each year, for a total level of premium subsidy of $595.3 million in 2019-20, $630.4 million in 2020-21, and $679.9 million in 2021-22.

Issue 2: High Deductible Health Plan Trailer Bill Proposal

DOF Issue#: None – Legislative Proposal

Legislative Proposal. Health Access California requests trailer bill language to allow Covered California to offer bronze level High Deductible Health Plans (HDHPs) at a higher actuarial value to comply with new regulations from the Internal Revenue Service. According to Health Access, there are over 235,000 Californians who have bronze HDHP products who are at risk of losing access to this type of coverage if California law is not updated. These are consumers both on and off Covered California and in both the individual and small group markets.

IRS rules for setting the maximum out-of-pocket costs for HDHPs are different than the rules for the maximum out of pocket for Covered California exchange plans. The result is that the maximum out-of-pocket costs for HDHPs are almost $1,000 lower than for other bronze products causing the actuarial

value to be richer. This actuarial value exceeds the threshold set in California law of plus or minus two percent. However, to meet the IRS rules, Covered California needs to be able to sell a product that is 62.2 percent actuarial value, which is higher than the 62 percent actuarial value maximum (60 percent plus or minus two percent). The proposed trailer bill language would allow the variation in the actuarial value for bronze HDHPs to range from plus four percent to minus two percent, creating an effective range for these plans' actuarial value of 58 percent to 64 percent.

This issue was heard during the subcommittee's May 9th hearing.

Subcommittee Staff Comment and Recommendation – Adopt placeholder trailer bill language to allow Covered California to offer bronze level plans at a higher actuarial value to comply with new federal regulations, consistent with the proposal.

Issue 3: Single Premium Invoice Trailer Bill Proposal

DOF Issue#: None – Legislative Proposal

Legislative Proposal. Health Access California requests trailer bill language to make statutory clarifications to allow health plans and insurers to comply with both the California Constitution and pending federal regulations. According to Health Access, the California Constitution requires coverage of the full range of medically necessary health care services. A pending federal rule would make it difficult for health plans and insurers to comply with the constitutional requirement and the federal rule. The proposed trailer bill language would require health plans and insurers to send a single invoice and collect one payment from subscribers, while segregating the portion of the payment collected for services for which federal funding is prohibited.

This issue was heard during the subcommittee's April 25th hearing.

Subcommittee Staff Comment and Recommendation – Adopt placeholder trailer bill language to make statutory clarifications to require health plans and insurers to send a single invoice and collect one payment from subscribers, consistent with the proposal.

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

SUBCOMMITTEE NO. 3 Agenda

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

Thursday, May 16, 2019
Upon adjournment of Appropriations Committee
State Capitol - Room 4203

Part B

Consultant: Renita Polk

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ISSUES FOR VOTE ONLY

0530 HEALTH AND HUMAN SERVICES AGENCY OFFICE OF SYSTEMS INTEGRATION
5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: Electronic Visit Verification (GB)

Governor's Proposal. The Governor's budget includes a one-time increase of $24.3 million ($2.7 million General Fund) for CDSS and a corresponding increase of $22.2 million for OSI to implement the federally mandated Electronic Visit Verification project. The requested resources would be for six permanent positions, two-year limited-term funding for 7.5 positions for CDSS.

This issue was heard at the subcommittee's March 28th hearing.

Staff Comment and Recommendation. Approve as budgeted.

4170 DEPARTMENT OF AGING

Issue 1: Long-Term Care Ombudsman Augmentation (MR)

May Revision. The Administration requests that Item 4170-102-0942 be increased by $1 million to provide additional one-time funding to local Long-Term Care Ombudsman programs.

This issue was heard at the subcommittee's May 14th hearing.

Staff Comment and Recommendation. Modify - Approve May Revision and additionally, approve an additional $4.2 million in 2019-20, and $5.2 million every year thereafter.

Issue 2: Dignity at Home Fall Prevention Program (Stakeholder Proposal)

Stakeholder Proposal. Multiple advocacy organizations, including the California Senior Legislature and the MS Society, request $5 million for the CDA to fund a program to help older adults and others at risk of falling make home modifications and take steps to reduce the risk of falls in the home.

This issue was heard at the subcommittee's May 9th hearing.

Staff Comment and Recommendation. Approve as proposed.

Issue 3: Increased Funding for Senior Nutrition Programs (Stakeholder Proposal)

Stakeholder Proposal. The California Association of Area Agencies on Aging and Meals on Wheels California request an ongoing $17.5 million to increase funding for senior nutrition programs.

This issue was heard at the subcommittee's March 14th hearing.

Staff Comment and Recommendation. Approve as proposed.

4300 DEPARTMENT OF DEVELOPMENTAL SERVICES (DDS)

Issue 1: Headquarters Restructure and Reorganization (GB)

Governor's Proposal. The Governor's budget includes $8.1 million ($6.5 million General Fund) for 54 permanent positions to restructure the organization and realign resources for safety net services, program modernization, risk management, federal and state compliance, and fiscal accountability. Of the requested amount, $400,000 is for 3-year limited-term funding for three positions for oversight of the HCBS provider assessment process.

This issue was heard at the subcommittee's May 2nd hearing.

Staff Comment and Recommendation. Approve as budgeted.

Issue 2: Federal Claims Reimbursement System Project (GB)

Governor's Proposal. The Governor's budget includes $3.2 million ($3 million General Fund) in 2019-20, and $12 million ($11.8 million General Fund) in both 2020-21 and 2021-22 for the planning and implementation of the Federal Reimbursement System Project. The request also includes three-year limited-term funding for five positions.

This issue was heard at the subcommittee's May 2nd hearing.

Staff Comment and Recommendation. Modify as follows: Approve funding for 2019-20 only and placeholder budget bill language on additional cost, schedule and scope information to be provided in stages three and four of the PAL process as part of the proposed 2020-21 budget.

Issue 3: Safety Net Facilities and Crisis Services (GB and Stakeholder Proposal)

Governor's Proposal. The Governor's budget includes a total of $11.7 million ($7.3 million General Fund) to enhance the system of crisis and safety net services.

Stakeholder Proposal. Disability Rights California proposed trailer bill language related to safety net facilities and acute crisis services.

This issue was heard at the subcommittee's May 2nd hearing.

Staff Comment and Recommendation. Approve as budgeted. In addition, approve placeholder trailer bill language to do the following:

- Require the department to update its Safety Net Plan, to be provided with the January release of the 2020-21 budget.

- Aligns IMD admission criteria, post-admission oversight, and process for judicial review with the laws governing placements in state-operated acute crisis settings.

- Notify the client rights advocate when an individual is placed in a restrictive setting.

Issue 4: HCBS Final Rule Site Assessments (GB)

Governor's Proposal. The Governor's budget includes a one-time augmentation of $3 million ($1.8 million General Fund) to contract for the coordination and completion of on-site visits and assessments of providers and programs as required by the HCBS final federal rules.

This issue was heard at the subcommittee's May 2nd hearing.

Staff Comment and Recommendation. Approve as budgeted. Additionally, approve placeholder trailer bill language to ensure that the California implements the new HCBS rules consistent with the federal requirements.

Issue 5: Foster Youth Trauma-Informed Systems of Care (Spring Finance Letter)

Governor's Proposal. The Governor's budget includes $158,000 ($134,000 million General Fund) in 2019-20 and annually thereafter; and $1.6 million ($1.1 million General Fund) in both 2019-20 and 2020-21 for statewide positions to implement AB 2083 (Cooley), Chapter 815, Statues of 2018.

This issue was heard at the subcommittee's May 2nd hearing.

Staff Comment and Recommendation. Approve as budgeted.

Issue 6: Crisis Homes for Children (GB TBL)

Governor's Proposal. The Governor's budget includes a one-time augmentation of $4.5 million General Fund for the development of three community crisis homes for children. Additionally, the department proposes trailer bill language (TBL) to amend statute to allow children in crisis to be placed into community crisis homes.

This issue was heard at the subcommittee's May 2nd hearing.

Staff Comment and Recommendation. Approve placeholder language per the Governor's proposal.

Issue 7: Specialized Caseload Ratios for Regional Centers (MR TBL)

Governor's Proposal. The Governor's budget includes $3.8 million ($2.6 million General Fund), and TBL to establish a 1:25 service coordinator-to-consumer caseload ratio for consumers with complex needs.

This issue was heard at the subcommittee's May 2nd hearing.

Staff Comment and Recommendation. Approve placeholder language per the Governor's proposal.

Issue 8: May Revision Adjustments (MR)

May Revision. The May Revision includes $8.2 billion total funds ($5.0 billion General Fund) for the department in 2019-20; a net increase of $736.5 million ($534.3 million General Fund) over the updated 2018-19 budget.

These issues were heard at the subcommittee's May 15th hearing.

Staff Comment and Recommendation. Approve actions detailed in the table below.

Issue	Topic	Staff Comment and Recommendation
405-MR	Population and Staffing Adjustment	Approve as proposed.
406-MR	Early Start Co-Payments	Approve as proposed, and approve related trailer bill language.
407-MR	Family Home Agency Oversight	Approve as proposed.
408-MR	Specialized Home Monitors	Approve as proposed.
409-MR	Caseload and Utilization Adjustment	Approve as proposed.
410-MR	Provider Rate Adjustment	Reject sunset date and approve on an ongoing basis.
411-MR	Uniform Holiday Schedule Suspension	Reject sunset date and permanently repeal the Uniform Holiday Schedule.
412-MR	Best Buddies	Approve as proposed.

Issue 10: Regional Center Transparency and Accountability (MR TBL and Senate Proposal)

May Revision. The Administration proposes language that would provide additional measures to enhance regional center and provider oversight.

This issue was heard at the subcommittee's May 15th hearing.

Staff Comment and Recommendation. Adopt placeholder trailer bill language. Additionally, adopt placeholder trailer bill language proposed by the Senate and stakeholders to address other transparency and accountability issues:

- Require the department, through the Developmental Services Task Force, to identify and track key indicators of the Regional Center systems' delivery of services, as well as a plan for reporting of best practices and recommendations for measuring and improving consumer outcomes. The department should provide these indicators, best practices, and recommendations in a report to the Legislature.

- Require each regional center to post specific information on compliance with the federal Home and Community Based Services Final Rule on its website.

- Require the department to annually update the Legislature on specific information on the filing and resolution of complaints and fair hearing requests filed at each regional center.

- Require the department and each regional center to include a link to the Protection and Advocacy Agency and Client Rights Advocate in a standard location on their web sites.

- Require the department to post all new directives issued to regional centers on its website.

- Requires the regional center to provide a list of agreed-upon services and supports to consumer at the conclusion of an individual program plan meeting.

- Requires the regional centers to post specific policies, guidelines, protocols, and assessment tools on their website.

Issue 11: Enhanced Behavioral Supports Homes Sunset Extension (MR TBL)

May Revision. The Administration proposes language that would extend the Enhanced Behavioral Support Home program sunset from Jan. 1, 2020 – to Jan 1. 2021. This will allow for continued development of homes that serve individuals who have challenging behavioral needs.

This issue was heard at the subcommittee's May 15th hearing.

Staff Comment and Recommendation. Approve as proposed.

Issue 12: Vendor Rate Reform (Senate Proposal)

Background. Pursuant to Welfare and Institutions Code (W&IC) Section 4519.8, the DDS was required to submit a rate study addressing the sustainability, quality, and transparency of community-based services for individuals with developmental disabilities to the Legislature. The Legislature approved $3 million General Fund for the study, and DDS contracted with Burns & Associates (B&A), Inc. to conduct the study. The study was submitted to the Legislature on March 15, 2019.

Proposed recommendations from the study were heard at the Subcommittee's May 2nd hearing.

Staff Comment and Recommendation. The subcommittee has heard testimony and feedback from many stakeholders on the proposed rate models. The proposed rate models offer many benefits and would significantly improve the current system, providing a much-needed relief for service providers. However, it seems that further fine-tuning is needed to better understand how the models would be implemented, and to avoid unintended consequences. As a first step of many on the road to rate reform staff recommends the following:

- **Approve placeholder trailer bill language** requiring the department to submit a plan for system-wide rate reform, considering the recommendations of the rate study and impending HCBS final rules, with stakeholder input, by January 10, 2020, with a planned beginning implementation date no later than January 2021.

- **Repeal the half-day billing policy**.

- **Approve placeholder trailer bill language** that would allow vendors in areas where the local minimum wage is higher than the state minimum wage access to rate adjustments associated with state minimum wage increases.

- **Permanently repeal the Uniform Holiday Schedule (see Issue 8).**

- **Restore social recreation and camp services. Adopt placeholder trailer bill language** to implement this change.

- **Approve the May Revision proposal for a provider rate adjustment but eliminate proposed sunset (see Issue 8)**.

Issue 13: Codify DDS Quarterly Briefings (Legislative Proposal)

Legislative Proposal. The Senate proposes to codify in statute the department's quarterly briefings to the Legislature. The briefings should include updates on service provider rate reform, safety net services, and disparities issues.

This issue was heard at the subcommittee's May 2nd hearing.

Staff Comment and Recommendation. Approve placeholder trailer bill language to codify departmental briefings in statute.

5160 DEPARTMENT OF REHABILITATION (DOR)

Issue 1: Supported Employment – Provider Rate Adjustment (May Revision)

May Revision. The Administration requests Item 5160-001-0001 be increased by $1.3 million to reflect a two-year limited-term provider rate increase for supported employment services, effective January 1,

2020. This adjustment aligns Vocational Rehabilitation program provider rates with those of the Department of Developmental Services for this service category.

This issue was heard at the Subcommittee's May 14th hearing.

Staff Comment and Recommendation. Approve, but eliminate proposed sunset to make ongoing.

5160 DEPARTMENT OF REHABILITATION (DOR)
4170 DEPARTMENT OF AGING

Issue 1: Increased Support for the "No Wrong Door" Model (Stakeholder Proposal)

Stakeholder Proposal. The California Association of Area Agencies on Aging and the California Foundation for Independent Living Centers request $5 million ongoing funding to expand the use of the "No Wrong Door" model within the Aging and Disability Resource Centers (ADRCs) throughout the state.

This issue was heard at the Subcommittee's May 9th hearing.

Staff Comment and Recommendation. Approve as proposed.

5175 DEPARTMENT OF CHILD SUPPORT SERVICES

Issue 1: Local Child Support Agencies (LCSA) Administrative Funding Augmentation

Budget Issue. The Governor's proposal includes an increase of $56 million ($19 million General Fund) in 2019-20 for LCSA administration costs based on a new budgeting methodology. The new funding formula for LCSAs will ultimately result in an additional $180.8 million ($61.5 million General Fund) for LCSA operations, which will be phased in over four years.
This issue was heard at the Subcommittee's March 28th hearing.

Staff Comment and Recommendation. Approve. Additionally, adopt placeholder trailer bill language that would clarify that the current components of the proposed funding methodology would only apply in 2019-20 with the expectation that the department, with stakeholder input, would propose updates to the methodology in January 2020 and provide a summary of the discussed programmatic and policy changes and outline potential impacts.

Issue 2: May Revision Estimate

May Revision. The Administration requests that Item 5175-101-0890 be increased by $2.6 million and Item 5175-101-8004 be decreased by $2.6 million to reflect revised forecasts of child support collections.

This issue was heard at the Subcommittee' May 14th hearing.

Staff Comment and Recommendation. Approve as proposed.

5180 DEPARTMENT OF SOCIAL SERVICES

Issue 1: Data Migration for Legacy Systems (GB)

Governor's Proposal. The Administration requests a total of $7.1 million for contract funds and two three-year limited-term positions to support data migration from the information technology systems that serve the Community Care Licensing Division. One position will be placed in the Community Care Licensing Division (CCLD) and the other will be placed in the department's Information Services Division.

This issue was heard at the subcommittee's April 4th hearing.

Staff Comment and Recommendation. Approved as budgeted. In addition, approve placeholder budget bill language requiring the department to report back on actual costs and to adjust funding levels accordingly.

Issue 2: CWS-CARES (MR)

May Revision. The Administration requests that Items 5180-001-0001 and 5180-001-0890 both be increased by $539,000 to provide two-year limited-term resources through fiscal year 2020-21 to support continuing development and implementation of the CWS-CARES project.

Staff Comment and Recommendation. Approve as proposed.

Issue 3: CalSAWS Augmentation (MR)

May Revision. The Administration requests that Provision 8 be added to Item 5180-141-0001 and Provision 1 of Item 5180-141-0890 be amended to authorize an increase in expenditures related to mid-year changes in CalSAWS project schedule and costs.

Staff Comment and Recommendation. Approve as proposed.

Issue 4: May Revision Caseload Adjustments

May Revision. The May Revision proposes a net increase of $266.4 million (increases of $71.6 million General Fund, $354.6 million reimbursements, $189,000 Emergency Food Assistance Program Fund, and $146,000 School Supplies for Homeless Children Fund, partially offset by decreases of $160.2 million Federal Trust Fund, and $2,000 Child Health and Safety Fund) primarily resulting from updated caseload estimates since the Governor's budget.

Staff Comment and Recommendation. Approve as proposed.

Issue 5: Special Olympics (MR)

May Revision. The Administration requests that Item 5180-101-0001 be increased by $2 million to provide one-time funding for the Special Olympics. It is also requested that provisional language be added to Item 5180-101-0001 to allow the DSS to provide the funding to the Special Olympics.

Staff Comment and Recommendation. Approve as proposed.

Issue 6: BBL – Cash Disbursement Authority (MR)

May Revision. The Administration requests that Provision 2 of Item 5180-101-0001 be amended to allow DSS to ensure county cash disbursements are met when federal funds and the Local Revenue Fund are insufficient to cover county expenditures.

Staff Comment and Recommendation. Approve as proposed.

Issue 7: Rapid Response Funding (GB, MR, and TBL)

Governor's Budget. Although not included in the department's budget, the Governor's proposed budget includes a one-time augmentation of $5 million General Fund in 2018-19, and $20 million General Fund in 2019-20, for an Immigration Rapid Response program to be set aside in a reserve until needed.

May Revision. The Administration requests that Item 5180-151-0001 be increased by $7.3 million to provide funding for nonprofits who operate emergency shelters for migrants in San Diego and Riverside counties. A corresponding decrease will be made to the Rapid Response Reserve. The Administration also proposes language that would transfer $12.7 million General Fund to the Rapid Response Reserve Fund. These funds will be available over three years to assist qualified community-based organizations and nonprofit entities in providing services during immigration emergent situations when federal funding is not available.

These issues were heard at the Subcommittee's April 11th, May 9th, and May 14th hearings.

Staff Comment and Recommendation. Approve, but provide an additional $5 million for the Rapid Response Reserve. Additionally, adopt placeholder budget bill language moving the funds from the DOF to the DSS.

Issue 8: Expansion of Immigration-Related Services (MR)

May Revision. The Administration requests that Provision 15 of Item 5180-151-0001 be amended and Provision 19 be added to Item 5180-151-0001 to authorize $5 million of the $10 million General Fund budgeted in 2019-20 for the provision of legal services to unaccompanied undocumented minors and Temporary Protected Status beneficiaries to: (1) provide mental health screenings and evaluations related to legal defense, and (2) develop a family reunification navigator pilot to link undocumented minors with services in the community.

This issue was heard at the Subcommittee's May 14th hearing.

Staff Comment and Recommendation. Approve as proposed.

Issue 9: Administration of Refugee Services (MR TBL)

May Revision. The Administration proposes language to update the existing statute governing the administration of refugee social services and Refugee Cash Assistance to provide the state with the authority to contract directly with a qualified nonprofit organization for services when necessary to ensure effective program delivery.

This issue was heard at the Subcommittee's May 14th hearing.

Staff Comment and Recommendation. Approve as proposed.

Issue 10: Resource Family Approval Administration and Backlog (MR)

May Revision. The Administration requests that Item 5180-151-0001 be increased by $14.4 million and Item 5180-151-0890 be increased by $6.2 million to provide one-time funding to support Resource Family Approval administration workload, including application backlogs.
This issue was heard at the Subcommittee's May 14th hearing.

Staff Comment and Recommendation. Approve as proposed.

Issue 11: Placement Prior to Approval (MR) and Emergency Caregiver Payments (TBL)

May Revision. The Administration requests that Item 5180-101-0001 be increased by $15.1 million and Item 5180-101-0890 be increased by $6.6 million for counties to support up to four months of emergency assistance payments prior to resource family approval in 2019-20.

The Administration also proposes language that would allow, through June 30, 2020, emergency assistance payments prior to resource family approval for up to 120 days, or up to 180 days if the county provides "good cause."

This issue was heard at the Subcommittee's May 14th hearing.

Staff Comment and Recommendation. Approve placeholder trailer bill language to allow emergency assistance payments prior to resource family approval for up to 120 days, or up to 365 days if the county provides "good cause" through June 30, 2020.

Issue 12: Foster Parent Recruitment, Retention, and Support (MR)

May Revision. The Administration requests that Item 5180-151-0001 be increased by $10.8 million, Item 5180-151-0890 be increased by $5.1 million, and Item 5180-153-0001 be increased by $10.9 million to provide one-time funding to counties for recruitment, retention, and support of foster parents.

This issue was heard at the Subcommittee's May 14th hearing.

Staff Comment and Recommendation. Approve as proposed.

Issue 13: Dependency Counsel Title IV-E Funding (MR)

May Revision. The Administration requests that Item 5180-151-0890 be increased by $34 million to provide the Judicial Branch with federal Title IV-E reimbursements for legal support provided to certain children and parents who are involved with the child welfare system.

This issue was heard at the Subcommittee's May 14th hearing.

Staff Comment and Recommendation. Approve as proposed.

Issue 14: Continuum of Care Reform Contracts (MR TBL)

May Revision. The Administration proposes language that would exempt DSS from specified contract laws, rules, and review processes until July 1, 2021 for training or technical assistance grants and contracts related to the implementation or evaluation of the Continuum of Care Reform (CCR) initiative.

This issue was heard at the Subcommittee's May 14th hearing.

Staff Comment and Recommendation. Approve as proposed.

Issue 15: Bringing Families Home (MR and Stakeholder Proposal)

May Revision. The Administration requests that Item 5180-492 be amended to allow the re-appropriation of unexpended funds appropriated in the 2017 Budget Act for the Bringing Families Home Program.

Stakeholder Proposal. CWDA, the California Association of Counties (CSAC), the Corporation for Supportive Housing, and Housing California requests additional funding to continue and expand the existing Bringing Families Home program.

These issues were heard at the Subcommittee's April 4th and May 14th hearings.

Staff Comment and Recommendation. Modify - Approve May Revision and additionally, approve $10 million one-time for the program.

Issue 16: Kin-GAP Beginning Date of Aid (MR TBL)

May Revision. The Administration proposes language that would change the beginning date of aid for Kin-GAP payments. The language clarifies that foster care payments cease immediately upon discontinuance of dependency and that Kin-GAP assistance payments may begin the following day.

This issue was heard at the Subcommittee's May 14th hearing.

Staff Comment and Recommendation. Approve as proposed.

Issue 17: Housing and Disability Advocacy Program (MR TBL)

May Revision. The Administration proposes language that would include recognized tribes to the list of eligible recipients, clarify that funding for the HDAP can be used for either SSI advocacy or housing supports for potentially SSI-eligible individuals, and adds flexibility to the requirement that HDAP clients must be housed in units sustainable upon approval of disability benefits.

This issue was heard at the Subcommittee's May 14th hearing.

Staff Comment and Recommendation. Approve as proposed.

Issue 18: Expanding CalFresh to Recipients of SSI Clean-up (MR TBL)

May Revision. The Administration proposes "clean-up" language to ensure the reversal of the "SSI Cash-out" is not subject to appropriation and to align the CAPI monthly benefit amount with the SSI/SSP grant amounts.

This issue was heard at the Subcommittee's May 14th hearing.

Staff Comment and Recommendation. Approve as proposed.

Issue 19: County Administration Funding for the Expanded CalFresh Population (MR)

May Revision. The Administration requests that Item 5180-141-0001 be increased by $15 million and Item 5180-141-0890 be increased by $21,428,000 to support county administrative efforts to process new CalFresh applicants as a result of eliminating the SSI Cash-Out policy. It is also requested that Provision 9 be added to Item 5180-141-0001 to allow the Department of Social Services to provide the additional General Fund to counties upon approval by the Department of Finance.

This issue was heard at the Subcommittee's May 14th hearing.

Staff Comment and Recommendation. Approve as proposed.

Issue 20: County Work Number Contract (MR)

May Revision. The Administration requests that Item 5180-101-0890 be increased by $1,916,000, Item 5180-141-0001 be increased by $2,235,000, and Item 5180-141-0890 be increased by $2,235,000 to reflect counties' increased usage of the Work Number Express Service for income and employment verification in the CalWORKs and CalFresh programs.

This issue was heard at the Subcommittee's May 14th hearing.

Staff Comment and Recommendation. Approve as proposed.

Issue 21: CalWORKs Grant Increases (GB)

Governor's Proposal. The Governor's budget includes $348 million General Fund in 2019-20 for a 13.1 percent across-the-board increase to CalWORKs grants. Full year costs are expected to be $455 million General Fund. The proposed grant increase would go into effect October 1, 2019.

This issue was heard at the Subcommittee's April 11th hearing.

Staff Comment and Recommendation. Modify – Within the funding amount proposed by the Governor ($348 million), adopt modified grant increase to raise grants to 50 percent of the Federal Poverty Level for assistance units (AUs) of one, and 48 percent for all other AUs, toward the goal of ending deep poverty for all AUs +1, per the 2018 budget agreement. Adopt placeholder TBL to implement this change.

Issue 22: Home Visiting Program (GB and MR)

Governor's Proposal. The Governor's budget includes $861,000 General Fund for six positions to ensure the timely and appropriate implementation of the CalWORKs Home Visiting program. Additionally, the Governor's budget proposes ongoing funding for the program.

May Revision. The Administration requests that Item 5180-101-0001 be decreased by $3,289,000 and Item 5180-101-0890 be increased by $13,969,000 to reflect revised projections of CalWORKs cases eligible for Home Visiting Services.

This issue was heard at the Subcommittee's April 11th and May 15th hearings.

Staff Comment and Recommendation. Approve Governor's January and May Revision proposals. Additionally, adopt no-cost placeholder TBL to expand program to all eligible children aged 0-2.

Issue 23: CalWORKs Stage One 12-month Eligibility (MR)

May Revision. The Administration requests that Item 5180-101-0001 be increased by $40,663,000 to establish a 12-month eligibility period for CalWORKs Stage One Child Care services, effective October 1, 2019. This proposal requires trailer bill language.

This issue was heard at the Subcommittee's May 15th hearing.

Staff Comment and Recommendation. Make the following changes to the MR proposal:

- Provide an $25 million in ongoing funding for this proposal (in addition to the funding provided in May Revision
- Provide stability and flexibility of care for CalWORKs families by authorizing full-time continuous child care in Stage 1 until families are transferred to Stage 2 or for 12 months in counties where stability is achieved after 12 months.

- Specify additional program activities for which child care is available to parents and times during which parents should be offered care in order to participate in certain activities.

- Funds a data sharing system between county welfare departments and child care contractors to ensure that child care is not disrupted during transfer

Issue 24: Cal-Learn Case Management Standards Change (MR)

May Revision. The Administration requests that Item 5180-101-0001 be increased by $230,000 and Item 5180-101-0890 be increased by $5,777,000 to reflect adherence to new case management standards in the CalWORKs Cal-Learn program.

This issue was heard at the Subcommittee's May 15th hearing.

Staff Comment and Recommendation. Approve as proposed.

Issue 25: Decreased TANF Funding for Cal Grants (MR)

May Revision. The Administration requests that Item 5180-101-0890 be decreased by $5.9 million to reflect a decrease in the amount of federal TANF block grant funds available to offset General Fund costs in the Cal Grant program.

This issue was heard at the Subcommittee's May 15th hearing.

Staff Comment and Recommendation. Approve as proposed.

Issue 26: CalWORKs Housing Support Program Re-appropriation (MR)

May Revision. The Administration requests that Item 5180-493 be amended for the purpose of re-appropriating the unexpended balances from funds appropriated in the 2018 Budget Act for the CalWORKs Housing Support Program.

This issue was heard at the Subcommittee's May 15th hearing.

Staff Comment and Recommendation. Approve as proposed.

Issue 27: TBL – SB 726 Terminology Change and Delayed Implementation (MR TBL)

May Revision. The Administration proposes trailer bill language to make a terminology change to the EBT expungement process changes as a result of Senate Bill 726 (Wiener), Chapter 930, Statutes of 2018.

This issue was heard at the Subcommittee's May 15th hearing.

Staff Comment and Recommendation. Approve as proposed.

Issue 28: IHSS MOE (GB, MR, and TBL)

Governor's Budget. In January, the Governor's budget proposed several changes to the IHSS county MOE, including the adjustment of the county MOE to $1.56 billion. The Governor's budget also included trailer bill language that would (1) apply an annual inflation factor of four percent to the MOE, beginning in 2020-21, (2) eliminate the General Fund mitigation and end redirection of health and mental Vehicle License Fee revenue, and (3) apply the MOE to fund only IHSS services.

May Revision. The May Revision requests that Item 5180-111-0001 be increased by $55,098,000 related to the re-benching of the County IHSS maintenance-of-effort to reflect revised 1991 Realignment revenue projections and revised IHSS caseload and cost estimates.

These issues were heard at the subcommittee's March 28th and May 15th hearings.

Staff Comment and Recommendation. Approve May Revision adjustments to the IHSS MOE. Additionally, adopt placeholder trailer bill language to reduce a county's IHSS MOE annual inflation factor to 4% only when a collective bargaining agreement is in place in which the negotiated wage for IHSS providers is at least above the state minimum wage.

Issue 29: Eliminate Fingerprint Licensing Fee Exemption (GB TBL)

Governor's Budget. The Governor's budget included trailer bill language that would eliminate a prohibition on charging a fee for fingerprinting or obtaining a criminal record for a license applicant who will provide services to six or fewer children. The language would allow both DSS and the Department of Justice to charge a fee for fingerprinting an applicant for a license or for obtaining a criminal record of an applicant.

Staff Comment and Recommendation. Approve as proposed.

Issue 30: Rapid Response Reserve (Governor's Budget, MR, and TBL)

Governor's Budget. Governor's proposed budget includes a one-time augmentation of $5 million General Fund in 2018-19, and $20 million General Fund in 2019-20, for an Immigration Rapid Response program to be set aside in a reserve until needed.

May Revision. The Administration requests that Item 5180-151-0001 be increased by $7.3 million to provide funding for nonprofits who operate emergency shelters for migrants in San Diego and Riverside counties. A corresponding decrease will be made to the Rapid Response Reserve. The Administration proposes language that would transfer $12.7 million General Fund to the Rapid Response Reserve Fund. These funds will be available over three years to assist qualified community-based organizations and nonprofit entities in providing services during immigration emergent situations when federal funding is not available.

These issues were heard at the subcommittee's March 11th and May 14th hearings.

Staff Comment and Recommendation. Approve as budgeted and proposed. Additionally, approve an additional $5 million for the fund and placeholder budget bill language that would shift the funding from the Department of Finance to DSS.

Issue 31: Codify EVV Protections (Stakeholder Proposal)

Budget Issue. The IHSS Coalition requests the Legislature codify protections that were made in the 2018 Budget Act to protect IHSS providers and consumers.

This issue was heard at the subcommittee's March 14th hearing.

Staff Comment and Recommendation. Adopt placeholder trailer bill language to codify EVV protections included in the 2018 budget.

Issue 32: Family Urgent Response System (Stakeholder Proposal)

Budget Issue. CWDA, Children NOW, SEIU California, and the County Behavioral Health Directors Association (CBHDA) request $15 million in 2019-20 and $30 million ongoing to support foster youth and caregivers. FURS provides foster youth and their caregivers with immediate trauma-informed support when issues arise, and link youth and families to community-based supports and services. The requested funds would help to establish and maintain a statewide hotline availble 24/7 for caregivers and youth who experience emotional, behavioral, or other difficulties in need of immediate help. It would also allow counties to establish mobile response teams to provide in-home response on a 24/7 basis to stabilize the situation, assess needs, and develop an action plan.

This issue was heard at the Subcommittee's April 4th hearing.

Staff Comment and Recommendation. Approve as requested and adopt placeholder trailer bill language to implement.

Issue 33: Earned Income Disregard (Stakeholder Proposal)

Budget Issue. The California Welfare Director's Association (CWDA) requests the 2019-20 budget strengthen the EID. The EID is the amount subtracted from a CalWORKs recipient's income to determine initial eligibility for assistance and monthly grant amounts. By allowing a certain amount of income to be excluded, the EID is intended to facilitate and encourage paid employment. However, the EID has not been changed since it was first established in 1997.

This issue was heard at the Subcommittee's April 11th hearing.

Staff Comment and Recommendation. Adopt placeholder trailer bill language that would change the current EID to $500 and 50 percent of income with a June 1, 2020, effective date and allowing subsequent adjustments in future fiscal years.

Issue 34: APS and Public Guardian Training (Stakeholder Proposal)

Budget Issue. The California Welfare Directors Association (CWDA), the California State Association of Public Administrators/Guardians/Conservators, the California Commission on Aging, and the California Elder Justice Coalition request $5.75 million General Fund over three years to provide additional resources for APS social worker training.

This issue was heard at the Subcommittee's March 14th hearing.

Staff Comment and Recommendation. Approve as requested.

Issue 35: Addressing Impact of State Minimum Wage on Foster Family Agencies (Stakeholder Proposal)

Stakeholder Proposal. NASW, the California Alliance, The California Alliance of Caregivers, John Burton Advocates for Youth, the California Coalition for Youth, the Inland Empire Alliance, the Orange County Alliance for Children and Families, and the Association of Community Human Services Agencies request funding to address the impact of the state minimum wage increases on the salaries of social workers employed by Foster Family Agencies.

This issue was heard at the Subcommittee's April 4th hearing.

Staff Comment and Recommendation. Approve one-time CNI-based COLA for the Foster Family Agency rate for operational activities.

Issue 36: Codification of CCR Quarterly Updates (Senate Proposal)

Senate Proposal. The Senate proposes to codify quarterly in-person updates to the Legislature on the progress toward the implementation of CCR, and specific components of those updates. Proposed components include, but are not limited to:

- Updates on the transition of providers to the CCR service model.
- Updates on capacity to provide mental health services.
- Tracking child outcomes over time
- Updates on CCR-related costs and savings.

This issue was heard at the Subcommittee's April 4th hearing.

Staff Comment and Recommendation. Adopt placeholder trailer bill language including the components described above.

Issue 37: Permanent Restoration of 7% Cut in IHSS Service Hours (Stakeholder Proposal)

Stakeholder Proposal. The IHSS Coalition requests the Legislature include trailer bill language to rescind Welfare and Institutions Code Sections 12301.01 through 12301.05 to permanently restore the

seven percent across-the-board IHSS service hours. The Governor's budget proposes to restore the seven percent services hours, but this restoration could be rescinded in future years. Making this restoration permanent would equate to a $342 million ongoing allocation.

This issue was heard at the Subcommittee's March 14th hearing.

Staff Comment and Recommendation. Adopt placeholder trailer bill language to remove statutory references to IHSS service hours reductions and **reject the sunset proposed in the May Revision** on the restoration.

Issue 38: Obsolete Reports (GB TBL)

Governor's Proposal. The Governor's budget proposed to remove the language from statute related to obsolete reports.

Staff Comment and Recommendation. Adopt placeholder trailer bill language to remove statutory references to the following reports, as they refer to programs that no longer exist, were never implemented, or were replaced by other updated reporting requirements:

- Automated Child Abuse Reports - Requires the DSS to submit a report to the counties and the Legislature that reflects data indicating the reasons as to why an automated one-time report was filed in lieu of an initial telephone report.

- Cost of Doing Business (CODB) - DSS, in consultation with CWDA, is required to develop a CODB survey to capture the costs for county administration to determine whether those costs are reasonable and necessary to meet program requirements and objectives.

- Reasons for the determination of non-cost-effectiveness and the changes necessary to make elements of the Consolidated Public Assistance Eligibility Determination (CPAED) Demonstration Project cost effective.

- SAWS Annual Report (report on progress in implementing the system, including recommendations for further legislative action, and any revisions in the long-range plan that will affect the objectives to be accomplished in the following year).

- Evaluations submitted by pilot counties regarding the Aid to Families with Dependent Children and CalFresh programs eligibility reporting systems.

- Foster Care Placements with AFDC recipients - (Report on the outcome measures of quality of care for foster youth placed with relatives receiving cash assistance.)

- Programmatic transition plan to enroll into a pilot project persons who are dually eligible under both Medi-Cal & Medicare programs.

- Resource Family Approval Pilot Report - (Report on the results of a pilot to establish a unified, family-friendly, and child-centered family approval process.)

- Report on Progress of Demonstration Projects for CalWORKs - Requires the DSS director to report annually on the progress of the demonstration projects.

- Non-assistance CalFresh Simplified and Shorter Application Form - Requires DSS to develop and implement a simplified and shorter application form for non-assistance CalFresh cases.

- San Bernardino Pilot Project - (Report on the effectiveness of the pilot in reducing group home complaints.)

- Initial data report on implementation of Section 11274 of the Welfare and Institutions Code regarding restricted payment provisions under Aid to Families with Dependent Children (AFDC) program.

Issue 39: CalFood Storage and Transportation Rate (Stakeholder Proposal)

Stakeholder Proposal. The California Association of Food Banks (CAFB) an increase in the storage and transportation rate to 15 percent.

This issue was heard at the Subcommittee's April 11th hearing.

Staff Comment and Recommendation. Approve as proposed.

Issue 40: Safety Net Reserve (GB TBL)

Governor's Proposal. The Governor's budget proposes a deposit of $700 million into the Safety Net Reserve, bringing the total funds to $900 million. The proposal also seeks to eliminate the CalWORKs and Medi-Cal subaccounts and the requirement to establish a caseload savings and cost per case contribution methodology.

This issue was heard at the Subcommittee's April 11th hearing.

Staff Comment and Recommendation. Approve as proposed.

Issue 41: SSP Grants

Senate Proposal. The Senate proposes to provide a Cost of Living Adjustment (COLA) to the state portion of the Supplemental Security Income/State Supplementary Payment (SSI/SSP) grant on a one-time basis, starting January 1, 2020.

Staff Comment and Recommendation. Approve the proposal to provide a COLA to the state portion of the Supplemental Security Income/State Supplementary Payment (SSI/SSP) grant on a one-time basis, beginning January 1, 2020. The half-year impact of this change has been estimated at approximately $60 million.

Issue 42: Group Home Extension TBL

Proposal. CWDA requests trailer bill language to provide for a one-year extension of the existing statutory requirement for all group home providers to convert to Short Term Residential Treatment Program licensure.

Staff Comment and Recommendation. Approve placeholder trailer bill language.